Long Term Care Covid-19 Commission Mtg.

Dr. Penny Sutcliffe, Medical Officer of Health,
Sudbury & District Public Health
on Monday, October 19, 2020

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

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 19th day of October, 2020, 9:00 a.m. to 9:57 a.m.

BEFORE:

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

PRESENTING:

Dr. Penny Sutcliffe, CEO and Medical Officer of Health, Public Health Sudbury & Districts.

Stacey Laforest, Director of Health Protection, Public Health Sudbury & Districts.

PARTICIPANTS:

Jessica Franklin, Policy Lead, Ministry of Long-Term Care

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat

Derek Lett, Policy Director, Long-Term Care Commission Secretariat

John Callaghan, Lead Counsel, Long-Term Care Commission Secretariat

Dawn Palin Rokosh, Director Of Operations at Ontario's Long Term Care Commission Secretariat

ALSO PRESENT:

Judith M. Caputo, Stenographer/Transcriptionist

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

COMMISSIONER MARROCCO: Well, then we'll get started. We're trying to understand what worked and what didn't as part of our lookback.

And at the same time, we are in the process of preparing something, of a more informal nature, to send to the Minister dealing with the more immediate problems that we're facing right now.

So that's what's been interesting for us, and we would be really interested in really anything that you, however you want to organize it, but we'd be interested in successes and what worked and what didn't from your perspective would be very helpful to us.

We have a court reporter, whom I think you may have met, and we do have a transcript and we do put the transcript on the website.

We tend to interrupt with questions, if that's okay, as we go along rather than trying to go back. So I think, Doctor, we're ready when you are.

DR. SUTCLIFFE: Thank you very much. And I have alerted that I have a few slides, would

it be all right if I share my screen to use those to help organize our comments?

COMMISSIONER MARROCCO: Absolutely. That will be fine.

DR. SUTCLIFFE: Thank you.

COMMISSIONER MARROCCO: We have it now I think.

DR. SUTCLIFFE: Terrific. Okay.

We really want to thank you so much for this opportunity and really pleased that the Commission has been established, that you're doing this work.

I am aware that you have consulted with lots of people, including a number of our colleague Medical Officers of Health from across the Province. So I certainly hope that our perspectives from the north are helpful to you in supplementing the information you have already heard about.

So I'm the Medical Officer of Health and CEO of Public Health Sudbury and Districts, and I've been in this role for 20 years now. Prior to that I worked in Yellowknife in the Northwest Territories and in Northern Manitoba after training in Toronto. So it's nice to have a northern

perspective on these issues.

And Stacey Laforest -- perhaps I'll just ask Stacey to introduce yourself.

MS. LAFOREST: Thank you very much.

So my name is Stacey Laforest and I'm the Director of Health Protection here at Public Health Sudbury and Districts. I've been in this current role since 2013, and my background is in Public Health inspection, and I've worked in the field since 2001.

DR. SUTCLIFFE: Thank you.

So a few slides, and there are only about five or six to go through. The last two I'd like to spend the most time on, but thought it might be helpful to have a bit of context in terms of where these comments come from.

So I have had an opportunity to discuss this opportunity with my colleague in Northern Medical Officers of Health, so there are seven of us that work as Medical Officers of Health and CEOs, including an additional eighth person who works with the First Nations Health Authority, Dr. Guilfoyle.

We have also conducted a brief evaluation, a community survey, and some of those

comments from long-term care partners are incorporated here. And lots of experience and reflections from our Public Health Sudbury and Districts team.

So our team, we're just under 300 staff. We are an autonomous board of health which of course, as you know, is the majority of the kinds of boards in Ontario. We have 19 municipalities in our catchment area, and it is a combination of rural and urban mix, with the city of greater Sudbury being about 85 percent of our population, with an additional 18 or so municipalities.

And, of course, the Board is established by the Health Protection and Promotion Act and our operations, of course, are driven by the Ontario Public Health Standards requirements.

I won't go into this in much detail, and I have had a chance to look at the transcripts from other consultations with Medical Officers of Health. So I believe that you have lots of information about the routine work in the long-term care homes.

We have 12 in our area. And during normal times, so non-COVID times, the list that you

will see on this slide describes our regular work. So routine annual inspections for both reinforcement of the requirements, as well as for reinforcing relationships and communication. Involvement with long-term care homes with regards to food premises and food safety. Certainly, as it relates to infection control, and their regular meetings. If there are outbreaks, we support the long-term care homes knowing it's their ultimate responsibility to manage those outbreaks with the use of the provincial protocol.

We have about 11 Public Health inspectors and six Public Health nurses that contribute to this work. So they have other duties, and they all fall within Stacey Laforest's direction in her division.

We'll just also say we have a longstanding infectious disease planning and response committee, or IDPRC, which was established, I believe in 2006, thinking about pandemic and pandemic planning. And this involves a number of stakeholders, including long-term care representatives, so that we are coordinated and thinking about how we would respond to a pandemic.

