

Long Term Care Commission Covid-19 Mtg.

Meeting with Doctor Moore
on Thursday, October 8, 2020



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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held via Zoom, with all participants attending
15	remotely, on the 8th day of October, 2020,
16	1:00 p.m. to 1:55 p.m.
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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

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8 PRESENTERS:

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10 Dr. Kieran Moore, MD, FCFP, FRCPC, Associate

11 Medical Officer of Health, KFL&A Public Health

12 Associate Professor, Departments of Emergency and

13 Family Medicine, KFL&A

14

15 PARTICIPANTS:

16

17 Alison Drummond, Assistant Deputy Minister,

18 Long-Term Care Commission Secretariat;

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

20 Care Commission Secretariat;

21 Derek Lett, Policy Director, Long-Term Care

22 Commission Secretariat;

23 Ida Bianchi, Counsel, Long-Term Care Commission

24 Secretariat;

25 Lynn Mahoney, Counsel to the Ministry of Health and

1 Long-Term Care;
2 Jessica Franklin, Policy Lead, Policy Unit,
3 Long-Term Care Commission Secretariat;
4 Dr. Azim Kasmani, Queen's Expert, Health Sciences,
5 Queen's University.

6
7 ALSO PRESENT:

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9 McKaya McDonald, Stenographer/Transcriptionist.
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1 -- Upon commencing at 1:00 p.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Well, Doctor, let me just sort of tell you, well,
5 we're in a bit of an odd position because typically
6 the Commission of Inquiry is called after something
7 has happened and looks back and attempts to explain
8 it to the public so that there's a complete
9 understanding of the events that occurred.

10 Our situation is different. We are
11 called to existence in the middle of something
12 which is not over. And so we are not so convinced
13 that the traditional way of doing things -- which
14 is an investigation, public hearings, and a report.

15 And two and a half years from now is
16 when you'd get the report. Two years to two and a
17 half years is when you'd likely get the report. We
18 thought we should try to communicate something
19 quickly that hits on some key points and then take,
20 perhaps, a more conventional approach with the
21 earlier events.

22 So that's where we're coming from. We
23 would appreciate any help you could give us. It
24 would be helpful, any perspective. That would be
25 very helpful from our point of view.

1 We have tended in the past to interrupt
2 and ask questions as we go along rather than
3 waiting until the end, if that's okay with you.

4 DR. KIERAN MOORE: Of course.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 All right. Well, then we're ready when you are.

7 DR. KIERAN MOORE: So if it's okay, I
8 did give you a PowerPoint, and I'm happy that
9 you -- I could review that with you, and then
10 please -- happy to interrupt and just make this
11 more of a dialogue.

12 We basically tried to document our
13 response at a local level in our attempts to
14 influence policy at a provincial level. So would
15 that be of interest?

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 That would be very helpful. So if we can get the
18 PowerPoint on the screen, we're ready to go.

19 Ms. McDonald, you --

20 There we go. There we are. So I can
21 see the PowerPoint now.

22 DR. KIERAN MOORE: All right. I'll
23 just --

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 And, Commissioner Coke and Commissioner Kitts, you

1 can both see it?

2 COMMISSIONER KITTS: Yes, yeah.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 So we've got it, so away we go.

5 DR. KIERAN MOORE: Okay. So I'll just
6 basically run through our experience at a local
7 level and some of the policies that we develop,
8 some of the responses that we've implemented that I
9 think have put it in a good position to date -- and
10 I'm knocking on wood when I say that -- and that
11 could be a model for the province.

12 So a quick review over KFL&A in our
13 region, our local response to LTC/RH spread of
14 COVID-19, our preparedness, and our approaches, and
15 then some recommendations.

16 As a Public Health physician, I was a
17 previous emerge physician for over 20 years and
18 moved into Public Health because I do strongly
19 believe in prevention, and certainly long-term care
20 facilities are -- we would love a provincial
21 strategy to keep our elderly ageing healthily and
22 in their own homes and certainly would want a home
23 care strategy as part of an overarching senior
24 strategy.

25 So I was remiss if I didn't admit to

1 this in advance in my first slides that we work
2 locally with the AVOID Frailty research network
3 across Canada -- avoid standing for increasing
4 activities; maximizing vaccination; optimizing
5 medications; increased interactions; the "I," so
6 minimizing social isolation; and then working on
7 diet and nutrition in the elderly as a strong frame
8 to minimize the need for LTC.

9 Certainly LTCs will be necessary, but I
10 think the vast majority of seniors -- and I'm
11 certainly approaching there -- would like to stay
12 many their own home as long as they can. So I know
13 you're targeted on LTCs, but this has to be part of
14 a senior strategy, a stay-at-home strategy, home
15 care support piece.

16 For KFL&A, this is a map of current
17 outbreaks. As of October 5th, we have no outbreaks
18 in our facilities, so I don't have a lot of
19 outbreak experience to share with you. And KFL&A
20 is over 7,000 square kilometres, so we're a very
21 large region. And resolved outbreaks, we only had
22 one outbreak of one healthcare provider.

23 We are a vulnerable population, so as
24 you can see, most of our population is below the
25 401 along the lake, but we have a boom, bust, echo

1 population distribution with a vast majority of our
2 population, a quarter of which is over 65 and
3 invulnerable.

4 And so when we saw how COVID was
5 spreading in Wuhan and how the elderly were getting
6 affected in January, we set up strategies to
7 protect our vulnerable, to protect our
8 facilities -- because we were watching in Wuhan how
9 the virus was spreading.

