Long-Term Care COVID-19 Commission Meeting

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

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 25th day of February, 2021, 4:00 p.m. to 6:00 p.m.

BEFORE:
The Honourable Frank N. Marrocco, Commission Chair
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:
THE REGIONAL MUNICIPALITY OF YORK COMMUNITY AND HEALTH SERVICES DEPARTMENT PUBLIC HEALTH BRANCH
Dr. Karim Kurji, Medical Officer of Health
Ewilla Castellan-Wong, Manager, Health Protection Division
Elena Hasheminejad, Acting Manager, Health Emergency Operation Centre, Liaison Officer for Congregate Settings
Shanna Hoetmer, Director, Health Emergency Operations Centre and Manager of Health Emergency Planning
Dr. Fareen Karachiwalla, Associate Medical Officer of Health
Andrea Main, Manager, Control of Infectious Diseases and Outbreak Management
Joe La Marca, Director, Health Protection
Joanne Mitchell, Senior Counsel, Legal and Court Services
Dr. Cindy Shen, Public Health Physician

Marie Wright, Manager, Child and Family Health Division
Selina Nazim, Manager, Health Protection Division

PARTICIPANTS:
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat
Angela Walwyn, Senior Policy Analyst, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Gowling WLG

ALSO PRESENT:
Deana Santedicola, Stenographer/Transcriptionist

-- Upon commencing at 4:00 p.m.

COMMISSION CHAIR FRANK MARROCCO: Good afternoon, everybody.

LYNN MAHONEY: Good afternoon, Commissioner.

DR. KARIM KURJI: Good afternoon, Commissioner.

COMMISSION CHAIR FRANK MARROCCO: Doctor.

LYNN MAHONEY: Is everybody here from your end?

COMMISSION CHAIR FRANK MARROCCO: Commissioner Kitts is at the bottom of my screen. I didn't see him right off the bat.

Ms. Mahoney, I think we are ready to proceed.

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

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

LYNN MAHONEY: Okay. Perfect.

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

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

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

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

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

So that is what you are in for for the

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

COMMISSION CHAIR FRANK MARROCCO: Let's proceed.

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

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

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

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

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

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

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

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

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

DR. KARIM KURJI: Sure.

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

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

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

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

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

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

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

[Court Reporter intervenes to resolve audio issue.]

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

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

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

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

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

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

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

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

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

The Regional EOC would report to the --

LYNN MAHONEY: EOC is Emergency

Operations Centre?

DR. KARIM KURJI: That's correct.

LYNN MAHONEY: Thank you.

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

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

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

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

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

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

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

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

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

Early on, we created an exceptional --

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

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

LYNN MAHONEY: Okay.

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

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

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

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

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

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

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

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

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

Later on, because we are part of the

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

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

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

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

LYNN MAHONEY: And including the province?

DR. KARIM KURJI: That is correct.

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

largely expired?

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

LYNN MAHONEY: Thank you.

COMMISSION CHAIR FRANK MARROCCO: Doctor, can I just interrupt for a second.

DR. KARIM KURJI: Yes.

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

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

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

DR. KARIM KURJI: Sure. So if it was

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Thank you.

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

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

LYNN MAHONEY: Okay. Thank you.

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

We should point out that we were

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

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

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

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

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

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

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

DR. KARIM KURJI: Yes.

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

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

LYNN MAHONEY: Okay.

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

So when vaccines became available and

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

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

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

DR. KARIM KURJI: Yes.

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

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

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

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

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

DR. KARIM KURJI: That is correct.

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

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

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

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

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

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

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

LYNN MAHONEY: The same Pfizer vaccine?

DR. KARIM KURJI: The same Pfizer vaccine.

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

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

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

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

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

DR. KARIM KURJI: That's right.

LYNN MAHONEY: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

DR. KARIM KURJI: Yes.

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

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

So we actually have a plan that we can

utilize for any emergency that may arise.

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

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

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

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

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

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

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

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

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

folks initially concentrating only on the variants.

LYNN MAHONEY: Thank you. Thank you very much.

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

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

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

Thank you.

COMMISSION CHAIR FRANK MARROCCO:

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

DR. KARIM KURJI: I would say, top of

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Okay. Thank you.