So that gives us a brief overview, if

it's all right, Justice, I'll continue to the next slide.

COMMISSIONER MARROCCO: Sure, go ahead. Oh, Mr. Kitts has a question.

COMMISSIONER KITTS: Yes, just before you do. Can you give us an idea of what other health partners are in the same region, in terms of community health centres, hospitals, that sort of support?

DR. SUTCLIFFE: Yes. So the main hub, healthcare hub is in the City of Greater Sudbury, there's no doubt about that. But there are regional hospitals throughout the district as far as Chapleau, Manitoulin Island, community health centres, including Aboriginal Health Access Centres, as well as the Francophone Community Health Centre.

Primary care, not, you know, sort of well organized. Whether they organize themselves, but in terms of not well organized as a collective, I would say in primary care. But many primary care practitioners in our area, certainly would be onset of the Northern Ontario School of Medicine, challenges around recruitment and retention, I think, are being addressed compared to previous

years.

COMMISSIONER KITTS: So when you say since 2006 you've had a pandemic, or I guess epidemic -- whatever it is -- response for communicable diseases in your area, are these all included in that relationship, and are the relationships solid?

DR. SUTCLIFFE: Yes. So the relationships for sure vary over time, as the people vary over time. But that has been a really key planning body, that was actually started by Dr. Vera Etches when she was here as our Associate Medical Officer of Health, called the "Pandemic Clinical Care Committee", at that point in time, bringing together multiple stakeholders.

And so this has stood the test of time, and people vote with their feet, and so they've been voting to stay. And, of course, we ramped that up by the work of this committee, actually weekly meetings in January, as we saw what could potentially be coming. And we made sure that we were prepared, had, you know, appropriate communication linkages, and that we were all dusting off or revisiting our respective protocols in each of the different sectors.

COMMISSIONER KITTS: One last question. Are you the chair of that group?

DR. SUTCLIFFE: Well, it has been our Associate Medical Officer of Health, and we no longer have an associate as of March of this year.

So in fact, it's either me or our director Stacey Laforest who is on the line with us today.

We do co-chair that with Health Sciences North, we'd be remiss not to note that. We are the secretariat and the lead, however, the actual chairing is co-chair with us in the acute care sector.

COMMISSIONER MARROCCO: Doctor, before you continue. You said you kind of started to pay attention in January to what might be happening.

Can you give us, or give me anyway, a bit of a sense of what you started to do? How you started to react to this problem that you saw on the horizon?

DR. SUTCLIFFE: Thank you for that question.

So certainly, we were alerted by news media coverage. But, also, quite significantly by communication from Dr. Barbara Yaffe in January,

towards the end of January.

So starting to alert all of us to be paying attention and to getting ourselves ready and prepared. So as a consequence of that, one of the concrete things we did, we have a newsletter that is produced for clinicians, and also an alert that is faxed out or e-mailed out to clinicians called our "advisory alert."

So on the 24th of January, we issued an advisory alert to -- this is a broad range of stakeholders. So long-term care homes for sure included in that, primary care, pharmacies, acute care, probably more people than want to get our alerts. We cover off as much as possible.

So this was alerting people to our clinicians, to what we were hearing and sharing Dr. Yaffe's communication with us. And then we began at that point to have these weekly infections, disease planning and response committee meetings to talk about preparedness.

We had a brief scenario that we asked people to review, so to try to make it real. You know, person X presents, they visited somebody who was at Wuhan in China, etcetera, to try to make it real, so that we could up the energy, if you will.

Because people are busy, they're not sitting around waiting for something to do. So to try to get everybody's attention so we could really start planning and preparing for this.

COMMISSIONER MARROCCO: Okay. Thanks.

Dr. Yaffe's communication, was it in writing or was it --

DR. SUTCLIFFE: Yes, it was in writing. And certainly, as Medical Officers of Health we receive that. I don't have it in front of me, so I don't recall if it was sent to other system stakeholders.

However, we then actioned that ourselves, in addition to her sending it to us, and perhaps other stakeholders at that time.

COMMISSIONER MARROCCO: Thank you.

DR. SUTCLIFFE: Again, by way of context on this slide, because the Province is big and varied as you know, and we all have had different experiences of COVID-19.

So I'll give you a bit of a sense, this is our MP curve in our area as of last week. We have had a total of 112 cases. And when I say this to family members who live down south, they wonder what we're so busy with, but we have been very busy

with these 112 cases of COVID-19.

This has included 10 outbreaks in 9 long-term care homes, and as a reminder, we have 12 in total. And across the north, there have been as of last week, 25 total outbreaks. So across all 7 northern health units in Northern Ontario.

Our 10 outbreaks included 19 cases; you'll see the breakdown of 6 resident and 13 staff cases. Sadly, that also concluded 1 death, in fact in the first outbreak that was declared. All of our outbreaks have been declared over; so throughout May, June and August.

Interestingly, the majority of our outbreaks were associated with asymptomatic positives. So individuals that were picked up on surveillance, only two of our outbreaks were associated with symptomatic individuals.