10 And we set up strategies to protect our
11 correctional facilities, our long-term care
12 facilities, our retirement homes, and minimize the
13 community rate of infection. And that was always
14 our goal, to have a low rate of infection in our
15 community. And that required a very robust
16 strategy, not just an LTC strategy. But we knew if
17 we kept our population rate low, we would protect
18 all our vulnerable populations.

19 This is a distribution of our long-term
20 care facilities and retirement homes, so many are
21 in our rural environment. Many are owned by our
22 municipal partners who co-fund KFL&A Public Health,
23 and they have all been partners long term with
24 Public Health because we work with them. And I'll
25 share some of the work we've done longitudinally

1 with them.

2 So we have 11 long-term care
3 facilities, 16 retirement homes, and a significant
4 number of individuals, around 2,600 individuals,
5 living in those environments. And I'll just say
6 for our corrections facilities, we have seven large
7 correctional facilities thankfully with the same
8 number of inmates.

9 And, if you've seen, all of these
10 congregate settings are high risk, so we had
11 strategies to protect not only our LTC and
12 retirement but also all of our congregate settings,
13 all vulnerable settings in our community.

14 This is just a list of the directives,
15 and we'll overlay our local action over these
16 provincial directives which came down in response
17 that I'm sure you're very much aware of.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Doctor, can I just interrupt you for a second?

20 DR. KIERAN MOORE: Yeah.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 You said -- so what started the wheels turning for
23 you was your observation of what was happening in
24 Wuhan?

25 DR. KIERAN MOORE: Correct, yeah. We

1 were monitoring the epidemiology in Wuhan. We were
2 seeing that the most affected were elderly, those
3 with chronic diseases.

4 And then we were monitoring the
5 outbreak in Seattle in Washington State. That was
6 a well-documented outbreak. We monitored how they
7 responded in Seattle.

8 Then we watched the activity in
9 Vancouver when Vancouver -- I think it was Fraser
10 Coastal -- had an outbreak in their LTC and how
11 they managed it. So we were monitoring this risk
12 for this population all along and studied each one
13 of those outbreaks to apply best practices with all
14 of our partners at a local level.

15 And we did raise awareness at a
16 provincial level that, you know, you have to
17 protect your LTCs and your retirement homes. That
18 wasn't a foundational message to local Public
19 Health agencies, by the way, from Central.

20 It was only after the outbreak started
21 happening that these interventions were put in
22 place to only allow essential visitors, et cetera.
23 So it --

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 When did you notify the province?

1 DR. KIERAN MOORE: Of our approach?

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Yeah. Well, to say that population in the

4 long-term care homes were at risk.

5 DR. KIERAN MOORE: Oh, we did that at

6 the very beginning of March. And we did inform the

7 province and our sister health units, all 34 of our

8 protocols that we put in place of our protocol to

9 visit all long-term care facilities, to audit all

10 long-term care facilities. That was shared through

11 the committee of medical officers of health.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 Thank you.

14 COMMISSIONER KITTS: Kieran, can I just

15 ask a question? I think you said that most of your

16 long-term care homes are municipal, and you have 11

17 long-term care facilities in your region.

18 Can you tell us how many are private,

19 municipal, or --

20 DR. KIERAN MOORE: Oh, sorry. Yeah,

21 Jack, the majority, actually, are private, but each

22 municipality, as per the regulation, is obligated

23 to have a long-term care facility. So we have the

24 Kingston, Frontenac and Lennox, and Addington. So

25 we have three major municipally-owned and operated

1 LTCs. The rest are private. Extendicare,
2 Chartwell, they're all represented.

3 COMMISSIONER KITTS: Okay. Thank you.

4 DR. KIERAN MOORE: So these were the
5 health recommendations that came out recently for
6 the second wave to protect long-term care
7 facilities and retirement homes.

8 I just want to say that we've had
9 ongoing systems collaborations with our long-term
10 care home facilities, so that wasn't new to us.
11 I'll just highlight that we meet with the medical
12 directors. I met with the medical directors on a
13 weekly basis through teleconference to keep them
14 appraised of the directives, to keep them appraised
15 of risk, to provide with them the local
16 epidemiology.

17 We had made a cutoff of ten per hundred
18 thousand per week as a risk level that above that
19 count, they should be very much vigilant that
20 there's a risk of a worker bringing the virus or a
21 visitor into their institutions and to heighten
22 awareness.

23 So we'd set cutoffs; we'd set targets,
24 alert levels. We provided infection prevention and
25 control on-site advice as well as remote advice to

1 our LTCs from the beginning. We supported any
2 outbreak.

3 And the one outbreak that we had of one
4 worker in one long-term care facility, we went in
5 and helped them swab everyone in that facility that
6 needed swabbing, so around 100 individuals, and
7 walked them through the outbreak management and how
8 to create a live list, et cetera.

9 As well, on the management orders, the
10 enforcement side, I'll give you an update of how we
11 used enforcement to bring online some LTCs and
12 retirement homes that weren't meeting our
13 requirements on all of these issues.

14 So as I said, we had one case of one
15 staff in our one long-term care facility that got
16 ill while at work. Quickly was isolated, and we
17 subsequently tested 100 people and didn't find any
18 transmission.

19 So we've had no hospitalizations from
20 long-term care facilities from COVID, and quite
21 proud of our institution and partners that we've
22 had no deaths amongst the 2,700 individuals that we
23 protect in our LTCs and retirement homes. So, you
24 know, I got to celebrate the record of our partners
25 in protecting their patients and clients and

1 families.

