Long-Term Care COVID-19 Commission meeting with Dr. Allison McGreer

Dr. McGreer
on Thursday, September 3, 2020

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

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Microsoft Teams Meeting, with all participants attending remotely, on the 3rd day of September, 2020, 9:00 a.m. to 10:15 a.m.

BEFORE:

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

PRESENTERS:

Dr. Allison McGeer, M.D., FRCPC

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

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

Lisa Di Felice, Administrative Assistant, Long-Term Care Commission Secretariat

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

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, my name's Frank Marrocco, and I'm the Chair of the Commission. The two other Commission members are Angela Coke and Dr. Jack Kitts from Ottawa.

COMMISSIONER ANGELA COKE: Morning.

COMMISSIONER JACK KITTS: Morning.

COMMISSIONER FRANK MARROCCO (CHAIR): Thanks very much, Doctor, for joining us today. We're embarking on this. You're the, I guess, really, the second person that we've met with. We are at the beginnings of our inquiries, as you can appreciate, and we would very much benefit, I think, from your expertise in the area.

I think you were going to make an opening set of remarks, and with that, your opening statement would be confidential. The only qualifier is we can't guarantee that there isn't a Court process that would cause us to produce it.

But absent that, we will respect your request for confidentiality as far as the opening statement is concerned. There's a court reporter here, or a reporter, so we'll have an accurate

transcript of everything you say. If we decided to publish the transcript, to put the transcript on the website, we would give you the option and see if there's something where you wanted, for example, to add a clarifying addendum or something of that nature, and we would do that before putting it out there.

DR. ALLISON McGEER: Yeah, my request is really more of a comment on the fact that I was not aware that people were thinking I was making an opening statement until 36 hours ago.

It's been a long six months. I wouldn't want somebody to take anything that I open with this morning as my carefully considered opinion on practically anything just because I haven't had time to, I think, appropriately organize my thoughts. And that was me not asking questions far enough ahead of time or maybe just, you know, life in the pandemic.

So I'm not worried about things that I have said being shared with other people. I'm only not wanting people to look at what I've said this morning as if it's the best I can do in thinking about what happened or how we might be responding to it. That was all.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that's understood. And, you know, if after where -- after you've given us the benefit of your thoughts, we may be able to ask some questions.

If it occurs to you after that there's something you wanted to add or anything of that nature, please feel free to contact us and tell us that because this is really part of an investigative inquiry that we're -- we're at the investigative phase. We're just trying to understand what we're dealing with here.

So with all of that, why don't you go ahead. Say whatever summary you have.

DR. ALLISON McGEER: Okay. So I think there were -- I think there were some questions about the virus and the viral behaviour and what maybe we should have or could have been expecting [indecipherable]. The --

THE REPORTER: I'm sorry to interrupt.

DR. ALLISON McGEER: This virus --

THE REPORTER: I'm sorry to interrupt.

DR. ALLISON McGEER: Yeah.

THE REPORTER: Doctor, I find your Internet connection a little bit choppy. Is anybody else finding that?

COMMISSIONER FRANK MARROCCO (CHAIR): That's the court reporter, Doctor.

THE REPORTER: Sorry, yeah. I'm taking everything down that's being said today. I just might need to jump in in case I miss a word because your Internet seems to be pretty choppy.

DR. ALLISON McGEER: Yes, you have my apologies. You're absolutely right. It comes and goes a little bit. It's just the best I can -- you know, it's not wireless. It should be fine, but it has its moments. So yeah, please feel free to stop me if it goes wonky. It's just the best I can do this morning.

THE REPORTER: Thank you.

Sorry, you can continue.

DR. ALLISON McGEER: So this is a new virus, originated presumptively in late October or early November of last year.

So what that translates to is that everybody in the world is susceptible to the virus, and in that setting, most of the way the virus is behaving is what we would expect statistically from what we know about respiratory viruses. So that starts with, it is more severe in older people; it is more severe in frail people.

The increase in case fatality across age looks, maybe, a little more marked than is usual for infectious diseases, but it's fairly standard. And again, that's probably an effect of nobody having any experience. Most infectious diseases, by the time you get to be over 65, over 85, you've had some experience with some related microbe before, and so there's a little bit of mitigation of severity that we don't see with COVID-19.

So you start -- if you think about it, if we had a pandemic of chicken pox, people my age would all be dying from it. The reason we're not is because everybody gets chicken pox when they're kids, and that's what's going to happen with this virus eventually, which is that everybody's going to be exposed to it when they're children. We will accumulate immunity to it over a lifetime, 80 years from now, and it will no longer be anything like as feared as now. When you look at it up front, there's an immediate increase in severity with age.

The only thing about this virus that is strikingly different and, I think, unexpected is that children don't appear to be having it. And, you know, viruses are viruses. They do what they

like. But it's not typical of most respiratory viruses that children very rarely become ill. And of course, it alters how we see and how we think about it because if a substantial fraction of children were becoming ill or seriously ill or dying from this virus, then we would be paying much less attention to us old folk dying from the virus.