Also, by way of context, during that time period, so January, mid-January to the end of May, our case rate was 34 per 100,000 compared with 190 for Ontario as a whole.

So we were relatively less -- I wouldn't say unaffected, but less affected by COVID, both with regards to outbreaks and the nature of those outbreaks, and the community

evidence of community transmission.

COMMISSIONER MARROCCO: Doctor, you said the majority were asymptomatic positive. And this information flowed from surveillance?

DR. SUTCLIFFE: That's correct.

COMMISSIONER MARROCCO: What does that surveillance look like?

DR. SUTCLIFFE: So this is the provincial surveillance as led by -- at this point, by Ontario Health. Where currently the testing is every two weeks of the staff, so that's what that was about.

Our protocols would be different today with regards to the near automatic declaration of an outbreak in an asymptomatic positive. So our protocols have evolved and developed over that time.

I don't know that we would be seeing so many outbreaks declared based on asymptomatic surveillance, because those protocols have changed. But at that point in time, that's what we did, with a really heightened vigilance and level of caution.

COMMISSIONER MARROCCO: The changes in the protocols, for the better, for the worse?

DR. SUTCLIFFE: Well, changes in the

protocols based on evolving science and information. And so practically, for the better, I would say.

So we take everything very seriously, but it's not that we have to institute really rigorous control measures, which were difficult on social, emotional, physical health, because we have an asymptomatic positive now. So there's more thoughtfulness, frankly, that we can put into it now with the evolution of the science in this area.

COMMISSIONER MARROCCO: Okay, thank you.

COMMISSIONER KITTS: Dr. Sutcliffe, when you received the notice from Dr. Yaffe in January 24th, did Public Health or anyone else do more than the usual, I guess the usual monitoring and surveillance of the long-term care homes knowing that they might be a hotspot?

You said you have 12 homes, 11 inspectors, I think. So did you ramp up and what did you ramp up with?

DR. SUTCLIFFE: So I might also turn to Stacey for the details of this. What I can tell you is we ramped up our communication with them, our expectations for their preparedness, unlike Kingston. So I'm aware of what was done in KFLA.

We did not ramp up training, or inspections, per se.

I think at that point in time it really was a question of overall system readiness, overall making sure that people had the information they needed, and it's hard to go back in time and remember how little we knew at that point in time. Because the information that they needed, the lines of communication were established, and no errors in that and that there was a sense of readiness.

If it's all right with you, I wouldn't mind asking if Stacey has anything to add to that.

MS. LAFOREST: Yes, thank you very much.

So certainly enhanced communication and supports, absolutely. And also an expectation that facilities report daily to us any symptomatic staff or residents. And then for our review and discussion in regards to application of Directive No. 3 as well. So I would say enhanced monitoring and surveillance as well.

COMMISSIONER KITTS: Okay, thank you.

DR. SUTCLIFFE: Thank you.

This slide is quite busy, and I actually would like to spend more times on the next

two slides than I have on this one. But we were sharing some questions ahead of time, I wanted to make sure we provided you with the information that hopefully will be helpful to you. And that was kind of what was our response, what was the impact, and the relationship or engagement with the province.

So there are many points on here, but our response -- I mean, overall, I would say Public Health has been and is the fulcrum of outbreak preparedness and response. That we are the go-to, not only for long-term care homes, but certainly long-term care homes around support for outbreaks, communication, understanding and interpreting the latest directions, etcetera.

And so the specific responses, certainly we have designated staff to homes to make sure those individuals were maintained and those lines of communication were excellent.

We increased our own capacity to make sure that we had management leadership, you know, availability through 24-7 phone line access. And in specific in talking to long-term care home to make sure we can focus on their needs.

We really have been a knowledge broker,

putting all the information that we could on our website, so that was easily accessible to our many partners.

And we have also acted, as Public Health often does, as a bridge or liaison between different parts of the system. So especially early on, thinking about primary care, hospitals, IPAC resources, etcetera, to make sure that we could help to bring different parts of the system together.

We provided assistance initially with the surveillance testing of staff, and the risk categorization of long-term care homes that then transferred more to our Terra Health colleagues, and supported the screening of policies and procedures.

We, as Stacey mentioned, have instituted the daily monitoring of all the staff and residents for any symptoms. So we have, actually, a pretty rigorous process of reporting symptomatics to us, so that we can review that with the long-term care homes.

And certainly, if there were outbreaks declared, then to provide the assistance and support, the daily outbreak management team

support.

And the last point here that I'd like to come back to in the next couple of slides, if that's all right, is about the new Ontario Health North, so the Regional Ontario Health Outbreak Prevention and Response Committee.

So that was a new structure that was implemented through the course of all of this, and I think there are benefits to that, and also challenges with that, which I would like to return to shortly.

Our overall impact, I think so far is really increased confidence and readiness in our long-term care homes. And I would say overall better coordination of the system. Nothing like a pandemic to focus mind, and make sure that we are coordinated and working together as a system. So those have been positive.