2 So just historically -- I just wanted
3 to put context -- we've had a great partnership
4 with our LTCs. Back in 2012, I created an
5 antibiotic stewardship guide. We were having high
6 rates of C. difficile in our acute care facilities.
7 Many patients were being transferred from LTC to
8 acute care because of C. diff. So we created an
9 antibiotic stewardship practice for our LTC.

10 So I know all the medical directors.
11 We know the nurse managers, the nurse
12 practitioners. We've worked with them
13 longitudinally. And really, if you're going to
14 have success, you have to have preexisting
15 partnerships. And I'm proud of the partnerships
16 we've already had with these institutions and
17 workers.

18 We also take the standard -- and we
19 read through this standard, the 2018 -- I would
20 suggest that this is a key component that all
21 health units should be held accountable on. It
22 says how you should interact with your long-term
23 care facilities, your retirement homes; how you
24 should manage outbreaks outside of COVID. And we
25 took that responsibility exceptionally seriously

1 and worked with them year in and year out on
2 prevention and infection management.

3 We host an annual event to educate our
4 long-term care facilities and retirement homes. We
5 have strong partnerships with them and have strong
6 and high testing within our LTC facilities for
7 respiratory outbreaks as well as GI outbreaks.

8 So this standard, I think, is a good
9 standard. I would say that all health units should
10 be able to account for whether they've met the key
11 deliverables in this standard. And it's rigorous,
12 and we adhere to it.

13 So, you know, I just think if you had
14 to boil it down, it's really about strong
15 communication, collaboration, and coordination, the
16 three Cs that we've established longitudinally long
17 before this outbreak.

18 And we do an annual update where we
19 bring all LTCs, retirement homes, medical
20 directors, nurse practitioners together and review
21 influenza and how to respond to any type of
22 outbreak. We do annual education. We have some of
23 the highest immunization rates in our facilities
24 amongst workers as well as clients and patients.
25 We're very proud of that achievement and generally

1 have some of the first or second amongst all health
2 units in the immunization rates across all sectors
3 of our community.

4 We also have assigned an infection
5 prevention and care nurse, coordination nurse,
6 dedicated to our LTCs and retirement homes. She
7 sits on all of their mandatory committees. It's
8 part of the long-term care regulatory framework
9 that they have to have an IPAC committee. We have
10 to prod them to have it on an annual basis.

11 I will say to this Commission that, you
12 know, to be the IPAC lead within those
13 institutions, you didn't need training; you didn't
14 need skill sets. You just had to be given the
15 title, and I think that certainly needs to be
16 strengthened, that they do need a skill set. They
17 do need the qualifications, the CIC qualifications
18 at a minimum, and that would add a robust response.

19 But otherwise, we have provided the
20 expertise to all of our LTCs over the years and
21 certainly in COVID.

22 Fortunately, as well, in 2019, in
23 September, we were monitoring influenza season in
24 New Zealand and Australia, which was severe, and we
25 decided to have a preparedness workshop. So we

1 brought all of our acute care, EMS, long-term care,
2 primary care partners together to prepare for a
3 potential mild, moderate, or severe influenza
4 season. And luckily that was four months before
5 COVID started.

6 So we have a history of bringing our
7 partners together to prepare. So I'm an emerge
8 physician.

9 Jack, you know, you do simulations.
10 I'm used to running simulations, running cardiac
11 arrests, pediatric arrests, and practicing until
12 it's perfect.

13 So we brought that same mentality to
14 Public Health. You practice outbreak management
15 until it's perfect with all the partners, and you
16 support partners with the three Cs of
17 communication, collaboration, and coordination.

18 So we've run multiple tabletops. And,
19 by the way, we continue to run those simulations.
20 All summer long, we ran longitudinal simulations
21 with our LTC and retirement homes, medical
22 directors, and nurse practitioners to prepare for
23 this winter where we're going to be seeing a
24 complexity we've never seen -- the co-circulation
25 of COVID-19, other respiratory pathogens, plus

1 influenza.

2 And we have a write-up that could be
3 available to you if you're interested in reviewing
4 it because that will prepare -- that is going to
5 set very unique circumstances where they're going
6 to have to have separate cohorts.

7 So these two significant infectious
8 disease agents -- COVID and influenza -- two
9 different staffing models, separating those
10 patients, building capacity to separate those
11 patients, and it's so important that agencies think
12 well ahead before this circumstance starts.

13 And I can tell you Influenza B and A is
14 circulating in the Ottawa region. It's already
15 been detected in LTCs as well as COVID-19, so it's
16 there already. And we're only in October, two
17 months before we're going to be seeing it starting
18 to peak.

19 So all that's to say we have provided
20 IPAC support, ongoing consultation, and we provide
21 a link between the acute care sector and our
22 long-term care sector partners.

23 We are a trusted intermediary, so if we
24 need extra IPAC support, we'll go to the Gerald
25 Evans, the infectious disease colleagues who have

1 expertise, and bring them in to do consultation, if
2 necessary.

3 And the same for patient care. We
4 support our medical directors by having e-health
5 consults, the OTNhub being able to provide
6 consultations in outbreak or outside of outbreak
7 between IV, geriatricians, et cetera. So that's a
8 key, important role.

9 So I've already talked about how we
10 were monitoring data across the globe. That's an
11 important intelligence-gathering function of Public
12 Health. We assign epidemiologists to look at this
13 data weekly early on, and we also created an
14 educational session.

