

# Long Term Care Covid-19 Commission Mtg.

Dr. Turnbull  
on Wednesday, December 16, 2020



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

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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held via Zoom Videoconferencing, with all
15	participants attending remotely, on the 16th day of
16	December, 2020, 9:00 a.m. to 10:00 a.m.
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1           BEFORE:

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3           The Honourable Frank N. Marrocco, Lead Commissioner

4           Angela Coke, Commissioner

5           Dr. Jack Kitts, Commissioner

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7           PRESENTERS:

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9           OTTAWA INNER CITY HEALTH INC.:

10          Dr. Jeff Turnbull, Medical Director of Ottawa

11          Inner City Health

12

13          PARTICIPANTS:

14

15          Alison Drummond, Assistant Deputy Minister,

16          Long-Term Care Commission Secretariat

17          Ida Bianchi, Counsel, Long-Term Care Commission

18          Secretariat

19          Kate McGrann, Counsel, Long-Term Care Commission

20          Secretariat

21          John Callaghan, Counsel, Long-Term Care Commission

22          Secretariat

23          Lynn Mahoney, Counsel, Long-Term Care Commission

24          Secretariat

25          Derek Lett, Policy Director, Long-Term Care

1 Commission Secretariat

2 Dawn Palin Rokosh, Director, Operations, Long-Term

3 Care Commission Secretariat

4 Jessica Franklin, Policy Lead, Long-Term Care

5 Commission Secretariat

6 Adriana Diaz Choconta, Senior Policy Analyst,

7 Long-Term Care Commission Secretariat

8

9 ALSO PRESENT:

10 Deana Santedicola, Stenographer/Transcriptionist

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1 -- Upon commencing at 9:00 a.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):  
4 I think you probably know basically the  
5 way we are conducting this. We will have a  
6 transcript which we will post on the website in a  
7 few days.

8 We tend to ask questions as we go  
9 along, if that is okay.

10 DR. JEFF TURNBULL: Absolutely.

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 And I don't know that there is anything  
13 else. I think we are ready to go when you are,  
14 Doctor.

15 DR. JEFF TURNBULL: Then I'll begin. I  
16 understood that we have about an hour. If that is  
17 still acceptable, then --

18 COMMISSIONER FRANK MARROCCO (CHAIR):  
19 Yes.

20 DR. JEFF TURNBULL: What I thought I  
21 would do is present to you our recommendations  
22 through the Royal Society of Canada. Now, I'll  
23 explain that a little bit.

24 The Royal Society of Canada is an  
25 academic organization of experts right across the

1 country, and they were taken by the impact of  
2 COVID, and they turned to people who are caring for  
3 different vulnerable populations, and they said,  
4 Would you mind writing a report?

5 And I know that there has been one  
6 co-authored by Sharon Straus that dealt with  
7 long-term care.

8 Ours deals with how we deal with COVID  
9 within the context of another conjugate setting,  
10 and that is in the homeless environment.

11 And so what I thought I would do is  
12 present -- use that as a focus, the recommendations  
13 that we provided, and first tell you a little bit  
14 about homelessness so you understand some of the  
15 challenges that we face, and then tell you about  
16 some of the recommendations that we have  
17 implemented right across the country, actually, to  
18 try and minimize the impact of COVID-19 on this  
19 very vulnerable population.

20 And I think that you will see, as we go  
21 along, that there are some very direct parallels to  
22 the long-term care environment.

23 So that is what I thought I would do,  
24 but first let me begin by talking about the issue  
25 of homelessness and so that you can see the

1 challenge that we face when we have a pandemic such  
2 as COVID or any other respiratory contagion,  
3 whether it be H1N1, influenza or other issues.

4 So if we could move to the next slide.  
5 So, first thing, let's dial back before we started  
6 COVID, and I will explain to you what homelessness  
7 is like, and then we'll talk about the advent of  
8 COVID.

9 So homelessness in Canada, there are  
10 tonight, at any one night, about 35,000 people who  
11 will be in an emergency shelter. Ottawa, that is  
12 1,000 people last night. It is cold now, so by  
13 around 4 o'clock we would have met all of our full  
14 capacity in our regular shelter beds, and we'll be  
15 rolling out cots in the chapel and common areas.  
16 And so we will try and get people in out of the  
17 cold by around 4:00 or 5:00, get them some food and  
18 into their respective beds or on the cots.