Lots of community concern and anxiety about long-term care home residents. We had the benefit, or the challenge of seeing what was happening elsewhere, and so that increased our vigilance here, and our anxiety and concern for these vulnerable residents.

Long-term care homes certainly took the

opportunity to re-examine their own contingency and pandemic plans; ramping up their communication and their own focus on their own internal policies and procedures.

Challenges with regards to staffing, which I'll return to on the next slide, if that's all right. But long-term care homes trying to increase their compliments, and making sure they were following the direction about just working on one site, etcetera.

Lots of concerns around the psychosocial health with the restrictions that were imposed; that's not a surprise. And I think we've had really good engagement with our political leaders of concern, wanting to know what's being done and what protective measures were being taken in the homes.

And the final piece on this is with regards to our relationships with the Chief Medical Officer of Health and with the Province. I would say, you know, I had the pleasure of working in the Public Health system during SARS as the Medical Officer of Health here, and also went to support our colleagues in Toronto during SARS. And it's night and day with regards to organization, with

regards to communication. So certainly the daily sit reports from the EOC, and being really responsive to our questions, their protocols have been very helpful. Twice weekly now, coordination calls with the Office of the Chief Medical Officer of Health and the Council of Ontario Medical Officers of Health, so all of the medical officers and associate medical officers have a list for e-mail communication, and that's been a really good way to share what's been happening and how we can support each other on various issues.

Directive No. 3, and the policies have been very helpful, and certainly have helped Ontario, the evidence briefs and the laboratory expertise have all certainly contributed to our ability to manage, and understand, and communicate what's been happening.

Would it be okay to proceed to the next slide?

COMMISSIONER MARROCCO: Yes, sure that's fine.

DR. SUTCLIFFE: Thank you.

This slide is on "lessons learned" and then my last slide is on "recommendations". And I was hoping that this would be helpful to you based

on our northern perspective and experience.

The first lesson learned, I would say it's been actually very good to be last in this instance. So I do think that the north benefited from the later introduction of the virus into our area. We were able to forecast and learn from other jurisdictions and really, you know, heightened our adrenalin and our vigilance. We could see what was happening elsewhere.

So because the provincial policies were across the Province, not regional, we were able to benefit, I think net greater than other areas, because the policies came in earlier in our pandemic curve. And because of our heightened vigilance, our concern, our experience of what we could see happening elsewhere, as well as the respective policies being introduced at an earlier point, we had greater benefit from those. Certainly, I don't believe our own circumstances would have triggered the long-term care policies in terms of what we were experiencing locally, but we could benefit from them.

So the "so what" of that, I think is that to prevent does require early intervention. The challenge, of course, is that there are

downsides to those interventions with regards to the unintended consequences that the restrictions, etcetera, have imposed.

The second point about lessons learned, I believe, is that relationships are really critical. We have, you know, under Stacey's leadership and her team, really excellent and longstanding relationships with long-term care homes, which meant that they were quick to call us. We knew what was going on, we knew how the facilities were managing and how they have historically managed issues. So that was excellent.

And so I do think the "so what" of that is that in times of crisis, make sure that you build on what already exists. And that's been really effective for us in the north, not just our area, but areas across the north.

COMMISSIONER MARROCCO: Can I stop you for a minute there, Doctor?

Were there already established -- in terms of building on what already exists -- were there already established relationships between hospitals and long-term care facilities, you know, a connection between the expertise and places that might need it?

DR. SUTCLIFFE: You know, Justice, I don't know that I can answer that fully. I don't know if Stacey, you might have comment on that in terms of the sharing of information and the transfer; and perhaps you're referring to IPAC and perhaps others?

COMMISSIONER MARROCCO: Yes, as a -- you were saying, you know, you have to build on what already exists.

So I was just trying to get a sense of whether these relationships existed, because you would think there's expertise at the hospitals that would be useful.

DR. SUTCLIFFE: I don't know if, Stacey, you might be able to further comment on that?

MS. LAFOREST: Yes. So I'm also not aware. But what I do know is the longstanding relationships that we've had here at Public Health, and other colleagues across the north at long-term care facilities, and really trying to maintain a common point of contact over time with our staff here, and the appropriate individuals at the facilities. So that we have a full understanding of, perhaps, the areas of need, and areas of

strength for the respective facilities. And also a history in regards to outbreak management at those individuals sites, as well, and so that they know who to reach out directly in order to seek clarification and information.

COMMISSIONER MARROCCO: Okay.

COMMISSIONER KITTS: In an earlier slide, I think you said that Public Health sometimes plays the broker facilitator role; did I see that on a slide?

DR. SUTCLIFFE: Yes.

COMMISSIONER KITTS: So I wonder if that's the Public Health, I think you're saying, had a very good relationship with the long-term care homes.

And if that's correct, perhaps you've also played the broker between the rest of the system that needed to come in to help during a crisis; is that fair?

