Long Term Care Covid-19 Commission Mtg.

Second Meeting with LTC Commission and Dr. Jennie Johnstone
on Thursday, January 28, 2021

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LONG TERM CARE

COVID-19 COMMISSION

PRESENTATION BY

JENNIE JOHNSTONE, MD, PhD, FRCPC

--- This is the transcript of a virtual Zoom meeting, taken by Neesons, a Veritext Company, on the 28th day of January, 2021, commencing at 2:00 P.M.

[All participants appearing virtually.]

REPORTED BY: Helen Martineau, CSR

C O M M I S S I O N E R S:

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

P R E S E N T E R S:

Jennie Johnstone	MD, PhD, FRCPC; Infection Prevention and Control Medical Director, Sinai Health; Infectious Diseases Physician, Sinai Health and University Health Network; Associate Professor, Department of Laboratory Medicine and Pathobiology, University of Toronto; Associate Professor, Dalla Lana School of Public Health, University of Toronto.

P R E S E N T E R S:	(continued)
Dr. Dylan Kain	ID physician, Currently doing a COVID-19 pandemic fellowship, (Sinai Health).
P A R T I C I P A N T S:	
Alison Drummond	Assistant Deputy Minister Long-Term Care Commission Secretariat
Jessica Franklin	Policy Lead Long-Term Care Commission Secretariat
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	Co-Lead Commission Counsel Gowling WLG
Patricia Brooks	Counsel, Gowling WLG

--- Upon commencing at 2:00 p.m.

JENNIE JOHNSTONE: So again thank you for having me back. I do have just a few slides on testing. I do know that there was a session on testing by Matt Anderson, Vanessa Allen, Frederick Escarf [ph] and Dirk Huyer.

I think the perspective I may share is just from an independent individual who was part of the testing strategy, and I'm really here to answer any questions that you may have that are outstanding. But, again, I just put a few slides together to help guide the conversation but truly I'm happy to answer anything that I am able to share, based on my knowledge, I mean.

So in terms of the expert testing strategy panel, we were conceived as a result of the backlog, the testing backlog that I'm sure you've heard about in March. As soon as they came out of that backlog and were starting to build additional testing capacity, it became clear that there was need for some guidance as to how you prioritize, as you build your capacity who's next, so to speak.

So on April the 5th we formed. Initially, again, we were -- I would say we

were -- it was a bit unclear who we reported to at the beginning, but we just put forward recommendations to the Office of the Chief Medical Officer of Health.

That did formalize, as you'll see a little bit more -- and I can't remember exactly when, in late May, early June where it became more of a formalized process. But again, we were just sending our recommendations forward and we are one source of input. So again, we were providing expert opinion or evidence-informed opinions, if there was any evidence, forward to the Ministry or to the Office of the Chief Medical Officer of Health who would then overlay whatever policy decisions. So we, of course, did not set policy but we did provide guidance.

So --

LEAD COMMISSIONER MARROCCO: Did I understand you to say, Doctor, that there were other people providing testing advice or expertise?

JENNIE JOHNSTONE: I don't know that there's other people providing expertise. I guess my only point is that expertise is only

one input into policy.

LEAD COMMISSIONER MARROCCO: I see.

JENNIE JOHNSTONE: So there might be additional -- you know, with any policy decision there are the scientific inputs as well as politics, logistics, whatever other --

LEAD COMMISSIONER MARROCCO: I understand.

JENNIE JOHNSTONE: -- inputs into the policy. So we just provided the science. We tried not to weigh into pragmatics. We just tried to stick to the science.

So I think it was late May, early June that we did formalize our structure such that we became a sub-committee of Public Health Ontario, because Public Health Ontario is the official body that provides scientific advice to the government. So we became a sub-committee of PHO.

So the way we make our recommendations is we put forward our recommendations to Public Health Ontario who very quickly, usually same day, would then provide those recommendations onward to the Office of the Chief Medical Officer of Health. And we do involve -- we

generally do copy both Frederick Escarf, who again I know you heard from, at the Ministry as well as Matt Anderson from Ontario Health because I guess there's multiple players that we find it helpful to make sure that everyone is aware of recommendations coming forward.

The membership is, I would say -- I would describe this as a very pragmatic panel. So this is comprised of experts from the field.

And so these are people who are on the ground, whether it be geriatricians, myself infectious disease, infection control, so people who are working in microbiology, so the microbiologists. We also have an ethicist on the panel, epidemiologist and analytics.

And so our hope was that we could again provide very practical and timely recommendations, recognizing that we are in a world where we didn't necessarily have science.

We tried to use science to the extent that we could. But, again, many, many times we had to make decisions in the absence of any guiding science. And we always -- we always revisited our recommendations and updated them as science became clearer. But, again, when we

were making decisions, many times there was -- there was only our pragmatics to guide us.

So the initial mandate, as mentioned, was to provide these recommendations to update the testing guidance mainly around a cascading sort of who is next as to who should get tested.

And then as the capacity increased and we were able to test, you know, most people who required testing from symptomatic individuals, then it sort of expanded into what other workplace testing recommendations, travel -- as we had more capacity, we could then shape it.

And then now --

LEAD COMMISSIONER MARROCCO: Doctor, where did the capacity come from? From the private labs?

JENNIE JOHNSTONE: Not necessarily. So this is where -- so I was not involved in building that capacity necessarily. I am aware, but in terms of the network of labs primarily it came from hospitals and so to a lesser degree private labs.

So it was -- so currently the network of labs includes Public Health Ontario labs as well as a number of large labs, and I feel I can

speak to that because one of the largest labs is at Sinai. And then there are some private labs leveraged as well.

This is a slide that -- I think this slide came from the Auditor General's report. And I just wanted to point out that it's not entirely accurate. This was from August, and this puts us as a sub-committee, as a technical advisory table that reports up to the Health command table, but technically it's actually, if you go to the next slide, we are -- the governance is through Public Health Ontario.

And again we report our recommendations to Public Health Ontario, and then that goes directly to the Chief Medical Officer of Health. So this reflects the reality. I know that the Auditor General and I think some other slide decks -- and I think John, you even had a slide which again isn't -- what you see here is actually more accurate and reflective of our guidance.

