

Long-Term Care COVID-19 Commission Meeting

Dr. Karim Kurji, Regional Municipality of York
on Thursday, February 25, 2021

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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held via Zoom Videoconferencing, with all
15	participants attending remotely, on the 25th day of
16	February, 2021, 4:00 p.m. to 6:00 p.m.
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1 BEFORE:

2 The Honourable Frank N. Marrocco, Commission Chair

3 Angela Coke, Commissioner

4 Dr. Jack Kitts, Commissioner

5

6 PRESENTERS:

7 THE REGIONAL MUNICIPALITY OF YORK COMMUNITY AND

8 HEALTH SERVICES DEPARTMENT PUBLIC HEALTH BRANCH

9 Dr. Karim Kurji, Medical Officer of Health

10 Ewilla Castellan-Wong, Manager, Health Protection

11 Division

12 Elena Hasheminejad, Acting Manager, Health

13 Emergency Operation Centre, Liaison Officer for

14 Congregate Settings

15 Shanna Hoetmer, Director, Health Emergency

16 Operations Centre and Manager of Health Emergency

17 Planning

18 Dr. Fareen Karachiwalla, Associate Medical Officer

19 of Health

20 Andrea Main, Manager, Control of Infectious

21 Diseases and Outbreak Management

22 Joe La Marca, Director, Health Protection

23 Joanne Mitchell, Senior Counsel, Legal and Court

24 Services

25 Dr. Cindy Shen, Public Health Physician

1 Marie Wright, Manager, Child and Family Health
2 Division

3 Selina Nazim, Manager, Health Protection Division
4

5

6 PARTICIPANTS:

7 Alison Drummond, Assistant Deputy Minister,
8 Long-Term Care Commission Secretariat

9 Adriana Diaz Choconta, Senior Policy Analyst,
10 Long-Term Care Commission Secretariat

11 Angela Walwyn, Senior Policy Analyst, Long-Term
12 Care Commission Secretariat

13 Lynn Mahoney, Counsel, Gowling WLG
14

15 ALSO PRESENT:

16 Deana Santedicola, Stenographer/Transcriptionist
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1 -- Upon commencing at 4:00 p.m.

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3 COMMISSION CHAIR FRANK MARROCCO: Good
4 afternoon, everybody.

5 LYNN MAHONEY: Good afternoon,
6 Commissioner.

7 DR. KARIM KURJI: Good afternoon,
8 Commissioner.

9 COMMISSION CHAIR FRANK MARROCCO:
10 Doctor.

11 LYNN MAHONEY: Is everybody here from
12 your end?

13 COMMISSION CHAIR FRANK MARROCCO:
14 Commissioner Kitts is at the bottom of
15 my screen. I didn't see him right off the bat.
16 Ms. Mahoney, I think we are ready to
17 proceed.

18 LYNN MAHONEY: Dr. Kurji, is everybody
19 from your team here?

20 DR. KARIM KURJI: I believe so. I
21 can't actually see everybody on the screen, but I
22 believe they are all here, yes.

23 LYNN MAHONEY: Okay. Perfect.

24 Okay. So, Commissioners, Commissioner
25 Marrocco, Commissioner Kitts, and Commissioner

1 Coke, this afternoon you are going to hear from
2 York Region Public Health. We have already heard
3 from York Region from the Commissioner and her
4 team, who told you about the two municipal homes
5 that are within York Region, and you would have
6 heard from the Commissioner as well that Dr. Kurji,
7 while he is the Local Medical Officer of Health and
8 reports to the board, which is the York Regional
9 Council, he does report in through the
10 Commissioner, who you have heard from.

11 So I will leave -- Dr. Kurji and his
12 team have divided up the presentation this
13 afternoon, and they are going to talk to you about
14 their dealings with the long-term care homes, both
15 pre-COVID and during COVID, waves one and wave two.

16 You will have read in the media,
17 Commissioners, as well that Dr. Kurji was one of I
18 believe only five Medical Officers of Health in the
19 province who issued section 29.2 orders, and he
20 will talk to you about that as well.

21 So pre-COVID and wave one and wave two
22 and the performance of the long-term care homes
23 within York Region and the role of Public Health in
24 York Region.

25 So that is what you are in for for the

1 next little while, and as we go through, I will
2 interject with questions periodically to the extent
3 that some things need to be clarified or elaborated
4 on, and as I have already told the Panel,
5 Commissioners, you will also interject with any
6 questions you may have.

7 COMMISSION CHAIR FRANK MARROCCO: Let's
8 proceed.

9 DR. KARIM KURJI: Thank you,
10 Commissioner, and thank you, Ms. Mahoney.

11 I am Dr. Karim Kurji, the Medical
12 Officer of Health for York Region.

13 Today, I will present some salient
14 areas that my colleagues will then expound upon.

15 We thank you for giving us the
16 opportunity for presenting today. We owe it to the
17 memory of over 225 long-term care home residents
18 who have passed in our region to tell you the story
19 frankly.

20 Given that we had established the
21 Incident Management System, I am accompanied by
22 many colleagues from our branch who are intimately
23 familiar with what transpired, and we have arranged
24 for them to take you through four separate areas,
25 after my emphasis on some salient areas.

1 I will introduce them briefly by name,
2 and they will expound on their introduction as they
3 speak.

4 So I have Joe La Marca. I have Andrea
5 Main, Shanna Hoetmer, Elena Hasheminejad, and
6 Dr. Fareen Karachiwalla, and also present are
7 Dr. Cindy Shen, Joanne Mitchell, who is our legal
8 counsel, and Marie Wright.

9 So we'll start with our first slide on
10 introductory remarks.

11 LYNN MAHONEY: Dr. Kurji, could I ask
12 you for a moment if you could expand for the
13 Commissioners as well on your own personal -- give
14 us some of the highlights from your career and your
15 Public Health experience, please.

16 DR. KARIM KURJI: Sure.

17 I qualified at University College
18 Hospital in London, England, and thereafter, I did
19 a family practice residency program, which in the
20 UK is four years long. And I then decided to go
21 into the practice of -- go into the training
22 program for Community Medicine, which is really the
23 old name for Public Health, and I went to the
24 London School of Hygiene & Tropical Medicine for a
25 Masters degree and subsequently went through my

1 specialization in the UK, somehow shortening it but
2 yet being able to get the thesis done in fairly
3 record time, and the requirement was getting the
4 thesis done to get my certification in Public
5 Health, or Community Medicine as it was called.

6 Subsequently, I actually got promoted
7 through nominations to become a Fellow of the
8 Faculty of Public Health in the Royal College of
9 Physicians of the United Kingdom.

10 I moved to Canada in Alberta in 1984,
11 and I was taken under the wing of a good mentor,
12 and he ensured that I join him with the University
13 of Calgary Residency Program and finished another
14 one year of a requirement for me to be able to sit
15 the Fellowship exams.

16 I subsequently moved to Dalhousie
17 University in Halifax, Nova Scotia, in a teaching
18 position as an Assistant Professor, and was also
19 the Director of the so-called residency program
20 there. It actually didn't exist, a residency
21 program, but we were trying to establish one. And
22 I got my Fellowship in the Royal College of
23 Physicians and Surgeons of Canada there.

24 I subsequently moved to York Region as
25 an Associate Medical Officer of Health, where I

1 practiced for about nine years, then moving over to
2 the province, initially as a Physician Manager and
3 then became the Associate Chief Medical Officer of
4 Health, and I was present at the Region for many
5 crises, including the West Nile virus and SARS
6 crisis.

7 [Court Reporter intervenes to resolve
8 audio issue.]

9 DR. KARIM KURJI: Yes, so I moved to
10 the Province and I became the Associate Chief
11 Medical Officer of Health, and then for maybe a
12 period of about two months I was the Chief Medical
13 Officer of Health of Ontario, just before
14 Dr. Sheela Basrur joined in.

15 I left the Province to come to the
16 Region of York, initially as an Associate Medical
17 Officer of Health, and then within a year or two
18 years - I think it was about two years - I became
19 the Medical Officer of Health in York Region.

20 And so that I think gives you a very
21 quick synopsis of my background.

22 So prior to COVID-19, we were being cut
23 to the bone with respect to our resourcing of
24 Public Health given the need to reduce our budgets
25 as a result of the modernization agenda. We had

1 protested through our regional council that during
2 SARS the province had lost \$5 billion and that the
3 cost savings that would be obtained through Public
4 Health were not worth pursuing.

5 We had also pointed out the benefits of
6 Public Health remaining within the regional
7 government in the event of a repeat of a SARS-like
8 emergency.

9 Now, our story really begins with brief
10 media reports in late December that caught my
11 attention, and then a memo from the Chief Medical
12 Officer of Health on January 3rd, drawing our
13 attention to viral pneumonia in Wuhan, China.

14 We immediately took notice and started
15 monitoring the situation closely, and on January
16 23rd, 2020, made the decision to activate our
17 Public Health Emergency Response Plan and open our
18 Health Emergency Operations Centre.

19 We quickly transitioned to the Incident
20 Management System within the Public Health Branch.
21 Our regional corporation had trained us for such an
22 emergency, and the Region itself activated the
23 Regional EOC in March.

24 The Regional EOC would report to the --
25 LYNN MAHONEY: EOC is Emergency

1 Operations Centre?

2 DR. KARIM KURJI: That's correct.

3 LYNN MAHONEY: Thank you.

4 DR. KARIM KURJI: I should have pointed
5 that out.

6 So the Regional EOC would then report
7 to the Regional Emergency Control Group. As per
8 our procedures for business continuity, measures
9 were instituted to shift staff to the COVID-19
10 response.

11 I want to draw your attention to the
12 extensive preparation pre-COVID-19 that had been
13 undertaken by our Public Health inspectors, both in
14 terms of audits of long-term care homes, as well as
15 outbreak preparedness.

16 Each long-term care home had an
17 identified contact within Public Health to call in
18 the event of an outbreak. Despite these
19 preparations and additional preparations for the
20 second wave with our partners, COVID-19 still
21 penetrated the long-term care homes and caused such
22 devastation.

23 Internally, we had re-organized our
24 COVID-19 response into specialized institutional
25 outbreak teams, in addition to case and contact

1 management. There were major challenges in
2 transitioning staff to work from home in the
3 absence of a good case and contact management
4 system.

5 Our IT people in the broader department
6 worked relentlessly to create a case and contact
7 management system, but eventually we went with the
8 provincial system, which had its own growing pains.

9 The complexity of the outbreaks at
10 long-term care homes required several consultations
11 with Public Health Ontario. There were no
12 protocols initially, and we developed our own
13 approaches. This was done through meetings of the
14 physicians and Communicable Disease Directors every
15 morning.

16 One of our Associate Medical Officers
17 of Health, Dr. Alanna Fitzgerald-Husek, had
18 contacts in British Columbia from whom we learned
19 to be very careful with long-term care homes.

20 Early on, we created an exceptional --

21 LYNN MAHONEY: Sorry, Dr. Kurji, could
22 you just -- sorry to interrupt you. Can you give
23 us an idea of sort of the timing of all of that,
24 the timing of when you realized that there was
25 going to be an issue in the long-term care homes?

1 DR. KARIM KURJI: I would say that
2 would have been around February and March of 2020.

3 LYNN MAHONEY: Okay.

4 DR. KARIM KURJI: Early on we created
5 an exceptional dashboard on our website,
6 york.ca/covid-19, to ensure transparency. This
7 provided a level of detail for our residents so
8 that they knew every home that had an outbreak and
9 the numbers of staff and residents that had
10 COVID-19.

11 Our corporate communications folks
12 continued to be exceptional. The support we had
13 from our regional corporation, including the
14 establishment of the Regional Emergency Operations
15 Centre and the Regional Emergency Control Group,
16 and many of our corporate departments, such as
17 Human Resources, Property Services, and Corporate
18 Services, was truly exceptional.

19 The leadership of our Regional
20 Chairman, Mr. Wayne Emmerson, and that of our Chief
21 Executive Officer, Bruce Macgregor, had been
22 exceptional. Our Regional Council has been very
23 supportive throughout the pandemic response.

24 As part of our preparation, we had a
25 unique stockpile of PPE for our staff of up to

1 100,000 masks, and this had been maintained since
2 the period of SARS 17 years ago. We also had
3 gloves, gowns, and eye protection, as a part of the
4 stockpile.

5 Much effort had been expended to keep
6 the supplies current, and we had worked out an
7 elaborate system with York Region EMS to rotate
8 supplies to prevent any waste.

9 The internal Public Health supply was
10 made available through judicious management to
11 long-term care homes, retirement homes, and
12 congregate living facilities, in outbreak mode, and
13 later to our emergency medical service colleagues
14 to replenish their supplies.

15 LYNN MAHONEY: Dr. Kurji, who is
16 responsible for the stockpile in York Region? Who
17 maintains the stockpile?

18 DR. KARIM KURJI: So we started out
19 maintaining our stockpile, and this had been a very
20 concerted effort requiring a lot of effort every
21 year, and there was an individual by the name of
22 Cathy Jaynes, who was one of our directors, who I
23 have to take my hat off for having, you know,
24 persevered.

25 Later on, because we are part of the

1 regional corporation, the regional corporation
2 stepped in and took on the role of ensuring we had
3 adequate supplies of PPE.

4 LYNN MAHONEY: And, Dr. Kurji, is it
5 fair to say that there was an importance placed on
6 the need for a stockpile, and it was recognized
7 that a stockpile of PPE was going to be needed in
8 the event of a pandemic?

9 DR. KARIM KURJI: Exactly so. However,
10 we were contemplating to use that stockpile for our
11 own needs. In the event of a pandemic, it was
12 possible that there may have been assessment
13 centres and our staff might have been used in
14 clinical roles, and therefore, we wanted to ensure
15 that they were adequately protected.

16 We never thought that we would need to
17 share these supplies with others in the community.
18 In fact, we were very surprised that hardly anybody
19 else had any major stockpiles, with the exception
20 of perhaps the hospitals.

21 LYNN MAHONEY: And including the
22 province?

23 DR. KARIM KURJI: That is correct.

24 LYNN MAHONEY: Did that surprise you
25 when you heard that the provincial stockpile was

1 largely expired?

2 DR. KARIM KURJI: I was very surprised
3 about that and very disappointed because that was
4 an important lesson from SARS, and we know that
5 there was a lot of effort that needed to go into
6 manage a PPE stockpile, and we had always thought
7 that somebody at the province was maintaining a
8 large enough stockpile for the province.

9 LYNN MAHONEY: Thank you.

10 COMMISSION CHAIR FRANK MARROCCO:

11 Doctor, can I just interrupt for a second.

12 DR. KARIM KURJI: Yes.

13 COMMISSION CHAIR FRANK MARROCCO: How
14 much of a stockpile did you have?

15 DR. KARIM KURJI: So we had the
16 equivalent of some 100,000 masks, and whilst I
17 don't have the details immediately here, we can
18 certainly send you those details. But these would
19 have included a very large number of N95 masks, a
20 very large number of surgical masks, gowns, gloves,
21 everything that you would normally require.

22 COMMISSION CHAIR FRANK MARROCCO: I was
23 more trying to get a sense of how many weeks do you
24 think it would last, that sort of thing, or months?

25 DR. KARIM KURJI: Sure. So if it was

1 to be used for Public Health alone, I would have
2 thought it would have lasted us for approximately
3 six months to a year, depending on the utilization
4 of them.

5 As it turned out, we did not need as
6 much for our own needs, except for going into the
7 homes where outbreaks were occurring, and so we had
8 to protect our own staff in those situations.

9 More importantly, we became the only
10 supplier of PPE to homes in distress, and this
11 included not just long-term care homes but also
12 retirement homes and congregate living facilities.

13 COMMISSION CHAIR FRANK MARROCCO: Thank
14 you.

15 LYNN MAHONEY: So it sounds like you
16 had a significant stockpile.

17 DR. KARIM KURJI: Yes, indeed. And
18 later on we used about half of that for EMS because
19 they had exhausted their own stockpile.

20 LYNN MAHONEY: Okay. Thank you.

21 DR. KARIM KURJI: We had a very good
22 working relationship with the hospitals, the LHINs,
23 Ontario Health, and later with the Ministry of
24 Long-Term Care.

25 We should point out that we were

1 heavily engaged in managing outbreaks and issues in
2 some 288 congregate settings in York Region too.

3 I have to point out that York Region
4 EMS provided exceptional support, and their
5 contributions to the testing and direct in-home
6 assistance was exceptional and actually made a
7 world of difference.

8 We had regular calls with the Ministry
9 Emergency Operations Centre where difficult
10 outbreak management protocols would be discussed.
11 On these calls, we had the Chief Medical Officer of
12 Health, the Associate Chief Medical Officers of
13 Health, and experts from Public Health Ontario, and
14 several guest speakers.