19 And so you have to understand that --  
20 first of all, the circumstances. We have massive  
21 over-crowding. So people are, you know, really  
22 cheek by jowl. We have one room at the Shepherds  
23 of Good Hope that has 70 beds. These are  
24 three-bunk beds, three bunks high, right  
25 throughout, about 30 of these beds. So that is

1 just one room in our shelter that is housing a  
2 thousand people throughout the city.

3 We have acute men and women's shelters,  
4 five of them, and that will house the 1,000 to  
5 1,200 people every night. So a lot of crowding.

6 At the same time, you'll line up with  
7 about 200 other people for your meals. There is  
8 one washroom per floor, and so hygiene is a  
9 challenge. And at the same time, think about the  
10 individuals. They are very vulnerable, their  
11 age-adjusted mortality rate is about 20 years older  
12 than their stated age. So if you are 50, you are  
13 really 70. The likelihood of getting to the age of  
14 70 in a shelter is only 20 percent. So these are  
15 sick people. They have chronic obstructive  
16 pulmonary disease. They have all sorts of issues  
17 related to mental health and addictions and the  
18 complications of all of that and the violence of  
19 living in a shelter. So these are the chronically  
20 homeless.

21 And so we have a population of very  
22 vulnerable people, vulnerable in terms of their  
23 physical and mental health, not particularly  
24 compliant with anything that you might want to ask  
25 them to do, such as wear masks, et cetera, sleeping



1 in very, very congested conjugate settings.

2 And we thought that when COVID was --  
3 there was a discussion about COVID. We thought we  
4 were going to be overrun. We could just see that  
5 when COVID got into this population that there  
6 would be absolutely no way that we were going to be  
7 able to restrict its growth and development, and it  
8 would have a huge impact.

9 So that was the circumstances that we  
10 were facing with.

11 At the same time as COVID was starting,  
12 many of the care providers withdrew their services  
13 from the homeless setting because of the risk of  
14 contagion. Mental health support and other care  
15 providers, social services, et cetera, stopped  
16 providing services in the shelters and said, Oh, we  
17 can do that at a distance with FaceTime or whatever  
18 that might be.

19 Well, this is not a population that  
20 deals well with FaceTime. They don't walk around  
21 with their cell phones, and they don't walk around  
22 with -- or their encounters, they lack trust in the  
23 best of times and then their encounters on a  
24 regular basis are infrequent. So it's a challenge.

25 So you can imagine, as I was thinking

1 about COVID, I was thinking, well, this is going to  
2 not be good for our community. It is not going to  
3 be good for other conjugate settings. It won't be  
4 good for people on reserves, et cetera.

5 But we knew that we had a massive  
6 problem on our hands, and we had to respond  
7 dramatically.

8 So if we could go to the next slide,  
9 please. These are a series of recommendations, and  
10 I am going to speak to each one. They are not that  
11 sort of relevant, per se, but it is more the  
12 discussion. So feel free to ask me questions about  
13 them.

14 But as I go through them -- there is  
15 eight or so, and then I am going to tell you about  
16 just what happened in the end and were we able to  
17 contain COVID within this environment and then why.

18 So the first one, it became immediately  
19 clear that in our environment, as opposed to  
20 long-term care, this is -- long-term care is  
21 housing and health. Homelessness is homeless. It  
22 is housing, with very little emphasis on health.  
23 There were no regulations on IPAC that applied to  
24 homelessness. There was a mass of different people  
25 who are playing different roles. Just think about

1           it. We have the shelters, we have social services,  
2           we have the municipality, we have Public Health, we  
3           have care providers, all with their finger in the  
4           pie, but nobody really running things and nobody  
5           coordinating a COVID response.

6                         And if you thought that we would have  
7           had in advance an emergency response to COVID  
8           thought out years before, you would be very, very  
9           wrong. This was on the fly, and one of the first  
10          things we encountered was there was no regulation,  
11          no coordination, and we needed to coordinate  
12          dramatically with our hospitals, our service  
13          providers, our shelters, all of those different  
14          groups that would be required to make decisive,  
15          immediate responses.