DR. KARIM KURJI: Thank you.

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

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

I thought I would, for the benefit of

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

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

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

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

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

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

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

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

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

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

We also respond to any complaints. We

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

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

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

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

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

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

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

LYNN MAHONEY: This is pre-COVID, so

this is your ongoing responsibilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LYNN MAHONEY: And they would largely be influenza outbreaks?

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

LYNN MAHONEY: Okay. 50 respiratory outbreaks in 2019?

JOE LA MARCA: That's correct.

LYNN MAHONEY: Okay. Thank you.

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

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

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

Next slide, please.

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

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

So that was sort of the process that we

sort of -- that took place prior to COVID.

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

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

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

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

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

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

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

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

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

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

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

LYNN MAHONEY: Okay.

JOE LA MARCA: And that started in 2010.

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

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

LYNN MAHONEY: Okay.

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

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

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

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

LYNN MAHONEY: Okay.

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

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

COMMISSIONER ANGELA COKE: Prior to COVID.

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

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

COMMISSIONER ANGELA COKE: Okay. Thank you.

LYNN MAHONEY: Thank you.

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

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

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

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

positive or not.

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

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

And --

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

JOE LA MARCA: Sure.

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

JOE LA MARCA: That is correct.

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

JOE LA MARCA: So just so that we are

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

LYNN MAHONEY: Okay.

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

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

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

JOE LA MARCA: We did.

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

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

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

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

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

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

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

LYNN MAHONEY: Yes.

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

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

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

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

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

One of the factors in this Ministry tracker was staffing?

JOE LA MARCA: Correct.

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

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

LYNN MAHONEY: Okay. And when your

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

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

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

LYNN MAHONEY: Okay. Thank you.

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

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

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

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

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

So I thought I would share that with the group.

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

whether they were not in an outbreak.

LYNN MAHONEY: And you did those --

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

JOE LA MARCA: Sure.

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Yes.

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

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

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

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

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

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

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

management team that occurs with Public Health staff on it.

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

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

doffing and the proper use of PPE.

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

COMMISSION CHAIR FRANK MARROCCO: Okay.

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

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

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

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

So I think that what you were saying,

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

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

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

LYNN MAHONEY: Yes. Okay. Thank you.

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

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

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

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

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

LYNN MAHONEY: Okay.

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

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

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

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

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

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

LYNN MAHONEY: Okay.

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

COMMISSION CHAIR FRANK MARROCCO: That is fine.

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

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

LYNN MAHONEY: Okay.

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

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

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

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

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

So taking us to wave two, one of the

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

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

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

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

JOE LA MARCA: Yes.

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

the homes. The homes completed them.

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

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

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

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

the creation --

LYNN MAHONEY: And who -- Ontario Health asked?

JOE LA MARCA: The LHINs.

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

JOE LA MARCA: So we deal with two LHINs, Central West and Central.

LYNN MAHONEY: Okay.

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

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

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

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

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

JOE LA MARCA: That is my understanding.

COMMISSIONER ANGELA COKE: Okay.

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

COMMISSIONER ANGELA COKE: Okay. Thank you.

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

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

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

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

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

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

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

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

LYNN MAHONEY: Okay.

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

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

LYNN MAHONEY: "They" being the home?

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

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

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

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

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

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

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

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

LHIN-led initiative.

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

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

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

LYNN MAHONEY: Yes.

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

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

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

Health.

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

LYNN MAHONEY: Okay.

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

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

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

LYNN MAHONEY: Perfect. Thank you.

Thank you. Sorry I took you off your

presentation.

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

So thank you, Selina.

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

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

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

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

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

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

inspections? Were they there?

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

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

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

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

JOE LA MARCA: So the -- sorry.

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

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

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

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

LYNN MAHONEY: Okay. Thank you.

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

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

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

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

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

LYNN MAHONEY: Yes, yes.

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

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

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

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

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

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

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

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

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

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

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

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

JOE LA MARCA: We can verify if you like.

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

JOE LA MARCA: That's correct.

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

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

LYNN MAHONEY: Okay.

JOE LA MARCA: Are we okay to proceed?