It's just not that -- maybe that fewer older people would be dying, but that we wouldn't be paying as much attention to it just because we appropriately value kids' lives much more than we value the lives of those of us who are at the end of our years.

The other thing that I think was difficult for all of us to adjust to is the difference between this virus and SARS-CoV-1 in when we saw the similarity of this virus genetically -- okay, 75 percent is -- 75 percent is further apart than humans and chimpanzees, okay, so it's a substantial difference, but it still looked related -- we were expecting some of the behaviour of SARS-CoV-1, and SARS-CoV-1 and MERS are members of a very small and different group of viruses epidemiologically.

Those viruses -- so SARS, MERS,

smallpox, Ebola, some of the hemorraghic fever viruses -- are viruses where you're not infectious before you get sick. You're not very infectious when you first get sick, but as you get sicker, your viral load increases, and you are most infectious to other people when you are severely ill or when you are dying.

In those viruses, transmission is focused in healthcare, right? So you're not sick, you start to get sick, nothing much happens. They're not community-spread diseases in general, but when you get into the hospital, particularly when you're ill enough to need a lot of care, intensive care, then there's transmission.

So we were substantially expecting when this virus came that we were going to have a problem with transmission in healthcare, okay? This turns out essentially not to be true, okay? SARS-CoV-2 is behaving like usual viruses: Think chicken pox, measles, influenza, respiratory syncytial viruses. All those viruses are viruses where you actually -- when you start shedding the virus before you get sick is when you are most infectious, either just before you get sick or on the first day or two of illness.

By the time you get to the hospital, by the time you have enough of a response, enough complications from the illness to get sick, you're not that infectious.

So in that setting, you'll have a lot of trouble with viruses in hospitals because by the time people get to the hospital, they're not that infectious, and you have community-spread disease. And a piece of what interfered with our response to the spread of this pandemic was that we were very focused on the trouble we thought we might get into in hospitals as opposed to how we were going to manage transmission of a predominantly community-spread virus.

With community-spread viruses, where you get into most trouble with transmission are congregate living settings, okay? Places where you crowd people together, where they have a lot of contact with each other, maybe where you don't have much ventilation, although that probably -- that may not be as important as we think it is at the moment.

And so predictably, in that setting, dormitories for anybody: Prisons, cruise ships, nursing homes, anywhere where large groups of

people live together in very close contact are going to be where you have transmission risks.

So the key to it is that people are staying in one place before they get sick, so when they're most infectious and as they're getting sick. There is transmission in other settings, obviously. You know, it can happen anywhere [indecipherable] so that somebody who's sick, you don't get the same amplification as you get in congregate living settings.

So picture a hospital, right? I'm a worker in a hospital; I'm coming down with COVID-19; I work a shift. Eight hours in; I'm out; I'm not back for four days. So you get exposure for a set period of time, but you don't get that ongoing exposure, and the people that I have contact with, you know, medium-length stay in the hospital, little over three days; so most of the patients that I've had contact with, if I transmit it to them, by the time they're infectious, they're going to be at home, and they're going to be away from other large groups of people.

And so you don't get the same amplification that you get in large, crowded living settings. Where I come to work, I'm here for eight

hours, maybe I only infect one other person. That other person then stays in the home, and they're going to infect two or three other people, right? Average number of infections from a single case in this virus is 2.5.

And so you get this -- in crowded living settings, you not only get more transmission, but you get the potential for amplification that you don't see in other settings where people go home, are separated.

You get the kind of clusters you're seeing in workplaces, and we've seen those clusters in hospitals, mostly workers who are -- you know, because we separated healthcare workers at hospitals from patients pretty effectively, but what we didn't recognize, and it's a human failing, okay: I know my patients might pose a risk to me in terms of infection; I don't think about the fact that my coworkers pose a risk to me.

So the trouble we get into with transmission in hospitals --

THE REPORTER: Sorry, Doctor, I think you froze.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, you absolutely did, Doctor, so we'll wait

until it gets sorted out. You might have to log back in.

Ah, just a minute. Oh, there you are. Okay.

DR. ALLISON McGEER: I'm so sorry. That's the first time that's happened. I just dropped Microsoft Teams totally. My apologies.

If this happens again, I'll try fixing --

COMMISSIONER FRANK MARROCCO (CHAIR): I think, Doctor, the last thing I really made a note of was the risk from coworkers.

DR. ALLISON McGEER: Yeah. So we had hospital outbreaks in the same way that there'd been a lot of workplace outbreaks. Nursing stations tend to be crowded, lunchrooms tend to be relatively crowded, people took off their masks in those crowded areas, and then you got small groups of transmission. But again, you don't get the amplification that you get in congregate living settings.

So from that perspective, as soon as -- truthfully, as soon as we saw the Diamond Princess outbreak, which was end of January, the beginning of it, you knew that we were going to have trouble

with nursing homes and migrant farm worker dormitories, and you would have had trouble in --

THE REPORTER: Sorry, can you repeat that?

DR. ALLISON McGEER: Yeah.