16                        COMMISSIONER FRANK MARROCCO (CHAIR):  
17                        Doctor, if I can interrupt for a  
18                        minute.

19                        DR. JEFF TURNBULL: Yes, please.

20                        COMMISSIONER FRANK MARROCCO (CHAIR):  
21                        This problem presents itself over and  
22                        over again, this lack of a coordinated response. A  
23                        lack of leadership, I think, is one of the ways we  
24                        have articulated it.

25                        Do you have any sense of why that was

1 true with the population that you were dealing  
2 with, that there was no plan, not so much for a  
3 pandemic but for some contagious disease that would  
4 run through the population and be bad for  
5 everybody? Do you have any sense of that?

6 DR. JEFF TURNBULL: One is that there  
7 are so many cooks in the kitchen. That is the  
8 first thing.

9 The second thing was that often those  
10 cooks don't get along, I have to tell you. They  
11 are looking after their own jurisdiction  
12 exclusively and not quite thinking about the better  
13 good for the whole group.

14 And then I think the other one is that  
15 in this environment, we never -- homelessness is  
16 just the beginning of a new understanding that this  
17 is a health problem, not a housing problem. These  
18 people have mental health and addictions that are  
19 profound, and that is the challenge in housing  
20 them.

21 And so if we can deal with their mental  
22 health and addictions and stabilization and have a  
23 health component, then I think we would be more  
24 fortunate and have a plan if there was greater  
25 health input.

1                   Now, finally, I have to tell you this  
2 world is a world of crisis. We just go from -- we  
3 are on our heels the whole time. We went from, you  
4 know, opioids to COVID in a heartbeat. We deal  
5 with one disaster after the next. So this is not a  
6 world of planning. It is a world of reaction.

7                   Now, we are good at reacting, as I  
8 think you'll see, but on the other hand, we don't  
9 plan very far ahead, and it is the culture.

10                  Now, I can't say if that would be  
11 translated to your environment, but that is our  
12 environment.

13                  COMMISSIONER FRANK MARROCCO (CHAIR):

14                  The thing that bothers me, it seems to  
15 me the ability to improvise is the function of  
16 whether there is a leadership-type person who  
17 happens to be in the place where you need them at  
18 that moment.

19                  DR. JEFF TURNBULL: Yes.

20                  COMMISSIONER FRANK MARROCCO (CHAIR):

21                  Some people are in positions but are  
22 not leaders, and they can't react in a crisis  
23 because either they don't want to take  
24 responsibility or they just don't have what it  
25 takes.

1 DR. JEFF TURNBULL: Yes, so this is --  
2 COMMISSIONER FRANK MARROCCO (CHAIR):  
3 And that seems distressing to me  
4 because it is happenstance then whether --

5 DR. JEFF TURNBULL: Absolutely. Yes,  
6 totally.

7 So let me just tell you -- Jack knows  
8 this force of nature that works with me. Her name  
9 is Wendy Muckle, and -- so Wendy would not be the  
10 person that you would normally run a coordinated  
11 program because of her role necessarily. However,  
12 everybody turned to Wendy to run this, and we  
13 had -- just to tell you, that we needed to test  
14 people -- I will talk about this in a minute -- so  
15 we had to create an isolation centre, because if  
16 you are testing positive, and you happen to be  
17 homeless, there is no place you are going to  
18 isolate.

19 So we knew we needed an isolation  
20 centre. Wendy had the municipality, the hospital,  
21 the homeless sector down, and within one week, we  
22 had commandeered a community center. We turned it  
23 into a hospital-based facility. It had oxygen  
24 rooms. It had every facility going. It could  
25 support 120 people with COVID. One week. The

1 floors were ripped up because they were carpet. We  
2 were putting in negative pressure stuff.

3 This turned into a -- so you are right,  
4 it is the strength of personality of probably one  
5 person. It may not necessarily be somebody who is  
6 the head of Public Health or the hospital or  
7 whatever, but everybody came together and said,  
8 Yeah, we've got a problem.