15 We had access to many tables, as the
16 Council of Medical Officers of Health meetings, the
17 Greater Toronto Area Medical Officers of Health
18 meetings a little later on, and many specific
19 working groups.

20 We mostly notified the Chief Medical
21 Officer of Health of orders before they were
22 issued, and the Chief Medical Officer of Health's
23 office always wanted to be kept apprised. There
24 has never been a time when we had difficulty in
25 accessing either the Chief Medical Officer of

1 Health or the Associates. I have had numerous
2 calls where he has been present and several
3 one-on-one calls on a variety of different COVID-19
4 issues. Any inquiry made of them would be
5 responded to promptly.

6 LYNN MAHONEY: Dr. Kurji, I know that
7 you issued five section 29.2 orders I believe in
8 York Region.

9 DR. KARIM KURJI: Yes.

10 LYNN MAHONEY: Did the Chief Medical
11 Officer of Health for the province issue any orders
12 with respect to any long-term care homes?

13 DR. KARIM KURJI: Not to my knowledge
14 and certainly not in York Region.

15 LYNN MAHONEY: Okay.

16 DR. KARIM KURJI: But the normal
17 process would have been for me to issue the orders,
18 and as a courtesy, I would normally let the Chief
19 Medical Officer of Health know that this is the
20 plan, and we would also, wherever possible, share
21 information with the legal counsel at the Ministry
22 of Health and Long-Term Care -- or Ministry of
23 Health, rather. Those protocols were followed
24 often but not always.

25 So when vaccines became available and

1 were transported to freezers at hospital locations,
2 there was some controversy within the Public Health
3 field with respect to the location of the freezers
4 in hospitals and the inability to vaccinate
5 long-term care home residents first, as there were
6 people who believed the vaccine could be safely
7 transported and administered to long-term care
8 homes.

9 When vaccines became available and were
10 transported to freezers at hospital locations --
11 sorry, the area of testing in long-term care homes
12 also merits attention --

13 LYNN MAHONEY: Could I just interrupt
14 you, sorry, before you move off the vaccination
15 issue.

16 DR. KARIM KURJI: Yes.

17 LYNN MAHONEY: I'm not quite clear on
18 what you were saying about the controversy. What
19 was the controversy? Is it that the long-term care
20 residents were not getting prioritized? They were
21 not receiving the vaccines, is that what the
22 controversy was?

23 DR. KARIM KURJI: So the problem with
24 Pfizer vaccine, when it was first made available,
25 was it needed to be kept at very, very cold

1 temperatures, you are aware, and we were not able
2 to move it from the hospital location.

3 And since the first Pfizer vaccines
4 went directly to the hospitals where some of them
5 had the freezers and some had additional freezers
6 brought in by the Ministry, the vaccines had to be
7 used on hospital staff rather than being
8 transportable to the long-term care homes and be
9 used for the long-term care home residents.

10 LYNN MAHONEY: Okay. So just so I am
11 clear, what happened was the vaccinations became
12 available. It was stated that the priority was for
13 long-term care residents, but because the freezers
14 were at the hospitals, the long-term care residents
15 were not prioritized, and other people -- other
16 people in the hospitals got the vaccines ahead of
17 the long-term care residents?

18 DR. KARIM KURJI: That is correct.

19 Now, there were a few folks that felt
20 that we could safely move those vaccines away from
21 the freezers in the hospitals and take them to
22 long-term care homes and administer it to the
23 residents.

24 And one of those individuals was one of
25 our Associate Medical Officers of Health,

1 Dr. Richard Gould, who holds a specialist degree in
2 medical microbiology as well, and he wrote to the
3 Chief Medical Officer of Health pointing out how it
4 could potentially be moved safely.

5 Now, there was a lot of debate going on
6 at that time, and Pfizer wasn't very forthcoming
7 with respect to how the vaccines could potentially
8 be moved safely.

9 LYNN MAHONEY: So what was the response
10 of the Chief Medical Officer of Health to your
11 Associate Medical Officer of Health who had
12 suggested that the long-term care residents could
13 safely get the vaccine? What was the response to
14 the Chief Medical Officer of Health?

15 DR. KARIM KURJI: We didn't receive any
16 response from the Chief Medical Officer of Health.

17 Eventually, in the current state is one
18 where the Pfizer vaccine can be moved to other
19 locations and can actually be administered.

20 LYNN MAHONEY: The same Pfizer vaccine?

21 DR. KARIM KURJI: The same Pfizer
22 vaccine.

23 LYNN MAHONEY: The same Pfizer vaccine
24 is -- but you are aware, I am sure, Dr. Kurji, that
25 all delays -- every day that you delay getting

1 vaccinations into the arms of the long-term care
2 residents is another day that there is the
3 possibility for infections and, unfortunately, we
4 know that 30 percent of the residents of long-term
5 care homes who get infected in fact die.

6 DR. KARIM KURJI: Yes. For that
7 reason, there were many individuals who felt that
8 the Pfizer vaccine could potentially be moved to
9 the long-term care homes.

10 That having been said, the prevailing
11 wisdom at the time was that it couldn't be moved.

12 LYNN MAHONEY: But the Chief Medical
13 Officer of Health never responded to your doctor
14 who had some expertise in the area?

15 DR. KARIM KURJI: That's right.

16 LYNN MAHONEY: Okay. Thank you.

17 DR. KARIM KURJI: The area of testing
18 in long-term care homes also merits attention, and
19 we will present on this too.

20 A special note is that the Auditor
21 General of Ontario early on started the inquiries.

22 We prepared extensive materials for
23 them which we feel will add to your understanding
24 of the situation and have shared these with the
25 Commission.

1 Now, I will just show you a slide about
2 our incident management structure. We activated
3 our Public Health Emergency Operations Centre on
4 January 23rd prior to York Region's case, which was
5 travel-related in February 2020.

6 York Region's first long-term care case
7 was reported externally on March 20th, 2020, and it
8 was also a hospitalized and fatal case.

9 A little bit more about our IMS
10 structure. The diagram shown here is a simplified
11 version of our Health Emergency Operations Centre,
12 which utilizes the Incident Management System.
13 When the response to a Public Health event exceeds
14 the capacity of our normal operations, the
15 Emergency Response Plan may be activated under my
16 authority so that resources can be leveraged across
17 the Health Unit to respond.

18 We activated our plan early on January
19 23rd as we began to investigate suspect cases in
20 returning travellers in January, and it became
21 clear that we needed to prepare for what was to
22 come.

23 York Region's first confirmed case was
24 travel-related and reported on February 29th, 2020.
25 The first outbreak in a York Region long-term care

1 home was at Markhaven Home for Seniors declared on
2 March 17th, 2020, and the first resident case was
3 reported March 20th, 2020.

4 The IMS system is scaleable and
5 flexible, and working in this structure has allowed
6 us to direct resources where they are most needed
7 very quickly; for example, to manage institutional
8 outbreaks and have clear lines of communications
9 with other Emergency Operations Centres and our
10 health system partners.

11 LYNN MAHONEY: Dr. Kurji, can I ask you
12 a question. You talk about your Emergency
13 Management Plan; is that right?

14 DR. KARIM KURJI: Yes.

15 LYNN MAHONEY: So is that the plan that
16 is instituted and invoked when there is, for
17 example, a pandemic?

18 DR. KARIM KURJI: Yes, indeed. So the
19 current best practice is instead of having a
20 separate plan for every emergency, like a pandemic
21 plan and maybe a flood plan, et cetera, we have an
22 all hazards plan, and the hazards are identified
23 through an exercise, which is usually conducted
24 every year.

25 So we actually have a plan that we can

1 utilize for any emergency that may arise.

2 LYNN MAHONEY: And do you update that
3 on a regular basis, and in fact, after you drill
4 your plan, if there are any gaps identified in the
5 plan, do you update it?

6 DR. KARIM KURJI: Not only do we have
7 to update it regularly, we actually have to conduct
8 exercises in accordance to some legislation, which
9 I believe is municipal legislation, and so our
10 regional municipality has regular exercises, I
11 would say about three exercises a year, and all the
12 senior partners within the corporation and some
13 external people also participate in those
14 exercises.

15 We also have dedicated health planners
16 who work on these emergency plans and ensure that
17 we have good business continuity planning and plans
18 already in place.

19 So all that got activated. And the
20 business continuity plans, as you no doubt can
21 guess, are geared to the level of the emergency and
22 so they are very scaleable. And as this pandemic
23 progressed, you know, we were able to, as it were,
24 move more and more staff into the COVID-19
25 response. And when the COVID-19 response kind of

1 flowed away, you know, during the summer months, we
2 were able to transfer staff back into essential
3 services.

4 LYNN MAHONEY: So is it fair to say,
5 Dr. Kurji, the fact that you had this plan in place
6 that had been drilled, the exercises, as you have
7 indicated, removed that factor, that planning, that
8 could have distracted you at the outset of the
9 pandemic, and you already had a structure in place,
10 and everybody knew what their role was and how
11 things were to evolve?

12 DR. KARIM KURJI: That is very true
13 indeed, because to us it was almost second nature
14 given the exercises that we had gone through as to
15 how this was to operate.

16 Now, we had to make a few amendments,
17 and the whole IMS structure kept on being changed a
18 little bit here and there. But that is the nature
19 of an IMS structure, because as you get more
20 details of the emergency, you adjust it according
21 to what is needed.

22 So, for example, instead of just having
23 institutional outbreak teams, we now currently have
24 a school team. We also have workplace outbreak
25 teams. And when the variants appeared, we had

1 folks initially concentrating only on the variants.

2 LYNN MAHONEY: Thank you. Thank you
3 very much.

4 DR. KARIM KURJI: So I would now like
5 to ask Joe La Marca, who is the Public Health
6 Director of our Health Protection Division, and for
7 the COVID-19 response, Joe's role is Chief of IPAC
8 and Enforcement Operations.

9 And Joe will be speaking to the roles
10 and responsibilities of Public Health, and
11 assisting him is Selina Nazim, who is a Public
12 Health Manager in the Health Protection Division,
13 and is present to support questions -- or further
14 information in this area.

15 Again, I want to reiterate the fact
16 that these individuals have a lot of in-depth
17 information, given the fact that we were following
18 the IMS structure, and this is why we have got many
19 more presenters today than otherwise in this
20 session.

21 Thank you.

22 COMMISSION CHAIR FRANK MARROCCO:

23 Doctor, just before we move on, when
24 did York Region create the plan that you described?

25 DR. KARIM KURJI: I would say, top of

1 my head, I think this would be going back several
2 years.

3 COMMISSION CHAIR FRANK MARROCCO: And
4 what caused them -- do you know what caused York
5 Region to do that?

6 DR. KARIM KURJI: This is actually part
7 of best practices and as best practices involved,
8 and we in York Region, not just in Public Health,
9 but the corporation as a whole, like to follow best
10 practices.

11 And to that effect, I would probably
12 add, again, that if there was any laxity on our
13 part, we would be quickly pulled into place by the
14 regional corporation because we belong to this
15 corporation that believes in best practices.

16 COMMISSION CHAIR FRANK MARROCCO: Okay.
17 Thank you.

18 DR. KARIM KURJI: Thank you.

19 LYNN MAHONEY: Okay. Joe, so we are
20 going to move to the topic one, Public Health Roles
21 and Responsibilities. Great.

22 JOE LA MARCA: Thank you very much and
23 good afternoon, and thank you, Commissioner, for
24 allowing us to share our story with you today.

25 I thought I would, for the benefit of

1 the Commission, give you a little bit of a -- where
2 we were or what our role would be in Public Health
3 prior to COVID in terms of how we intersect with
4 long-term care facilities and then take you through
5 specifically in my area how IPAC responded to COVID
6 one and COVID two.

7 So I'll start by saying that during
8 sort of non-COVID times, there is going to be two
9 divisions that intersect with long-term care
10 facilities. My division is the Environmental
11 Health Division, and that is predominantly looking
12 at sort of IPAC and sort of some of the food safety
13 and so forth.

14 But there is also my colleague Andrea,
15 who is in the Infectious Disease Division, who will
16 take you through the outbreak management side of
17 things.

18 And so you'll see through the
19 presentation there is quite a bit of dovetailing
20 together, because you can an outbreak and IPAC go
21 very hand in hand in trying to sort of mitigate or
22 stabilize the home.

23 So our mandate really comes from the
24 Ontario Public Health Standards, and these
25 standards dictate sort of the services and delivery

1 for Public Health Units, and they are found under
2 the Health Protection and Promotion Act.

3 So in terms of the programs that we
4 deliver for homes, it would be food safety. So you
5 can imagine we would inspect the kitchens of the
6 long-term care homes, and those are normally done
7 three times a year based on a risk rating. We
8 would be inspecting personal service settings.
9 These would be sort of places like nail salons or
10 hairdressing.

11 In York Region, of the 28 homes, 26 of
12 them have a personal service setting in them, so
13 that is a regulated function.

14 And also, sometimes the Safe Water
15 Program would also interact, and this is
16 particularly for four of our homes in York Region
17 where they are on private systems. In other words,
18 they use well water for their water, and that
19 requires a dedicated sort of -- it is a regulated
20 system. So our role there would be sort of water
21 sampling and responding to any adverses depending
22 on the results.

23 So I just thought I would give you sort
24 of areas that we would intersect.

25 We also respond to any complaints. We

1 have a mandate to respond within 24 hours to any
2 complaints associated with the home, whether it be
3 sort from public or from people within the home.

4 But obviously for today you would want
5 us to focus on -- I would imagine more on the
6 responsibility to -- for outbreaks of reportable
7 infectious disease.

8 As mentioned, there is the standards,
9 and underneath the standards, there is going to be
10 protocols and then sometimes I'll have guidance
11 documents and regulations.

12 So under the overarching, which is the
13 standard, you will find three particular areas that
14 intersect with long-term care facilities.

15 One is the Public Health management of
16 cases and contacts and outbreaks, and my colleague
17 Andrea will sort of elaborate a little further on
18 that in terms of the outbreaks.

19 One is to participate on committees,
20 advisory bodies and networks to address infection
21 prevention and control in long term care.

22 Now, this is predominantly -- where we
23 interact with the home here is in their IPAC
24 meetings.

25 LYNN MAHONEY: This is pre-COVID, so

1 this is your ongoing responsibilities.

2 JOE LA MARCA: Correct. So all of this
3 right now is pre-COVID. So what we would do there
4 is that the long-term care homes will have IPAC
5 committees, and they normally meet quarterly and --
6 most of them quarterly, and they set them up, and
7 we would be invited to them. So to give you a
8 little bit of an idea, in 2019, we attended 112 of
9 these, and these are intended for us to share with
10 them any sort of pertinent information with regards
11 to IPAC or outbreak management, for that matter,
12 for us to show them any surveillance data in terms
13 of outbreaks across the Region.

14 And also an opportunity for them to ask
15 us any questions in advance that we would sort
16 of -- would be relevant for their staff that they
17 would want to hear.

18 And again, these are all on-site at the
19 actual locations.

20 Within the standard, there is also this
21 requirement of 24/7 on-call response, which I
22 alluded to.

23 Under the protocols, which now gets a
24 little bit more specific, there is a couple of
25 areas of interest that I think that the Commission

1 should be aware of. One is that obviously we would
2 assist long-term care homes with outbreak
3 management preparation, and Andrea will be
4 elaborating a little bit further on that in terms
5 of what work we have done pre-COVID.

6 And obviously provide ongoing support
7 to long-term care homes by providing infection
8 prevention and control guidance and education as
9 needed.

10 So we do many things to sort of meet
11 this requirement, and one I just mentioned about
12 sort of providing education during IPAC meetings,
13 but we also have done some proactive work. We have
14 looked at sort of auditing their policies and
15 procedures, and so we created a template for them.
16 And we would ask them to sort of look at and see if
17 there is any sort of report back on the template,
18 and then from there, we would look at sort of if
19 there is any gaps, and we would provide any
20 resources that they would need to fill those gaps.

21 We also provide them a dashboard every
22 year of sort of the different sort of topics that
23 we have available for them that, upon request, we
24 would come in and do any sort of training. And
25 these run the gamut of a variety of different sort

1 of topics from IPAC to food safety to sort of
2 donning and doffing and a number of those
3 particular topics.

4 And we provide that for them, and they
5 would sort of -- through our health connection,
6 they can actually book a time, and we actually
7 would go into that home.

8 What I am trying to share with the
9 Commission is that we had well-established
10 relationships with our home, and these take through
11 different forms, but clearly on the education
12 front, we had a very good relationship.

13 And we try to make it -- we call them
14 Liaison Officers, so they knew exactly who the
15 individual was. There was a point of contact for
16 every particular home in terms of how they would
17 access us.

18 On top of that, one of the things that
19 we had, we utilized a provincial platform which was
20 called UPHNS, which is Urgent Public Health
21 Notification Systems, and this was intended for us
22 to sort of send out at a moment's notice any
23 particular -- whether it be a directive or
24 something that was coming from the province or from
25 PHO for that matter that we thought it was relevant

1 that they had. And that was particularly useful
2 during COVID, and I'll elaborate once I get there.