THE REPORTER: At the beginning of it, you knew you would have to what? Sorry.

DR. ALLISON McGEER: We really are having trouble with this connection. Hm.

COMMISSIONER FRANK MARROCCO (CHAIR): What you were saying, Doctor, was that the Diamond Princess outbreak --

DR. ALLISON McGEER: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR):

-- which I think you said was the end of January, you said, when we saw that, and I think if you take it from there --

DR. ALLISON McGEER: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR):

-- that gets you to what we missed.

DR. ALLISON McGEER: Yeah. Then you immediately knew that we were going to have problems with outbreaks in nursing homes.

And the outbreaks that we've had in nursing homes in Ontario have been seen around the

world. We are not -- you know, we're nothing like the only country or the only province where there have been really substantial outbreaks in nursing homes.

It's reflected in almost every country around the world. I think it doesn't mean that there aren't some countries that didn't do much better than us with prevention, and there aren't some countries and some provinces that didn't do much better than us in mitigation once outbreaks had started.

So as always with disasters, this is a multi-part problem. I think -- and none of it, I think as we all know, are things that we didn't know before the pandemic, and none of them are problems that we haven't tried to fix, but they remain problems in Ontario.

So let's start with: We systematically underfund and under-resource public health. We say that a lot. And in Ontario, a piece of trying to fix it was the creation of Public Health Ontario, and, to me, one of the saddest things of the pandemic is to be watching the implosion of what we tried after SARS.

I think PHO has not been able to be as

effective. All of us hoped it was going to be, and that's a complex failure around its relationship with the Ministry and its capacity, its funding over time, and that includes the funding of Public Health Ontario labs.

You know, I think there's a view that we couldn't have had a public health lab that could have managed testing for this pandemic, but I would point out to you that every other province in the country has been able to do it. So we do have a specific problem in public health labs in Ontario that other provinces don't have.

We might choose not to invest in it and choose not to fix it, but I think we need to recognize that the inability to provide testing and the inability of our public health system to respond with contact tracing and the inability of our public health system to support outbreaks in nursing homes are a long-standing issue with us not valuing prevention and not valuing public health.

I think our long-term care homes, it's -- you know, again, we've all been there before. We have been very focused on keeping the cost of long-term care down. We have a long-term care system that, you know, relative to long-term

care systems in Northern Europe is, to me, an embarrassment and a marker of how we value the lives of people, older people with dementia.

I don't think there's anybody on this call who would willingly share a bathroom with four strangers when they travel, should we ever get to travel again, but we think it's perfectly normal that our older people with Alzheimer's share bathrooms with eight or ten strangers and have one shower room for 30 people and live in a four-bed room with no space for, you know, visitors or anything else.

And that's really a question, I think at base, of how much we're willing to spend in long-term care.

And a piece of that in long-term care is that our preparedness for outbreaks and our infection prevention in long-term care is just plainly not adequate. We have a problem with infection prevention in general. Like public health, it is systematically underfunded and under-organized.

You know, I've been doing infection prevention for a long time, and I was a long way into my career when I finally figured out that, you

know, if I want a public health inspector, I hire a public health inspector. If I want a nurse, I hire a nurse. If I want a doctor, I hire a doctor. If I want an infection control practitioner, I hire somebody and train them on the job, you know?

This is [indecipherable] about, right? But it's a piece of this whole system of the fact that we don't have a system for infection control. And I think, actually, that -- I think that SARS in Ontario actually made infection prevent -- actually made our ability to respond to this pandemic worse rather than better.

And I think the reason for that is that before SARS, okay, the relatively small number of us, infection prevention and control physicians, who trained before 2003, all had to provide support for long-term care infection prevention and control because it fundamentally didn't exist.

So the people who trained before me and with me have worked, to some degree, in long-term care, understand what its problems were, you know, know a bit about where it's coming from.

After SARS, when we made a decision that we needed to strengthen infection prevention and control programs, and we did a lot for them

after SARS, we moved infection prevention into long-term care so that bigger long-term care organizations and bigger facilities got their own infection prevention and control.

And then we thought that was okay. The problem, of course, is the people who are doing infection prevention and control. So they have a title, okay, and I can tell you that in our large corporations, the people who carry that title in individual facilities, training is Public Health Ontario's core competencies that are intended for all healthcare providers.

So we now have this labelled workforce in long-term care that are said to be infection prevention and control and who are doing their best, okay, but who are under-qualified and under-resourced.

And the people who do infection prevention and control in hospitals who trained after 2003 don't have any relation with the long-term care system. They don't know how the long-term care system works. They haven't seen it. And when we put them at the tables in planning at the beginning of the pandemic, they weren't able to say we're going to have a disaster in long-term

care we need to do something about. And so by the time we realized that there was a disaster, we were too far into it to not have the size of the outbreaks and deaths.

And again -- you know, I think that's just a circumstance, but, you know, it's a marker, I think, of our failure in infection prevention and control.