9 And Wendy, just by virtue of the fact  
10 of her personality, which is -- unfortunately you  
11 can't guarantee that it is going to be there in  
12 every place, just as you have said.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 Yes, that is a problem. It is  
15 frustrating too because we have heard repeatedly of  
16 examples where people created temporary facilities  
17 in a matter of a few days or a couple of weeks, and  
18 it got them through the problem, which in the end  
19 is all you are really trying to do. You are not  
20 building a pyramid here. We are erecting a tent.

21 DR. JEFF TURNBULL: Yes. So --

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Anyway, I'm taking you off the --

24 DR. JEFF TURNBULL: No, no.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 I should be listening and not giving  
2 away some of the thoughts that are rattling around.

3 DR. JEFF TURNBULL: And so I'll give  
4 you some other examples of just how I think we have  
5 an advantage because we are unregulated. We have a  
6 disadvantage because we are unregulated. But we  
7 were able to be flexible, quick, nimble, and  
8 responsive because we are the only game in town,  
9 and we don't have to worry about regulations, and  
10 we had some very good partners who helped us out.

11 So the next thing we did was we said we  
12 are in trouble if we don't support our service  
13 providers, and here we had a much broader view of  
14 people who are service providers. These are not  
15 just my health care staff in the shelters and my  
16 colleagues. It is, you know, the person who is  
17 serving lunches in a shelter. It is the person  
18 cleaning. And we recognized if we can't help that  
19 first-line group of people and protect them, they  
20 won't be able to protect the homeless.

21 And so we spent a lot of time early on  
22 educating them about infection control. This was  
23 new for them. Unlike, I think, in the long-term  
24 care world, this kind of hygiene and personal  
25 protective equipment, all of that kind of stuff,



1           that was new to this community. So we spent a lot  
2           of time talking to them and trying to educate them  
3           about how to be safe for themselves and then how to  
4           be safe for their clients.

5                         And so we early on didn't have enough  
6           PPE, like the long-term care, but again, what we  
7           did is we put the word out. And I have to say --  
8           and Jack will know Leonor Ward, who used to work  
9           with me at the hospital, she said, All right, what  
10          do you need? And we said we need -- oh, we need  
11          gowns and we need masks. How many? Oh, 3 or 4,000  
12          at least that we would have to, you know, get  
13          cleaned on a regular basis, but at least let's  
14          begin with 4,000. One week later, all the sewers  
15          in Ottawa, Huntsville, Bancroft, were sewing gowns  
16          and masks, and they were on our door in a week. It  
17          is just amazing.

18                        People donated hand hygiene equipment,  
19          you know, alcohol. They donated masks. They  
20          donated visors. It was amazing. And the hospital  
21          was a great supporter, because if these people were  
22          not going to stay with us, they were going to be in  
23          the hospital, and so the hospital, you know,  
24          recognized very quickly that they better be part of  
25          this.

1                                   And then this gets to the  
2                                   recommendation 3 here, got to the exact same place  
3                                   where you were, decongesting our shelters. You  
4                                   know, how could you really control COVID if you  
5                                   have got a 70-bed room? Just impossible.

6                                   And so what has happened is a lot of  
7                                   people have moved into encampments on their own  
8                                   volition. They feel that the shelters are too  
9                                   unsafe. So that is a new problem for us, how do we  
10                                  service those encampments, especially during the  
11                                  winter.

12                                  But very quickly we went to our hotels  
13                                  around us, the university, and they all volunteered  
14                                  space. We commandeered the Jim Durrell Community  
15                                  Centre. We commandeered different hotels and  
16                                  immediately started to decant people who were in  
17                                  shelters and get them out of those congested  
18                                  environments.

19                                  COMMISSIONER FRANK MARROCCO (CHAIR):

20                                  Doctor, if I could stop you for a  
21                                  second. As I look at the recommendations, you  
22                                  know, put somebody in charge, support the support  
23                                  workers, be prepared to move people out, how long  
24                                  did it take to realize that these were the things  
25                                  you had to do to have even a chance at controlling

1           this thing?

2                         DR. JEFF TURNBULL: I think these  
3 things are self-evident, you know. If you sat down  
4 in a quiet moment, you would say, somebody  
5 better -- we better be able to govern this, and you  
6 better look after your staff, and you had better  
7 decongest and manage outbreaks, et cetera. You  
8 know, this is not rocket science. This is project  
9 management is what this is.