15 That's the last time I brought a
16 hundred doctors together was March 5th, 2020. And
17 we brought all of our long-term care physicians,
18 nurse practitioners, primary care physicians
19 together to review the science, the epidemiology,
20 the symptoms of COVID-19.

21 We reviewed how to do an NP swab for
22 everybody. We reviewed the multiplex. We reviewed
23 how the PCR. And having this Public Health-led
24 educational session early on in the epidemic put us
25 well ahead because our primary care partners felt

1 comfortable swabbing. They felt comfortable for
2 IPAC.

3 And our primary care partners,
4 especially in our rural environments, detected the
5 virus in KFL&A first. And this was amongst
6 healthcare workers that were actively assigned to
7 LTCs.

8 But they tested, they caught it for us,
9 and we prevented outbreaks because we harnessed the
10 energy of our primary care partners and brought
11 them in to the solution.

12 And I think, across Ontario, that has
13 been an issue, how to bring primary care into the
14 solution, and how to strengthen the medical
15 directors' capacity to respond to COVID-19.

16 We -- during the pandemic, so starting
17 in late February -- met and continued to meet with
18 each of the medical directors. And I'd do an
19 hour-long teleconference. We'd review the
20 directives. We'd support them. We'd give them
21 situational awareness. We'd answer their
22 questions. We do the same with the administrators.

23 At the end of February of this year, I
24 had an hour-long talk with the administrators
25 saying "this is the largest threat you're ever

1 going to have to the community you serve."

2 They took it seriously. I read them
3 the riot act, and since then, the partnership is
4 even strengthened with these weekly coordination
5 teleconferences.

6 March 10th, we set up -- and if you
7 know -- if you remember what the directives were,
8 we set up -- we anticipated restaurants and
9 businesses being closed. We realigned our
10 inspectors and nurses to be -- to work with our
11 LTCs, and they went in to -- I sent them in to the
12 long-term care facilities/retirement homes. I
13 wanted assurance, as the medical officer of health,
14 that all of these false were screening
15 appropriately; they had good IPAC; and that they
16 felt confident to be able to test, isolate,
17 quarantine contacts, and respond quickly.

18 And so we created a team of a public
19 health inspector -- that's not been done anywhere
20 else in the province -- and a nurse to go in early.
21 And I honestly believe this is a very key and
22 important role for public health.

23 My colleagues disagree. They don't
24 think they have capacity, but we realigned all of
25 our services to meet this function. I stopped many

1 other aspects of our business to ensure that this
2 was done and that we protected the most vulnerable
3 members of our community. It seems to have done us
4 well. It's been well accepted by our LTC partners,
5 and it was supervised by our IPAC lead and myself.

6 And so now we have eight public health
7 inspectors, eight nurses. These aren't funded by
8 anybody. They're coming from the Public Health
9 budget. It's no additional funding. We just
10 realigned our services to meet this need, and we
11 continue to -- we have continued to do it all
12 along.

13 So if you just look at the time line,
14 we did this March 10th. We visited all homes.
15 We've done 31 repeat visits to 19 homes. I think
16 this is a brilliant role for Public Health because
17 inspectors have the right and ability to write an
18 order against a home. If they find that they're
19 not adhering to public health guidance and/or any
20 directives.

21 And I'm not aware of many other health
22 units that have done this except, you know, in a
23 lockdown in an outbreak mode. So we did start this
24 very early and were proactive, and many consider
25 this to be the reason why we've had no deaths/no

1 outbreaks in our region.

2 This is an example of a checklist. So
3 we've created an evidence-based checklist based on
4 our expertise with IPAC that every inspector went
5 into the LTC. They reviewed all of these. Just as
6 an example, with the LTC, if they didn't adhere to
7 this checklist, we would write an order that they
8 will.

9 And so we gave them warnings. We used
10 progressive enforcement. First educate and then
11 use the stick, as it were. Warnings and specific
12 time lines to rectify, and then we would put in a
13 Public Health order.

14 So we put in five Section 13 orders
15 under that Health Protection and Promotion Act, and
16 we put two tickets under the Reopening of Ontario
17 Act to ensure that our population was protected.

18 These are not easy. The facilities
19 balk. They threaten. But we wanted to ensure that
20 our populations in these facilities were protected.

21 That's a question you could ask any
22 other health unit -- how many orders did they put
23 in; how many actions on their Reopening of Ontario
24 Act. I think it's very important to be able to use
25 enforcement, and that's the way I think Public

1 Health is perfectly positioned to work with the
2 Ministry of Labour and the Ministry of Long-Term
3 Care that has oversight directly in their
4 inspectors to do this work longitudinally. I see
5 it. Because we have expertise in IPAC and
6 enforcement, we are perfectly positioned.

7 I know in the new model, the hospital
8 is positioned to do this or Ontario Health. I
9 honestly believe that Public Health should be given
10 the opportunity to do this work.

11 We've also been logging -- many of our
12 facilities are short-staffed, and that's true
13 across Ontario. We've been logging to allow our
14 many educational facilities to have their student
15 learners in as long as they have the appropriate
16 precautions in play.

17 But because of the directives in place,
18 this has not been allowed. But I think we need --
19 they're going to need staffing, especially if we go
20 into outbreaks longitudinally.

21 It's also important to know that KFL&A
22 Public Health set up the testing strategy. It
23 wasn't Ontario Health. It wasn't our hospitals.
24 We opened the testing sites in Kingston, and we
25 followed a very aggressive testing strategy that

1 was a little ahead -- I'll say it honestly to the
2 Commission, ahead of the guidance from the Ministry
3 because we were able to follow the epidemiology a
4 little more closely. And we understand, at the
5 provincial level, there's a bureaucracy to go
6 through.