I also think, you know, one of the challenges that we have that got us into trouble in this pandemic -- it's a little bit hard for me to see our way out of -- is, I think, the moving in the long-term care sector to make it not part of the healthcare system. It's a different sector, right? We just moved it out of the Ministry of Health into its own ministry. We've been working really hard on getting long-term care to be homes for older people, and that is a -- you know, that's a noble and good thing, okay? There's nothing wrong with that objective.

But where we got into trouble was when we needed a response that involved care and health experience and expertise, we didn't have it. And we had no mechanism for getting it to those facilities, and so we just -- you know, we

systematically failed them in every way.

But where it gets specific, I think, you know, there are a short list of countries that have had very few outbreaks in long-term care, and some of them, like Taiwan and New Zealand, have done it because they've maintained very good community control.

It's easier to do if you're an island, okay, but some of it, like Hong Kong, was done by a specific focus on what you needed to do for long-term care: So a recognition that long-term care was going to be an issue and early interventions.

So in Hong Kong, starting in January, they increased pay for workers in long-term care. They increased funding so that long-term care facilities could hire more staff so that they could manage outbreaks. They bought personal protective equipment and disinfection supplies for long-term care facilities. They organized long-term care facilities to have temporary isolation wards so that they could separate people who were ill. They banned non-essential visiting -- that's six weeks before we did -- and they provided funding for support for virtual visits to long-term care

facilities.

So they set up all of the things that we eventually set up, and I think, you know, one of the things about this winter is the jury is still out on how effective what we have done will be.

I have to say at a personal level that I'm -- I'm not sure at the moment whether I'm going to be more upset if we don't have outbreaks because if we don't have outbreaks, it just tells you how easy it would have been for us to do this right the first time, or whether we do have outbreaks because I really don't want us to have outbreaks.

But, you know, I think we're not going to have outbreaks this fall, and that makes me very sad because it tells me how easy it would have been retrospectively not to have had them.

So nursing homes went into this outbreak without adequate PPE. We had a supply shortage of all sorts of PPE everywhere, right? And I mean, and that's again -- I think one of the other things that looked evident to me is that it's much easier to face a pandemic if you have a system of health authorities.

You know, we have a system in Ontario where there's a lot of individual hospitals and a

lot of individual nursing homes, and so we have no mechanism for, you know -- we had no mechanism for organizing testing. We had no mechanism for organizing purchase of supplies. And so the bigger and more organized you were as an organization, the easier it was to access things.

The advantage in this setting of health authorities was twofold, okay? The first was that you -- then there's a limited number of people trying to organize, managing limited supplies of all sorts.

I think the second thing is it brought long-term care into the healthcare system. It gives them links with the healthcare system. It gives them relationships with the healthcare system so that when things started to go wrong, there was a much easier response.

I was on a call the other day with a group of long-term care facilities with an organization that has facilities in both B.C. and Ontario, and the facility from B.C. said, you know, if we get into any trouble here, we just pick up the phone and we call the SWAT team and they come and they fix it for us or with us, right?

So right at the beginning when they had

the first outbreak in B.C., B.C. set up a health authority system of teams that went out to long-term care facilities and assessed them for supplies and assessed them for practice and provided support for additional training. They set up weekly phone calls for all of their long-term care facilities so that if long-term care facilities were running short of supplies that they needed, they could talk at the table and somebody would organize supplies for them.

So, you know, the health authority, I think, permitted a response across the sector, and we just don't have that organization in Ontario to try to move support effectively. Yes, we're bigger; yes, it's more complicated. But that system-level, I think, response was missing in Ontario.

And you saw the same thing with laboratory support, right? We were much slower than other provinces and many other countries in organizing laboratory support and getting appropriate tests done and getting results back to people. And, you know, six months in, we're still really struggling with that.

And then I think the last question is

about why some long-term care homes did better than others in terms of management of outbreaks, and there is a rapidly growing literature on outbreaks in long-term care. The Commission might want to think about a systematic review of the literature from different countries on risk factors for long-term care.

And a couple of the larger long-term care organizations in Canada have also done some in-depth looks at their variation between their facilities that hopefully will become available to the Commission and to other people, and they tell you what I think you would totally expect about outbreaks, which is you are less likely to have an outbreak and likely to have a smaller outbreak.

And so this is my list of things that have been identified in at least two studies, and all of them are observational, obviously, and a lot of these things are relatively hard to measure, so I think there's room to argue about all of them, but there will be more literature coming.

So crowding -- measured as number of four-bed rooms; square footage per resident done in a bunch of different ways -- results in bigger outbreaks. Higher quality care measured in the CMS

system in the U.S. is, you know, the number of stars measured as the number of deficiencies identified in inspections. Better quality of care pre-pandemic resulted in smaller outbreaks. Higher nursing staffing and higher staffing per resident results in few outbreaks: General measures of infection prevention and control. So higher staff vaccination -- influenza vaccination rates, some other measures of infection control have resulted in smaller outbreaks.