3 Okay. So now it is pre-COVID, but now
4 we are in outbreak time, and what I am trying to
5 share with the Commission is that besides having
6 the relationship with the homes, the actual
7 processes are very similar that we were pre-COVID
8 to actually during COVID.

9 So this is an example of sort of when a
10 home was in an outbreak, and just to give you a bit
11 of context, in 2019, we had -- we were responding
12 to 55 outbreaks in long-term care homes
13 specifically.

14 LYNN MAHONEY: And they would largely
15 be influenza outbreaks?

16 JOE LA MARCA: Of those 55, 50 are
17 respiratory and five were enteric?

18 LYNN MAHONEY: Okay. 50 respiratory
19 outbreaks in 2019?

20 JOE LA MARCA: That's correct.

21 LYNN MAHONEY: Okay. Thank you.

22 JOE LA MARCA: And so it would take the
23 same format where we would sort of create an
24 outbreak management team, and you are going to hear
25 a little bit more about that later on.

1 We then would obviously sort of be
2 on-site to do any sort of inspections and to
3 collaborate with the home to sort of minimize or
4 mitigate the impacts of that particular outbreak,
5 and of course after we would be doing a debrief.

6 Those are the same sort of patterns
7 that we would be taking during COVID, and I thought
8 that would be important for the Commission to know.

9 Next slide, please.

10 So I think -- I alluded to sort of the
11 on-site inspections, and so this is what we would
12 normally do in terms of an outbreak, and those
13 inspections would involve looking at sort of
14 outbreak control measures, routine practices, and
15 additional precautions, cleaning and disinfection,
16 PPE availability and use.

17 And inevitably, very similar to COVID,
18 we would go to sort of -- for that inspection, but
19 then we either would observe education or --
20 just-in-time education or on-site education if
21 people were not donning and doffing properly, or
22 the home would call us back to do additional
23 sessions, whether it be on hand hygiene or, like I
24 mentioned, just donning and doffing.

25 So that was sort of the process that we

1 sort of -- that took place prior to COVID.

2 One of the additional things we did in
3 York Region -- everything I said up to now was
4 mandated. This is not a mandated request, is that
5 we were proactive since 2010 in doing what we call
6 IPAC audits and environmental audits of the home.

7 What this meant was we were actually
8 on-site, and with a very detailed checklist, we
9 went through the home with the operator on a whole
10 gamut of different topics, whether it be from
11 cleaning and disinfecting the different types of
12 surfaces they had, to sort of how they handled sort
13 of their waste disposal, to sort of how they
14 handled PPE, where they would store PPE, the proper
15 signages in place.

16 All that was done on -- where we could
17 on a yearly basis, and we started that in 2010.

18 So this kind of gives you a sense of
19 where we were prior to COVID. Now I want to just
20 tell you sort of from the IPAC perspective during
21 COVID what we did.

22 So early on -- and I am talking now
23 early March. What we did was, right from the
24 get-go when we started getting communications from
25 the province --

1 LYNN MAHONEY: So, Joe, could I just
2 interrupt you for a minute. Could you just go back
3 to the previous slide?

4 So you went into every long-term care
5 home in York Region and did an IPAC audit?

6 JOE LA MARCA: Right. So since the
7 beginning of 2010, we thought that this was an
8 important piece that augments the previous -- what
9 I mentioned about education and so forth, because I
10 think it is important, that if we are going to
11 educate, we need to have a sense of what is
12 happening on the ground.

13 So we felt that we would actually go in
14 and do this particular audit. I'm not sure if we
15 sent you a copy of our checklist, for example,
16 that -- that goes through the different topics that
17 we actually would be doing with the home.

18 And the intent was, FTE permitting,
19 because some years there was some stressors, we
20 tried to get every long-term care home.

21 And so, for example, in 2019, we were
22 able to get to 25 of our homes.

23 LYNN MAHONEY: Okay.

24 JOE LA MARCA: And that started in
25 2010.

1 LYNN MAHONEY: Can I ask you, when you
2 went into those homes and you did this audit, was
3 it like a pass/fail? Did you give recommendations?
4 Did they get a report? Like how was the findings
5 noted to the home, and was there any follow-up
6 regarding the findings?

7 JOE LA MARCA: Sure. So the findings
8 were intended to sort of bring the level up of that
9 particular home. So really it is about sort of --
10 so one, they had a copy of our checklist, so they
11 had the written report that would show sort of the
12 gaps and the recommendations.

13 LYNN MAHONEY: Okay.

14 JOE LA MARCA: When we looked at the
15 recommendations, the intent there was for them to
16 sort of follow up on those recommendations and
17 either augment policies or make some changes within
18 the home.

19 And then those were continually
20 followed up, because like I mentioned, we would try
21 to get there from year to year.

22 And of course the intent there was,
23 again, like I said, to increase the education
24 within the home, that would ultimately change
25 policies, and like I said, we audited their

1 policies. So wherever there were gaps based on
2 this process, plus the additional process that I
3 referred to, they should have been in a better
4 situation.

5 LYNN MAHONEY: Okay.

6 COMMISSIONER ANGELA COKE: If I could
7 ask a question. Did you share any of this
8 information with the Ministry of Long-Term Care or
9 have any relationship or intersection with the
10 inspection folks from the Ministry? Or this is an
11 independent exercise?

12 JOE LA MARCA: Are we talking prior to
13 COVID or --

14 COMMISSIONER ANGELA COKE: Prior to
15 COVID.

16 JOE LA MARCA: Yeah. So I would say
17 that our interactions were relatively limited with
18 Ministry of Long-Term Care. Certainly they -- they
19 would certainly -- besides these reports -- our
20 previous reports were obviously disclosed, so they
21 would have access to those.

22 It was only until -- if I recall, it
23 would be sort of if there was an issue with a
24 particular home that there will be some dialogue
25 with them, but beyond that, not really.

1 COMMISSIONER ANGELA COKE: Okay. Thank
2 you.

3 LYNN MAHONEY: Thank you.

4 JOE LA MARCA: You are welcome. So we
5 get to wave one. This is sort of the beginning of
6 March, and what we have done there -- this is prior
7 to any sort of outbreaks in long-term care
8 facilities. What we did was we used our
9 communication, that UPHNS that I was referring to.
10 As we received information from the province with
11 directives or a different sort of announcements, we
12 would send those out to the long-term care
13 facilities.

14 The other thing that we did is we
15 created a COVID assessment. So this is, again,
16 early March, and we went through a number of
17 different topics with regards to that.

18 And that was really intended to see if
19 they had the proper signage, if they had received
20 the directives, if they knew how to get a hold of
21 us, again, in the event that sort of they started
22 seeing staff or residents exhibiting symptoms.

23 So all this was done with a phone call
24 from our liaisons that I referred to earlier, and
25 so that was done all before any sort of home became

1 positive or not.

2 Along the same time, then the Ministry
3 created this tracker, and the tracker -- and this
4 was sort of the first beginnings of our involvement
5 with the LHINs. For myself, anyway. And what we
6 did with the LHINs at that point was sort of track
7 our homes in terms of -- as they started getting
8 into outbreak, and there was a colour coding system
9 of red, yellow, green, that sort of then we would
10 report that up.

11 But that tracker was important because
12 it identified a number of key areas, staffing
13 issues, PPE requirements, and any IPAC issues.

14 And --

15 LYNN MAHONEY: So, Joe, can I just stop
16 you for a minute, please, just to make sure that I
17 understand.

18 JOE LA MARCA: Sure.

19 LYNN MAHONEY: So you contacted
20 proactively all homes in March of 2020?

21 JOE LA MARCA: That is correct.

22 LYNN MAHONEY: And did you complete --
23 did you work with the home to complete the COVID
24 assessments?

25 JOE LA MARCA: So just so that we are

1 clear, this is -- when we talk -- it is not an
2 assessment. It was just our own checklist that we
3 had created.

4 LYNN MAHONEY: Okay.

5 JOE LA MARCA: Recognizing that sort of
6 potentially there could be impact on our long-term
7 care facilities, we wanted to sort of reach out to
8 our long-term care homes to say, you know, first of
9 all, have you received the directives? Are you
10 okay with some of these things? Do you know how to
11 get ahold of us? Is there anything we can kind of
12 assist you with? And I believe that particular
13 checklist is part of the submission, so you can see
14 that, but that was the intent of that particular
15 sort of document.

16 And of course, if there was any
17 additional sort of -- additional questions that the
18 home may have, we certainly responded to that,
19 because, again, this was the liaison person who was
20 an IPAC-trained person that was speaking to that
21 individual on the other end.

22 LYNN MAHONEY: Okay. So you had an
23 IPAC-trained person contacting all of your
24 long-term care homes in March of 2020. Did you ask
25 them about their PPE supply?

1 JOE LA MARCA: We did.

2 LYNN MAHONEY: Okay. And if there were
3 issues, identified issues with PPE supply, as I
4 understand from what Dr. Kurji said, you then
5 helped them and supplied PPE until they were able
6 to obtain their own supply; is that right?

7 JOE LA MARCA: That is absolutely
8 correct, and I think that is something that the
9 Commission should be well aware of, and I think
10 Dr. Kurji did a good job articulating that. There
11 were a number of homes early on that were in dire
12 situations, and either it is because they didn't
13 recognize their burn rate in PPE -- so they may
14 have called us and said we are fine, but then it
15 wasn't until they were in outbreak that they
16 realized, Oh my, I didn't have enough.

17 And so what we did was, we had -- sort
18 of got them through the first 48 hours until they
19 were able to sort of get through the Ontario Health
20 chain supply, if you will, because there was an
21 ordering mechanism where they could get PPE.

22 So in some of the homes were -- they
23 were in real dire straits, we filled that gap, and
24 we actually -- as Dr. Kurji alluded to, we gave
25 them gloves, we gave them masks, and we gave them

1 sort of wipes and gowns. And we gave them packages
2 of -- depending on the size of the home, to get
3 them through that first 48 hours, and then we would
4 deliver that to them through our logistics under
5 the IMS system.

6 LYNN MAHONEY: Okay. What about
7 staffing? When you did the assessments with them
8 in March, was there a conversation with them about
9 the staffing, any staffing issues?

10 JOE LA MARCA: So just so that we are
11 clear, so our COVID sort of document that we
12 created wasn't really sort of looking at staffing.
13 If they had asked -- we asked if there was any
14 issue, they may have sort of alluded to that.

15 LYNN MAHONEY: Yes.

16 JOE LA MARCA: When it came to the
17 tracker, that is really where the LHIN came in.
18 They had the expertise in terms of sort of
19 supporting the homes with regards to access to
20 additional agencies or other mechanisms to help
21 them with sort of staffing.

22 So they led that part. We certainly
23 asked the question later on to the tracker, because
24 that tracker I was referencing to that LHINs and us
25 were involved in, we all sort of took to call the

1 homes directly and say -- because remember, this
2 tracker had to be updated every day. So every day
3 we were getting this information to the point where
4 I think long-term care homes were quite annoyed
5 with us. So we kind of sort, you know, went to
6 every second day.

7 But the intent there was sort of ask
8 the question, and then once we sort of convened
9 with the group, when it came to staffing, really
10 the LHINS took the lead on that because they had
11 the expertise and the connections with the home as
12 it relates to sort of the staffing.

13 LYNN MAHONEY: But just so I'm clear,
14 in this bullet here, it says "Completed daily
15 Ministry tracker on each home to determine risk
16 rating".

17 One of the factors in this Ministry
18 tracker was staffing?

19 JOE LA MARCA: Correct.

20 LYNN MAHONEY: Okay. So when you
21 contacted the home -- and did you do it over the
22 phone or did you go into the home?

23 JOE LA MARCA: For the purpose of the
24 tracker, we did this over the phone.

25 LYNN MAHONEY: Okay. And when your

1 staff would contact the long-term care homes, if
2 they indicated that there was an issue with
3 staffing, you would pass that information along to
4 the LHIN, is that what I am understanding, and the
5 LHIN would follow up?

6 JOE LA MARCA: So once the tracker was
7 populated -- we were meeting with the LHINS three
8 times a week, so we would go through that
9 particular tracker, and you are quite right,
10 sometimes the staffing concerns alone got them to a
11 red. When those were identified, the LHIN, in the
12 case of just staffing, they would have additional
13 meetings with the long-term care homes, potentially
14 other sort of agencies, to see where they can get
15 help from.

16 During the course of that, they also
17 looked at sort of how the hospital could help with
18 some of that staffing issues, and in some cases,
19 they did just that.

20 LYNN MAHONEY: Okay. Thank you.

21 JOE LA MARCA: You are welcome. So I
22 think we are good to go to the next slide.

23 So early on -- now I'm taking you to
24 sort of mid sort of March when we started to get
25 some of -- sort of our homes that were starting to

1 sort of suggest that there was outbreaks, we used
2 our inspection forms. So remember the inspection
3 form I alluded to prior to COVID, that is the
4 inspection form we used because they were familiar
5 with that and sort of that is -- now that then
6 became changed when Public Health Ontario created
7 an assessment form.

8 So we utilized what we had until Public
9 Health Ontario came up with their own assessment
10 form, and that is significant, because early on,
11 you can imagine, as we were going into long-term
12 care homes and the hospitals were as well, we were
13 using one form, they were using another form, and
14 so that was a significant piece that happened
15 towards sort of the -- towards the end of March,
16 early April, if my memory is correct.

17 And that now becomes the assessment
18 form that we use and have used since.

19 So I thought I would share that with
20 the group.

21 So we did all of our assessments
22 obviously of an outbreak because we were obligated
23 to follow that up, but then, by the end of July, we
24 had conducted an assessment of all our long-term
25 care homes, whether they were in an outbreak or

1 whether they were not in an outbreak.

2 LYNN MAHONEY: And you did those --

3 COMMISSION CHAIR FRANK MARROCCO: Can I
4 just stop you there for a minute.

5 JOE LA MARCA: Sure.

6 COMMISSION CHAIR FRANK MARROCCO: End
7 of July, I guess wave one is over, and we are in
8 that period between wave one and wave two. At
9 least that is how I experienced it.

10 And I guess I would like to get a sense
11 of what you figured out from wave one and figured
12 we better get done because wave two is coming.

13 If you can help me with that, it would
14 be appreciated.

15 JOE LA MARCA: Sure. So just for
16 clarity on this is that -- so what we did was
17 for -- again, we are just talking on long-term care
18 homes.

19 COMMISSION CHAIR FRANK MARROCCO: Yes.

20 JOE LA MARCA: Because there is a
21 bigger answer to this as well, because for the
22 long-term care homes we sort of -- if you recall, I
23 mentioned that early on, when we first sort of
24 started, we used our own checklist, and then what
25 we did was, as we were getting outbreaks, we would

1 respond, and then sort of, when we went through
2 that, we went back to some of those homes using the
3 Public Health Ontario assessment.

4 So we wanted to make that sure all the
5 long-term care homes used a consistent tool. So by
6 the end of that particular time frame, we went
7 through all of those, and all the retirement homes.

8 And so appreciate that the focus is on
9 long-term care homes, but there was these other
10 congregate settings that we were also going to.

11 So in terms of -- I hope I have
12 answered your question on that, that the --

13 COMMISSION CHAIR FRANK MARROCCO: So in
14 terms of the process you developed, you had a
15 checklist. You used then the provincial checklist,
16 created sort of terms of reference for yourselves,
17 and then went through all the congregate settings
18 in the Region to see how they measured up against
19 the checklist?

20 JOE LA MARCA: So it is really -- the
21 checklist was intended to sort of help mitigate the
22 situation, so it was part of the outbreak
23 management. You'll hear through Andrea that -- so
24 there is the outbreak -- or the IPAC assessment is
25 one piece of it. Every day there is an outbreak

1 management team that occurs with Public Health
2 staff on it.

3 In between our assessment -- because
4 when we go in there, we will also have staff
5 potentially sort of continue with education visits,
6 and it is a good question in terms of what we have
7 learned, and it goes into my next slide.

8 But just to answer your question, is
9 that one of the things that we learned early on is
10 that we would go in to do an assessment, but it was
11 a point in time. So then when you left, it was
12 very difficult, sometimes, for that home to
13 continue with some of those IPAC, I'll just say
14 knowledge, and so that is where we either had to
15 augment that with sending additional staff to say,
16 by the way, we need to get more education there,
17 and then that became the development of what you
18 probably heard about the IPAC Extenders. It sort
19 of filled that gap between sort of when we were
20 doing the assessment to sort of when we would leave
21 that home to go into the next outbreak because we
22 were having outbreaks everywhere. You wanted that
23 continuity or champions sort of to make sure that
24 the home was following some of those
25 recommendations, especially around donning and

1 doffing and the proper use of PPE.