JOHN CALLAGHAN: Do you actually meet with the Chief Medical Officer of Health or was it all through Public Health Ontario?

JENNIE JOHNSTONE: No, we don't meet

with him formally in this capacity, but we do have -- we have individuals from his office on our committee.

JOHN CALLAGHAN: And I'm going to take you through one of the decisions, but was it ever relayed to you what happened to your advice?

JENNIE JOHNSTONE: Oh no. So I would say that -- so from my perspective, our recommendations go forward to the Office of the Chief Medical Officer of Health. And I would say -- I didn't do a line-by-line, but I would say about 95 percent of our recommendations to this office came through in the official testing guidance that's issued. So there's the Chief Medical Officer of Health testing, testing guidance that comes out every once in a while. And I would say those very clearly mirror our recommendations.

So that line from our recommendations forward there is very clear. And I would say that, you know, there may be some tweaks here along the way, but as a general statement that was a very clear pathway that I think was quite transparent.

And if something was slightly altered, it was very minor and you know not of any consequence.

So that pathway was very straightforward.

JOHN CALLAGHAN: I'm assuming that wasn't the only pathway.

JENNIE JOHNSTONE: Well, we'll get into that.

JOHN CALLAGHAN: Okay.

JENNIE JOHNSTONE: I think that in terms of testing, testing has been a very political aspect of this pandemic. I think, you know, when I was chairing the panel starting April 5th, it was the number one thing in the media every day, talking about testing, testing, testing. That was at the same time that the WHO was talking about test, test, test, test. And it was building the capacity and trying to keep up with the demand.

And then it did become, in my opinion anyway, it appeared to be a very central, important policy statement of the Premier's Office in that anyone who wants a test could get a test, which came about in May.

And so those types of decisions, I'm not sure where those decisions were made. And then since then as well, every ministry does issue their own testing. So whether that's the Ministry of Colleges and Universities issues testing, the Ministry of Seniors Issues testing guidance, the Ministry of Long-Term Care issues guidance. There's many ministries, pretty much any ministry you can think of issues testing guidance, which isn't necessarily collated all in one place.

And I would say our relationship with other ministries is not linear or clear. So how those decisions are made, I have no idea.

But in terms of the Office of the Chief Medical Officer of Health, as a general statement it's -- I think that's -- I do believe that Office accepted most of our recommendations.

Next slide. I share this just to make sure that it's clear. So I do know that you spoke with Dr. Vanessa Allen again when she was here at I think the more formal testing testimony, myself as chair, and then again I just share this with mostly to reflect it is

reflective of people across the province. It includes public health. And I want to mention specifically Lianne Catton is from the north, so I do feel like we had good geographic representation across the province with representation across all sorts of different aspects of -- that may get impacted by testing.

And you can see, so Elizabeth Walker and Daniel Warshafsky are from the Office of the Chief Medical Officer of Health.

And I share this not because I want you to read it, the next slide. It was just to share the cadence of our recommendations. In terms of April, so, again, we met for the first time on April 5th at the very top, and by April 7th is when we issued our first recommendations. And then from there it was April 7th -- it was a very, very busy month because as we were building the capacity we were trying to change the recommendations and improve our recommendations as quickly as possible.

And then -- and then I think it was from about May 20th -- or May 23rd actually were our most formal -- that was the most comprehensive recommendations. That was kind of

the end of that beginning. And then from there we became more responsive to whatever queries and questions came across our way, so essentially we were able to, you know, respond to whatever questions.

You know, what do you think of school testing? What do you think of workplace testing? et cetera, et cetera.

LEAD COMMISSIONER MARROCCO: Can you help with what problems, if any, were identified in relation to long-term care homes?

JENNIE JOHNSTONE: Back in April?

LEAD COMMISSIONER MARROCCO: Yeah, well I noticed that on April 7th I think that was -- I mean it was -- I had a quick glance at it and I'm just curious. I'm not so much concerned -- I'm just curious about the issues.

JENNIE JOHNSTONE: Yeah, I would share. So absolutely, so I think it was -- I would say the first week or two of our meetings were almost entirely consumed by discussion about long-term care because we recognized that that was one of the most important groups to make sure we were highlighting.

So within -- sort of within March I

would say that it was very clear that healthcare workers in the hospital had good access to testing, and many of us had assessment centres on site. So those were built right around that time.

So in terms of access to testing for those of us in the hospitals, our healthcare workers were getting timely testing.

But I do know that before our recommendations, anecdotally anyway, it wasn't clear necessarily that long-term care healthcare workers were getting the same testing.

And I had heard that there were even some that were being turned away. So one of the first priorities we wanted to make sure that it was clear that long-term care healthcare workers were in that category of essential, you know, people who required testing. Because remember going back there it was a very, very narrow group of individuals that could access testing.

So essentially if you've getting hospitalized or if you are a healthcare worker, but again, I don't know -- and certainly when we went sort of by front-line experience, there were many staff that maybe didn't get tested

when they should have. And whether it was because they got turned away or didn't know they were supposed to.

So certainly, I can speak at Sinai very early on we said you need to have a low threshold of test to get tested, and we just hammered that home. So every staff person knew that you needed to get tested even if you felt slightly unwell.

I would say that that wasn't -- we needed to make sure -- with the testing strategy, we wanted to make sure that same approach was adopted for the workers in long-term care.

The other piece of it was about the resident testing. So again, we had many conversations at the table about the fact that -- and we talked about this last time, the culture of testing the residents was not the same as how we approach it in the hospital, meaning that historically in prepandemic time you only sort of get your one, two test even if you had an outbreak and you stop there whereas in the hospital setting we always test people routinely at the onset of symptoms. We didn't

stop after a certain point.

And again, knowing that, number one, there was also a lack of access to testing -- tests and pee swabs in the long-term care homes and those pathways of how you get a swab from a long-term care home to the lab. Now, that was beyond our scope, because we were making recommendations. But we were trying to make -- put forward recommendations to make sure that it was clear that every symptomatic resident needed to get tested.

And then from there, one of the, I'd say, errors we made, perhaps, is that we wanted to make sure there was a lot of flexibility for how you would then manage on outbreak for the public health physicians who were involved in the outbreaks.