Not in nursing homes yet, but a couple of studies in U.S. hospitals that have had more trouble with supplies, shortage of supplies results in higher infection rates. So I don't think there's -- you know, I don't think there's anything new in the literature so far about what you would expect with [indecipherable] other than it's very clear that --

THE REPORTER: Sorry, "what you would expect with" what? Sorry.

DR. ALLISON McGEER: -- better infrastructure, higher quality care --

THE REPORTER: Sorry, Doctor --

DR. ALLISON McGEER: Sorry?

THE REPORTER: "I don't think there's

anything new in the literature so far about what you would expect with" and then --

DR. ALLISON McGEER: Yeah, sorry.

About what you would expect with outcomes from outbreaks, right? It's, you know, better staffing, better quality care, better infrastructure, better infection prevention and control, smaller outbreaks, less risk.

So I think I've talked way too long. I'm sorry. Wind me up, and --

COMMISSIONER FRANK MARROCCO (CHAIR): No, on the contrary. It's very informative, Doctor, but I did have a couple of questions, and I'm sure some of the Commissioners will too. So in order to make a beginning, I guess I'll start with myself.

If somebody recognized at the time of the Diamond Princess outbreak that there was going to be a problem in long-term care homes in Ontario, if someone had appreciated that -- or I appreciate that some people did, but I'm speaking more in terms of people who could immediately respond -- was there enough time to avert or avoid or -- what happened?

DR. ALLISON McGEER: Yeah. You know,

not much time, okay? But I think if you look at the experience in B.C., B.C. did much better than us.

And so, you know, was there enough time to be able to deliver it in Ontario, given the failings of our system? I'm not sure. Would there have been enough time if, you know, we had been better off? Yeah, absolutely. Not to prevent all outbreaks, for sure, but to prevent a substantial fraction of them and to mitigate many of them, yeah. No question.

COMMISSIONER FRANK MARROCCO (CHAIR): The second question I wanted to ask dealt with the public labs. You referenced the testing limitation -- or you referenced the ability or inability of public labs to respond.

Would there have been anything preventing the government from resorting to private labs?

DR. ALLISON McGEER: No, and we did. And I think that's -- I think we weren't -- again, it put us behind in our response, right, so if you look at it -- and every jurisdiction was behind in some -- well, not every jurisdiction, okay?

Hong Kong and Taiwan and, you know,

there's a list of countries that did really well, but most of us were behind in some part of a system, and that's what you would expect. And I think the disaster in Ontario was that we were behind in so many places, relatively speaking.

So, yes, I mean, and we -- that's what we've done, right, in Ontario. We recognized that we were not going to get enough testing out of public health labs alone, and we have moved to a combination of public health labs, hospital labs, private labs. So it's everybody in to work on it and to respond to it.

But we were much shorter of lab tests. We had many more restrictions on what lab testing we could do in the early days than somewhere like Alberta, and that combined with us not thinking about long-term care; you know, we could have focused more testing on long-term care. But we were so worried about what was going to happen in hospitals that we had all of our eyes on what was going to happen in hospitals and how we were getting enough tests for hospitals. And so there was no testing -- not quite no, but very close to no testing available for the long-term care facilities.

You know, I think there were some other things. We did say to long-term care facilities, I think relatively early on, that instead of waiting for an outbreak, a respiratory outbreak, you could test any single resident with symptoms.

But, you know, there's 600 and how many, you know, licensed nursing homes in Ontario, and we didn't have a mechanism for getting that out to every frontline staff person in every nursing home in Ontario. So, you know, the table said it. People knew. They kind of thought it was being done, but it didn't get to people. It wasn't actually being done. So, you know, there is this layered piece.

But we also -- you know, we could have recognized that, you know, in long-term care outbreaks that we were going to have to focus testing and get testing to people, and we failed to do that because our eyes were not on long-term care and because we didn't -- you know, the whole system of how we deal with respiratory outbreaks in long-term care is a long-term care facility has a very small number, like, five swabs on hand, and if they have an outbreak, they call their public health department and their public health

department okays testing for them.

And then they do three tests -- those are the rules -- and you send those off, and then eventually Public Health gives you another three swabs. So if you want to do more testing than that, you have to get swabs from your public health department. But, you know, public health departments aren't in the business of supplying swabs, and we were short of swabs. So just figuring out how to get them was a real problem.

And in hospitals, you know, people stood on their heads, and, you know, we had whole teams of people who did nothing but figure out how to get us swabs. But there was no group of designated people who got swabs for long-term care facilities.

COMMISSIONER FRANK MARROCCO (CHAIR): And one final question before I ask the other Commissioners if they have questions.

Is there a jurisdiction that we should think about copying? You know, Canada is a -- Ontario is a democracy, so is there a jurisdiction that kind of looks like us in a broad general sense? Looks like us, and we should think about copying in terms of an organized -- putting

ourselves in a better position to respond?

DR. ALLISON McGEER: You know, I think it depends on -- at base, okay, the -- well, probably on both fronts. You know, I think it's, you know, Hong Kong and the Northern European countries, so the line of the Netherlands, Germany, Sweden, Norway are the -- Sweden, you'll recognize, also had a substantial problem in their long-term care homes, but they have a slightly different system and an even frailer group of people in their long-term care homes with a much shorter life expectancy than people in our long-term care homes have.