2 So those would be the lessons that we
3 learned, either through ourselves in terms of
4 providing education, or the creation of these IPAC
5 Extenders with the PHO and our LHINS.

6 COMMISSION CHAIR FRANK MARROCCO: Okay.

7 LYNN MAHONEY: Joe, I am going to
8 actually kind of bring you back to the
9 Commissioner's question because I'm not sure that I
10 am clear on it.

11 So as I understand, in wave one, you
12 basically went in to all the homes that were in
13 outbreak with your original checklist and then
14 subsequently with the provincial checklist when
15 they developed it, the PHO one, and at the same
16 time, you also went into all the other homes that
17 were not in outbreak to see how they were faring;
18 is that right?

19 JOE LA MARCA: Correct, and I apologize
20 if I was not clear.

21 LYNN MAHONEY: No, no, no, it is not
22 you. It is me. It is Friday -- whatever day -- it
23 is Thursday afternoon, and I am probably not
24 hearing straight.

25 So I think that what you were saying,

1 and I think what the Commissioner was asking --
2 which I'm not sure I heard the answer. You may
3 have said it, and I apologize, is -- so that was
4 wave one, and you were about I think to get into
5 wave two.

6 And so there was a lull, and what did
7 you do, if you did, what did Public Health do, to
8 see if the -- we saw what happened in wave one with
9 the homes. What did you do to see how ready they
10 were for wave two?

11 JOE LA MARCA: All right. So if it is
12 okay, I'll continue with my slide deck because it
13 answers that question.

14 LYNN MAHONEY: Yes. Okay. Thank you.

15 COMMISSION CHAIR FRANK MARROCCO: Go
16 right ahead. Don't let us take you out of the
17 rhythm of it.

18 JOE LA MARCA: But I apologize, because
19 what I was trying to sort of get across is that
20 pre-COVID I shared with you that we would go and do
21 inspections and we would do follow-up.

22 It is the same sort of scenario here,
23 that every outbreak that York Region had, we would
24 follow up with an inspection and augment it with
25 any education, but what I was trying to say beyond

1 that, then we went back and finished it with the
2 PHO assessment again.

3 And that was all completed by July in
4 long-term care homes.

5 LYNN MAHONEY: Okay.

6 JOE LA MARCA: I apologize if that
7 wasn't clear.

8 LYNN MAHONEY: No, that is now very
9 clear. Thank you.

10 JOE LA MARCA: So one of the things we
11 learned, as I was saying, is sort of this first
12 bullet, is that we recognized that we needed
13 champions on the ground. So when we left, we
14 wanted to make sure that the things that we left
15 for that home to follow up on was going to
16 continue, because sometimes you would leave and
17 then it is almost like they would panic, and they
18 would forget some things.

19 So you needed somebody there on a
20 regular basis, and that was some of the feedback we
21 got from the LHINs and the homes, is that we need
22 people on the ground on a regular basis.

23 And so this is sort of where my staff
24 couldn't augment that. We also then created -- not
25 we, but the system created sort of these IPAC

1 Extenders that would fill that gap, and that was
2 feedback that all of us provided, that we
3 recognized that we needed this additional help.

4 LYNN MAHONEY: Okay.

5 JOE LA MARCA: And I will get to sort
6 of what we did after, but just to finish the slide
7 there, during wave one, we also issued an order,
8 and I know the Commission is interested in orders,
9 so I have a slide on orders. So unless you have a
10 question now, I'll take it on later on.

11 COMMISSION CHAIR FRANK MARROCCO: That
12 is fine.

13 LYNN MAHONEY: So the answer to the
14 specific question was these IPAC Extenders were how
15 you were going to ensure that what you saw and
16 heard and learned in wave one was hopefully going
17 to help with wave two in these homes?

18 JOE LA MARCA: So -- part of it. So
19 one of the things that we sort of recognized is
20 that we needed this continuation after we left, and
21 that was one piece.

22 LYNN MAHONEY: Okay.

23 JOE LA MARCA: If we go to the next
24 slide, one of the additional pieces that sort of we
25 learned -- and when we say "we learned", you'll

1 hear a lot about -- I'm one piece of it, but you'll
2 hear through our outbreak management group in terms
3 of some of the things that they found in the
4 mitigation, all of those were also shared with
5 homes.

6 And so this is -- the learning is for
7 everyone as we learned from one outbreak to the
8 other outbreak, and our outbreak managers would
9 sort of share that.

10 But this is a clear example of what
11 maybe the Commission might be interested in.

12 So after -- and I just -- sorry, if it
13 is okay, I just want to make it very clear because
14 I think it is important that the Commission
15 understand that, although this is long-term care,
16 what we also did was we actually went and as part
17 of the summer after wave one -- because our focus
18 was long-term care, retirement homes, and dealing
19 with outbreaks, but we also wanted to get into
20 the -- to use the PHO assessment for all the other
21 congregate settings. So as Dr. Kurji alluded to,
22 there is some 280 or so out there that really
23 needed our help as well, and we did that over the
24 summertime as well, so I just point that out.

25 So taking us to wave two, one of the

1 things that the LHINs, through Ontario Health,
2 asked us to do was, in preparation for a wave two,
3 they wanted to do these preparedness checks, and
4 they had this assessment tool that was developed by
5 Ontario Health, led by the LHINs, and what they did
6 was they sent this survey out to long-term care
7 homes to sort of fill out, and they asked if we
8 wanted to participate along with them and along
9 with the hospital of that particular catchment area
10 to do an assessment based on these four areas that
11 they sort of identified.

12 And so they then met with the long-term
13 care home, and they scored it, and the homes that
14 sort of scored poorly on IPAC, we then went back
15 and did another assessment.

16 So in York Region, there was four homes
17 that scored poorly, and so we went back -- and when
18 I say "we", my staff went back to do another Public
19 Health assessment.

20 LYNN MAHONEY: Can I just ask you, Joe,
21 we have heard about these -- I think they were
22 called preparedness surveys.

23 JOE LA MARCA: Yes.

24 LYNN MAHONEY: And we heard that the
25 Ministry sent them out, that they were sent out to

1 the homes. The homes completed them.

2 What you are saying is, in York Region,
3 the LHIN actually helped the home complete them as
4 well?

5 JOE LA MARCA: What I am sharing is
6 that the LHIN led this. So in other words, the
7 LHIN -- this was Ontario Health created this
8 strategy. The LHIN sort of was the lead for it.
9 They called us and said, Would you like to
10 participate in this? This is what we are thinking
11 of doing for preparedness.

12 We didn't have any input on the tool.
13 This tool was already developed for us. They sent
14 it in a day in advance to the long-term care home,
15 as I understood it.

16 And then what this group would do,
17 "this group" meaning the LHIN, the long-term care
18 home, the hospital, ourselves, would sort of have
19 the conversation to say, Well, through the
20 different criteria, where do we think the home
21 should be, based on sort where they are, based
22 on -- because some of them had already gone through
23 outbreaks and what have you. So the ones that sort
24 of scored poorly, we then were asked to go and do
25 another assessment, and that is what we did, and

1 the creation --

2 LYNN MAHONEY: And who -- Ontario
3 Health asked?

4 JOE LA MARCA: The LHINS.

5 LYNN MAHONEY: The LHIN asked. And
6 what LHIN do you deal with?

7 JOE LA MARCA: So we deal with two
8 LHINS, Central West and Central.

9 LYNN MAHONEY: Okay.

10 COMMISSIONER ANGELA COKE: Can I just
11 clarify something? So was this based on the
12 combination of the group coming up with an
13 assessment versus self-assessment by the home?

14 JOE LA MARCA: So as I understand it,
15 the home was given the tool, and then they would
16 fill it, and then sort of the next day or so, they
17 would meet together. When I say "meet together",
18 with the four stakeholders, if you will. And they
19 would go over that rating.

20 And if the agreement was that -- sort
21 of, for example, under the IPAC category -- because
22 there was other categories, like leadership, at the
23 top of my head, et cetera, but I know one was IPAC.
24 If that home sort of scored poorly or needed more
25 help on IPAC, for example, then that particular

1 home got another visit from us using the Public
2 Health assessment.

3 COMMISSIONER ANGELA COKE: What I am
4 saying is this wasn't based on just their sole
5 assessment?

6 JOE LA MARCA: That is my
7 understanding.

8 COMMISSIONER ANGELA COKE: Okay.

9 JOE LA MARCA: It was based on them,
10 plus then the team coming together.

11 COMMISSIONER ANGELA COKE: Okay. Thank
12 you.

13 LYNN MAHONEY: I am just going to ask
14 more questions about it, because I can tell you
15 that the evidence that we have heard is confusing
16 at best.

17 These surveys were sent to the homes by
18 Ontario Health, I believe, or -- I think that is
19 where we are at. What we have seen is we have seen
20 the surveys. We have seen the home having
21 completed the survey, the completed survey.

22 And then we have seen some assessment
23 that was done by Ontario Health of all of the
24 various homes and then the homes categorized as
25 red -- like high risk. There is some report that

1 says, for example, that a home is high risk.

2 So is what you are saying that the home
3 itself completed the survey. That survey was then
4 fed into Ontario Health, who would meet with the
5 LHIN, with Public Health, with the home itself, and
6 review that survey and then would decide how to
7 categorize the home?

8 JOE LA MARCA: So maybe, Lynn, for
9 greater certainty, if that is okay with you, I am
10 going to invite Selina to sort of speak to that
11 particular -- I just don't want to in any way get
12 it wrong.

13 LYNN MAHONEY: No, that is no problem.
14 Okay.

15 JOE LA MARCA: So I thought maybe --
16 because it is sort of our staff that sort of were
17 part of this.

18 LYNN MAHONEY: Okay.

19 JOE LA MARCA: So, Selina, I'm
20 wondering if you can kind of shed light on some of
21 the specifics around the process around here.

22 SELINA NAZIM: So what I understand is
23 that they would be filling out this assessment.
24 Then there would be --

25 LYNN MAHONEY: "They" being the home?

1 SELINA NAZIM: The home would have
2 their -- they would fill out an assessment, and
3 they would rank themselves. They would score
4 themselves. Then as Joe explained, they would meet
5 with the hospital and the LHIN partner -- or sorry,
6 not the hospitals, with the LHIN and with Public
7 Health, and they would go around and discuss all
8 the different metrics. And everybody sort of in
9 that meeting would sort of weigh in on whether they
10 felt the metric was right or if the score needed to
11 be adjusted.

12 And then there was a requirement that
13 if there were a certain score -- if you were below
14 a certain score, as it relates to IPAC, then there
15 would be a requirement for an IPAC assessment.

16 What I understand it to be with the
17 IPAC assessment, it would be up to the home to
18 decide if they want to do the assessment
19 themselves, or they can do it in collaboration with
20 the hospital extender or in collaboration with
21 Public Health.

22 And I think on an earlier slide Joe
23 alluded to, we went into four homes that we
24 actually did it in collaboration with the home for
25 that reassessment.

1 LYNN MAHONEY: Okay. So the questions
2 I have about that, so what if a home ranked itself
3 really well on all these things? We have no issues
4 with PPE, no issues with -- I can't remember what
5 the metrics were. I know staffing. I think
6 leadership was another one. What about if a home
7 ranked itself really well? Was there any review
8 done to see whether or not -- because this was to
9 see whether the homes were ready for wave two. So
10 did anybody go and independently verify what the
11 home was reporting?

12 SELINA NAZIM: So for the purposes of
13 IPAC, because we had been doing on-site
14 assessments, we would have that as our background
15 on what the feedback would be. So if the home said
16 that they were rated high in IPAC, and our on-site
17 assessment indicated -- it didn't align, then we
18 would weigh in on that feedback.

19 I can speak to the IPAC pieces. I'm
20 not sure if there is someone else in the group that
21 can speak to the staffing and the other pieces,
22 Joe, but that is how we would deal with the IPAC
23 pieces.

24 JOE LA MARCA: And I think it is worth
25 exploring only because, remember, this was a

1 LHIN-led initiative.

2 So if you are asking me, Joe, did you
3 get a report of all -- I was never given that. And
4 so certainly on the leadership pieces and the
5 staffing pieces, they would weigh in. Our main
6 focus was on the IPAC, as Selina sort of alluded
7 to.

8 LYNN MAHONEY: Okay. And you would
9 have information to essentially verify or refute
10 what the home was self-reporting?

11 JOE LA MARCA: Remember -- only
12 because, remember, we went to all the homes, right,
13 so we --

14 LYNN MAHONEY: Yes.

15 JOE LA MARCA: So we actually have our
16 own assessment and so we would be able to say that.

17 LYNN MAHONEY: And that was very
18 valuable to be able to do that, and the four homes,
19 Selina, that you went into, why did you go into
20 those four homes?

21 SELINA NAZIM: So as I mentioned, so
22 they would have scored low on their IPAC metric,
23 and so then the home was given an opportunity to do
24 a reassessment and submit it, or they can ask one
25 of the stakeholders, the extenders, or Public

1 Health.

2 So we did it in collaboration with the
3 home and submitted that reassessment.

4 LYNN MAHONEY: Okay.

5 SELINA NAZIM: Upon the request. So
6 the home gets to decide if they want to do the
7 reassessment, and they ask to do it in partnership
8 with Public Health.

9 LYNN MAHONEY: Was there any concern
10 raised about the fact that the homes were able to
11 do their own assessments if they were ranked poorly
12 on IPAC, given what we saw happening in wave one?
13 Did anyone push back on that and say, Well, maybe
14 there should be an independent verification of it,
15 given the fact that they are scored low?

16 JOE LA MARCA: Given that Ontario
17 Health was sort of leading and it the LHINS were
18 leading it, we didn't sort of -- we didn't question
19 that because that was their process. They didn't
20 even ask us early on to say what does that actual
21 questionnaire look like. So we just were actually
22 coordinating with them in terms of just on the IPAC
23 side.

24 LYNN MAHONEY: Perfect. Thank you.

25 Thank you. Sorry I took you off your

1 presentation.

2 JOE LA MARCA: No, it is okay. It is
3 good questions. So thank you.

4 So thank you, Selina.

5 So where were we here? So, again,
6 COVID two, we continued on very similarly in terms
7 of any additional sort of UPHNS that we had, and I
8 think for the submission, I think we had over 30 of
9 them we sent specifically messaging to long-term
10 care homes, so I think you have copies of those.

11 Again, we would still use the same
12 process of any outbreak had an actual inspection,
13 with the PHO on-site, and I'm actually very proud
14 of the fact that we had staff actually on-site from
15 the get-go. The PHO inspection, plus any
16 educational visits to support the actual
17 inspection.

18 We sort of -- then later on what
19 happened was the development of the IPAC hubs, and
20 that IPAC HUB happened somewhere around October.
21 You can imagine that, up to that point, we had
22 hospitals on-site with us, and there was other
23 stakeholders, like LHINs and so forth, and what the
24 IPAC HUB did was really define roles and
25 responsibilities. I think that was a value that

1 they brought to the table, and we have four hubs
2 that we were part of in York Region. They are all
3 around sort of the hospital catchment areas and --
4 so we are part of those. Selina sits on those
5 particular committees. And what we had decided or
6 agreed upon that, when it came to an outbreak,
7 Public Health would be the lead in assisting the
8 outbreak management, and Public Health would be the
9 lead in terms of doing the Public Health
10 assessment. Because we didn't want to sort of
11 confuse the home that if they got different players
12 coming in to do the assessment, which one do they
13 follow.

14 So that was very good to clarify that
15 it was our assessment, and then sort of anybody --
16 any extender that came after from the hospital or
17 from the LHINS would sort of just follow our
18 assessment and sort of reinforce some of those
19 messaging and things that we had found.

20 LYNN MAHONEY: Could I just interrupt,
21 Joe, for a second, and we spoke about this when we
22 had our earlier meeting last week. What about the
23 Ministry of Long-Term Care? What about them in
24 wave one? What about their involvement with the
25 homes and with yourselves in terms of doing

1 inspections? Were they there?

2 JOE LA MARCA: So, Lynn, I can just
3 tell you from my experience in terms of what I saw,
4 and I don't want to sort of make any soft of
5 disparaging comments, that -- I only know what I
6 know.

7 With regards to sort of our
8 inspections, especially during wave one, we saw
9 very little of the Ministry of Long-Term Care. I
10 think through the course of the entire pandemic to
11 date, we have only been on-site with them twice,
12 but not because it was coordinated. We just sort
13 of happened to know that they were there. So I
14 can't answer it more than that. I know that during
15 wave two, we saw -- we heard more of them being at
16 IMT meetings, and I think you'll hear the term
17 "IMT", which is the incident management meetings
18 for the homes later on in wave two.

19 But certainly in wave one, I saw very
20 little of them. It is not to say that they weren't
21 there. I'm just letting you know my experience.