So we left it open to say, you know, you can always do a point prevalence of the whole home. You can do a point prevalence of the unit. Whatever you want to do. And when I say point prevalence I mean testing of everyone in that area. We didn't want to paint anyone into a corner. So we left it to say, everything is at the discretion of the public health team

beyond testing of symptomatic residents and their roommates.

LEAD COMMISSIONER MARROCCO: What about -- go ahead.

JENNIE JOHNSTONE: I was just going to say, one of the things I learned and the feedback that we got was that that led to a lot of nonstandardization and lack of clarity within the system as to what to do.

So what we heard was that Public Health units wanted to it to be very explicit. So coming from a hospital perspective, as an infection control physician in a hospital, our perspective is we want flexibility to be able to manage an outbreak in the way that we think is best whereas I think what we heard from the Public Health perspective, because there was variability from the Public Health units, is they wanted it to be very clear.

So by May 23rd, you'll see there's a -- if you read through the recommendations, they kind of go from more flexible to less flexible and very, very black and white in terms of the recommendations about if you have a case test the whole building.

LEAD COMMISSIONER MARROCCO: When you're making recommendations in part about testing long-term care residents and staff, correct?

JENNIE JOHNSTONE: That's one of the pieces, yeah.

LEAD COMMISSIONER MARROCCO: One of the many pieces you're giving advice about.

JENNIE JOHNSTONE: Yes, correct.

LEAD COMMISSIONER MARROCCO: And when do you start giving advice about testing long-term care residents and staff?

JENNIE JOHNSTONE: When did we first start giving?

LEAD COMMISSIONER MARROCCO: Yes.

JENNIE JOHNSTONE: I think that was one of our first recommendations.

LEAD COMMISSIONER MARROCCO: And between the time that you make the recommendation and a decision, how much time goes by?

JENNIE JOHNSTONE: That's variable. So, for example, in the early days -- and I don't have overlaid here when the testing guidance came out -- but I'd say from the very

first set of recommendations we put forward, gosh, I would have expected -- it would have been within the week that there was guidance that was issued.

And so I would say in the early days, meaning April and May, there were recommendations that came out from the Office fairly regularly.

I didn't go back and look, but I don't know the last time the testing guidance was updated and I feel like it was probably September or October now. So I mean, they haven't been updated for a while because the recommendations we're making aren't recommendations that would change that sort of testing guidance. I would say from May 23rd the Chief Medical Officer of Health recommendations haven't changed a whole lot.

So that's not the nature of the questions we're being asked at this point. I don't know if I've answered your question.

LEAD COMMISSIONER MARROCCO: Not exactly. So your recommendations commence around the end of May -- the end of March?

THE WITNESS: No, our panel started

April 5th and we put forward our first recommendations April 7th.

LEAD COMMISSIONER MARROCCO: So between the declaration of the state of emergency, or the WHO's declaration that there is a pandemic, and April 7th, there's no recommendation from -- concerning testing of long-term care residents and staff? Have I got that right?

JENNIE JOHNSTONE: There was no recommendation from our panel.

LEAD COMMISSIONER MARROCCO: Correct.

JENNIE JOHNSTONE: I would have to go back to find out what the recommendations were. I don't know for sure.

They may have relied on the existing respiratory viral testing guidance that exists prepandemic, which is how you approach testing for respiratory viruses. I think actually that's what it was. I think. I couldn't -- I don't want to swear to that, but I believe that is what we were using, which was, we use it for any -- throughout every respiratory viral season. So I think we may have been using --

LEAD COMMISSIONER MARROCCO: If that's

the case then, did you ever come to understand why there was some confusion about whether long-term care staff should be tested in a manner consistent with hospital staff being tested? Or whether there was -- why there was some confusion about, if there was conclusion, about testing the long-term care residents?

JENNIE JOHNSTONE: So that is an excellent question, and I must admit I only moved forward. I didn't look backwards. So I never reflected on what existed before us. We just started it to say, this is where we're at and we're moving forward.

Because remembering that part of the recommendations were a bit moot because of the backlog that existed. So whether or not they were getting tested or not was almost irrelevant because the -- there was such a significant backlog that there was no timely testing at all.

LEAD COMMISSIONER MARROCCO: So even if they had testing --

JENNIE JOHNSTONE: When we were given our mandate --

LEAD COMMISSIONER MARROCCO: To repeat the question. The problem is there is testing

backlog, so even if you give advice that urges rigorous testing of long-term care staff in residents, it isn't going to be effective because you can't get the results back in a timely fashion.

JENNIE JOHNSTONE: That is correct. Which was the state of affairs in March, late March.

LEAD COMMISSIONER MARROCCO: In late March.

JENNIE JOHNSTONE: That's right. So it didn't occur to me on April 5th to think about what had been happening. I think we all knew, or at least on the panel were quite comfortable knowing what our recommendations should be.

I must admit I don't think we thought about what they may have been. We just sort of started from scratch.

LEAD COMMISSIONER MARROCCO: Thank you. Go ahead.

JENNIE JOHNSTONE: So anyway, I think the point of this slide was mostly just to show, you know, sort of in April it was very, very busy and then it sort of slowed down through the

summer, and then through the fall we were -- we stayed busy but it's more, again, more specific, more specific questions that may be relevant for a specific sector. For example, in September we necessarily had a lot of conversations about schools, which you can imagine.

More recently we're having a conversation about the role of testing post vaccination, for example. So these are -- just as things become relevant we have -- we put forward recommendations about that.

JOHN CALLAGHAN: Let me ask, we've heard several hospitals who went into long-term care, and consistent with Dillon's slide from March, but we heard continual delays in getting results. I mean, I think in December I believe one hospital talked about a five-day delay in a long-term care getting the results and had they had them in a day they could have contained things.

Is that continuing, that kind of delay with backlog? or is that something your committee looks at?

JENNIE JOHNSTONE: So our committee doesn't look at that so much. What we look at

is more what is the -- so we don't -- I mean, we're aware of their testing turnaround times. Our recommendations are to have fast and timely turnaround times, but we don't work on the operational aspect of what those delays may be.

