Long Term Care Covid-19 Commission Mtg.

Dr. Turnbull
on Wednesday, December 16, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 16th day of December, 2020, 9:00 a.m. to 10:00 a.m.

BEFORE:

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

PRESENTERS:

OTTAWA INNER CITY HEALTH INC.:
Dr. Jeff Turnbull, Medical Director of Ottawa Inner City Health

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care

Commission Secretariat

Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat

Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat

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

ALSO PRESENT:

Deana Santedicola, Stenographer/Transcriptionist

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

COMMISSIONER FRANK MARROCCO (CHAIR):

I think you probably know basically the way we are conducting this. We will have a transcript which we will post on the website in a few days.

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

DR. JEFF TURNBULL: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR):

And I don't know that there is anything else. I think we are ready to go when you are, Doctor.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

in very, very congested conjugate settings.

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

So that was the circumstances that we were facing with.

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

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

So you can imagine, as I was thinking

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

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

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

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

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

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

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

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

DR. JEFF TURNBULL: Yes, please.

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

Do you have any sense of why that was

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. JEFF TURNBULL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. JEFF TURNBULL: Yes, so this is --

COMMISSIONER FRANK MARROCCO (CHAIR): And that seems distressing to me because it is happenstance then whether --

DR. JEFF TURNBULL: Absolutely. Yes, totally.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. JEFF TURNBULL: Yes. So --

COMMISSIONER FRANK MARROCCO (CHAIR):

Anyway, I'm taking you off the --

DR. JEFF TURNBULL: No, no.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

this thing?

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. JEFF TURNBULL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): And are in that sense difficult to "manage", I guess, is one of the words that comes to mind, but it is hard to reach a consensus with a person who can't remember what they agreed to.

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. JEFF TURNBULL: Well, it was empty

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. JEFF TURNBULL: So the next slide,

if we could.

So what are the outcomes? What happened?

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

So seven times as many people?

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

We have had several outbreaks in different sites.

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

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

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

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

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

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

about our experience.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think we -- I don't know. Commissioner Kitts?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

a lot of the doctors live in the neighbourhood somewhere.

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

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

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

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

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

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

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

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

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

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

DR. JEFF TURNBULL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

Thanks so much.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. JEFF TURNBULL: No, my pleasure.

COMMISSIONER FRANK MARROCCO (CHAIR):

It's very much appreciated.

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

COMMISSIONER JACK KITTS: Thanks, Jeff.

-- Adjourned at 9:40 a.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 16th day of December, 2020.

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NEESONS, A VERITEXT COMPANY

PER: DEANA SANTEDICOLA, RPR, CRR, CSR

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