22 LYNN MAHONEY: Does the Ministry of
23 Long-Term Care have any role in those IPAC
24 committees at the --

25 JOE LA MARCA: So the -- sorry.

1 LYNN MAHONEY: The ones that you told
2 us about that you are mandated to sort of attend
3 and that you do attend, does the Ministry of
4 Long-Term Care have any role in attending those
5 meetings.

6 JOE LA MARCA: So as mentioned, those
7 are meetings that are sort of held by the home, so
8 they invite us, and we go. But, Selina, to answer
9 that question, do you know if any of those meetings
10 we ever had the Ministry there?

11 SELINA NAZIM: They are not one of the
12 listed members. So in the legislation under the
13 Long-Term Care Homes Act, it says that you have to
14 have the committee and the MOH is invited to the
15 committee. Generally who is present at those
16 meetings are representatives from the home, such
17 as, you know, the heads of dietary, pharmacy, the
18 Medical Director, a representative from Public
19 Health.

20 But we don't -- the Ministry of
21 Long-Term Care is not present at those meetings.

22 LYNN MAHONEY: Okay. Thank you.

23 JOE LA MARCA: So that was another --
24 so I just finished off with the HUB and the
25 introduction of that particular framework.

1 And during wave three, up until now, we
2 have issued three orders with regards to homes.

3 LYNN MAHONEY: Sorry, I could be wrong.
4 So, Dr. Kurji, was the total of -- I thought there
5 was a total of five orders that you issued?

6 DR. KARIM KURJI: Sorry, Joe, I think
7 I'll need a little bit of assistance here. Was it
8 five or was it six?

9 JOE LA MARCA: So again, we are talking
10 long-term care, right?

11 LYNN MAHONEY: Yes, yes.

12 JOE LA MARCA: It is four long-term
13 care orders with two letters that we sent.

14 We have issued orders to retirement
15 homes, but I don't know if you want to hear about
16 that.

17 LYNN MAHONEY: No, it is not -- as I
18 explained to you, we are very aware of the fact
19 that retirement homes have suffered terribly as
20 well, but the mandate of this Commission is to look
21 at the long-term care homes. The issues we
22 understand are similar.

23 So there was four section 29.2 orders
24 issued against long-term care homes. I'm just
25 looking at an article from The Globe and Mail, and

1 they talk about you, Dr. Kurji, and they talk about
2 the fact that you issued five orders. It says:

3 "[...] including four against
4 Sienna Seniors Living Inc., one of
5 Canada's largest operators of
6 private for-profit long-term care
7 homes."

8 Were they the long-term care homes or
9 retirement homes?

10 DR. KARIM KURJI: They were long-term
11 care homes.

12 LYNN MAHONEY: So four Sienna homes in
13 York Region, you issued section 29.2 orders
14 against?

15 DR. KARIM KURJI: Joe, can I just get
16 validation of that?

17 JOE LA MARCA: So again -- and maybe
18 Selina can help us out. I know the names off the
19 top of my head, but I don't know the corporation
20 behind it, right? So I would imagine -- I know two
21 for sure are Sienna homes. Selina, is that
22 correct, all four of them were Sienna homes?

23 SELINA NAZIM: No, not all four of
24 them. At least two of them were Sienna homes, but
25 not all four of them.

1 JOE LA MARCA: We can verify if you
2 like.

3 LYNN MAHONEY: It says Langstaff Square
4 Care Community in Richmond Hill, where no residents
5 have died during an outbreak; Villa Leonardo Gambin
6 in Woodbridge, where 25 residents have died; and
7 the Villa Da Vinci Retirement residence, also in
8 Woodbridge, where six people had died.

9 JOE LA MARCA: That's correct.

10 LYNN MAHONEY: So that was three, and
11 then there is a fourth.

12 JOE LA MARCA: I believe it was
13 Woodbridge Vista was the first one.

14 LYNN MAHONEY: Okay.

15 JOE LA MARCA: Are we okay to proceed?

16 LYNN MAHONEY: Yes. Thank you.

17 JOE LA MARCA: Of course.

18 SELINA NAZIM: Sorry, can I just
19 correct that? Sorry, you said Villa Da Vinci?

20 LYNN MAHONEY: Yes, Villa Da Vinci
21 Retirement residence in Woodbridge.

22 SELINA NAZIM: Yeah. So it is Villa
23 Leonardo Gambin was the order against.

24 LYNN MAHONEY: Okay. Thank you.

25 [Court reporter intervenes for

1 clarification.]

2 LYNN MAHONEY: Thanks, Deana. That is
3 my fault. I will be mindful of that.

4 JOE LA MARCA: So we have issued three
5 orders, and the next slide -- and I think the
6 Commission was interested in our orders, and so we
7 thought we would provide you a little bit.

8 So the orders are -- again, that is
9 under the Health Protection and Promotion Act, and
10 Dr. Kurji is the one that issues those.

11 A little bit about our process in terms
12 of when we get to an order.

13 So, you know, an order is just one tool
14 that we have at our disposal, and throughout the
15 course of this particular response, we try to be
16 collaborative as much as we can with our partners,
17 because there is a number of us at the table that
18 are trying to mitigate and try to help the home in
19 terms of the response.

20 So the process is normally sort of we
21 would go and do an assessment, and based on that,
22 we would do a re-inspection, and in between that, I
23 talked to you about some of those education visits
24 in between. And so we are trying to get
25 compliance, and we are trying to stabilize the

1 home. That is the intent of sort of our work
2 there.

3 And for the most part, we have had good
4 sort of willingness from the home and different
5 partners because hospitals are there to assist as
6 well and so are the LHINs.

7 But in some really sort of, I'll say,
8 extreme cases, we can't get -- or we feel that
9 there is the continued non-compliance and
10 transmission not being sort of dealt with that we
11 had to issue these orders. And I just thought I
12 would give you a sense of what those -- sort of
13 some common themes within those orders were.

14 So lack of knowledge of point of care
15 assessment, and that is really important because we
16 recognized throughout the -- the point of care
17 assessment is when that health care professional,
18 depending on what their interaction is going to be
19 with that resident, will determine what sort of PPE
20 they wear and don't wear.

21 And so we start seeing a lot of that
22 sort of problem, and in some cases, it wasn't
23 rectified. A lot of it had to do with fear, and
24 people sort of started doing some really crazy
25 things in terms of double-masking and other things,

1 and my colleagues will sort of elaborate on some of
2 this stuff a little further.

3 Staffing was certainly an issue, and in
4 some cases they just could not shore it up.

5 Lack of equipment; examples of those
6 would be something like the PPE cards, and so one
7 of the requirements is to have PPE cards outside of
8 every particular -- in every room, on every floor,
9 so that it is easy, accessible, for their staff to
10 sort of get to.

11 And so a lot of times those things were
12 missing, supplies in terms of not having the proper
13 PPE and so forth and so on.

14 So I thought I would just share a
15 little bit of sort of examples of what we would see
16 in some of our orders, and this is sort of what led
17 to it.

18 So I thought I would conclude with some
19 of our recommendations, and the first
20 recommendation is probably something that you have
21 seen, and it is sort of having a dedicated IPAC
22 staff on the ground at all long-term care homes.

23 And what we further want to clarify
24 here is that this should be a dedicated position,
25 so it is not sort of that they have IPAC, but they

1 have three other different roles on top of that,
2 and I think that is really, really important.

3 I think what is also important to note
4 is that not every home is the same size. So if you
5 have a 200-bed sort of facility, you may need more
6 than one IPAC. So that ratio between sort of IPAC
7 professional to sort of number of beds I think will
8 be very, very important.

9 I think it is important to also note --
10 sort of making sure that we have knowledgeable
11 staff that sort of are dedicated to that. So this
12 is not something that -- I think they have to have
13 work experience with regards to IPAC, because that
14 is really important when you know the foundational
15 pieces, but then you can troubleshoot depending on
16 sort of the circumstance you find yourself.

17 We believe that there needs to be an
18 implemented accountability framework, and so this
19 is sort of where the home sort of would report on
20 IPAC assessments, similar to what we do now with
21 regards to our food inspections and disclose them,
22 and that should be tied into their licensing on an
23 annual basis and as part of sort of the -- just
24 ensure that this is occurring.

25 Now, whether or not it is the long-term

1 care home that sort of conducts that or if that is
2 done by an outside agency or the Ministry of Labour
3 or us, that sort of can be worked on, but we
4 definitely need to make sure that there is an
5 accountability mechanism for all homes.

6 We need a systems approach to IPAC. So
7 some of the things are rather obvious, that sort
8 of -- there is a number of people that interact
9 with homes. Whether it be the agency staff,
10 whether it be sort of the essential caregivers,
11 whether it be their cooks, their maintenance staff,
12 there needs to be a level of sort of, I'll say,
13 IPAC awareness for staff that sort of are regularly
14 in those homes.

15 And furthermore, I would say,
16 especially when it comes to agency staff, we
17 certainly saw a problem with agency staff with
18 regards to lack of proper, you know, IPAC
19 preparedness.

20 So I think we need to look a little
21 further upstream to look at sort of agencies that
22 employ, for example, personal service workers.
23 What is the curriculum for a personal service
24 worker? So we need to sort of dive in a little
25 deeper to that to make sure that there is a core

1 competency on IPAC because their role is so
2 important, and they come in contact with our
3 residents in different ways. And that is really
4 important because we saw, certainly in our
5 experience - and my colleagues will elaborate a
6 little further - that that was certainly an issue
7 that we observed in both wave one and wave two.

8 And lastly, I think it is the question
9 that you had asked earlier. A lot of our work that
10 we talked about in preparedness deals with sort of
11 normal -- what I will say normal sort of outbreaks
12 of a given sort of organism, and they have a
13 specific duration.

14 But there isn't, that I see, is sort of
15 the large scale sort of planning that needs to
16 occur for every home as part of their sort of
17 outbreak management.

18 So these are sort of the
19 recommendations that we would ask you to consider.

20 COMMISSION CHAIR FRANK MARROCCO: Thank
21 you. Thank you for the recommendations.

22 JOE LA MARCA: Thank you.

23 DR. KARIM KURJI: Thank you. So if it
24 is okay, we'll move to the next topic, and it is
25 Andrea Main, who is a Public Health Manager in the

1 Infectious Disease Control Division, and for the
2 COVID-19 response, Andrea's role is Chief COVID-19
3 Case Contact and Outbreak Operations. And Andrea
4 will be speaking to Public Health outbreak
5 management.

6 And Ewilla Castellan-Wong, who is a
7 Public Health Manager in the Public Health
8 Protection Division, is present to support any
9 questions or further information in this area.

10 So thank you, Andrea.

11 ANDREA MAIN: Thank you, Dr. Kurji, and
12 thank you to the Commission for this opportunity to
13 speak to you today.

14 For my portion of the presentation
15 today, I will be speaking to a little bit on our
16 role in outbreak response prior to the pandemic as
17 well as the pandemic.

18 I would like to highlight some of the
19 key challenges from our outbreak team that they
20 experienced during the response and how we
21 addressed some of these challenges.

22 I'm also hoping to touch on some of the
23 mental health impacts of the pandemic that we saw
24 on residents, long-term care staff, and also our
25 Public Health staff.

1 Finally, I'll finish up as well with
2 some recommendations that we would like to put
3 forward for your consideration.

4 So for the roles and responsibilities,
5 Joe already spoke to this. But for the Ontario
6 Public Health standards and the requirements for
7 programs and services that are published by the
8 Minister of Health and Long-Term Care, these are
9 the standards that our program is guided by and
10 that is the Institutional/Facility Outbreak
11 Management Protocols.

12 So under the direction of this
13 protocol, our Public Health program provides
14 guidance to homes in outbreak, in infectious
15 disease outbreaks.

16 We assist in confirming the existence
17 of the outbreak, and then we manage it, together
18 with the home, right until the outbreak is declared
19 over.

20 For long-term care homes, their
21 responsibility is to meet the regulatory
22 requirements of the Ministry of Long-Term Care, and
23 they are responsible for managing the outbreaks and
24 following the IPAC recommendations that Joe and
25 Selina were speaking to.

1 And under this protocol, an outbreak
2 can be declared either by the institution or by
3 Public Health.

4 So next slide. Prior to COVID, the
5 Infectious Disease Program at York Region Public
6 Health was actively involved in preparing long-term
7 care homes and retirement homes for the outbreak
8 season.

9 Education sessions were offered to all
10 facilities in the Region. These were an Outbreak
11 101-type session that covered all aspects of
12 outbreak management from detection to reporting of
13 outbreaks and the application of outbreak control
14 measures.

15 We also set up visits with each
16 long-term care home and retirement home in the
17 Region prior to the outbreak season.

18 For these visits, we used a
19 pre-outbreak checklist as well, which was sent in
20 advance to each facility for their review and
21 preparation for the visit.

22 During the visit, Public Health staff
23 provided an education on-site at the facility and
24 worked in partnership with the facility staff to
25 complete this pre-outbreak checklist.

1 During the visit, Public Health staff
2 conducted a walk-through as well just to understand
3 the overall facility structure, the number of
4 floors, the number of locked units, and the
5 services provided within that facility.

6 And this enabled our Public Health
7 staff and long-term care staff to better understand
8 the challenges that might be faced by each
9 particular facility when in outbreak.

10 LYNN MAHONEY: So, Andrea, if I could
11 just interrupt for a second. So when did you do
12 this with I think the 25 long-term care homes you
13 had?

14 ANDREA MAIN: 28.

15 LYNN MAHONEY: 28. Sorry. Yes. So
16 when was this done?

17 ANDREA MAIN: This took place in
18 October of 2019 we started -- sorry, the summer of
19 2019 up until the fall.

20 LYNN MAHONEY: Thank you.

21 ANDREA MAINE: So as part of this
22 process, each of our staff on our team were
23 assigned specific homes to be that single point of
24 contact that Joe spoke to, and this allowed each
25 home to have a dedicated Public Health

1 representative to reach out to when they had a
2 suspected outbreak, and we also wanted to make sure
3 that they felt prepared for the outbreak season.

4 So our staff dropped off swabs at each
5 of the facilities, and this would assist the
6 facility. If they had a suspected outbreak, they
7 could quickly test and send that in for the
8 results.

9 So the next slide.

10 I know this slide is busy, but -- for
11 this slide, I was hoping to show you a comparison
12 of the pre-COVID routine steps and outbreak
13 management that Public Health is involved in prior
14 to the pandemic versus the additional outbreak
15 actions that we would need to take for COVID-19
16 outbreaks.

17 So I just hope that this highlights for
18 the Commission the added complexities that we
19 experience with outbreak management at each step in
20 the process.

21 Part of our usual Public Health
22 management actions are that we assist the facility
23 in confirming the existence of the outbreak, and
24 this is often based on our Ministry case
25 definitions. For example, a respiratory outbreak

1 in an institution is defined as two cases of acute
2 respiratory infection within 48 hours, with a
3 common epidemiological link, like a floor or a
4 unit, and at least one of these cases must be
5 laboratory confirmed.

6 And you will see on the other side of
7 the slide, for COVID-19, an outbreak is defined as
8 just one case of confirmed COVID-19 in a resident
9 or a staff member at the home.

10 And as you can imagine, this really
11 lowered the threshold for declaring a confirmed
12 outbreak.

13 The next action taken is to determine
14 the population at risk and advise on testing. So
15 normally, you will see there pre-COVID, we would
16 only test about three to four residents per
17 outbreak. And for COVID outbreaks, we would do a
18 much more in-depth assessment along with individual
19 case and contact tracing and then arrange for
20 expanded testing in the homes, often advising the
21 home to swab an entire unit of staff and residents
22 in order to stem the spread of COVID.

23 And these actions were necessary in the
24 face of this new virus that spread so quickly.

25 The next step speaks to the outbreak

1 management meetings that we have with the facility
2 after the outbreak is declared.

3 So normally there is one outbreak
4 management meeting. We call this the OMT meeting.
5 And then daily check-ins with the facility and the
6 Director of Care after that.

7 For COVID, there were often, beyond
8 this initial meeting, daily meetings attended by
9 multiple stakeholders, and often included more than
10 our traditional outbreak management review. Joe
11 spoke to this. It may include reviewing their PPE
12 supplies, getting updates on their staffing
13 situation, and how they were faring.

14 The next two steps speak to active case
15 finding and assessment of the status of the
16 outbreak. We rely heavily on the home to actively
17 report any additional cases and send in that daily
18 line list with the update.

19 So during COVID, there would be lengthy
20 meetings with our facilities and Directors of Care
21 to pour over these line lists and identify all new
22 cases, hospitalization, deaths, and additional lab
23 results for both staff and residents.

24 For COVID, Public Health staff, who
25 were tracking the results of the expanded testing,

1 we would track all positive tests and negative on
2 electronic line lists in order to fully understand
3 the spread and the scope of the outbreak.