We certainly flag that if there are lags that that is a problem. And as it relates to long-term care, perhaps I can just share as on the ground it has proven to be a challenge.

I know Public Health Ontario, which historically did all of the testing for long-term care for respiratory viruses prepandemic, they did implement -- so most care homes are still sending their swabs to Public Health Ontario.

They did work on implementing what they call "a green sheet process" whereby swabs with this green sheet would be expedited. On the ground though, there was a continued frustration with slow turnaround times.

And so I think I spoke to the IPAC hub-and-spoke model that exists and I think quite robustly in the Toronto region, and I think many of us, in the Toronto region anyway, are associated with hospital labs.

And so I think all of us, I think, have redirected long-term care home swabs to our own hospital labs because it -- because it's not just the challenge of the turnaround time, it's also the challenge in accessing the results.

So they may be done, but if they went to a variety of different labs you're trying to tracking it down from a variety of different places and you don't even know where those swab results went, or maybe you're still trying to tracking down the last two or three or whatever.

So from our perspective it was much easier to have them flow through the Sinai lab, and then that way we can get the results directly. And there's no gap in time between when they're processed or very little gap in time from when they're processed to when we are getting the result. And then if we need to track down results, we know exactly where to look and who to talk to, because we have those relationships, or if there's a problem with the result.

So I think, again, within -- at least for us anyhow, it became much easier just to relay them through an existing structure that we

ourselves were using.

And we don't have the same problems with turnaround times since we've gone to that model.

JOHN CALLAGHAN: Can I ask probably a simplistic question here.

LEAD COMMISSIONER MARROCCO: Just a second, John. I just want to follow up on this.

Do most hospital labs have the capability of analyzing a test?

JENNIE JOHNSTONE: Most -- so, most? I think that every hospital is affiliated with a microbiology lab. It is not always on site.

So, for example, Sinai serves UHN, Women's College, ourselves. And then for Covid testing we also get additional overflow specimens, whether it's from Humber, William Osler, et cetera.

But prepandemic we only have Sinai lab that has served UHN, Women's College and ourselves. And then again, now we have additional -- and Baycrest, for example. Baycrest has a contract with us as well.

So every hospital would have a known existing lab, and most of those larger labs do

have the capability. I wouldn't say everyone, but it sort of has -- there's been a natural organization whereby there are sort of these larger labs that hospitals feed into.

LEAD COMMISSIONER MARROCCO: So as a matter of planning, pandemic planning then, as far as long-term care homes are concerned, you would want to tell each long-term care home where to send the samples in a pandemic as opposed to in a time when there's no pandemic, is that right?

JENNIE JOHNSTONE: Potentially. So I would say that these -- well this relationship exists just for our own microbiology processing. So it wasn't really -- it wasn't a pandemic plan; it was just our existing plan.

And then for the -- I guess the challenge here is that long-term care was sending their specimens prepandemic to the Public Health Ontario lab, sort of. Meaning that there wasn't -- it wasn't like they sent 10, 15, 20 specimens a day. They were sending two or three a year.

So I think it was more the lack of existing pathways and approach, because in a

perfect world it should be Public Health Ontario lab. I think that that makes sense.

LEAD COMMISSIONER MARROCCO: I guess it does if they can do it. If they can't do it, and it's a pandemic then you have to go to somebody who can do it.

JENNIE JOHNSTONE: Exactly. Right now I think it's variable depending on the hospital -- sorry, on the long-term care home where they're sending their specimens, whether it's to Public Health Ontario labs still or whether it's through their hospital partner.

JOHN CALLAGHAN: To ask then a simplistic question, I'm assuming when you request a lab result from Sinai it comes to your desktop computer?

JENNIE JOHNSTONE: Right, we have our electronic chart that I would just look it up.

JOHN CALLAGHAN: And I don't know if you are aware whether you've heard, but we've heard that in some long-term care homes they're getting results by mail; they're getting them by fax. But did that ever come up in your deliberations about the delay because of the mode of delivery of the results?

JENNIE JOHNSTONE: I think that there's delays at every step along the way. So whether it's, how do you get them? Is it through taxi -- who is your courier? How are you getting it to the lab? And then there's the necessary turnaround time in the lab. And then there's the data entry in the lab. And then there's the question of how the lab then submits it back to the home.

So I think that it's not the in-lab turnaround time necessarily that's the problem; it's all these different pieces along the way. And I think what you've touched upon there, I mean I think fax is like the go-to -- I think that's more the norm, which is shocking in this day and age. I agree.

JOHN CALLAGHAN: Okay. Thank you.

JENNIE JOHNSTONE: So I think the electronic interface is definitely lacking.

But I would say that that isn't -- I mean, just -- we're just sort of talking about things that impactful and important to discuss, but that isn't necessarily something that we discussed other than flagging that turnaround time is a problem and the importance of having

timely turnaround time.

Beyond that our testing strategy panel was more focused on the populations to test and who to test, but not, again, the operational aspects of that.

JOHN CALLAGHAN: Was there a table that was dealing with the operational part of the testing, to your knowledge?

JENNIE JOHNSTONE: To my knowledge that would have been the network of labs. The network of labs, they set the goals in terms of the turnaround times that they were aiming for. I think -- I can't think of what it is off the top of my head, but I think it's, what, 60 or 70 percent in a 24-hour time period and whatever it is, 80 or 90 percent within a 48-hour time period. Those are the targets. You would have to find the exact targets, but it's something like that. And the proportion of people meeting those timelines.

LEAD COMMISSIONER MARROCCO:

Commissioner Kitts has a question.

COMMISSIONER KITTS: Just, back to your pragmatic panel, in your discussions and recommendations did you consider the capability

of the system in terms of setting standards or guidelines? Or did you aim for the ideal and then have to look at it more pragmatically as to what was possible?

JENNIE JOHNSTONE: We considered the -- we considered it in terms of numbers. We were very careful in terms of -- so, for example, on April the 5th we didn't say everybody who is symptomatic can get a test because we would have overwhelmed the system.

We were very concerned -- we all lived the experience of the backlog and how detrimental that was. So we were very careful to make sure that our recommendations, we were trying to pull the data about, you know, if we add -- if we add, you know, this group of essential workers how many additional people might that be?