10                        COMMISSIONER FRANK MARROCCO (CHAIR):

11                        Yes.

12                        DR. JEFF TURNBULL: However, the  
13 implementation of it is challenging, getting your  
14 partners together, getting that sense of urgency,  
15 you know, just doing it and worrying about the  
16 money later.

17                        COMMISSIONER FRANK MARROCCO (CHAIR):

18                        Yes.

19                        DR. JEFF TURNBULL: Getting on with --  
20 you know, if somebody is in the way, then, you  
21 know, just go around. We can't afford to have  
22 petty politics affecting the life of our people.

23                        And so we just moved ahead, and you  
24 might say this is the jurisdiction of Public  
25 Health. But we found Public Health at times -- you

1 know, they would give us conflicting advice. They  
2 were not supported or staffed to make major inroads  
3 here. And so even though they felt perhaps that  
4 they should be engaged more and do more, we, to be  
5 honest, didn't feel that they were in a position to  
6 lead. And they became very good colleagues in  
7 supporting us as we went ahead, but we were not  
8 waiting.

9 I think it makes sense that you have an  
10 outbreak management plan. That is pretty easy.  
11 However, what is an outbreak? How do you define an  
12 "outbreak"? What is going to happen to the people  
13 in your facility if you have got 200 people in a  
14 facility that it now has an outbreak? Are you  
15 going to restrict them, prevent them from moving  
16 around? Are you going to decant that population?

17 Remember, these people have mental  
18 health and addictions. They don't stay put. They  
19 are moving from place to place. So it is very,  
20 very difficult. So we needed that plan in a hurry,  
21 and so that very rapidly evolved.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Well, you know, there is a similarity  
24 because so many residents of long-term care homes  
25 have some level of dementia.

1 DR. JEFF TURNBULL: Yes.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 And are in that sense difficult to  
4 "manage", I guess, is one of the words that comes  
5 to mind, but it is hard to reach a consensus with a  
6 person who can't remember what they agreed to.

7 DR. JEFF TURNBULL: Yes, or reach a  
8 consensus with somebody who is 35, an opioid addict  
9 who is profoundly addicted to their opioids, who  
10 has mental health problems, schizophrenia and, you  
11 know -- and lack of trust of organizations. So  
12 these people move around. They have got to earn  
13 money to get to their addictions, and, you know,  
14 just the big issue for them are the voices that  
15 they hear every day, and when I tell them, I think  
16 you should wear a mask, they look at me and sort of  
17 giggle.

18 So the next one -- if we can go to the  
19 next series, the next slide, and I am going to end  
20 on this honestly, I promise.

21 We created isolation centres that I  
22 mentioned, but, you know, the isolation centres,  
23 they had to be a place where we could support  
24 people. So you have to think about who you were --  
25 going to be there. They had to be culturally

1 relevant. You have to think that these people are,  
2 you know, using and injecting opioids very  
3 constantly, so we needed to have a quick Health  
4 Canada exemption that would allow us to have a safe  
5 injection facility right in the site.

6 We provided them food, and all of our  
7 shelters came together and helped us put this  
8 isolation centre together in a very short order.  
9 As I said, less than a week.

10 Establish and implement screening,  
11 testing and contact tracing strategies. It kind of  
12 makes sense, doesn't it? But somebody who won't  
13 stay put, whose biggest issues are their addiction  
14 and mental health, who care very little about  
15 COVID -- and 30 percent of my population have a  
16 cough and cold anyways at any one point in time.

17 And so figuring out what is a new  
18 symptom, figuring out how to test somebody, then  
19 telling them that they, once tested, have to go to  
20 an isolation facility and await the results, and it  
21 may be seven days before they get the results.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Can I just ask you, do you have any  
24 sense of what the isolation facility cost?

25 DR. JEFF TURNBULL: Well, it was empty

1            anyway, so we got it from the municipality for  
2            free.

3                            Then there was the retrofitting, and  
4            that was substantial. We had to do many, you know,  
5            things like get rid of the carpet, et cetera.