4 With this information, we would also
5 request floor plans of the facility and consider
6 cohorting and movement of residents. This was a
7 new step for us in the outbreak management tool
8 box. Prior to COVID, we had influenza immunization
9 or the use of antivirals to assist in controlling
10 respiratory outbreaks.

11 And the next step speaks to outbreak
12 management and IPAC investigations, and as Joe
13 mentioned, we have on-site education provided to
14 the institutions, as well as IPAC support.

15 LYNN MAHONEY: Andrea, I'm sorry, I
16 think I may have misunderstood you.

17 You said that the cohorting was a new
18 step?

19 ANDREA MAIN: Yeah. So prior to COVID,
20 we wouldn't necessarily be involved in moving
21 residents from their room. During COVID, we would
22 create sometimes an affected end of the unit versus
23 an unaffected end. So we would move positive
24 residents to one side of the unit and then negative
25 residents to another side of the unit in order to

1 stem the spread.

2 LYNN MAHONEY: So what caused this --
3 so it sounds like it is not something that you used
4 to do, and is it correct that the long-term care
5 homes were not being trained about cohorting or
6 they weren't aware of cohorting?

7 ANDREA MAIN: No, we do speak to
8 cohorting in the sense of staff cohorting, and we
9 would attempt to put that in place as much as
10 possible in our usual routine outbreak management
11 steps.

12 But in terms of actual movement of
13 residents, that was a new step for us.

14 LYNN MAHONEY: Okay. And where did you
15 get the direction that you needed on that issue of
16 cohorting? Cohorting of residents/isolation of
17 residents, where did you get the direction on that?

18 ANDREA MAIN: So initially in the first
19 wave, there was a lot of our own internal
20 conversations. We also followed the Directive 3
21 from the Ministry of Health and Long-Term Care and
22 a lot of this stemmed from some of the physical
23 infrastructure of the long-term care homes. We had
24 homes with a number of quad rooms where you would
25 have four residents in one room. When one resident

1 tested positive, we made every effort to cohort and
2 move that resident out to try and protect the rest
3 of the residents in the room.

4 LYNN MAHONEY: Okay. Thank you.

5 ANDREA MAIN: Thanks. So pre-COVID, I
6 was speaking to fact that we provided IPAC support
7 and education, and for some of our more complex
8 outbreaks post-COVID, we visited homes regularly
9 for IPAC support.

10 And then the last step in the process
11 is declaring the outbreak over. Our processes have
12 not changed. We continue to meet with the home,
13 review the measures that should continue, and
14 provide recommendations to the home in the form of
15 a letter.

16 Next slide, please.

17 So for this, I would just like to do a
18 bit of a deeper dive into some of the specific
19 challenges and how we managed them at our Health
20 Unit.

21 But for the testing portion, Shanna is
22 up next after me in the presentation, and she will
23 speak more specifically to testing.

24 So next slide.

25 We saw early in the pandemic that homes

1 were really struggling with controlling COVID-19
2 outbreaks versus the traditional respiratory
3 outbreak. Homes that had residents with dementia,
4 for example, were at higher risk and had a hard
5 time controlling the outbreaks.

6 In order to assist the home in
7 controlling the spread, we needed to perform an
8 in-depth risk assessment to really understand the
9 spread within the home and collect the necessary
10 information to manage that outbreak.

11 We brought in additional
12 epidemiological staff to help collect, interpret,
13 and report on the numbers of cases,
14 hospitalizations, and deaths that were occurring.

15 This was quite challenging, and as I
16 described earlier, in order to effectively manage
17 an outbreak, it requires an accurate, up-to-date
18 line list each day from the facility.

19 We also took calls from families as
20 well who wanted to express their concerns and
21 complaints, which our staff don't normally deal
22 with the volume of calls that we were receiving, so
23 that was an added challenge.

24 We also worked with institutions to
25 stay on top of all the updates to the Ministry

1 guidance documents and consulted with Public Health
2 Ontario and the Ministry of Health and Long-Term
3 Care on the more challenging outbreaks that we were
4 dealing with.

5 And as Joe also alluded to, we pulled
6 in staff from other parts of Public Health,
7 particularly our specialists in infection
8 prevention and control, as well as outbreak
9 management, our Public Health inspectors, and
10 Public Health nurses to help lead the response in
11 long-term care.

12 And --

13 COMMISSION CHAIR FRANK MARROCCO: Could
14 I just stop you for a second. The contact tracing,
15 how did you staff it? Or was it a big problem to
16 staff it?

17 ANDREA MAIN: Yeah, so contact tracing
18 was difficult to staff right up front, and so we
19 did work to bring in some of the provincial
20 workforce staff to assist in our contact tracing
21 teams and that has been very helpful in the
22 response, so that we can pull some of our more
23 skilled staff into the outbreak management and
24 infection prevention and control work.

25 COMMISSION CHAIR FRANK MARROCCO: Would

1 there be any reason why other staff, like police
2 officers or inspectors, could be -- would there be
3 any reason why they couldn't be drafted into
4 contact tracing, or is there more to it than might
5 appear to someone who is not experienced with it?

6 ANDREA MAIN: I think within Public
7 Health we have some of our Dental Hygienists,
8 Dental Assistants, who are helping. We have
9 Registered Nurses. We have brought in staff within
10 Public Health and within the corporation who are
11 able to and willing to assist.

12 COMMISSION CHAIR FRANK MARROCCO: Okay.

13 ANDREA MAIN: Yes.

14 COMMISSION CHAIR FRANK MARROCCO: That
15 is fine, Andrea. Thank you.

16 ANDREA MAIN: Thanks.

17 Okay. So next slide. So with this
18 slide, I'm going to speak to some of the staffing
19 challenges that we observed in the long-term care
20 homes during the outbreaks.

21 We would like to note also that
22 staffing issues in long-term care have been a
23 long-standing problem and this has made managing
24 outbreaks challenging.

25 During COVID, there were staffing

1 shortages, especially during the outbreaks, due to
2 the need to cohort staff to specific units versus
3 working throughout the facility. Staff who were
4 sick or fearful did not come in to work, and there
5 was an increased demand on staff due to wandering
6 or ill residents as well.

7 There were challenges from staff
8 working between homes. When staff were limited to
9 working in one home, this presented staffing
10 challenges for that institution. In a few
11 situations, staff who worked at multiple locations
12 were the index case in a number of outbreaks in
13 institutions.

14 We had challenges receiving line lists
15 from long-term care homes that were short-staffed
16 and struggling to manage their outbreaks. They
17 reported to us that they didn't have time to fill
18 out the line lists. In some circumstances, Public
19 Health staff actually went on-site to support the
20 staff with the documentation pieces and to get that
21 line list back to Public Health.

22 We also noticed that staffing knowledge
23 was a concern. Not all staff are equally trained
24 in IPAC. We saw that housing, dietary,
25 maintenance, activationists, had less IPAC

1 experience and were pulled in to help during the
2 outbreak in duties that they were not used to and
3 lacked the IPAC training to perform those duties
4 safely.

5 We found that some of the homes lacked
6 on-site clinical leadership, which contributed to
7 more serious outcomes and hospitalizations. We
8 found that this was especially challenging on
9 weekends and evenings to ensure that the outbreak
10 was managed properly.

11 Next slide, please.

12 As was mentioned earlier, we worked in
13 collaboration with the Local Health Integration
14 Network to assist homes in ordering supplies, and
15 if PPE was needed urgently, we pulled supplies from
16 our Public Health stockpile and provided these to
17 the institutions in outbreak.

18 And some of the challenges --

19 COMMISSION CHAIR FRANK MARROCCO:

20 Andrea, can you help me? Why wouldn't the homes
21 know how to order supplies? I appreciate the whole
22 world is trying to buy them. I understand that.
23 But in terms of you having to help them -- how did
24 you put it? But in terms of you having to help
25 them, would they not know on their own how to go

1 out into the marketplace and buy supplies? Is
2 there something I'm missing there?

3 ANDREA MAIN: Yeah, and I think what we
4 heard early on is there were shortages of PPE, and
5 people were trying to secure them from any number
6 of organizations. And we also heard that staff
7 were double-masking and double-gowning and
8 double-gloving, and sort of burning through that
9 supply very quickly.

10 And the ordering -- the ability to
11 order was offered, and so we were that sort of
12 point of contact with the facility and the Local
13 Health Integration Network to order those supplies.

14 Okay. And so we just wanted to speak,
15 again, about the lack of IPAC knowledge in staff
16 and the fear which resulted in a lot of long-term
17 care staff who, as I mentioned, were using PPE
18 inappropriately, and this contributed to waste, as
19 well as contamination, and contributing to the
20 spread of the virus within the home.

21 Next slide, please.

22 So for infection prevention and
23 control, we found that homes lacked the on-site
24 dedicated infection prevention and control
25 expertise, and as I mentioned, after-hours,

1 evenings, and weekends, we were often working with
2 the Charge Nurse to declare the outbreak and
3 implement the control measures, which was quite
4 challenging.

5 On many occasions, we had to hold
6 outbreak declaration meetings twice, once after
7 hours to ensure that the measures were in place,
8 and, again, during business hours when
9 Administrators and any of the IPAC-trained staff at
10 the facility were back in the building.

11 IPAC duties were often assigned as part
12 of somebody's work, rather than their assigned
13 role. So as I mentioned earlier, during the
14 pandemic, we brought a good portion of our own
15 IPAC-trained staff in Public Health to support our
16 institutional outbreak team and the facilities and
17 institutions that were in outbreak.

18 These staff provided additional IPAC
19 supports through on-site visits, as well as
20 education and support. We found this was key to
21 helping the facilities manage the outbreak.

22 Next slide, please.

23 Staff cohorting, as I mentioned, has
24 been a long-standing challenge in that we often
25 find there is just one to two staff working

1 after-hours, and it is nearly impossible for them
2 to be cohorted to either one outbreak-affected
3 floor or to even just a few floors.

4 So strictly cohorting staff was very
5 challenging to prevent further spread and clearly
6 impossible in some of the homes.

7 Resident cohorting was challenging in
8 long-term care homes with dementia units and
9 wandering residents. We worked with our IPAC staff
10 and epidemiologists and long-term care staff to
11 test and then move residents within the facility.

12 COMMISSION CHAIR FRANK MARROCCO:
13 Andrea, was there any discussion of decanting or
14 whatever the -- but moving them off-site?

15 ANDREA MAIN: Yeah, there were a few
16 situations where that did happen in some of our
17 outbreaks. It was I think in one or two of the
18 outbreaks that I know of in wave one, and I'm not
19 sure, Ewilla, if you can speak to that for wave
20 two.

21 COMMISSION CHAIR FRANK MARROCCO: In
22 your experience, was it effective?

23 ANDREA MAIN: I think in my experience
24 it was because the residents were not faring well
25 and that there was a number of residents whose

1 health was deteriorating, and so those particular
2 residents were transported to hospital.

3 Ewilla, I don't know if you have
4 anything to add on that.

5 EWILLA CASTELLAN-WONG: Thank you.
6 Unfortunately, there weren't many opportunities
7 where we had decanting occur. Finding a location
8 for them to be decanted to often posed to be an
9 issue.

10 Unfortunately, with the number of
11 people that were passing away during the outbreak,
12 often there became availability within the home to
13 relocate the individuals within the home, and quite
14 often we would resort to that as a technique to be
15 able to at least relocate individuals and try to
16 appropriately cohort them such that you could
17 achieve the appropriate staffing cohorting that was
18 required to try to minimize people from working
19 between floors.

20 COMMISSION CHAIR FRANK MARROCCO: Okay.
21 Thanks.

22 LYNN MAHONEY: Can I just ask a
23 follow-up question on that, because the same issue
24 occurred to me, Commissioner. When you say -- so
25 were there discussions within York Region and with

1 the province about the need to decant residents
2 from long-term care homes?

3 EWILLA CASTELLAN-WONG: So often the
4 conversations that were had at the level of the
5 outbreak team occurred mainly within our team.
6 There were conversations with our AMOHs to decide
7 whether or not there was an opportunity to decant,
8 and I am not sure if perhaps, Selina, if we want to
9 speak to the work that we did in collaboration to
10 seek out opportunities to perhaps remove them to
11 hospitals, but often it couldn't occur. It is just
12 there simply wasn't the capacity to move these
13 individuals.

14 There were also conversations with the
15 families as well who were concerned because these
16 long-term care homes were the homes of these
17 individuals, and the disruption of moving them and
18 how they would fare being removed from their home
19 to these other areas also was taken into
20 consideration for their health and well-being.

21 COMMISSION CHAIR FRANK MARROCCO: Yes.
22 The reason we are on that is, you know, we have
23 talked to and met with individuals who -- one in
24 Windsor, for example, where they -- it was the CEO
25 of the hospital, but they created 50 beds -- I may

1 have the number wrong, but off-site in a very short
2 period of time.

3 And they were able to use hospital
4 staff who weren't as busy as they would otherwise
5 have been because people were avoiding the
6 emergency and that sort of thing, and they were
7 able to use that staff to staff the temporary
8 off-site facility.

9 And that struck us as, in an emergency,
10 not a bad idea if you can actually pull it off, and
11 that is why we are asking about it. We also heard
12 that after awhile the residents didn't want to
13 leave the new facility. They liked it there. They
14 were getting a lot of attention.

15 But in any event, that is fine. That
16 is why we asked the question.

17 EWILLA CASTELLAN-WONG: We did have
18 opportunities where there were individuals that
19 were brought in from the hospital to help support
20 within the homes. So as opposed to moving the
21 residents out, we were bringing additional help in
22 from the hospitals, who were actively working with
23 the homes to try to offer support at that level as
24 well.

25 COMMISSION CHAIR FRANK MARROCCO: Yes.

1 Yes, Doctor, Dr. Kurji?

2 DR. KARIM KURJI: So my distinct
3 impression was that the hospitals wanted to retain
4 the capacity to be able to take in large numbers of
5 potentially COVID-19 patients than they were
6 expecting, and so they seemed to prefer working
7 with family physicians who were supporting
8 long-term care homes in order to manage the
9 long-term care patients in their own homes.

10 COMMISSION CHAIR FRANK MARROCCO: Okay.

11 ANDREA MAIN: Thank you. So I think
12 that speaks to the cohorting side.

13 We felt it was really important to
14 protect working with the facility to protect the
15 residents, and it was a collaborative effort that
16 included the members of the institutional outbreak
17 team, our Associate Medical Officers of Health, as
18 well as the IPAC team.

19 So the next slide, please.

20 We also thought for your consideration
21 today it would be very important to speak to the
22 mental health impacts that the pandemic had on our
23 residents and their families, the long-term care
24 staff, as well as our Public Health staff.

25 For residents, we received many

1 complaints from families telling us that their
2 loved ones felt isolated and alone, lacking social
3 interaction or exercise for long periods of time.

4 We heard that cohorting and moving
5 residents from their usual room to a different room
6 in order to protect them from the spread of the
7 virus was difficult on them as well.

8 Families expressed how challenging it
9 was to try and receive updates on their loved ones,
10 and this caused a lot of stress.

11 Some of the ideas and solutions that we
12 heard of from homes to address these challenges
13 were the use of iPads or phones to help set up some
14 FaceTime for the residents and their loved ones,
15 but we also heard from the facilities that they
16 often didn't have enough staffing to make this
17 happen and to set up the technology for each
18 individual resident.

19 We also heard of virtual activities for
20 fitness or games. Some homes had a channel that
21 residents could turn on their TV and participate
22 and connect with the staff in the home.

23 One of the other homes we heard of had
24 hallway activities where the residents could open
25 their door and the staff would lead an activity

1 from the hallway and at least they could partake in
2 that.

3 We also heard of -- sorry.

4 COMMISSION CHAIR FRANK MARROCCO: I'll
5 wait until you are finished and then I'll ask my
6 question.

7 ANDREA MAIN: We also heard of homes
8 that had dedicated phone lines for families to
9 receive updates and that was very helpful.

10 For this, you wanted to ask me?

11 COMMISSION CHAIR FRANK MARROCCO: Well,
12 I just wanted to say, we also heard of instances --
13 not in York Region, obviously, but where homes
14 hired essential caregivers as employees so that
15 they would no longer be -- during that period when
16 they were excluded, and I wondered if you had run
17 across that? It struck -- I mean, it was an
18 obvious -- it was an obvious source of -- I mean, I
19 don't know, and I don't want to assume what
20 happened to the -- I don't want to -- I'm not sure
21 what would have happened ultimately to the salary.
22 I'm not sure any of them were doing it for the
23 money.

24 But they hired them as a source of
25 employees because they had a critical employee

1 shortage, and they had these caregivers who were
2 anxious to get in the home and help.

3 So I just wondered if that practice
4 had -- if you had seen that in York Region?

5 ANDREA MAIN: I think in some
6 circumstances, yes, we have heard of families and
7 different individuals who were regularly associated
8 with the facility being hired on to help support,
9 yes.