So we were really trying to make sure that we didn't overload, and possibly we undershot somewhat. I think with the benefit of retrospectoscope, I think every sort of estimate of numbers, we ended up with fewer people than we expected who actually sought testing. But it was an imperfect science, and we wanted to make

sure that we controlled the output more so -- we just knew how terrible it would be to go into a -- to overshoot it and go into a backlog.

And the other thing is we wanted to make sure that we didn't add a group which we would then have to rescind, because that would be -- that would be very politically unpalatable and also I think that is very confusing and difficult. So we wanted to make sure that we added in a controlled manner.

COMMISSIONER KITTS: And the other question is, initially all specimens went to Public Health labs. At some point the hospital labs were incorporated and I think even private labs.

Had that happened by April 5th or did that happen after you started?

JENNIE JOHNSTONE: So it happened before. Again, I'm not the perfect person to speak to this, but just based on what I know, it was that building of the network of labs which got everyone out of that backlog.

So it was started with PHOL, got into the backlog. The network of labs was created towards the end of March and you would have to

ask exactly when that happened. And then as these additional labs came on line, that added that capacity.

So I would say that we came on board right as that capacity was building. So it had started and was adding to it. So it was sort of all a very dynamic process whereby labs were coming on line and building and getting additional machines and whatnot.

COMMISSIONER KITTS: And how long would it take a large hospital lab from the time they said "go, you're going to do this testing for Covid-19" until they got up to full capacity? Is there a ramp-up period?

JENNIE JOHNSTONE: Well, for sure. I think it depends on whether you had the machine or not. Some of us had existing machines. But this gets into the challenge in the fall when there was -- so just going backward, all the labs had some machinery because we did influenza and RSV testing on site. So that PCR machinery existed.

As you had to purchase additional machines in a pandemic, it depended on whether or not they were available or not and then

whether or not there was a backlog in actually getting those in place.

So you had to wait for a guarantee that you were going to get reimbursed for those purchases, and then you had to make the purchase. And then you had to get it in house.

So it's the delays, those unknowns, those are the dependencies as to when you can actually get started.

The other thing at play, in April anyway, were challenges with those NP swabs, securing that. Because as you remember, our main NP swab supplier came from Copan, Italy so when Italy was hit that supply chain went down and that was a huge problem, and also reagents.

So to answer your question, it just depends -- so if you have the machines, you can get started -- you know, you have to do some validation and what not. And I think they also have to get an approval license, but that didn't take very long in the order of, I think -- well, you would have to ask the Sinai lab how long it took, but not long, in the order of a few weeks to be able to go from not testing to testing.

But if you don't have the machinery,

it can take several months. And that was the concern in the fall when we knew we needed the capacity to be built but people hadn't been green lit. And so it's not something you can build overnight because you actually had to purchase the machines, you had to renovate the space, find the space and get it into place and whatnot, and that takes several months.

COMMISSIONER KITTS: And then have enough swabs and enough reagent to --

JENNIE JOHNSTONE: And so in the second wave that has the been the bigger challenge. Because in Wave 1 in terms of the capacity, most of it could be dealt with by the existing staff, and just -- we stopped doing influenza testing and RSV testing because flu season was ending.

But as Wave 2, once we actually built the capacity that was substantially more than anything we had done before, finding the people to man those machines has proven to be a challenge.

COMMISSIONER KITTS: So in Wave 2, and this may not be a fair question, are we operating at full capacity or is there still

some essential resource that is keeping us from getting to full testing capacity?

JENNIE JOHNSTONE: I believe actually as of today, I believe today we have hit 100,000 test capacity, which I think is what we're aiming for.

COMMISSIONER KITTS: Thank you.

LEAD COMMISSIONER MARROCCO: And how long have we been aiming for that? Since March?

JENNIE JOHNSTONE: No. I would say that it became clear in the summer that when we were going to look forward to the fall, as we knew that we were going to have a very big wave and as we were a more open society with children in school and the respiratory virus season hitting, I think it was at that point that it looked like we were going to need a testing capacity of about a hundred thousand.

We can move to next slide maybe, and I'll just talk -- and I don't want to spend a ton of time on where we landed because probably the structure might be more -- I separated the recommendations into content versus structure. But I did think that there might be some commentary about rapid testing. I think that

might be of interest.

In terms of where we are at for testing of residents, right now we continue to have guidance where we want to test, have a low threshold of testing. So we have active surveillance of symptoms in the home of all residents, every day twice a day to make sure that everybody remains healthy. And if anybody does develop symptoms, they are to be placed, ideally in a private room, if one is available, on precautions and have their tests done.

If, in fact, you find a resident case that is at that point that you would test the whole facility to see whether there are additional cases.

And we know from a lot of the asymptomatic testing that occurred in the spring that this is a safe approach, meaning if you don't have cases, if you don't have resident cases, if you don't have staff cases, truly you don't have Covid in the home.

We have quite the opposite problem. If you have Covid in the home you don't have asymptomatic people, you actually have more significant mortality associated with this. So

generally speaking, we don't need to test residents every day or sporadically or syndrome. We just test around a case, which is the same approach we take in the hospital for our hospital patients.

You test them. If you find a case, you test widely around that case.

For staff, again, making sure that we have testing of symptomatic staff, making sure they don't work sick. This is not a small point. Making -- I think there's been lots made about people coming to work -- or feeling like they need to work so making sure that people are not working sick.

And then broad testing again. If you identify a staff case, make being sure you test broadly around that case. And if there's any residents that they have worked for, it may be a whole floor, et cetera, you make sure you test broadly around that.

We have said -- so in terms of our recommendations, we have said in low prevalent state, meaning when you don't have -- when you're in green with our current state of rates, that you don't need to do surveillance testing

of staff.

Now that is a recommendation that was not taken up. And I understand the reason. I know that there was a lot of concern. But I just want to share, if we're making evidence-informed recommendations, truly when you have no Covid around, the testing is of very low value and in fact the majority of cases you find are actually false positives. So it's very disruptive on the ground.

I do understand why that recommendation continued. I know that there was no appetite for -- through the summer for any concern around the residents.

But we put forward the recommendation that you don't need to be doing the staff testing in that setting, but that again is not a recommendation that was taken up.