But they are all -- you know, they're all jurisdictions that have better organized systems for the delivery of care for older adults, and they've also done better than us in their pandemic response in long-term care.

COMMISSIONER FRANK MARROCCO (CHAIR): Thanks, Doctor. I'll stop monopolizing the questioning.

Ms. Coke, did you want to ask any questions?

COMMISSIONER ANGELA COKE: Yes, please. Just two things.

One, you spoke a bit about the skills and capacity for IPAC in the long-term care homes, and I'm just wanting to understand -- you talked about people not really having the qualifications or -- you know, what are the things that you can do to address that issue of skills and capacity and people operating to whatever the standard is for that kind of work?

DR. ALLISON McGEER: So I think, you know, one of the things that we, in my view, need in infection prevention and control is a training program; you know, some degree program. There's a bunch of choices about how people do it. It's not like people haven't been working on it, but some degree program that provides training in infection prevention and control so that we are not dependent on people doing infection prevention and control to have done a single introductory course and think that that gives us, you know, qualifications.

I do think, you know, there is no question that the Ministry-specific funding for infection prevention in hospitals after SARS has made a substantial difference to infection prevention in hospitals.

I may still be critical of many things

about infection prevention in hospitals, but that directed funding from the Ministry was very helpful in terms of strengthening infection prevention and helping us to do better in hospitals.

I think systems in which you have -- you know, figuring out systems in which you have access to expertise is also helpful. You know, it's a little hard to split out because, you know, I think of infection prevention and control as being public health inside our healthcare institutions.

And any time that you're running a prevention system in a treatment organization, you can expect to be under-resourced and underfunded. It's human nature not to invest in prevention adequately.

But one of the things that Public Health Ontario did that I think we're in imminent danger of losing was provide an Ontario resource for infection prevention and control. We had a relatively large section, until earlier this year, of expertise in infection control.

We have, since SARS, produced some of the best infection prevention guidelines -- we're talking hospitals now, not long-term care. We

could do the same thing in long-term care, although we didn't get that far, haven't chosen to. But that group in Public Health Ontario has been substantially reduced in size and sort of effectively taken out of the important parts of that organization.

So I think making sure that we have a provincial-level resource to lead IPAC for the province and then helping us to get it to outside of -- more effectively get it outside of hospitals, I think, would be very helpful in the long term. And at the moment, if we don't change, we are about to lose it.

COMMISSIONER ANGELA COKE: So just another question that just follows up on your comments about Public Health Ontario. You mentioned earlier, they're proven not to be as effective as people maybe had hoped when it was constructed. So I just want to understand. Obviously that's one challenge you just spoke about.

What other challenges and what do you think are the priority areas for improvement in that organization?

DR. ALLISON McGEER: So I'm probably

not the best person to answer that question. I think the purpose of moving Public Health Ontario out of government was to allow you to have a science-based organization that was capable of responding more quickly than government.

And so I think the first thing about Public Health Ontario is that we have substantially failed to do that. We have an organization that is very similar to government in terms of its ability to respond quickly and the restrictions on how it operates. And to me, a piece of that was about we fundamentally staffed Public Health Ontario with people from the Ministry, and then we maintained the same culture and organization and structure, which I think was not what was intended originally.

I think we -- it's also -- you know, Public Health Ontario is only effective if the government listens to it. And I think ever since its creation, there has been -- the relationships between Public Health Ontario and relevant pieces of the Ministry of Health have been difficult.

And I can't tell you what all of the sources are for that, but it's been clearly true, and an organization like PHO is only effective if government is listening to it and trusts it when

crises come. And that has not worked with Public Health Ontario. It's not working.

You know, Public Health Ontario should be -- theoretically, you know, it was built to be front and centre in pandemic responses, right? It was intended to be the group of people who provided advice to government, you know, functionally, around the outbreak. It was supposed to be the CDC. The CDC's been sidelined for other reasons than Public Health Ontario. But, you know, they're clearly not doing that, and a big piece of that is the relationship between them and the government.

And I think it may be intrinsic to the structure and function of our current Ministry of Health, but all I can think of is that it's not a problem -- it was a problem -- people knew it was going to be a problem, but we did not succeed in fixing it.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Dr. Kitts?

COMMISSIONER JACK KITTS: Yeah, thank you very much. It's been very informative. I've admired you since the SARS outbreak. I was a brand-new CO in hospital at the time and listened

to your wise advice.

I want to follow up on -- you know, you've said that we know that our frail elders are at risk, and we still have not done but we know we should do, which is sort of a reflection of how we value that part of our population.

The thing that keeps coming back even since SARS is we can't figure out how to do it, and I think a lot of your comments this morning were, you know, we seem to know how. And to me, I'd like to hear your thoughts on leadership.

You've hinted at it through the Ministry of Health and Public Health Ontario, but, you know, we have government which, you know, has been well aware of what needs to be done. You gave us an incredible list of things that most of which aren't done, and you've correctly remarked that even when we saw the pandemic coming, we hadn't advanced enough to be prepared for the wave, the surge.