LYNN MAHONEY: Yes. Thank you.

JOE LA MARCA: Of course.

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

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

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

LYNN MAHONEY: Okay. Thank you.

[Court reporter intervenes for

clarification.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Now, whether or not it is the long-term

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

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

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

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

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

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

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

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

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

JOE LA MARCA: Thank you.

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

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

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

So thank you, Andrea.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ANDREA MAIN: 28.

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

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

LYNN MAHONEY: Thank you.

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

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

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

So the next slide.

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

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

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

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

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

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

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

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

The next step speaks to the outbreak

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

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

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

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

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

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

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

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

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

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

You said that the cohorting was a new step?

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

stem the spread.

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

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

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

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

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

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

LYNN MAHONEY: Okay. Thank you.

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

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

Next slide, please.

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

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

So next slide.

We saw early in the pandemic that homes

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

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

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

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

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

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

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

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

And --

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

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

COMMISSION CHAIR FRANK MARROCCO: Would

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

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

COMMISSION CHAIR FRANK MARROCCO: Okay.

ANDREA MAIN: Yes.

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

ANDREA MAIN: Thanks.

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

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

During COVID, there were staffing

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

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

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

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

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

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

Next slide, please.

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

And some of the challenges --

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

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

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

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

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

Next slide, please.

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

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

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

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

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

Next slide, please.

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Okay. Thanks.

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

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

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Yes.

Yes, Doctor, Dr. Kurji?

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

COMMISSION CHAIR FRANK MARROCCO: Okay.

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

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

So the next slide, please.

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

For residents, we received many

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

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

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

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

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

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

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

We also heard of -- sorry.

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

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

For this, you wanted to ask me?

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Okay.

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

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

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

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

hours.

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

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

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

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

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: I see, okay.

ANDREA MAIN: That is available to all staff.

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

We feel that improved wages and access

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

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

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

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

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

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

And lastly, I just wanted to highlight

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

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

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

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

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

And that is my slides for today.

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

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

IPAC expertise.

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

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

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

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

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

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

COMMISSION CHAIR FRANK MARROCCO: Thank you.

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

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

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

ANDREA MAIN: That I am not sure of.

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

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

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

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

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

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

Okay, thank you.

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

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

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

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

So next slide, please.

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

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

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

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

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

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

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

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

SHANNA HOETMER: Yes, that is my

understanding.

LYNN MAHONEY: Okay, thank you.

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

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

Next slide.

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

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

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

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

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

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

fax from the labs.

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

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

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

SHANNA HOETMER: Yes, we do.

LYNN MAHONEY: CCM and a fax?

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

LYNN MAHONEY: Okay.

SHANNA HOETMER: Next slide, please.

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

many things have been improved since wave one.

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

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

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

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

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

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

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

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

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

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

LYNN MAHONEY: Did you mail results?

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

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

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

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

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

LYNN MAHONEY: Okay, thanks.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And, Elena, thanks.

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

So --

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

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

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

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

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

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

LYNN MAHONEY: That is better.

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

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

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

interconnected partnerships.

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

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

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

Next slide, please.

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

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

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

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

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

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

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

And I would just like to pass it over

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

So next slide, please.

DR. FAREEN KARACHIWALLA: Thank you so much.

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

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

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

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

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

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

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

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

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

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

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

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

So in wave one, one of our other

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

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

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

Next slide, please.

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

course, the long-term care sector.

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

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

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

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

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

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

Next slide, please.

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

We also want, you know, consideration

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

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

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

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

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

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

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

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

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

Next slide, please.

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

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

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

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

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

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

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

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

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

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

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

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

Thank you so much.

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

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

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

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

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

DR. KARIM KURJI: Thank you, Commissioner.

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

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

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

COMMISSION CHAIR FRANK MARROCCO: You are welcome.

COMMISSIONER JACK KITTS: Thank you.

LYNN MAHONEY: Thank you very much.

COMMISSIONER ANGELA COKE: Thank you.

-- Adjourned at 6:30 p.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 25th day of February, 2021.

NEESONS, A VERITEXT COMPANY

PER: DEANA SANTEDICOLA, RPR, CRR, CSR

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

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"

WORD INDEX