JOHN CALLAGHAN: Can I just stop you there? Because we are getting into the symptomatic/asymptomatic testing and can you tell us, because I want to review the decision made by the government in May to test everybody.

So what was the advice of your committee about general testing?

JENNIE JOHNSTONE: So I think we have had the same recommendation pretty much the whole time, which is that we should be doing PCR testing, diagnostic testing on symptomatic individuals, high-risk contacts, and outbreak setting.

And that there is no need to do what we call low-value testing, meaning -- so the decision made in May to do anyone who wants a test gets a test was not based on the recommendation from our panel.

JOHN CALLAGHAN: So I just want to show you an email note from Vanessa Allen to Dirk Hire who was on the -- I think he chaired the testing committee, the testing --

JENNIE JOHNSTONE: Implementation, Dirk was testing implementation.

JOHN CALLAGHAN: This a note of May 3rd, and she reiterates what you say, which is that we shouldn't be testing asymptomatic; but she also points out, it says:

> "It is important to note that we will not have enough tests to test everyone even with incredible success with building up capacity."

And that's May 3rd. So was that -- was that the view of the committee at that time?

JENNIE JOHNSTONE: For sure. I think there was -- we don't need to do it either. But certainly I mean we will never have enough tests to test everybody every day.

JOHN CALLAGHAN: Right. So then there's a memorandum that comes out May 24th. If we can just put that up. And this is the one I think you're referring to?

JENNIE JOHNSTONE: Oh, it is.

JOHN CALLAGHAN: In other words:

> "Asymptomatic, risk-based testing. People who are concerned that they have been exposed to Covid-19. This includes people who are contacts of or may have been exposed to a confirmed or suspected case [...]", and it goes on, "[...] no Ontarian who is concerned that they have been exposed to Covid-19 will be declined a test at an assessment centre either through appointment or walk-in for the processes [...]."

What was the view of the committee

about general ability for everybody who sought a test to get a test? And what was it's --

JENNIE JOHNSTONE: I mean, I think we had real concerns. Again, we were tasked with creating a strategy, a testing strategy. And from a testing strategy perspective, the only thing that would make sense from a testing strategy is that anyone who wants a test you would have to get a test every day, which is not a strategy at all.

So I think we were very concerned the sustainability of this approach, the inequity of this approach, because I think what we saw were essentially -- this was used as an excuse to bypass public health measures. And I think I shared that we knew that through the summer this type of thing was being used and being mandated, in fact, by many people before you come to the cottage make sure you get a test.

So it wasn't being used in the way in which it was supposed to be designed which is preserving this capacity for those who need it, meaning symptomatic individuals, high-risk contacts, outbreak investigations and specifically -- and again, so we were very

worried that people were using -- because again the lay public doesn't understand that a negative test, the negative test is only on the time you actually got it. It doesn't mean -- an hour later you might actually be positive.

So, in fact, we thought that this approach may actually lead to increased transmission because people were doing risky behaviour, potentially to bypass the public health measures.

And then what we were most particularly worried about is the sustainability going into the fall when we knew we were going to need increased capacity because you're going to have more symptomatic individuals, because we are going to start to see, as we did, more respiratory viruses circulating, rhino virus first and then followed by, you know, RSV and then influenza.

So if you have this as a policy and that people expect to be able to get a test whenever they want, to change it becomes very difficult. So -- and I think there was a lot of moral distress at the level of the labs because people were working extremely hard, using up

valuable resources for very questionable benefit.

And so I think -- I'll speak for myself anyway -- that this approach did not jive with any sort of strategy.

LEAD COMMISSIONER MARROCCO:

Dr. Kitts, I think.

COMMISSIONER KITTS: And I understand that, Dr. Johnstone, but if there is a sense or any evidence to suggest that asymptomatic spread is of higher risk than I think it is, and maybe you can tell us what it is, then it would make sense. So it all depends on how risky is it that asymptomatic people are spreading it?

JENNIE JOHNSTONE: Right. And so what we were able to do -- and that was the counter argument that was made in April. And I think to be fair to the government, there were two groups of individuals -- there was a very loud group of individuals saying that 70 percent of the spread is from these asymptomatic individuals and there was a fear of that.

I guess my argument to that was, number one, you have a scientific people which is making recommendations. It might be nice to

actually listen to our recommendations as opposed to a media. That's point number one.

But point number two is that we were able to collate the data from the information -- from the testing that was done. And we were able to show, pretty much in every place you looked, when you did this low-value asymptomatic testing, the percentage was .2 percent, consistently. No matter which group you were doing it in.

And if you look now even, the pharmacy testing that is ongoing, which continues to be that low-value asymptomatic group, continues to be .2 percent.

So I think that I understand that in April there was reluctance to potentially take the advice. I completely understand that. However, we were able to start sharing the data in May and June which demonstrated that that fear was unfounded.

COMMISSIONER KITTS: And with evidence.

JENNIE JOHNSTONE: With evidence.

COMMISSIONER KITTS: Thank you.

JOHN CALLAGHAN: Thank you. Can you

just go down the document a little bit? So the approval of this was done by Helen Angus, David Williams and Matthew Anderson. Did any of them provide an explanation as to why the advice wasn't accepted from the panel that you recall?

JENNIE JOHNSTONE: No.

JOHN CALLAGHAN: And then to just put up the slide deck of your slide deck, because I gather -- if you could go to page 5. This is in July of 2020, you continued to be of the view, number 5, there that, "End testing" -- this is your recommendation:

"End testing of asymptomatic general population [...]."

That is the point we've been talking about --

JENNIE JOHNSTONE: We did. Because a lot of employers were also demanding that workers were coming -- that workers would have to get tested before they started work again.

But again, from a strategy perspective that makes no sense. If you're going to demand workers get tested, they need to get tested every day. Doing it the one time before they come back to work makes no sense.

JOHN CALLAGHAN: So what happened then in the fall that caused this -- everybody could get a test to change? Because I understood that that position -- the government's position changed this past fall.

JENNIE JOHNSTONE: I don't pretend to know how. I mean I think we were very clear and continued to just -- in every forum we were invited to speak we shared our recommendations. I think we continued to share our representations and going up the pathway.