10 COMMISSION CHAIR FRANK MARROCCO: Okay.

11 ANDREA MAIN: So for the staff in
12 long-term care, we heard that they reported feeling
13 overwhelmed and defeated. Administrators reported
14 feeling like they were walking on egg shells
15 worried that their staff would walk off the job.

16 Some staff refused to come in to work,
17 fearful that they may bring the virus home to their
18 families.

19 And so some of the ideas that we heard
20 from the homes to help the staff were that some
21 facilities provided hotel accommodations for their
22 staff to allow them to stay there for the duration
23 of the outbreak.

24 In other homes we heard that meals were
25 provided to staff who were working long, extended

1 hours.

2 And then we also heard that when
3 staffing levels were better, this really helped
4 stabilize the situation at the home and the staff
5 reported feeling like they were supported and it
6 helped reduce their workload as well as the number
7 of working hours for them.

8 And then lastly, I'll just mention some
9 of the impacts on our Public Health staff, and we
10 thought it would be important to bring this forward
11 as well.

12 The staff on our outbreak team reported
13 that their work was often overwhelming and that
14 they worked overtime most days to keep up.

15 During wave one, our teams also needed
16 to learn a completely new database for case and
17 contact management, as well as transition all of
18 our work in outbreak management to electronic
19 documentation, and then we also shifted all of our
20 staff to working from home, all the while juggling
21 multiple outbreaks in institutions.

22 Staff reported that they were feeling
23 mentally and physically drained, and some staff
24 reported acute feelings of grief and loss over the
25 number of deaths in homes and a feeling of

1 helplessness that, despite their best efforts to
2 test and cohort, the virus continued to spread,
3 taking many lives.

4 We found what was helpful for Public
5 Health staff was to activate a Public Health
6 Emergency Support Group, and this group provided
7 virtual team huddles and check-in chats to see how
8 they were coping.

9 And more recently, we have been having
10 some debrief sessions with our staff as well.

11 COMMISSION CHAIR FRANK MARROCCO: Has
12 there been any suggestion that there should be some
13 counselling, some professional counselling offered?
14 Obviously there has to be some process for doing
15 that, but was that discussed?

16 ANDREA MAIN: Internally, we do have
17 employee health supports for counselling, yes.

18 COMMISSION CHAIR FRANK MARROCCO: I
19 see, okay.

20 ANDREA MAIN: That is available to all
21 staff.

22 And then lastly, our last slide just
23 speaks to some of the recommendations that we
24 wanted to put forward for your consideration.

25 We feel that improved wages and access

1 to sick leave and benefits for staff in long-term
2 care may help with securing full-time staffing
3 complements.

4 Mandatory IPAC education and hands-on
5 PPE training for all staff that work in long-term
6 care homes.

7 IPAC staff who are available 24/7 to
8 assist with after-hours outbreak management would
9 also be very beneficial.

10 An enhanced public health workforce as
11 well from our end, as we have found that the
12 management of outbreaks is very heavy, and that is
13 what I was hoping to demonstrate to you today.

14 The improvements to current long-term
15 care home physical infrastructures, and as I
16 mentioned, the homes with quad rooms, with four
17 residents to a room were very challenging to manage
18 from an outbreak perspective.

19 Enhanced provision of information and
20 education for family members and residents, and
21 perhaps a dedicated phone line for family members
22 of loved ones to speak directly to somebody about
23 their concerns and questions when a facility is in
24 outbreak.

25 And lastly, I just wanted to highlight

1 for the homes that we saw that managed well, we
2 wanted to highlight some of the things that we
3 observed.

4 We observed that the management of the
5 home and the leadership on the frontlines of the
6 home were strong, and that helped manage the
7 outbreaks well.

8 They had an adequate, stable staffing
9 complement, and then they accounted for any
10 absenteeism that they might see due to illness.

11 We also noticed if they had 24/7 IPAC
12 support, that was really, really helpful.

13 And again, the IPAC expertise on staff
14 at the home was very important, as well as homes
15 with single and double rooms versus the quad rooms.

16 And that is my slides for today.

17 COMMISSION CHAIR FRANK MARROCCO: Did
18 you have any observations about, when you say the
19 leadership was strong, what qualities they
20 manifested that conveyed that they were strong or
21 what qualities were helpful in leading?

22 ANDREA MAIN: Well, I think it is that
23 on-site dedicated support to the staff, really a
24 good collaborative relationship working with Public
25 Health, and then supporting their staff with the

1 IPAC expertise.

2 And, Ewilla, I'm not sure if you have
3 anything further to add on this?

4 EWILLA CASTELLAN-WONG: We definitely
5 found that the leadership which made ensuring that
6 meeting with Public Health and attending our daily
7 meetings and ensuring that the information that we
8 required was provided to us definitely showed the
9 importance of outbreak management to their team and
10 certainly led for very, very high quality
11 communications with the home.

12 That said, with the shortages that were
13 being experienced, quite often the leaders were
14 taking on more of the frontline roles, and they had
15 to actually have more of a hands-on role than
16 typically they did.

17 And there were quite a few outbreaks
18 where Directors of Care were actually unfortunately
19 infected with the virus, and so having a backup
20 plan and people who were able to step up in their
21 place when they were off also afforded the home
22 much more of an advantage to controlling the
23 outbreak and the spread of the outbreak.

24 We see in many homes, unfortunately,
25 when the leadership became ill, that there was a

1 little bit of disrepair in the home in terms of
2 trying to follow up. So having that structure in
3 place that there is a backup plan should that
4 happen was very important.

5 COMMISSION CHAIR FRANK MARROCCO: Thank
6 you.

7 COMMISSIONER JACK KITTS: Andrea, can I
8 ask about your first bullet point there:

9 "Improved wages, access to sick
10 leave and benefits for staff may
11 help with securing full time
12 staffing complements."

13 Do full-time staff get sick leave and
14 benefits now?

15 ANDREA MAIN: That I am not sure of.

16 I am not sure, Ewilla, if you are aware
17 of that either?

18 COMMISSIONER JACK KITTS: Because I was
19 just wondering how that would attract -- full-time
20 staff I think get sick leave benefits, but I don't
21 know whether you are asking for sick leave and
22 benefits for part-time staff as well as full-time.

23 EWILLA CASTELLAN-WONG: I think the
24 point we are trying to make here or to allude to is
25 that what we were finding is that a number of the

1 employees were working from one home to another
2 home, and what we were finding the rationale behind
3 why they were working is either because when they
4 were off from one location, they did not have sick
5 time leave or that it was only part-time work and
6 they were required to work in another location to
7 clearly be able to meet their own standard of
8 living and to support their own families.

9 So the intention here being that there
10 is naturally a benefit for individuals, that when
11 they are off and they are not well, that they are
12 able to be off with the pay, and if that comes in
13 line with the full-time status, that is certainly
14 preferable to the part-time positions that are
15 available at the homes that aren't affording the
16 individual to meet their current needs with the
17 part-time work that we are finding is very common
18 throughout a lot of the long-term care homes.

19 COMMISSIONER JACK KITTS: So I think
20 what you are saying is increase the number of
21 full-time staff because they'll have sick leave and
22 benefits.

23 Okay, thank you.

24 DR. KARIM KURJI: Thank you very much,
25 Andrea.

1 Our next area really is on testing, and
2 Shanna Hoetmer, who is our Health EOC Director,
3 will be speaking to this.

4 SHANNA HOETMER: Okay, thanks very
5 much, Dr. Kurji.

6 So as Dr. Kurji mentioned, I am
7 currently one of the Directors in our Health
8 Emergency Operations Centre, and my role in the
9 Emergency Operations Centre means that I supported
10 the escalation of some of the issues needed
11 regarding testing when they needed to be escalated
12 to our Ministry colleagues.

13 So next slide, please.

14 So as you are aware, the response to
15 COVID-19 is integrated with many players across the
16 system. So it goes all the way from testing and
17 diagnosis, which is the role of Ontario Health and
18 our laboratory partners, to Public Health
19 management, which is the role of the Public Health
20 Unit, and then the medical management of the case,
21 which is the role of our physicians, hospitals and
22 the health care system.

23 So for staff and residents in long-term
24 care homes, testing could take place either because
25 a staff or resident had symptoms of COVID-19 or as

1 part of surveillance testing which means that the
2 staff did not have symptoms but they undertook
3 routine testing to make sure they were not bringing
4 the virus into the home. And that began around the
5 end of April last year.

6 In non-outbreak situations, the
7 physician at the home is typically the
8 requisitioner of the test, and the specimen is
9 collected on-site and sent to the labs for
10 processing.

11 Many homes use different labs to send
12 their swabs to, for example, private labs such as
13 Dynacare or hospital labs such as SickKids, or they
14 may send directly to the Public Health Ontario
15 Laboratory, which is PHOL is the acronym we use.

16 LYNN MAHONEY: So, Shanna, are you
17 saying that it is up to the home itself? They
18 decide where the test results go?

19 SHANNA HOETMER: Some homes have
20 agreements with different labs, and then some send
21 them directly to the Public Health Ontario lab.

22 LYNN MAHONEY: So the home decides
23 where the test results are going to -- the tests
24 are going to go?

25 SHANNA HOETMER: Yes, that is my

1 understanding.

2 LYNN MAHONEY: Okay, thank you.

3 SHANNA HOETMER: Laboratories report
4 the results back to the physician on the
5 requisition form, and they also have the duty to
6 report under the Health Protection and Promotion
7 Act all of the positive cases to the Public Health
8 Unit.

9 So as mentioned by Andrea, in an
10 outbreak Public Health supports the homes to
11 determine who should be tested based on their risk
12 assessment to support with active case finding.
13 On-site testing support may be provided to a home
14 that is in outbreak if they are having challenges
15 with the internal swabbing on their own. And in
16 collaboration with our hospitals and our paramedic
17 partners, testing teams can be mobilized to swab
18 residents on-site. And staff are encouraged to go
19 to the local assessment centres.

20 Next slide.

21 So long-term care homes may get the
22 results in a variety of ways and not just from
23 Public Health.

24 So the labs may get -- the labs may
25 send them directly to the home, and that is

1 typically to the ordering physician, either through
2 a fax or a phone call, and that is generally how
3 the homes first hear of the results.

4 They may also get them from the Public
5 Health Units, as the lab reports to us as well. So
6 currently, in the current state, positive labs are
7 received every 30 minutes from the Ontario
8 Laboratory Information System, called OLIS, and we
9 get that through our case contact and management
10 system.

11 The labs automatically feed the results
12 into OLIS, and that is the database that is owned
13 and operated by the province. And then we monitor
14 the feed in CCM and the queue, and we do that every
15 day between 8:30 and 4:30, seven days a week. So
16 any cases that are associated with an outbreak will
17 be flagged with our outbreak number, and that
18 allows us to immediately refer them to the
19 Institutional Outbreak Team.

20 Public Health does not have direct
21 access to OLIS to look at the results. We use the
22 CCM interface. However, our Planning Team does
23 have access to that to ensure that the flow of
24 results is moving, and this process that we have
25 now is much faster than receiving the results from

1 fax from the labs.

2 So the third way is through the Medical
3 Officer of Health, and we do get these results
4 still by fax, which is the traditional method of
5 receiving the positive results, and when we get
6 them by fax, we validate those against what we get
7 in CCM, just to make sure that none of the results
8 are missed.

9 So we have a team dedicated to lab
10 processing that makes sure that we get every lab
11 and that there aren't any duplicates or any missed
12 labs.

13 LYNN MAHONEY: So do you get negative
14 and positive results?

15 SHANNA HOETMER: Yes, we do.

16 LYNN MAHONEY: CCM and a fax?

17 SHANNA HOETMER: Yes. So the negative
18 results, and maybe I'll speak to that a little more
19 on the next slide, but the negative results, they
20 don't get flagged to us the same way. The positive
21 results are the ones that are flagged in CCM.

22 LYNN MAHONEY: Okay.

23 SHANNA HOETMER: Next slide, please.

24 So over time there have been a number
25 of challenges faced as it relates to testing, and

1 many things have been improved since wave one.

2 So with respect to manual processes, so
3 at the beginning our systems were paper-based and
4 we relied on the faxed results. So the manual
5 processes were very cumbersome, and as the volume
6 increased, it was clear that these processes needed
7 to be automated.

8 As the assessment centres opened,
9 Public Health Units were asked to communicate
10 negative results and not just the positive ones,
11 which is our traditional practice, and this put
12 further pressure on our teams given the volume of
13 the tests being processed. So we re-deployed staff
14 from across the corporation to support our negative
15 results team.

16 Our Planning Team epidemiologists
17 started to use machine learning in an effort to
18 take the results in OLIS, which included results
19 for all lab specimens, so not just for COVID-19, so
20 any labs, even sexually transmitted infections, as
21 an example, where we would get a dump from the OLIS
22 feed and we used machine learning to try to
23 automate things on our end. So we did have
24 supports from across the corporation to try to get
25 these results into a more automated process.

1 And then came the provincial case
2 contact management system which did that for us, so
3 we were early adopters of that system and we were
4 the third Health Unit in the province to implement
5 it.

6 LYNN MAHONEY: Shanna, if I could, just
7 from my end, and it might have been on your
8 previous slide, and just so I understand, we have
9 heard lots of evidence from long-term care homes
10 about the confusing way that they received test
11 results, the delay in getting test results, the
12 role that -- you know, things were faxed to them,
13 mailed to them.

14 So what role did Public Health have in
15 that? So do I understand it that all the labs
16 would report directly to the home. As well, all
17 the labs reported directly to Public Health. And
18 did Public Health then report to the home as well?

19 SHANNA HOETMER: It depended on really
20 what was on the requisition form.

21 So the lab will report to the ordering
22 physician on the form, so if the home has entered
23 its information onto the requisition form, then the
24 results would be sent by either my understanding is
25 fax or phone call to the home directly.

1 Now, some homes did not put the
2 ordering physician name on that, and so that would
3 mean that when the lab received the result, they
4 have the duty to report that to Public Health, so
5 we would be the ones to receive first.

6 And that is why there is the many
7 different ways where they may have received the
8 results. So they may receive directly to
9 themselves, but they may get it from us once we
10 receive the lab results.

11 LYNN MAHONEY: Did you mail results?

12 SHANNA HOETMER: No, we don't mail the
13 results.

14 LYNN MAHONEY: So we did hear that some
15 of the homes got mailed test results. So you say
16 that would have been an issue from the lab to the
17 home.

18 SHANNA HOETMER: Yes, I can suspect
19 that might be the case where an ordering physician
20 might not have been entered in the req form, but
21 there may have been an address of the home on the
22 form and that may have been why they reported that
23 way.

24 I'll speak a little bit more to it, but
25 the filling out of the requisition form is one of

1 the challenges where we found that there were many
2 issues with that.

3 LYNN MAHONEY: Okay, thanks.

4 SHANNA HOETMER: So another challenge
5 that we saw was the prioritization of the
6 specimens.

7 So as surveillance testing was
8 implemented, our highest priority specimens were
9 part of a large and growing volume of results. So
10 we saw clear impacts in the turn-around times as
11 the eligibility for testing expanded to include
12 more and more groups.

13 So as part of the system, if there is
14 delays in the lab processing, we will also see
15 downstream delays at the Public Health Unit level
16 as well.

17 So Public Health Ontario did implement
18 prioritization criteria so that specimens related
19 to outbreaks in our long-term care homes could be
20 colour-coded, and that way they could be easily
21 identified and brought to the front of the line and
22 processed more quickly.

23 So the lab network, so in terms of the
24 many different labs that were able to process
25 specimens, that was also expanded so that lab

1 specimens could be deferred from one lab to another
2 if there was any type of backlog, so that means
3 that a specimen could get sent to one lab and then
4 it could get deferred to another one that was not
5 as busy in order to increase timeliness in the
6 processing.

7 As a Public Health Unit, we also did
8 leverage partnerships with our local hospitals to
9 test the specimens for our long-term care homes.

10 So for requisition forms, as I
11 mentioned, the labelling of the specimens as well
12 as filling out of the requisition forms is critical
13 to make sure that the results make it back to the
14 ordering physician and to the Health Unit. So we
15 did escalate several cases to the Ministry where
16 labs were taking longer than expected, and those we
17 would send to the Ministry Emergency Operations
18 Centre or the MEOC.

19 These get very thoroughly investigated
20 at the provincial level. The most common scenario
21 we found in these investigations was that the forms
22 didn't have the necessary information or sometimes
23 the specimen wouldn't be labelled correctly, so for
24 example, the ordering physician name would not be
25 included or the long-term care home name or the

1 address wasn't clear or the outbreak number would
2 be missing.

3 So Public Health Ontario does have form
4 templates and instructions to help alleviate this
5 issue, and there has been a lot of education to
6 ensure that the forms are completed with the
7 necessary information.