DR. SUTCLIFFE: Absolutely. And I think what perhaps Stacey and I are referring to in response to the Justice's question is, I don't know that we can comment on pre-COVID, the relationship between, or the strength of those ties, or the interconnections between the long-term care home

and Health Sciences North or other hospitals.

We're not aware of there being challenges certainly but I'm not sure where their points of intersection are. Often pre-COVID, where we would intersect would be planned districts, hospitals to long-term care home, and helping to navigate the players in those instances. But in terms of hospital support to long-term care homes or relationships there, I don't know that we can comment on that.

COMMISSIONER KITTS: Thank you.

DR. SUTCLIFFE: The third lesson I would say for us has been, you know, that we need to be prepared to drink from a firehose and for a long period of time.

So in a crisis, as we know, there is just a rapid rate of new information and data that is shared. And that, of course, has to be learned, has to be interpreted, communicated, and Public Health has a real role in the interpretation and actioning of a lot of that information. Helping our community understand what it means, and the implications for their own actions, in this instance, to prevent the spread of COVID.

So all players need to plan for

sustainability. So I think the "so what" of that is that it's really critical pre-emergency to develop and reinforce business continuity plans, surge and redundancy contingencies, really have effective handover and transition processes, because no one person can do it all the time and we need to build in those redundancies and handovers.

And also I think very importantly is cultures of self-care. That our healthcare workers, our social service workers, everybody is working incredibly long hours to respond to the needs of our community. And, of course, obviously to be there for others, we need to be there for ourselves.

So the lesson learned there is that there's lots and lots of information, and lots and lots of actions and responsibilities. And we have to plan for that, think about what we can do to mitigate the challenges of that, and make sure ultimately that we're looking after ourselves, so we can look after others.

COMMISSIONER MARROCCO: How do you think you achieve in pre-emergency times the development that you're describing there?

DR. SUTCLIFFE: Well, I think that that

is extremely difficult. Because, again, it's not that we are sitting around waiting for, you know, work to happen or building up. But one of the things that we have done, and that we've encouraged with our partners, of course, is the planning, thinking about continuity, business continuity. So that can be done, your business continuity, "what would you do if..."

The surge and redundancy is difficult. Difficult certainly in times of scarcity, which is the public sector, to build for the surge and redundancy. But I do think there are human resource practices that can be put in place that will help for with that. There is cross-training that can occur to help with that. We've certainly done that within our own organization, to make sure that out staff are cross-trained so they can help in an instance of an emergency.

Just prior to COVID, we were actually dealing again in Stacey's area, with a Hepatitis A outbreak. So we were already, pre-Christmas over the holiday period and post-Christmas, quite maxed with the community response that was required of us related to Hepatitis A.

It's really important to know that

sometimes bad things would only happen once, but there are multiple things that happen at the same time. So plan as much as we can for cross-training, for recognition of what people need to do to look after themselves.

We also have in the north, formal, actually, memorandums of understanding to cross -- to help each other across the north within Public Health. And so this, of course, is not helpful when we're all experiencing the same thing, we're all in the pandemic.

But if one of our agencies was experiencing big challenges that had impact on staffing, and our ability to respond, that we could call on the others to help. So that's something that could be done in non-emergency times to help with that. In our sector and I'm sure in other sectors, too.

The other point, number four, is looking at: Are the right people doing the right things? So in this instance, it's getting somebody else to look after the logistics. So our focus is on surveillance, infection, prevention and control and the outbreak management.

And there are certainly enabling

logistics that are not insignificant, that are very important; but they are enabling logistics. For example, the PPE, access to testing, etcetera. And so for Public Health to be responsible for the core pieces related to outbreak prevention, outbreak management, as well as needing to respond to the really real concerns about access to testing and access to PPE, was distracting, I guess, at best and quite difficult.

So ultimately, Ontario Health took on core responsibilities as it related to those logistics. So I think the "so what" of that is in making sure that we have the right people, doing the right thing, and that appropriate delegation needs to occur. So that was very helpful when that happened, but initially it was all on Public Health, I would say, and not manageable. So that was an effective change, ultimately.

We also noted that for sure, risk assessment and risk tolerance varies, you know, really widely in our communities, and our province, probably in our own homes. And that responses really in the long-term care homes ranged from, you know, poor compliance initially of long-term care staff who, you know, didn't -- perhaps didn't

appreciate yet the significance of the virus, and the significance of the potential impact in long-term care homes. So challenges with compliance to hypervigilance. So range from that to, you know, long-term care homes, perhaps being really fear-based and increasing the frequency of their testing, or the staff exclusions, etcetera.

And so our lesson from that is to think about anticipating that variability in risk tolerance, and to respond effectively to deal with that. So by ways of, for example, providing real life examples, addressing the underlying emotions that are behind that, and to talk about realistic consequences.

So not good enough just to tell people what they should be doing, but to really get at underlying rationale, underlying barriers, perhaps taking on those behaviors, and so that we have a risk assessment that really is commensurate with the risk that we're facing.