6                            But then I think the biggest cost, of  
7            course, at the isolation facility would be the  
8            staffing, and interestingly, the people who came  
9            first and foremost to help staff this were our  
10           peers, the people who have lived experience, who  
11           have been working with this community, who have  
12           been through our programs and recovered to a  
13           greater extent. They said, This is our community;  
14           we are going to work for free; we'll get this  
15           going.

16                            And then, I think, you have to  
17            recognize that there are different populations that  
18            we have, so our Indigenous community, women, people  
19            who have a past history of trauma, newcomers,  
20            families, children, adolescents. So we had to be  
21            respectful of the different populations that we  
22            were serving.

23                            And then as we start to think about it,  
24            we are going to think about the challenges of  
25            vaccination for us -- and this is where I'll end --

1 in that you have got two doses. You have got  
2 somebody who may not even give you their real name.  
3 You'll give them the first dose. If we can find  
4 them, if they'll agree, if they are trusting enough  
5 by a provider that they know, they'll take a  
6 vaccination.

7 However, now you have got to document  
8 that, find them in a month, get them a second dose.  
9 This is a very mobile community, and it is tough to  
10 actually -- you know, as Jack knows, you know, if I  
11 ask for an ultrasound, if it is two days away, the  
12 chances are that is not going to happen because we  
13 can't find them in two days. So how am I going to  
14 find these people and make sure they get their  
15 second dose? It is going to be very challenging in  
16 this environment.

17 So what I wanted to do, if you can  
18 just -- I'll end in just a second, but to tell you  
19 how did it work out.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Don't feel unduly rushed, Doctor. We  
22 are taking all this in. I think I speak for all  
23 three of us. It is a bit presumptuous on my part,  
24 but just go ahead.

25 DR. JEFF TURNBULL: So the next slide,



1 if we could.

2 So what are the outcomes? What  
3 happened?

4 So as I said, we moved people quickly.  
5 Some moved into encampments. Some people we moved  
6 into hotels, and so we have been able to decongest  
7 our shelters to a greater extent.

8 We created an isolation centre, and we  
9 then -- for people who are awaiting test results or  
10 who had tested positive. We retrofitted one of our  
11 vans that is used for outreach mental health  
12 through Telus and that was going to be our testing  
13 van. So we went out and tested everybody, anybody  
14 who had a sniffle.

15 And remember, that symptoms in this  
16 population are very atypical. The most common  
17 presenting symptom of COVID, headaches. Not  
18 shortness of breath, cough, fever. Headaches. So  
19 we had to think of atypical symptoms, and now just  
20 think of this population and who has got an  
21 atypical symptom? Everybody.

22 So we tested an awful lot of people.  
23 We trained all of the kitchen staff of shelters.  
24 We trained all our personal support workers and  
25 peers. We did a lot of outreach. We got everybody

1           into PPE. And these shelters have been wiped down.  
2           They are clean. And we have hand hygiene  
3           everywhere, and we have enforced that all of our  
4           clients, the homeless themselves, wear masks. And  
5           all that has happened in a very short order.

6                        So then what we started to do is we  
7           started to say, you know, where are all these  
8           people with COVID? Maybe they are asymptomatic,  
9           because we were -- you know, we were finding one,  
10          two cases of COVID every three or four days. Our  
11          isolation unit would have anywhere from 10 to 15  
12          people in it who are positive, no more. Remember,  
13          we've got a thousand people who are at high risk.  
14          We thought we would be overrun.

15                      And so then we started to actually do  
16          surveillance testing and just test everybody in our  
17          shelters, and we found the prevalence in our  
18          shelters, with all of these precautions, et cetera,  
19          to be about 2 percent if there is no cases  
20          whatsoever.

21                      When you actually have somebody with  
22          symptoms, then when we test around, you know,  
23          making sure that that person -- you know, we know  
24          where they are, we know where they slept, we know  
25          who they work with, so we tested all of those

1 people, then you have got about a 14 percent  
2 prevalence of COVID.

3 So asymptomatic, about 2 percent is  
4 what our prevalence rate was, and if you have got  
5 symptoms, it gets up to around 14 percent.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 So seven times as many people?