7 So if the epidemiology was changing, as
8 it quickly did from Iran to Italy to New York, we
9 would change our testing strategy to ensure that
10 those returning travellers, especially, were tested
11 aggressively, quickly. And because we ran the
12 testing sites, we could be very nimble and
13 responsive in who we tested and how we tested.

14 So testing led by Public Health, I
15 think, worked well in our instance. We have
16 subsequently handed over the testing after the
17 first six months to Ontario Health, and Kingston
18 Health Sciences Centre runs the testing.

19 But we do all outbreaks in LTCs and
20 retirement homes. We will send our staff in to
21 support testing in those instances. And during the
22 universal testing strategy, we were a very low
23 endemic area, low comminute activities. So we did
24 participate in universal testing and had no cases,
25 no positives detected.

1 I don't know how fruitful that measure
2 was, and we could have had a new nuanced testing
3 approach given the low epidemiology in our area. I
4 absolutely understand universal testing in a
5 high-risk area. It wasn't fruitful in our region.

6 We also had worked with many in our
7 community to expand testing. We worked enclosed
8 certain businesses that were high risk, with other
9 outbreaks in the community, and basically have had
10 a strong community response.

11 So just a rundown, during the pandemic
12 in August, this is the longitudinal simulations of
13 outbreaks in LTCs. We had them go through COVID
14 outbreaks plus influenza outbreaks plus any other
15 viral pathogen outbreak like RSV, which still has
16 significant morbidity and mortality in the elderly,
17 and have done these all summer long getting into
18 the fall.

19 We also have tried to interact with the
20 Canadian Foundation for Healthcare Improvement.
21 I've done a couple of knowledge-translation
22 activities with them and was interviewed for their
23 report and these patients' safety organizations.

24 And we basically broke down our
25 response in preparation prevention, working to

1 increase the capacity and skill sets of the work
2 force, and then we talked about outbreak management
3 and surge response, COVID and non-COVID care, and
4 certainly the requirement for the presence of
5 family.

6 I'm sure you've heard that social
7 isolation can be devastating to family members and
8 to the individuals affected, and I hope we can have
9 a more nuanced approach going forward as a lesson
10 learned, especially in a low endemic area where we
11 have no community spread.

12 We've never had significant community
13 spread in the KFL&A in our eight months and
14 wouldn't have had to have directives in place that
15 stopped the presence of family members. It could
16 have been restricted, but it didn't have to be
17 stopped.

18 And so if I had any advice to
19 provincial leaders and for our commission, it would
20 be have a regional risk-based approach when you
21 have directives in place. I think we can be more
22 nuanced -- and, Jack, I mean, we learned that in
23 SARS. You didn't have to close all hospitals in
24 Ontario because Toronto was suffering.

25 That was my message to leadership this

1 time around as well: Please be nuanced. Please
2 have a regional approach.

3 I wrote the premier about having a
4 regional approach, and I was called "rogue"
5 publicly, but we certainly have a regional approach
6 now to the epidemic.

7 COMMISSIONER KITTS: Kieran, can I just
8 interrupt you for a second? Can you go back one
9 slide?

10 So the six key areas, clearly you've
11 talked about preparation and prevention very
12 clearly. Did you have a shortage of workers in
13 long-term care homes going into the COVID epidemic?

14 DR. KIERAN MOORE: No, we did not. So
15 people in the workforce for us was mainly in
16 augmenting their skill sets in infection prevention
17 and control; protecting them by ensuring, through
18 audits -- so we physically went in and watched them
19 wash their hands, don and doff, ensure they knew
20 how to test efficiently and effectively, knew how
21 to cohort, and that they were screening
22 appropriately.

23 So we had adequate numbers. And we
24 never had, because we never had an outbreak, any
25 issue with the workforce. I was absolutely

1 prepared to write an order if there was an outbreak
2 for Kingston Health Sciences Centre or our other
3 community hospital in Napanee to support the
4 long-term care facilities and to mandate that they
5 support them with staffing because I was not going
6 to see what was happening elsewhere occur in our
7 region. And I believe, in Ottawa, an order has
8 been written recently as well under Section 29.2.

9 COMMISSIONER KITTS: Yeah.

10 DR. KIERAN MOORE: So we had all the
11 orders prepared, all written in case, and our role
12 from a public health management point was always a
13 supportive role, an educative role.

14 And we would supplement them in
15 outbreak for outbreak management, for swabbing, for
16 testing, for IPAC, for auditing. But if they had a
17 shortage in staffing, they would have to go to the
18 acute care sector to help them with staffing.

19 COMMISSIONER KITTS: Okay. And then on
20 the pandemic response and surge capacity, I think
21 we're all aware of the surge capacity created in
22 the acute care sector. Are you talking about any
23 surge capacity in the long-term care homes?

24 DR. KIERAN MOORE: That's correct, to
25 support them if they need surge. So in particular,

1 if they're a -- we realize that if they have both
2 COVID and influenza, both staff can't work across
3 those units. So if an LTC has an outbreak, they're
4 going to have to have a COVID floor, an influenza
5 floor. Isolate those patients. Those staff are
6 isolated. They can't cross-mingle, and it adds a
7 complexity I've never had to deal with.