Finally, just on communication, that we can't get enough information out, you know, to enough people ever in a crisis, and really difficult to satisfy the communication needs, as well as with an ongoing crisis, how easy it is to

get mixed messages, we've all heard of misinformation in social media.

So to try to make sure that there are credible sources, that Public Health is one of those reliable sources, either as a knowledge broker, a source of information, or pointing to the appropriate sources of information.

And across the north, all seven Medical Officers of Health, we very quickly established weekly teleconferences, so these are the Public Health leaders in our communities and our health units, to make sure that -- you know, there's no cookbook. So as we were navigating the new information in how to implement that locally in our northern context, that we were doing that with some consistency and communicating in a way that would be coherent to our communities in the north.

We don't have that many media outlets in the north. So, for example, our local CBC in the morning covers all of Northeastern Ontario and in the afternoon, covers all of Northern Ontario. But really important is that we're communicating consistently.

I'll go on to the next slide, if that's all right.

COMMISSIONER MARROCCO: Yes. Please.

DR. SUTCLIFFE: Thank you.

So we were asked if there might be any recommendations that we would have based on our own experiences. And so there are six here that I hope will be helpful to your deliberations.

Again, thinking about our own experiences, and from a northern context. Certainly, really important, that there is coordination of the direction from the Ministry of Health and the Ministry of Long-Term Care. And where there are inconsistencies, to make sure that those are surfaced and that they're explicitly addressed.

So, for example, challenges earlier on as it related to the importance or not of surveillance testing, challenges as it related to access to testing. So making sure there's really good alignment of their messages; or if there can't be alignment for various reasons, to explain those inconsistencies and make sure that those are clear for the homes, for the families of people in homes, and certainly also for Public Health with regards to the role that we have.

And perhaps related to that, is making

sure that local Public Health is included in the Ministry of Long-Term Care communication loop. We really are seen as, locally, as being pivotal in this outbreak, and we're expected to be the authority on COVID-19. And so it's really important that we are aware of what's communicated to homes and to the systems. For sure that role can be compromised if we're not aware of direct communication that goes to long-term care homes.

Our third thoughts around recommendations is around the importance of being really clear on the roles and the related authorities and accountabilities of all the players.

So two examples that we have here, is the role, for example, of Local Public Health versus Ontario Health, and I referred to that earlier. There has been some confusion about leadership, and I would say, some duplication in committees -- or inefficiencies in our committees or structures.

So Public Health, as we mentioned, has a longstanding relationship with long-term care homes, we are the lead go-to, as it relates to the management of outbreaks. And with the onset of

Ontario Health North, and committees and structures that they were then putting together, I think there wasn't such a great awareness of what we do in Public Health and the relationships and processes that we have as it relates to outbreaks. So that resulted in some confusion, certainly additional meetings.

And again, in terms of the lessons learned about leveraging or building on preexisting relationships versus creating new relationships unless really required.

I'm not saying they weren't value add, or are not. And absolutely with regards to the PPE, and the testing, and now subsequently with looking to potential for hospitals to support IPAC. And in other instances, where we see hospitals taking over management of long-term care, so they're part of the picture, absolutely, and I think need to be integrated into its existing structures versus -- in our area anyway -- in creating new structures.

The other example would be the role about being clear about the authority and the roles of local Public Health versus our Ministry of Long-Term Care. So we had to have examples of

long-term care seeking direction from the Ministry or from Ontario Health, just sort of workaround local Public Health.

So an example where a long-term care home -- and I can't remember the circumstances, Stacey, whether this was a PPE or a direction to staff, that they weren't so happy what we were telling them, so they had asked the Ministry and actually got different direction. Which is fine, except we need to be clear on who holds the ball. Like whose responsibility it is to do what.

COMMISSIONER MARROCCO: But that registers with me, I mean, local Public Health has the power. I mean, they could talk to anybody that they want to, but they can't -- if there's an order, they have to comply with it.

Was there any inhibition or any restriction placed on your ability -- apart from the legal test, any restrictions on your ability to make orders?

DR. SUTCLIFFE: No. And, Justice, there has not been an incident to this point where we would have to consider an order.

The kinds of examples are more policy and process. And certainly would not hit the

scale, you know, the register to require an order. And absolutely, if an order was necessary, I would take that action. This is about relationships, I think. And also knowing who is responsible for what, and being very clear about that.

But, no, as it relates to the legal order, absolutely that is very clear to us and I think to our partners, also.

COMMISSIONER MARROCCO: So what would happen then in a situation where they said, "well, you told us to do one thing, and I was speaking with someone else in the system and they told us to do something different".

What happens in that type of situation?

DR. SUTCLIFFE: So I think it would depend on the nature of the situation. If it was such that my Public Health assessment was that that would be putting people at risk, either the staff or the outbreak, etcetera, that I would put my foot down.