And why it changed I could never pretend to know, but I do believe it was out of necessity. Because if you remember back in September, there was the very long lineups in the assessment centres: Children waiting four hours, five hours, out of school, people needing to miss work. And so I think that it was a pragmatic decision. It was just an unsustainable decision.

JOHN CALLAGHAN: That is to have everybody tested whenever anybody wanted?

JENNIE JOHNSTONE: Correct.

JOHN CALLAGHAN: Was unsustainable.

JENNIE JOHNSTONE: And I think the

other thing we were seeing and pulling it back to long-term care is the turnaround time tests were increasing. And it was September as well that the numbers were starting to climb with Covid and then the outbreaks were starting. And so it became incredibly important that you had that faster turnaround time, so the turnaround times became, you know, unacceptable as well.

So it really didn't make sense to have this low-value testing for people who just felt like it in with long-term care residents that were in outbreak trying to -- they were all in the same queue. So that didn't seem right at all. So something had to happen.

JOHN CALLAGHAN: Can we go back to the slide deck?

JENNIE JOHNSTONE: Now, I do want to touch on rapid testing, and I have read through the recommendations here. And I do want to just share and make sure for the record the concerns associated with rapid testing. Because I know that it has been touted in the -- certainly in the media, and I think in concept it is a good concept. So I wanted to make sure that people understand the reluctance or the concerns

associated with rapid testing.

So first of all, we know that these rapid antigen -- and we're talking about rapid antigen tests, because there are the other rapid tests. But let's talk rapid antigen testing.

So we know that they are not good enough in outbreak setting, and I don't think there is any move from the Ministry to use them in an outbreak setting. So we do need diagnostic, the PCR gold standard in that setting.

So when we -- remembering that the testing approach -- the surveillance testing approach is additive. In theory, you shouldn't need this additional approach at all.

So in the hospital setting we don't use it. We do not use -- we don't test our staff every day. We don't use this approach, because if you mask appropriately, socially distance, don't work while sick, and all of those good things, you shouldn't have transmission.

Now, I understand that that is not the perfect world we're talking about in long-term care. And I understand why we have added this

additional layer, especially in high prevalence regions. So again our testing strategy panel has acknowledged that we need this additional layer of protection in high prevalent state, because once it gets high prevalence the room for error is so small.

So one of the things that hampered things is the fact that up until now we have had to use antigen testing with NP swabs still. And I don't hear that in the press very often.

But remembering we have these staff -- and I don't know how often you've had an MP swab but they are very uncomfortable. So as it is, it's been a stretch to get them tested once a week to. To have to do it three times a week was not a reasonable ask.

Now with the rollout, they do have permission to actually use the NP swabs as nasal swabs but I want to share that that has not been validated.

So we know that the challenge with this rapid, the rapid antigen test is the lower sensitivity on average with an NP swab about 56 percent of a PCR test and as you -- if you use nasal swabs, it's going to be less than that.

The offset of that is, because you are doing it so frequently, so if you are doing it three times a week, the offset is that you will catch it eventually.

But the challenge we are having in the high -- like right now, especially in January, it was like tinder boxes. So we didn't want to roll out rapid tests at a time that we're trying to have staff focus on preventing outbreaks, and vaccines and introducing this thing that there's no data to say that three times a week with a lower sensitivity is any better than once a week. And we were still doing once a week. So we just said, can question we just pause? We're still doing testing. Can we just continue with this?

Because the HHR, the human resource associated with this -- this is a massive undertaking. You have to hire two additional people, are the estimates, in order to run these essentially assessment centre clinics in homes three times a week. It is a huge undertaking, and we know staffing is a huge issue.

So our challenge with antigen testing isn't in concept; it is just so say, can we just

pause? Continue with the testing that we're doing. We're doing testing. Can we just pause until it's the right time?

And the other thing is that's at play here is that staff are now vaccinated or many of them are vaccinated, so the other question that is still an unknown, that we are going to address at the testing panel, is whether or not you still need this surveillance testing if you've been vaccinated.

So what we didn't want to have is to build this huge infrastructure, infrastructure that quite frankly the homes can't do right now, because there's all these competing priorities and they are challenged with staffing at the best of times, to work toward something that we don't even know if we're going to need in a month, or at least to those who have been vaccinated.

So I just wanted to share some of the counter arguments. Like in concept it's great, but in reality it's an incredibly challenging thing.

If you just think about your own workplace and if you said, three times a week

before you come on site your entire staff has to be tested, it's huge. If someone told me we would have to do this in the hospital, I don't even know how we would do it.

So I just want to make sure that it's clear why there is a bit of concern about the approach. It is not to say that it's not about the testing approach; it's just about the modality and the actual reality of doing it properly.

So with that I'll just -- I can pause. I'm happy to answer any questions about it. But I just wanted to share the sentiment.

Both of at the panel as well as the rapid testing task force as well, so I'm not just sharing my opinion.

COMMISSIONER KITTS: Let me just ask, what is accuracy compared to this gold standard?

JENNIE JOHNSTONE: So on average if you're using NP it's about -- well they -- on average about 56 percent. It ranges.

COMMISSIONER KITTS: Versus what, 90 plus percent?

JENNIE JOHNSTONE: Well compared to a PCR test. So remembering a PCR test isn't

perfect. So it would be -- this is compared to a PCR test knowing that the PCR test itself isn't perfect.

COMMISSIONER KITTS: But the PCR is what, 90 percent?

JENNIE JOHNSTONE: Yeah, 80 to 90 percent.

COMMISSIONER KITTS: And this one is 50 to 60?

JENNIE JOHNSTONE: Of 80 to 90.

COMMISSIONER KITTS: Oh, 50 of --

JENNIE JOHNSTONE: That's what I'm saying. Because it's compared to the PCR. So the PCR. So the PCR -- so that's using that as the gold standard, which we know is actually not perfect itself.

COMMISSIONER KITTS: Okay. Thank you.

JENNIE JOHNSTONE: And then, but we know nasal is another drop of about 10 percent.

COMMISSIONER KITTS: Correct.

JENNIE JOHNSTONE: So I just want to make sure that people understand the antigen test sensitivity is not the same as PCR, which is okay because you are going to do it three times a week so the offset is there.