So I'd like to get your thoughts on government, particularly Ministry of Long-term Care, Ministry of Health, and Ontario Health now, all three involved in this outbreak.

The second is long-term care homes. We

have, you know, various types: Not-for-profit, private, municipal, and so the leadership and governance and management in those may be different, and I'm wondering if you know much about that.

Comment on the administrator, the lead administrator and the medical director because if I think of it as an analogy to hospitals, you have a CO and a chief of medical staff who respond to quality issues and risks, and then I guess the medical director, are they responsible for the IPAC, the public health interventions?

So it's a long question, but I can imagine over the years you've thought a lot about if there was a leader, who would that leader be, and could we be much more successful.

DR. ALLISON McGEER: So, you know, I think our inability to fix -- let me start with the bigger-picture long-term care issue.

I think our inability to fix long-term care is maybe less about leadership than about us getting what we value. I mean, I think the reflection of what we're doing in long-term care is substantially about what we as a society are willing to tolerate.

And I suppose if you had the right leadership, you could fix that, but, you know, it seems to me that it's deeply entrenched in what we're willing to pay in taxes and how we're willing to treat our elders.

And, you know, that just makes me very discouraged about it. I don't see that we can change it because I think it's reflecting our societal values, and I may not like them very much, but I don't know how we change that.

I do think -- you know, one of the things that is hardest to deal with [indecipherable] outside the system, as I now do, about this outbreak is that we have -- I'm not sure in Ontario who's in charge, but I am sure that that's a bad thing, and I don't think -- well, yeah.

It is part and parcel of the system. I think the fact that we didn't have -- the fact that we didn't have a plan that left us with designated people in charge who had people giving advice to them that they trusted in February is a piece of how we got to where we were with long-term care, no question. I mean, I think it is substantially about structure and leadership.

In long-term care -- so I think one of the things that a number of different countries have recognized is a problem in care or a challenge in long-term care; something we need to deal with is medical directors in long-term care are not like medical chiefs of staff in hospitals. In many facilities, they are peripheral, completely peripheral to the running of long-term care homes.

And again, this is about the fact that there's been a very -- I think among organizations of long-term care homes, there's really been a desire to de-medicalize long-term care homes, to get them to be homes and part of the community as opposed to part of the healthcare system. And so there hasn't been the desire or the pressure in many areas of the long-term care sector to have medical directors who are involved.

So, you know, there are people who are medical directors of five or six homes who have large numbers of residents that they technically take care of but who -- you know, who don't ever see the home. They're not part of the organization of the home in the same way that physicians are in hospitals.

I think it's partly a time thing. You

know, I think 30 or 40 years ago, physicians were not that much a part of hospitals, either, and that's changed, and that's a change for the better. You know, physicians now recognize they're part of the system, but they're really not part of a system in long-term care at all.

And no, a medical director would have absolutely nothing to do with infection prevention and control in a long-term care home. I think even the -- you know, even homes that have active medical directors who are a part of the system would not have any responsibility for outbreak management or support for outbreak management or infection control.

COMMISSIONER JACK KITTS: Okay. So it appears that there's a lack of understanding of where the leadership is and who is accountable for what.

So I'm going to jump forward to -- and I don't know whether you're aware of what's happening with this government in terms of Ontario Health and Ontario Health Teams. If you are aware of them, I'm asking, do you think that the integration and sharing of resources can be improved between organizations through the Ontario

Health Teams where they have to be made up of primary care, home and community care, long-term care, and acute care?

DR. ALLISON McGEER: Direct answer is I don't know. I'm cynical about the Ontario Health Teams, but that doesn't make me correct.

COMMISSIONER JACK KITTS: No, I appreciate that answer.

DR. ALLISON McGEER: Anything further, Dr. Kitts?

COMMISSIONER JACK KITTS: No, I think it's been very comprehensive and very invaluable.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, one thing I didn't want to -- as I've been listening, I was sort of reflecting on what you said.

Were there changes in Public Health Ontario that made it harder or easier -- made it harder to respond? You know, are there changes that you can identify that made it harder for Public Health to do its job?

DR. ALLISON McGEER: Specifically Public Health Ontario?

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I had the impression that that's what you

were referring to.

DR. ALLISON McGEER: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): If I misunderstood, then please clear it up for me.

DR. ALLISON McGEER: Well, I mean, it's just, you know, there's a broader issue with public health, and then there's, I think, some specific issues with Public Health Ontario.

You know, last year, we took 35 percent out of the budget of public health units and Public Health Ontario, right? Now, we restored some of it, but we took a system that is already in serious trouble, not able to do what public health systems should be able to do, and proposed to remove a third of its funding.

Clearly, one of the problems with the response at Public Health Ontario and Public Health Ontario labs is that everybody who was working there spent the year before this, they started thinking they were going to lose their job because everybody knew that a 35-percent cut was coming, and nobody knew how it was going to work.