8 So that is when they're going to need
9 extra staffing, and that was -- it's a very -- it
10 was nuanced to bring that to their attention, but
11 they've clearly and quickly realized that they will
12 be short-staffed if they have two pathogens within
13 one organization.

14 COMMISSIONER KITTS: Thank you.

15 DR. KIERAN MOORE: This is the model
16 that's been proposed for supporting infection
17 prevention and control going forward. And you can
18 see there's a dotted line to public health, and
19 this is relevant to, I guess, Central LHIN where
20 we're only involved in outbreak. That is clearly
21 not our structure nor our -- hold on a minute.

22 (BRIEF INTERRUPTION)

23 COMMISSIONER FRANK MARROCCO (CHAIR): I
24 know the feeling.

25 DR. KIERAN MOORE: Sorry.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Doctor, mine almost always rings right in the
3 middle of these presentations.

4 DR. KEIRAN MOORE: I hope it's not an
5 LTC.

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 No.

8 DR. KIERAN MOORE: So in our model, we
9 would be -- you know, the hospital is still -- in
10 the case of health sciences in our region, Ottawa
11 General and Ottawa Civic -- Ottawa Hospital, would
12 be the clinical IPAC lead.

13 We would be a coordination role. We
14 would be the agency that goes into the field. And
15 I do think we're perfectly positioned because we
16 have inspectors, nurses, and the ability to enforce
17 the Health Protection and Promotion Act. You know,
18 Public Health does have a key role.

19 And we're not pulling out. I'm not
20 going to pull out until Ontario Health can
21 guarantee that they can replicate the service that
22 we're currently providing to our LTCs and
23 retirement homes and the expertise that we add and
24 the support of the medical directors and nurse
25 practitioners and staff.

1 Yes?

2 COMMISSIONER COKE: Can I just ask a
3 question in terms of the way you've positioned
4 yourself as a leader and a coordinator in your
5 area? The capacity and resources in the public
6 health units, is there more of an issue in other
7 ones?

8 DR. KIERAN MOORE: Well, it really is
9 having the vision and the direction in outbreak
10 mode to make this happen. We didn't ask for any
11 extra cash. We just realigned our services and our
12 staff. I shared this model with others. They
13 didn't want to be involved. They didn't -- other
14 health units. They didn't want to do this type of
15 work, but I thought it was key, central, and core
16 to our role in outbreak management to do this work.

17 But you're absolutely right. Ours is
18 probably an abhorrent approach, and I couldn't get
19 consensus from my sister health units. I shared
20 our approach, and I shared our audit tools. Public
21 Health Ontario eventually created audit tools for
22 LTCs and retirement homes. I badgered them, and I
23 shared ours with our partners.

24 And I didn't see a direction from the
25 CMOH office or the Ministry of Health or Ministry

1 of Long-Term Care or endorse a model and/or a
2 direction for Public Health agencies to take. We
3 just took it. It worked for us. We believe we've
4 had success to date.

5 But if you're looking at gaps at a
6 provincial level, I would say that's a gap, the
7 strategic from direction from on high either
8 mandating or enabling or directing Public Health to
9 have this role. Any local public health agency
10 could have done this. They would just need to have
11 business continuity planning and realign.

12 COMMISSIONER COKE: Okay.

13 COMMISSIONER KITTS: Just to follow up,
14 Kieran, I recall vividly when with the SARS, it was
15 Public Health needed to have a stronger leadership
16 role in epidemics, pandemics, whatever.

17 And the governance of the Public Health
18 units was an issue in terms of not being in the
19 Ministry of Health but more in the municipal. Is
20 the governance a problematic or an asset?

21 DR. KIERAN MOORE: The governance in
22 ours -- so we're an autonomous board, so to me,
23 that's wonderful. I don't have to work within a
24 municipality. I don't report to a CAO and then to
25 a board. I report directly to a board.

1 The board is primarily municipally led,
2 so our funders plus the citizens in the community.
3 So I find autonomous boards are very responsive.
4 They give you the flexibility to get job done.

5 I think working in a more rigorous,
6 bureaucratic-structured municipal government would
7 have been much more difficult, I think, to get the
8 job done. If we're going to continue to have
9 boards, autonomous boards, to me, is the direction
10 to go.

11 COMMISSIONER KITTS: Do you know what
12 the other 30 units/32 units have in terms of
13 boards?

14 DR. KIERAN MOORE: Yeah. The vast
15 majority, I think 23, are autonomous boards. And
16 then the large ones -- Toronto, Peel, Ottawa -- are
17 integrated within regional structures and so a
18 little more complex governance model.

19 COMMISSIONER KITTS: Okay. Thank you.

20 DR. KIERAN MOORE: And so I talked
21 briefly about our plan for COVID and influenza. I
22 think that's key heading into the fall. As you're
23 seeing, we're just constantly thinking ahead and
24 anticipating the need and building capacity so that
25 they, at least, have thought through how their

1 agencies can respond to the two pathogens. And
2 again, it's having space, having staffing capacity.

3 And if we had recommendations, again,
4 being proactive, follow the EPI, follow data,
5 operationalize, have the relationships with your
6 acute care, long-term care.

7 Public Health really can be that middle
8 ground, that trusted partner, between acute care
9 services, community services, long-term care, and
10 primary care.

11 In our instance, we are the neutral,
12 trusted ground. People come to us to discuss
13 problems and get solutions. And also, what's
14 worked well for us is the inspections of the
15 properties within LTCs, and these are some of the
16 documents that were core to our functioning down
17 the road.