If it's really an instance -- and I believe if my memory serves, that this was an instance about getting, I'll say preferential treatment, access to supplies or something that -- I don't think the details are so important -- but

access to supplies in advance of, or in a way that wouldn't have followed the protocol, it wasn't something I was going to argue or fight.

My point is more around being really clear about the relationships and the authority. Because if it's not, those are simple examples, but if it came down to more severe examples, then that is difficult. It's difficult, not from a legal perspective, but a relationship perspective and ongoing working and effective relationships together.

COMMISSIONER MARROCCO: Okay.

DR. SUTCLIFFE: Our fourth is about the importance of enhancing capacity for compliance of the long-term care staff with Public Health measures. And so what we mean by this is not just the compliance itself, but the capacity for compliance.

So how can we ensure that we build within the system the greatest chance possible of compliance with these measures, so thinking about COVID.

So for sure, challenges with part-time staff, with not complete benefits, with remuneration, this all makes it very difficult, of course, for our long-term care homes to actually

readily be able to comply with the Public Health measures that are required of them.

So if you think about just working in one location, cohorting of staff, if somebody is ill, visitor restrictions, testing of visitors, it's difficult to do, not impossible, but difficult to do. Our staff are marginally employed or they have precarious or limited benefits.

And I think with that, from a northern perspective, there are additional considerations about equity. So the ability for the northern health long-term care homes to be able -- further to be able to comply with Public Health measures.

So there are potentially issues related to First Nations, to Francophone and rural and remote settings, where, you know, issues of culture, of language, the travel distances and the cost associated with that, the decreased access to testing, and the fact that in many of our small communities, there aren't many employers. So staff may well, and often do work in more than one institution. So a hospital and long-term care shared staff.

And so it's really important that we give some consideration to those factors. And I'm

not saying that we have solutions to that, but I'm saying that those need to be surfaced and talked about. A long-term care home in Toronto is different than from a long-term care home in Chapleau. And the challenges that they will face to comply with Public Health measures are very different.

So I think that needs to be unpacked further with our northern partners in long-term care homes to fully understand what are the nuances that will make it barriers or facilitators to compliance with the Public Health measures that we're requiring of them.

COMMISSIONER MARROCCO: Just to try to understand that. We've heard from a number of people, that there are too many part-time staff and not enough full-time and so on.

But should we understand that in the areas that you're concerned about, that part-time staff, that people have to do it that -- so if somebody issued some broad, general edict that 70 percent of the staff had to be full-time, that that might have an implication for you that wouldn't be apparent, say, if you were dealing with a long-term care home in Hamilton or --

DR. SUTCLIFFE: Exactly.

COMMISSIONER MARROCCO: -- they require part-time staff in these situations.

DR. SUTCLIFFE: Well, that's right.

Again, we don't have all the details or all the answers. But there are nuances, there are differences in circumstances that are not inconsequential with regard to the long-term care homes' ability to follow the directions.

So even thinking in our First Nations communities, the role of elders in those communities and not being able to visit your elder. There are many factors, I think that, you know, really do need to be taken into consideration with regards to, as I say, the environment or the supports for a home to be able to be compliant and to protect their residents.

The other, you know, when we think about travel in the north, so the distances are huge, as you know. So Chapleau, for example, part of our district is at least a five-hour drive away from our main office. So if you think about our family members being in long-term care homes, it's not always right next door; it can be very far. And so restricting to, say, one visitor or the

essential visitors has really been an enhancement right now in helping to -- with the psychosocial and the isolation that long-term care residents are feeling, there are just specific, there are circumstances that make it quite different in the north and in rural and remote areas. Cultural distance, language, etcetera.

COMMISSIONER MARROCCO: Okay.

DR. SUTCLIFFE: The fifth point is the need, we would say, to level the playing field in our long-term care homes as it relates to infection, prevention and control.

So as Stacey has mentioned, we know our long-term care homes, and we know which ones tend to do better, or respond more effectively in an outbreak, and we try to make sure that they're resourced and have more attention from us. But we know that there is variability in their capacities and in their competencies.

And I believe you're aware of the IPAC Hubs and Spokes investment that is occurring right now. And I think that that is promising, in terms of leveling the playing field of IPAC incompetencies within our homes. And especially in the north, again, the information is just emerging right now

about what it will mean. But we understand the hubs in the north, seven health units will be those health units and will, therefore, be able to build on the existing relationships that long-term care homes have with Public Health.

And so one thing to potentially consider, is to establish a structure, you know, whose lead function it is to ensure excellence in IPAC in long-term care homes -- and potentially retirement homes and other congregate settings -- with the consideration for Public Health to take on that mandate.

So it seems to us that there's nobody who holds this responsibility. And I'm well aware of what Kingston has done with regards to trying to take that on, and kudos to them for the work, the proactive work that they have done. We can talk more about that, but however that is a challenge for local Public Health to do that.

I do feel that there is a need for somebody to hold that, for that responsibility, accountability and function to support excellence in IPAC in long-term care homes that it needs to be the centre of somebody's desk.