We laid off a bunch of people at Public Health Ontario in October after six months of waiting, you know, and then as traditionally

happens in Ontario, once we lay everybody off, we got the pandemic, you know?

But, you know, I think -- I'm not sure that things got worse with Public Health Ontario. I think we weren't able -- I think Public Health Ontario got started, and then we weren't able to get it past the issues with dealing with government.

And that is -- you know, a piece of that is about leadership. I think if Sheela Basrur had survived, if Don Low had survived beyond 2013, had we had other leadership at Public Health Ontario, it might have been possible to have built Public Health Ontario into the organization that it was intended to be, but it's, I think, less about individual events than just about that Public Health Ontario has slowly been sinking back into a very bureaucratic organization that isn't capable of response.

So that's one piece of it, and then the other piece is that it just -- it couldn't build the relationship with government that it needed to do what it should have been -- had it had that relationship with government, then it probably wouldn't have been talking about the cuts last

year. But it just failed.

If you look at -- you know, I think the best example of total failure is -- of that communication and that trust is what happened during Ebola. I can't tell you exactly when it was. I was in West Africa at the time, but I just remember coming home from, you know, one of those awful days in outbreaks where, you know, everybody is yelling at everybody because nothing is going right, and, you know, it's okay because that's just the way life is.

And I got back to my hotel room, and I turned on my computer and opened my e-mail to discover that the Ministry had ordered Public Health Ontario to [take down] (ph) all of its advice about Ebola that Public Health Ontario had been writing guidelines for months and months on a whole variety of things, and Ontario ordered them to take it all down and replace the advice with a series of directives on the same day.

And, you know, that made me feel much better about my day at the time, but, you know, it's just a marker of the level of the relationship and issues of trust between the government and PHO that did not get solved.

COMMISSIONER FRANK MARROCCO (CHAIR): I'll end it with this, at least from my perspective.

When you say "the Ministry," do you mean the Ministry of Long-Term Care or the Ministry of Health?

DR. ALLISON McGEER: The Ministry of Health.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Thank you.

Anything further, Angela? Ms. Coke?

COMMISSIONER ANGELA COKE: Just wanted to follow up on a comment that you made. And you talk about there having been an effort to de-medicalize homes to be part of the community versus part of the healthcare system, and I'm assuming -- I'm interested in your view on that, but I'm assuming it might be fine, but when you get into a situation like this, not so much.

I'm just trying to think about how that impacts how they interact with the rest of the healthcare system and how integrated they can be when they're sort of on the side.

DR. ALLISON McGEER: Yeah, so I think it's a -- you know, it's a double-edged sword. I

think you can do it well, and it's something you should be doing, but, you know, where it -- so from my perspective, I'd [indecipherable] thought to managing the risks involved.

So for instance, okay, there's -- and I had a long discussion a couple of years ago with a nursing home trainer in a public health unit in Ontario because in an effort to integrate a particular long-term care facility into the community, they had set up a family medicine practice inside, sharing the building with the long-term care facility, okay, which resulted in snotty-nosed two- and three-year-olds walking through the corridors of the long-term care facility on their way to the family health office.

And, you know, having children around, we would agree, is a good thing for, you know, socialization and company for older folks, but it poses infectious disease risks, and you'd just like people to have thought that through and balanced that out. And I think we have not -- you know, I think we're lacking the expertise in many ways to make what could be best decisions about that.

And then, you know what, I think you're right. I think we need some very careful thought

about, you know, the -- I think many people in hospitals see long-term care homes, particularly nursing homes, right, licensed, regulated long-term care homes as places where substantial amounts of care are delivered and where we want to keep patients from -- residents from going to the hospital, and the way to do that is to provide more care in the home; whereas the people on the long-term care side are trying to move to more like a home, and we're expecting that residents, if they need care, are going to the hospitals.

And so I think we need to have a system-level discussion about where those lines are because I do think we're running up against the people in hospitals not wanting residents to come to hospitals and for good reason.

You know, a cognitively impaired older person going to hospitals is a bad idea for a whole bunch of reasons. If they don't have to, better to keep them in place if you can. But that, then, I think directly conflicts with trying to make long-term care more like a home and less like a care facility. And I'm not sure there are easy solutions to that, but I think we're really having trouble with how we're thinking about that.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, Doctor, to say that it's been informative is an understatement. It's been a great -- it's a great help to us. With your permission, we may come back to you and bother you again, but this has been extremely, extremely helpful for us, and on behalf of all of us, thank you very much.

DR. ALLISON McGEER: Thank you for asking, and yes, we are in this together. If I can do something for the Commission, please do not hesitate to ask.

COMMISSIONER FRANK MARROCCO (CHAIR): We'll do that.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Perhaps we can let Dr. McGeer go, but perhaps we should reassemble in a few minutes.

Alison Drummond, can you make that happen, and we'll just have a brief meeting after?

ALISON DRUMMOND: For sure.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Fine. See you all in a few minutes.

-- Adjourned at 10:15 a.m.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, 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 3rd day of September, 2020.

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