18 So that was a brief intro. I'm happy
19 to have further questions.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 You indicated that the local Public Health unit is
22 sort of uniquely positioned to drive this kind of
23 arrangement. What's the alternative?

24 Like, was there an alternative
25 suggested that would -- because it does seem rather

1 logical that --

2 DR. KIERAN MOORE: Yeah. So most
3 Public Health physicians -- I'm a program director
4 for a residency program, so I train public health
5 preventive medicine specialists, and I've been
6 doing so for eight years.

7 And, you know, outbreak management is
8 101. You can't leave my program without being an
9 expert in outbreak management, understanding
10 testing, and understanding communication
11 collaboration coordination are your key tools. And
12 foundational to that is having to bring in all
13 health system partners to any dialogue in outbreak
14 management, especially pandemic.

15 We do yearly pandemic training amongst
16 our residents. They have to graduate with that
17 expertise and competence to lead an agency
18 response.

19 So the competence of the medical
20 director, the medical leader of the Public Health
21 agency, is key. The desire to be the leader in an
22 outbreak, I think, is exceptionally important.
23 There's no one better than a Public Health
24 physician to lead this.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Well, from your perspective, you have the
2 order-making function.

3 DR. KIERAN MOORE: Correct.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 So it's fairly efficient if you're looking for
6 reasonable and probable grounds because you need an
7 order.

8 DR. KIERAN MOORE: Oh, for us to be
9 involved in LTCs and retirement homes is brilliant
10 because of the Health Protection and Promotion Act.
11 In its capacity, it's very, very nimble and a
12 trusted legislation.

13 We didn't have to go to Ministry of
14 Labour. We didn't have to go to the inspector. We
15 always kept the inspectors, the Ministry of
16 Long-Term Care inspectors informed, and we know who
17 they are. But many of the times, they hadn't been
18 to facilities in quite a while.

19 We are the eyes and ears on the ground.
20 If we don't see something that we like, we can
21 write the order. We can be immediately responsive.
22 The order is in place to -- we give them a week to
23 remediate, and then we go back in. If it's not
24 there, they're financially in charge.

25 And as I pointed out, we've done that

1 numerous times, and I don't think any Justice of
2 the Peace or a Court would, at the time of an
3 outbreak, question Public Health's direction. And
4 I think the long-term care facilities knew it, and
5 so they were very quick to remediate and to improve
6 and to respond to our suggestions.

7 So you need honey, but you also need to
8 be able to sting when necessary.

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Is there a resistance to this model, like, up above
11 you?

12 DR. KIERAN MOORE: Yes. I think
13 there -- I haven't seen it embraced by my sister
14 health units nor by the leadership. You know, if
15 you compare us to BC where Public Health is very
16 much integrated with the acute care sector --
17 they're part of a regional health authority, and
18 LTCs report to the same leadership -- you're at the
19 same table. That works very well as well.

20 We basically function like a regional
21 health authority. David Pichora, the CEO of the
22 hospital -- I'm on all their committees. We report
23 and discuss on a daily basis what's going on.

24 So I do like the regional health
25 authority model where Public Health is a partner

1 integrated with acute care and long-term care, but
2 we also have the authority to implement and inspect
3 and to penalize if you don't adhere to the basic
4 recommendations.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Yes, Ms. Coke?

7 COMMISSIONER COKE: Yeah. You said,
8 you know, there's some resistance to this approach,
9 so I guess I'm just trying to understand what is
10 that resistance grounded in?

11 Is it just I don't feel I have the
12 capacity to take on a larger role, the fact that --
13 you know, does it matter depending on where you are
14 locally in terms of having the capacity and ability
15 to manage this way?

16 DR. KIERAN MOORE: Yeah, I can't answer
17 for all 34 health units, but when I brought these
18 subjects up, many didn't want the role. They
19 don't -- they said they did not have capacity. It
20 is my belief, given a direction from the CMOH
21 office, they could have made capacity.

22 Just, for instance, all restaurants
23 were closed, all bars were closed, March 17th in
24 Ontario. Our inspectors -- I wasn't going to have
25 them sitting around not doing work in the middle of

1 a pandemic. So we just repurposed them.

2 They have expertise in infection
3 prevention and control. We did do some education
4 with them on this role, but they embraced it. They
5 wanted to be a part of the response and took on
6 this role brilliantly within our agency, and so did
7 our nurses in supporting these facilities.

8 So it's clearly within their education,
9 within their skill sets. It just needed a little
10 improvement in terms of reviewing best practices in
11 LTCs, and they were very easy to adapt and adopt
12 this new role. So it could have been put in place
13 in any jurisdiction.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 And do you have the authority, as the local
16 officer, to make orders directed at restaurants
17 and --

18 DR. KIERAN MOORE: Correct.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 -- bars and that sort of thing?

21 DR. KIERAN MOORE: Yes.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Yeah. So it's a simple thing to deal with some
24 place that has too many Queen's University students
25 on a patio, if it comes to your attention.

1 DR. KIERAN MOORE: Don't get me
2 started. Yes, so we -- oh, I didn't mention. We
3 formed a whole enforcement committee. So we
4 brought -- and this was back in March. We brought
5 our bylaws officers from our municipal partners.
6 We brought our Kingston Police, the OPP, our
7 enforcement officers together just so we could have
8 the same universal approach to these issues.

9 Whether it's an aggregation of students
10 and/or someone, you know, not wearing a mask going
11 into a long-term care facility, we were all on the
12 same page.