8 DR. JEFF TURNBULL: Yeah, when you have  
9 somebody who has documented symptoms.

10 We have had several outbreaks in  
11 different sites.

12 Interesting -- you'll like this one --  
13 in one of our women's shelters, we had an outbreak  
14 of two people with COVID. And I said, Well, how  
15 would these people get COVID? And it turns out  
16 that they live in a shelter, but they work outside  
17 of the shelter. They just can't earn enough money  
18 to afford Ottawa's rental circumstances. And where  
19 do they work? Long-term care. And so they brought  
20 COVID from a long-term care facility into the  
21 shelters where we had an outbreak.

22 And I just -- it was stupid of me. I  
23 just didn't think that that would be a likely  
24 possibility of people working outside of -- and  
25 exposing themselves and bringing COVID in that way.

1                   And so we had to say to people that,  
2                   you know, we don't want you to do that, but on the  
3                   other hand, if that is the case, then you have to  
4                   think that they have no income. Some of our  
5                   personal support workers that work so hard in the  
6                   shelter environment, they work in two jobs, two,  
7                   three sites. We had to say no to that and restrict  
8                   movement, and again, that affected their income,  
9                   et cetera.

10                   So we had a lot of HR issues to deal  
11                   with, but by and large, right now -- and the  
12                   fingers crossed -- I would have to say that we have  
13                   had no deaths. We have a very challenging  
14                   population. We have a population that is at a very  
15                   high risk. We should be overrun, but we haven't  
16                   been.

17                   And that could be because of good luck.  
18                   It could be because of the fact that these people  
19                   are exposed to a lot of infections and may have  
20                   been exposed to some coronaviruses in the past and  
21                   have partial T-cell immunity, or it could be  
22                   because of all of the plans that we took into place  
23                   and we initiated immediately.

24                   So that is where I'll end, and I would  
25                   be delighted to answer any questions you might have

1 about our experience.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, I think we -- I don't know.

4 Commissioner Kitts?

5 COMMISSIONER JACK KITTS: Yes, I just  
6 want to follow up, Jeff, on your comment about the  
7 strong leadership that Wendy Muckle provided.

8 You are right, I know her. She is a  
9 very strong leader. So from the administrative  
10 side, that was evident.

11 I want to state also that you need the  
12 medical or clinical side, and I know your head is  
13 going to swell, but you provide that leadership.

14 And I think it is the combination of  
15 administrative and medical leadership or clinical  
16 leadership that brings this all together.

17 And you are right, there may have been  
18 some luck involved, but what you have described is  
19 what we have been hearing as being an appropriate  
20 plan or approach for the past few months in terms  
21 of dealing with this, I think.

22 My question is -- clearly the  
23 relationships were critical in getting you up to  
24 speed so fast, leadership and relationships. Were  
25 these existing relationships, or did you have to go

1 out and create a lot of relationships that hadn't  
2 existed, given that you said that it is a siloed  
3 system to begin with?

4 DR. JEFF TURNBULL: So I thought of  
5 that too, Jack, and I was trying to think about  
6 what might be a helpful suggestion.

7 The relationships, I think it is  
8 important to understand that before COVID, we had  
9 brought health services delivery programs through  
10 Jack's help and through the hospital, and so we  
11 were embedded right in the shelters. We have  
12 primary care, secondary level care, even tertiary  
13 level care delivered right in the shelter, not in  
14 the hospital. Our people do not go to the  
15 hospital. We bring the hospital to them. We have  
16 palliative care, end-of-life care as well.

17 So that relationship, as Jack has  
18 mentioned, was an essential first start. We were  
19 there. We had our feet on the ground. It wasn't  
20 as if you had to suddenly invite the hospital or  
21 care providers in to help. We were there, and we  
22 had these links.

23 We worked well with the hospital. You  
24 know, we -- and the hospital said, Do you need PPE?  
25 You know, we need it for our own staff, the

1 hospital, but they said, If you need it, we'll help  
2 you too.

3 And so it was those relationships that  
4 existed before that we just built on.

5 But we basically look at the shelters  
6 as an extension of the hospital where the hospital,  
7 their staff, everything is done within the shelter  
8 environment.