But the one other point I did want to make about the antigen test that we were concerned with in the height of a Wave 2, introducing it, is that sense of security that is not based in reality. So this is the so-called White House approach or the White House concern.

Meaning that if you have individuals who truly don't understand the limitation of the test, you now have somebody who is told you're negative. And we don't have data on how that influences behaviour.

We know in the White House it influenced behaviour such that it led to an outbreak, because you get this false sense of reassurance. The nice thing about the PCR is you don't find out about it right on the spot so you have to continue to that adherence

So I'm not saying that it is a problem, but you can anticipate how that might play into people's actions and that you could see how you may theoretically have increased risk of outbreaks because of it.

So our issue was, there are all these unknowns. Can we just not do it at the height

of Wave 2? Let's just wait until things calm down a little bit.

COMMISSIONER KITTS: I think some of the confusion may be that Health Canada approval, I think to the general public is go, fire away, it's a good thing.

JENNIE JOHNSTONE: Yeah. And we know that if -- as I know you know, but if you talk to Health Canada, they are just doing approval, that's it. They're not -- they are not weighing in on whether it is or isn't a good thing. They're just saying based on our criteria it meets it.

COMMISSIONER KITTS: Okay, thank you.

JENNIE JOHNSTONE: Next slide.

So then I just wanted to end on structural issues, which are several. So I do think that -- I want to reiterate, our testing panel to the Office of the CMOH was fairly straightforward, but other Ministry testing decisions, I really do not know who approves those or how those move forward.

And the other thing that I have concern about is who has a sort of bird's eye view of all the different decisions being made?

And that doesn't appear, again to me, on the ground, that there is co-ordination at that level. There may be, but I don't know -- I don't know who is doing it or how that's happening. It just seems like each individual body is making decisions, and no one is sort of overseeing those decisions.

The other challenge is the lack of centralization of guidance. So with two hats on, I have had to collate the data -- or collate the different guidance documents.

So for the Toronto region, I helped the hospital operations table collate everything for the assessment centre. Because of course when the guidance changed in September, only specific people met criteria, but understanding who that was came from numerous documents, memos to the field, guide -- it was everywhere and you have to pull it all together in one place.

And it changed almost weekly. And you almost had to know that something existed to be able to tracking it down and find out, because you are not necessarily on the all the distributions. Because, again, if you're just getting stuff from -- you know, I'm not

receiving Ministry of Long-term Care memos, so I would have to know that Ministry of Long-term Care memo exists to track it down to know what it says in order to incorporate it into the Guidance Assessment Centre document. And that was a recurrent theme. It was very confusing.

And then also for the long-term care providers, understanding who needs to get tested -- or retirement homes, it took us three months to find out what is the cadence of testing for retirement home staff? And who needs to get tested and who doesn't?

So it's not straightforward to the -- because, again, it's in different memos. And you have to collate all of it, and it's very challenging.

So having a co-ordinated table or co-ordinated document that shared all of the different testing that existed would have been very helpful.

And then with respect long-term care, this was very challenging for me as an infection control person. There was an overreliance on testing.

So at the beginning access to testing

was a problem, no question. We had to fix that, for sure. So in terms of the recommendations for residents getting tested and those symptomatic and making sure we had all of that testing guidance clear was very important.

But all of the other pieces of adding -- you know, testing every single resident in long-term care in the province, testing of the staff, especially in the low prevalence time, became what I felt like was a crutch. Because that was an easy thing to say or relatively easy thing to say.

Fixing the fundamentals is much harder. And I think that in Ontario we do more testing, I think, of this population than anywhere else in the province -- than any other provinces yet we have one of the worst track records.

And so it felt like, to me, that any time we got into trouble, we tried to throw more testing at it instead of actually saying, what is the problem here? And the problem isn't testing. Yes, there was some problems in test turnaround testing, whatever.

But at its core, there were all the

other things that you guys are looking into, which were staffing, infection control, infrastructure and all of these other pieces, which are far harder to fix.

So I felt like many times adding this additional testing created -- becomes a distraction in the sense that now you're taking staffing, especially -- so like today there is the Ministry of Long-term Care memo that says there is the mandatory shift to rapid antigen testing. And they say that you can reach out to pharmacies, and some people have already reached out to pharmacies and they said, sorry, we're not going to be able to do that for you. So this is going to have to come as an opportunity cost of staffing.

If they are staffing this within the home, and they are saying you are going to have to do it for essential care partners so you're going to have to have seven days a week staffing for this, that means those people -- you're robbing Peter to pay Paul. The staff are only going to come from the staffing of the residents.

So I don't have a -- like it's more

about thinking through how this testing is going to add and making sure that you're doing it in a way that is implemented such that it's going to achieve your goal. Otherwise, again it just becomes a distraction. So it's not about being anti-testing -- certainly I'm for it -- but you have to do it properly. Otherwise it's actually going to do a disservice.

So with that I think that's everything I wanted to say. I think I have a conclusion slide but I think it's essentially -- oh, this included the conclusions from the original presentation.

JOHN CALLAGHAN: Thank you, Dr. Johnstone, that's been very helpful and thank you very much for agreeing to come back.

I hate to say it but I think we're on tap to see you one more time but you probably don't know that yet.

JENNIE JOHNSTONE: I don't know that but I'll always happy to -- I can't say how happy I am that you guys are doing this very good work and any way that I can support, or any of our colleagues, I know that we're all happy to help.

LEAD COMMISSIONER MARROCCO: Well, thank you very much for that. It gives us some reassurance that we're not being unduly bothersome. But as you can appreciate, we need to get inside these things in order to avoid saying something that turns out to be incorrect. So thanks very much for the insight.

COMMISSIONER KITTS: Thank you.

JENNIE JOHNSTONE: Thank you.

--- Meeting adjourned at 3:09 p.m.

REPORTER'S CERTIFICATE

I, HELEN MARTINEAU, CSR, Certified Shorthand Reporter, certify;

That the foregoing meeting was taken before me at the time and date 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 accurate transcript of my shorthand notes so taken. Dated this 28th day of January, 2021.

_____

PER: HELEN MARTINEAU

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