8 So lastly, I just wanted to add that
9 when the home is waiting for the results, as Andrea
10 mentioned, our Public Health Team is engaged with
11 them during this time by completing the risk
12 assessment, putting the infection prevention and
13 control measures and the outbreak measures in place
14 while the results are pending.

15 DR. KARIM KURJI: Thank you very much,
16 Shanna.

17 Our next area is on collaboration and
18 partnerships, and Elena Hasheminejad who is the
19 Acting Manager of the Health Emergency Operations
20 Centre and who is also Liaison Officer For
21 Congregate Settings will be speaking to this.

22 And, Elena, thanks.

23 ELENA HASHEMINEJAD: Thank you, Dr.
24 Kurji, and thank you to the Commission for the
25 opportunity to speak today.

1 So --

2 LYNN MAHONEY: Elena, you are quite --
3 the volume is quite low. I don't know, Deana, if
4 you can hear.

5 ELENA HASHEMINEJAD: I apologize. If I
6 speak louder, is that better?

7 LYNN MAHONEY: Yeah, you are going to
8 have to get a lot closer, I think.

9 ELENA HASHEMINEJAD: Is that better
10 now? I can set up a headset if it would assist.

11 THE COURT REPORTER: The volume is fine
12 for me, thank you.

13 ELENA HASHEMINEJAD: Thank you. If you
14 can't hear me, please let me know and I can put a
15 headset on as well.

16 LYNN MAHONEY: That is better.

17 ELENA HASHEMINEJAD: Okay, so I'll get
18 started. Thank you.

19 We have shared a summary -- the next
20 slide, please.

21 We have shared in each area information
22 about our partnerships and collaborations, and I
23 would like to try to bring it all together, as each
24 topic area or area of our response is dependent
25 upon each other and involved in these

1 interconnected partnerships.

2 As you can see from today, York Region
3 Public Health is part of an integrated health
4 system and plays a unique role in conjunction with
5 other health care services in York Region.

6 Our well-established foundation of
7 collaboration and partnerships with our local
8 health sectors has been integral in supporting the
9 COVID-19 response.

10 With that in mind, one piece we would
11 like to highlight is the strengths of our
12 collaboration and partnerships with our local
13 hospitals, paramedic services, Ontario Health, the
14 LHINs, and long-term care homes and the impact this
15 has had during the COVID-19 response.

16 Next slide, please.

17 As COVID-19 became a threat to our
18 community, we soon learned there was a need to
19 further strengthen and expand our relationships.
20 To support this, our Health Emergency Operations
21 Centre Liaison Team created a dedicated role for
22 congregate settings.

23 The Liaison Officer's role has been to
24 collaborate with hospital, paramedic and provincial
25 partners to coordinate the response to support

1 long-term care homes, retirement homes and other
2 congregate settings with respect to outbreak
3 prevention and management.

4 This would include participating in
5 weekly calls with the LHINs, as Joe has discussed
6 earlier. If additional needs are identified during
7 these calls, they would be actioned appropriately
8 and the Liaison Officer would liaise with the
9 different partners.

10 It could include things such as PPE and
11 staffing challenges, coordinating IPAC assessments
12 and requesting additional IPAC Extenders to go out
13 to the different homes.

14 As requested, we also participate in
15 the long-term care home administrator calls that
16 are hosted by the LHINs. This would include
17 providing appropriate updates or information as
18 requested.

19 And lastly, from the start of wave one,
20 we have collaborated with Ontario Health, our three
21 hospital partners and our paramedic partners on
22 mobilizing on-site testing supports for outbreak
23 management, and this has continued onward
24 throughout wave two as well.

25 And I would just like to pass it over

1 to Dr. Karachiwalla, who will also speak to some
2 different partnerships and collaborations.

3 So next slide, please.

4 DR. FAREEN KARACHIWALLA: Thank you so
5 much.

6 So hi, I'm Dr. Fareen Karachiwalla, and
7 I am one of the Associate Medical Officers of
8 Health reporting directly to Dr. Kurji.

9 So similar to Dr. Kurji, I also am a
10 Public Health physician by training and have helped
11 support the strategic direction of the response and
12 gotten quite involved in outbreak management in
13 long-term care, retirement homes and other
14 congregate care settings when it comes to the sort
15 of clinical Public Health management of the
16 trickier homes.

17 So from our sort of group of physicians
18 standpoint, we also had a number of different
19 collaborations and partners that we thought were
20 worth noting.

21 So we enjoyed a very productive
22 relationship with the consultants at Public Health
23 Ontario. We relied on them quite a lot, including
24 with the CMOH office and MEOC, as Dr. Kurji alluded
25 to also, just to give us some further thoughts and

1 consultations when it came to managing very complex
2 outbreaks, so ones with high attack rates, ones
3 where we were seeing ongoing transmission or were
4 having some challenges with implementing some
5 infection prevention and control measures.

6 Sometimes these meetings would also
7 involve the MEOC and the CMOH office, and we would
8 keep them abreast of any developments, major
9 developments that might be high profile or
10 media-sensitive type events.

11 And we also consulted people like the
12 MEOC and the CMOH Office quite often when it came
13 to interpretation of guidance and directives that
14 they would have issued, and we did find them very
15 responsive to our needs, you know, arranging very
16 timely consultations when it came to helping us
17 manage some of the outbreaks and get input into
18 preliminary guidance.

19 So Public Health Ontario also helped us
20 establish some informal and formal connections or
21 communities of practice, so we would be linked up
22 with other Health Units to have some phone
23 conferences around practice challenges. We would
24 also give input into preliminary guidance that they
25 were developing with a group of other Health Units.

1 We ourselves also formed some informal
2 networks across the GTA, for example, where we
3 would meet with other physicians in other Health
4 Units to get a sense of how they were managing
5 complex situations in similar outbreaks.

6 And again, like Dr. Kurji mentioned in
7 the intro statements, one of our other associates
8 and myself were liaising with folks in BC early on
9 when we had our first outbreak here at Markhaven to
10 try to get a sense of their guidance, because our
11 provincial guidance at that time hadn't yet been
12 completely formalized.

13 We also had pretty regular meetings
14 with our three hospital partners, so we would
15 discuss issues relating to outbreak management,
16 often when it came to the transfer of residents,
17 let's say, or repatriation from the hospital back
18 to a long-term care facility. That was one of the
19 things we talked about often.

20 And we made quite a few efforts to
21 liaise with our community-based physicians, many of
22 whom are also involved in the long-term care
23 process either as Medical Directors or working
24 there as staff.

25 So in wave one, one of our other

1 associates, Dr. Richard Gould, was involved in a
2 sort of community of practice or meeting with our
3 primary care physicians who work in long-term, and
4 he would sit on those meetings regularly to provide
5 the Public Health lens or perspective.

6 And then we started a webinar series as
7 well in the summertime to provide monthly updates
8 to all our community-based providers to update them
9 on changes in guidance, protocols and keep them
10 abreast of sort of Public Health developments and
11 what is happening in York Region. And of course,
12 some of that was pertaining to outbreak management.

13 And we also have a good system of
14 communication set up, so that we can send the homes
15 and the providers bulletins when guidance changes
16 when it comes to testing or outbreak control
17 measures or anything like that.

18 Next slide, please.

19 So I am just going to transition now
20 into summarizing some of our recommendations, a lot
21 of which you have already heard during this
22 presentation. We have tried to group them
23 according to theme at this point and just narrow
24 down the ones we thought we thought would be very
25 high yield for the Public Health sector and, of

1 course, the long-term care sector.

2 And I think this is the last part of
3 our presentation, so we can all sort of breathe
4 easy soon.

5 So Joe did a really great job in
6 summarizing some of the recommendations, of course,
7 as they pertain to infection prevention and
8 control, and we strongly feel that on-site IPAC
9 resources and trained personnel is really
10 important, both before and after an outbreak but
11 also during, so for that proactive piece as well.

12 And like Joe mentioned, we feel that
13 the Ministry of Long-Term Care should develop and
14 implement some sort of accountability framework and
15 that mandates long-term care facilities to conduct
16 these annual IPAC assessments that are somehow tied
17 into the licensing process.

18 We also feel there could be a greater
19 focus in the area of emergency preparedness within
20 long-term care facilities. So just like we have,
21 Public Health and the Region has, you know,
22 developing emergency plans, and exercising those
23 plans as well, so ensuring you are doing things
24 like tabletop exercises and other activities that
25 really allow them to walk through what would happen

1 in a large scale outbreak, that they think ahead of
2 time of surge capacity for their staff and how to
3 procure PPE quickly, that kind of thing.

4 And we understand that in other
5 jurisdictions, so Kingston being one example, that
6 approach has worked really well in terms of the
7 sort of tabletops and things like that.

8 Next slide, please.

9 Another thing we have really picked out
10 is some sort of solution or set of solutions to
11 address the workforce capacity issues across the
12 health system. So we are looking for sort of a
13 systems level approach to ensure that people that
14 graduate into the health workforce have a basic or
15 working knowledge of infection prevention and
16 control and communicable disease principles, so
17 even understanding things like incubation period or
18 period of communicability and basic epidemiology,
19 that people graduate into the workforce with those
20 skills and then there is opportunities to be kept
21 up to date with that type of information because it
22 is sort of all across the spectrum where the
23 responsibility for infection prevention and
24 outbreak management lies.

25 We also want, you know, consideration

1 given to having more in-depth training, and so more
2 IPAC-focussed specialists who have that in-depth
3 knowledge across the system. I think we found that
4 that was a bit of a shortage as well.

5 And you know, we have been finding ways
6 to make things like getting that CIC, the
7 Certification in Infection Control sort of
8 designation a bit easier.

9 And then in general, just that
10 investment in the public health nursing and
11 inspector workforce as well so that we can ensure
12 enough personnel, trained personnel and that sort
13 of cross-training in a bunch of disciplines so that
14 we also have the surge capacity, as you have heard
15 that we had some challenges in finding skilled
16 personnel in outbreak management.

17 And then we know from our experiences
18 with the long-term care outbreaks that not having
19 enough staff during an outbreak, and then relying
20 on agency staff, employing staff that work across
21 multiple homes, but also we have heard situations
22 where people worked in a home but also, you know,
23 retail like Walmart or something, that really
24 presents a risk of transmission. So the
25 consideration of interventions like finding ways so

1 that homes can have more permanent or regular staff
2 or offering more full-time hours can help a lot.

3 We did allude to some of the challenges
4 we experienced in the area of information systems,
5 particularly in wave one. Quite a bit of that is
6 getting better, particularly in the provincial
7 system, the CCM.

8 So you know, initially we did have to
9 ourselves develop a more streamlined electronic way
10 to get line lists and merge that with our own
11 system and database, and then we were struggling
12 with the provincial system that was largely
13 designed for sort of intermittent community cases
14 and their contacts and not necessarily having what
15 is needed to manage an outbreak. So that
16 functionality of having line lists or
17 auto-populating an epidemiological curve, for
18 example, was missing early on, and we understand
19 that is being added but probably there will be some
20 growing pains along with that.

21 And so some of the time it took to
22 develop those side systems for our own selves
23 internally before the provincial system was created
24 of course resulted in a lot of our staff having to
25 be on-site for many long hours and worried about

1 the risk, of course, to themselves despite, you
2 know, safety protocols obviously that were
3 followed, but that risk and that fear was
4 definitely there.

5 Next slide, please.

6 So one other theme that we thought was
7 quite important was just a greater focus on the
8 social determinants of health as well which we know
9 shape community risk.

10 So we alluded to policy conversations
11 earlier about exploring things like improved wages
12 and benefits, access to sick time, and that would
13 really help folks to follow the Public Health
14 advice around, you know, staying home when you are
15 ill, just working in the one place and not across
16 facilities.

17 And then just a general focus on more
18 tailored interventions for some more vulnerable
19 worker populations who might need more targeted
20 messaging, more supports, for example, and that
21 could happen at all levels, provincially and
22 locally as well.

23 And then when it comes to partnerships
24 and collaborations, so we really enjoyed the
25 support of some key partners already mentioned, but

1 would really like the province to outline, you
2 know, key roles and responsibilities of each and
3 making it clear that in the face of that outbreak
4 or disease risk that the recommendations and advice
5 of Public Health would sort of trump or be
6 paramount, to avoid some of the conflicting advice
7 folks might have been hearing in case things were
8 not a hundred percent aligned.

9 And then making it clear that it is the
10 home, of course, that has the ultimate
11 accountability, and so having that strong
12 leadership from the Director of Care, like we have
13 talked about, is something to invest in.

14 And I know we have mentioned this
15 before, but the CMOH Office and particularly Public
16 Health Ontario was pretty critical to us in
17 developing that scientific guidance and providing
18 those consultations, and so continuing to invest in
19 those types of organizations like Public Health
20 Ontario which is arm's length is really helpful for
21 the field locally.

22 I think similarly, and this is sort of
23 my last point, the ongoing investment in Local
24 Public Health as well, ensuring that Public Health
25 Units are well resourced is really important, since

1 we are the ones doing the sort of proactive work as
2 well as the management once that risk or outbreak
3 occurs.

4 And you know, in light of conversations
5 around Public Health modernization - and I know Dr.
6 Kurji has said this as well - but having York
7 Region embedded into that regional structure has
8 been really helpful, so it helped with getting on
9 staff more quickly, recruitment, hiring, developing
10 those IT solutions. That was made possible because
11 of sort of our CHS or our departmental and
12 corporate IT folks testing with our EMS partners is
13 another great example of why being linked in with
14 the region was really important, and a whole bunch
15 of other aspects.

16 So with that, that concludes our sort
17 of final recommendations and thoughts.

18 And we are happy, of course, to take
19 any questions. I know that has been happening
20 throughout.

21 Thank you so much.

22 COMMISSION CHAIR FRANK MARROCCO: We
23 asked the questions as we went along.

24 Your last slide says "thank you". I
25 think we should have had our own slide that said

1 thank you to you, because this is an extremely
2 helpful presentation.

3 We really benefit from receiving
4 presentations from people who actually lived
5 through the wave one and wave two, and your
6 reflections on how that can be better handled in
7 the future are very valuable for us in formulating
8 our recommendations.

9 So I noticed Dr. Kurji didn't do all
10 the work, but since he is the leader of the
11 delegation, Doctor, thank you and please thank
12 everyone associated with the presentation.

13 DR. KARIM KURJI: Thank you,
14 Commissioner.

15 COMMISSION CHAIR FRANK MARROCCO: And
16 good luck to everybody if there is a wave three.

17 DR. KARIM KURJI: Thank you,
18 Commissioner, and we certainly appreciate being
19 given the opportunity to tell our part of the
20 story.

21 And I know that you went out of your
22 way to be able to hear us, so thank you so much.

23 COMMISSION CHAIR FRANK MARROCCO: You
24 are welcome.

25 COMMISSIONER JACK KITTS: Thank you.

1 LYNN MAHONEY: Thank you very much.

2 COMMISSIONER ANGELA COKE: Thank you.

3

4 -- Adjourned at 6:30 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, DEANA SANTEDICOLA, RPR, CRR,
4 CSR, Certified Shorthand Reporter, certify:

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

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

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

13
14
15
16 Dated this 25th day of February, 2021.

17
18
19
20
21 
22 _____
23 NEESONS, A VERITEXT COMPANY

24 PER: DEANA SANTEDICOLA, RPR, CRR, CSR
25

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

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Page 6, line 14: "expand upon" not "expound upon"

Page 7, line 2: "expand on" not "expound on"

Page 19, line 21: "wherever possible, share information with the legal counsel" should be clarified to read, "wherever possible, share Class Section 22 orders with legal counsel"

Page 36, line 17: "five were enteric." Not "five were enteric?"

Page 37, lines 2-3: "obviously be on-site" not "obviously sort of be on-site"

Page 37, lines 10-11: "alluded to the on-site inspections" not "alluded to sort of the on-site inspections"

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

(Continued)

Page 40, line 16: "follow up" not "sort of follow up"

Page 49, lines 15-16: "April 29, 2020" not "towards the end of March, early April"

Page 49, line 23: "by June 11, 2020" not "by the end of July"

Page 55, line 3: "completed by June 11, 2020" not "completed by July"

Page 63, line 1: "Some homes" not "The home"

Page 63, lines 5-6: Strike "or sorry, not the hospitals"

Page 63, line 12: "discussion" not "requirement"

Page 63, line 23: "into a minimum of four homes" not "into four homes"

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

(Continued)

Page 65, line 24: "a reassessment with one or more
of the stakeholders" not "a
reassessment and submit it"

Page 66, lines 2-3: "in collaboration with the
home and in conjunction with
the hospital IPAC extenders."
not "in collaboration with the
home and submitted that
reassessment."

Page 76, line 6: "PPE carts" not "PPE cards"

Page 88, line 21: "of the Chief Medical Officer of
Health" not "from the Ministry
of Health and Long-Term Care"

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