13 I wrote an order for our community that
14 you must wear a mask very early on in this outbreak
15 in any public setting going to any business. We
16 were well ahead of that provincial direction which
17 just came out. All businesses were to have masking
18 and hand hygiene product. So we had a strong
19 emphasis on prevention very early on.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Jack?

22 COMMISSIONER KITTS: Kieran, clearly
23 leadership accountability and authority to act are
24 the key ingredients for this success.

25 This may sound like an odd question,

1 but do most Public Health officers in the various
2 units believe that, in a pandemic, they are the
3 leader, that they are accountable, and that they do
4 have the authority to act?

5 DR. KIERAN MOORE: I mean, that's a
6 very good question. I have always considered that
7 to be a key role of Public Health, and I've always
8 considered it at the CMOH --

9 COMMISSIONER KITTS: Yeah.

10 DR. KIERAN MOORE: -- our position in
11 Ontario. You are the lead, and you tell the acute
12 care sector what you want of them and the LTC and
13 retirement homes.

14 Leadership isn't always embraced, but I
15 do think it's foundational to our practice, that we
16 would be the leads of any outbreak.

17 You know, Ontario Public Health
18 Standard clearly states our role and responsibility
19 for LTC outbreaks in influenza or other, and we've
20 followed that to the T. We've embraced it, and it
21 is essential.

22 COMMISSIONER KITTS: So your class at
23 Queen's, I take it they get that in spades. I know
24 you well enough that they don't leave there without
25 knowing that they're the leader, they're

1 accountable, and they have the authority to act.
2 But it doesn't sound like it's widespread.

3 And the second part is is there any
4 leadership training involved in becoming a Public
5 Health Officer?

6 DR. KIERAN MOORE: Oh, great question.

7 So we do leadership training. We do
8 risk communication training at Queen's. The OMA
9 runs a leadership course which leads to a
10 certificate. I have encouraged all my residents to
11 take that longitudinal, one-year leadership
12 training, six long weekends, to teach the skills of
13 leadership. So we have done that. We've done that
14 through the School of Business here at Queen's as
15 well.

16 Foundational. Leadership can be
17 learned, and it certainly can be taught. But if we
18 learn, those skills can be adopted.

19 COMMISSIONER KITTS: So is it as easy
20 as getting the new Public Health Officer manual?

21 The first line says:

22 "In any pandemic or outbreak,
23 you are the leader."

24 DR. KIERAN MOORE: You're the general.
25 You're running the show. This is your

1 responsibility. And honestly, it starts from the
2 top down. And if your CMOH, like Bonnie Henry, is
3 saying "you are the leader," "you're the
4 spokesperson," "I'm going to be the communicator on
5 behalf of all public health within my jurisdiction.
6 No one else speaks except me, and the authority
7 comes from me and is distributed to all of you.
8 You're going to do X, Y, and Z."

9 Yeah. That's paramount, responsibility
10 and authority, being recognized and being
11 replicated across the province.

12 COMMISSIONER KITTS: Thank you.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 I'm just not sure that that can be learned. I
15 think you can teach it, but I'm not sure it can be
16 learned by anybody who hears you.

17 DR. KIERAN MOORE: I did find the
18 course that I took instrumental. It did improve my
19 understanding of the qualities of leadership. And
20 yes, you have to practice it, and you have to be in
21 a position to utilize the skill sets, but --

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 But you have to embrace it.

24 DR. KIERAN MOORE: And if you're going
25 to become a medical officer of health -- so I'm a

1 CEO. I have 200 something staff. By its nature,
2 you're a leader. You may have variable styles in
3 your leadership, but by its nature, you're a leader
4 of that organization, and you have to take charge.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 Well, unless there are -- this, I must say, for
7 me -- and perhaps less so for Dr. Kitts, but for
8 me, anyway -- and I can't speak for Ms. Coke --
9 this clears up a sense of how the lines of
10 authority flow.

11 I'm familiar with the Act, and I read
12 it very much the same way that you enforce it. But
13 when you read something on the page, how it plays
14 itself out is different. But this was very helpful
15 for me; I can tell you that.

16 DR. KIERAN MOORE: I mean, it would be
17 good in hindsight to review how many local Public
18 Health agencies use Section 13, use Section 29.2,
19 implemented orders to protect the health of
20 vulnerables within these settings, how many
21 audited.

22 I don't think this activity was
23 widespread, but that could be done in a survey to
24 local Public Health agencies fairly quickly.

25 I have spoken to the auditor general as

1 well and discussed some of those opportunities to
2 improve the care of the vulnerable heading forward.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, I think unless there's anything else, Doctor,
5 thank you very much for your time and for your
6 insight. It's extremely helpful to us.

7 DR. KIERAN MOORE: If you want to have
8 any further information, you know how to contact
9 me.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 No, you shouldn't have said that. We may very well
12 be back.

13 DR. KIERAN MOORE: Honoured. And I'm
14 little more familiar with the regional health
15 authority model because I reached out to Bonnie on
16 their structure. I do like that model of
17 integration with Public Health with partners in a
18 governed way, although it can happen naturally as
19 it's occurred in our region.

20 But thank you very much for your time
21 as well and for the work that you're doing.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Thank you.

24 COMMISSIONER KITTS: Thank you, Kieran.

25 COMMISSIONER COKE: Thank you very

1 much.

2 DR. KEIRAN MOORE: Thank you.

3 -- Adjourned at 1:55 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, MCKAYA MCDONALD, CSR, Certified
4 Shorthand Reporter, certify:

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

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

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

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18 Dated this 8th day of October, 2020.

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