9 And so you don't need the hospital as  
10 much. You still need them for an ICU, you still  
11 need them for an operating room, but we don't need  
12 them for an emergency department. We don't need  
13 them for primary care or ambulatory care. That is  
14 done by us on-site with the hospital coming to us.

15 And it is that model that may be  
16 helpful in terms of long-term care and its response  
17 to this and any future pandemics.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 How did the relationships get started  
20 originally? The reason I ask is Toronto, for  
21 example, is a series of neighbourhoods. It is  
22 commonly perceived by people to be a big city, but  
23 it is actually a collection of neighbourhoods, and  
24 in a neighbourhood, you do know where the senior  
25 link people are and where the local hospital is and

1 a lot of the doctors live in the neighbourhood  
2 somewhere.

3 How did -- the relationships, how does  
4 that happen?

5 DR. JEFF TURNBULL: So it happened 20  
6 years ago, and the hospitals slowly, through Jack's  
7 help -- you know, I mean, I have to say it, Ottawa  
8 Inner City Health has now become a huge enterprise,  
9 and who does all of our IT work? TOH. Who does  
10 our HR work? TOH.

11 So we are supported by the hospitals,  
12 and I like to think we give back as much as we  
13 take, but -- over these last 20 years, we have been  
14 working as an extension of the hospital, and the  
15 hospital has been in every shelter, every outreach  
16 program. Our nursing program is  
17 hospital-supported. We have nursing clinics. We  
18 have the hospital ID people doing rounds, you know.

19 It is an integrated kind of approach  
20 right throughout the city, and it began 20 years  
21 ago, and it has just built progressively since.

22 But when COVID occurred, it was -- you  
23 know, it became then very easy to build on those  
24 relationships, and just as I said, you know -- I  
25 mean, the hospital came to us and said, How are you



1           guys doing? It wasn't as if we were screaming.  
2           They said, How are you doing?

3                           COMMISSIONER FRANK MARROCCO (CHAIR):  
4                           There is a common commitment to the  
5           health of the community.

6                           DR. JEFF TURNBULL: Yes, and, you know,  
7           there is self-service there. I have to  
8           understand -- you know, those 20 or 30 people that  
9           are tested in our isolation centre would be in the  
10          hospital.

11                          COMMISSIONER FRANK MARROCCO (CHAIR):  
12                          Right. We don't have any other  
13          questions. I just want to say, speaking I am sure  
14          for all of us, this has been very informative, and  
15          it has been very helpful because it has pulled  
16          together, in the context of homelessness, so much  
17          of what we have been hearing about successful  
18          strategies that could easily be employed and  
19          perhaps should have been employed in the long-term  
20          care environment as this problem was evolving.

21                          And what is also helpful is to realize  
22          that even if there was no plans, this can be done,  
23          at least in your example, on an ad hoc basis and  
24          done quickly and, as the results show, effectively.

25                          DR. JEFF TURNBULL: Yes.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Thanks so much.

3 DR. JEFF TURNBULL: I sincerely hope  
4 that those general principles are generalizable to  
5 just about any conjugate setting, you know, or a  
6 setting where there is -- you know, maybe it is an  
7 Indigenous reserve in the north. It may be a  
8 long-term care facility. But I think that these  
9 are all principles that hopefully would help us for  
10 this pandemic, as we still live it, but, you know,  
11 frankly, there is going to be other ones. There  
12 will be other crises that are going to affect these  
13 communities.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 All right. Well -- and even if it is  
16 not completely applicable, there may be local  
17 variations, but at least you have some confidence  
18 that your journey is -- you are walking in the  
19 right direction to start with, you know.

20 DR. JEFF TURNBULL: Yes. That's right.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Well, Doctor, thank you very much for  
23 taking the time.

24 DR. JEFF TURNBULL: No, my pleasure.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 It's very much appreciated.

2 COMMISSIONER ANGELA COKE: That was  
3 very valuable. Thank you.

4 COMMISSIONER JACK KITTS: Thanks, Jeff.

5  
6 -- Adjourned at 9:40 a.m.

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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 16th day of December, 2020.



---

NEESONS, A VERITEXT COMPANY

PER: DEANA SANTEDICOLA, RPR, CRR, CSR

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