So for example, with these hubs and

spokes, with health units being that hub in the northern health units, that might well be a model to further explore about perhaps that ownership and that leadership should be with Public Health.

And I just note, for example, historically Boards of Health were responsible for home care. It's gone through several iterations and is now with Ontario Health, but there are structures that have been in place historically for Public Health to take on -- and if not us, then somebody -- to take on responsibilities so that it is the middle of somebody's desk, and it's not just an afterthought or a consideration, you know, when things go sideways.

COMMISSIONER KITTS: I was just going to ask the question, how many IPAC specialists or leaders do you have in your Public Health unit to provide the hub and spoke service to long-term care homes?

DR. SUTCLIFFE: So if you mean the training, the CIC training and certification, or if you mean ID physicians?

COMMISSIONER KITTS: I just mean the whole package of IPAC control, prevention, education, the whole package of IPAC measures.

DR. SUTCLIFFE: Stacey, if you could comment on that from our health unit. I don't know that we'd be able to comment from other northern health units.

MS. LAFOREST: Thank you.

So in our health unit, we have one individual that's CIC certified currently. And another who has just completed the training and is waiting to take the exam early in the new year. So one currently is the official CIC designated individual.

However, we do have a number of staff who have received more, I would say, informal training through Public Health Ontario and so forth, and through their Public Health nurse and Public Health inspector roles.

COMMISSIONER KITTS: So in your hub and spoke model, would you draw upon the, I guess, the infectious disease IPAC expertise in the local hospitals or wherever they might be?

DR. SUTCLIFFE: So I think -- in fact, this is all evolving. And we have a meeting this afternoon to hopefully get more details about this model. So talk to me tomorrow, I might have more information.

COMMISSIONER KITTS: Okay.

DR. SUTCLIFFE: For sure there is expertise in the hospital. Our colleagues, our other colleagues across the Province have also commented on the transferability, or not, of that expertise to long-term care homes.

That is a different kind of environment. It's not ID docs that are needed in that setting. It really is, you know, protocols, rigorous practice, making sure there are good metrics in place and accountabilities.

I don't want to over or understate the expertise that's needed. But I would say that it's different from a hospital setting.

COMMISSIONER MARROCCO: Sometimes you need somebody, though, to enforce the best practices, just to find a shorthand to describe it.

And it's hard, in my experience anyway, it's hard to do that if you're employed by the organization; it can be hard to do that. It's sometimes easier if you're outside the organization that you're putting the hammer down on.

DR. SUTCLIFFE: Completely agree. And we certainly have a progressive enforcement approach. So it's not the hammer right away in our

work, but absolutely trying to build capacity within the institutions. They're the ones who are ultimately responsible for the management of their outbreaks, they need to have the tools to do that.

COMMISSIONER MARROCCO: Okay.

DR. SUTCLIFFE: Our final point, for the final slide is, you know, if we can say to the Commission, I mean, we think it's really important to really explicitly articulate the values that underpin and guide the investments in long-term care homes and the policy decisions.

So just an explicit, upfront articulation of the value about how imperative it is to protect the most vulnerable. And the imperative of ensuring that we have to make sure that the physical gains are really carefully weighed against the risks of the social and emotional health costs. That these things for our loved ones who are in long-term care homes, you know, they're counting on us. And we need to make sure that we do that for them, and do it in a way that is respectful of their wishes.

And if I could just go to my very last slide to share with you a reflection from one of our colleagues across the north. When I asked

about what input they might have, you know, he said, really, what have we learned? We learned that a marginalized group with many comorbidities who are cared for by another somewhat marginalized group, will not be at the forefront of preparedness and/or concern in a pandemic.

Populations were not well looked after in normal time, will fare badly when things go sideways. They will be second string in terms of priority, allocation of resources, etcetera. And that properly prepared long-term care homes likely would have saved more lives and suffering in Ontario than the hospital system did.

We need to put our focus very squarely, as the Commission is doing, on those needs. And certainly that upstream, the preparedness, training, equipment, relevant protocols matter. It's not a nice to do, it is a must do. And, really, that's all that we have when we're faced with these threats.

The picture on the side is a diagram we often use in explaining the role of Public Health, and thinking upstream and not the downstream; it's very important. You know, when people fall in the river, they need good EMS, and they need hospitals

to resuscitate and care for them. But somebody has to be looking upstream in terms of preventing those folks from falling in the river, preventing those infections in long-term care homes.

Once we have outbreaks there, I won't say it's too late, but we really need to prevent them from occurring in the first place through the resources and attention policy, and explicit values orientation of this investment and this work.

Thank you.

COMMISSIONER MARROCCO: Thank you. I don't think we have any further questions.

Well, Doctor, thank you very much for the presentation. It's helpful, because our perspective can very easily become too urban, too Southern Ontario focused, and this is a very helpful -- Ontario is a complex place, and this was very helpful and reminding us of that. And it also reinforces some of the things we've observed about how to be prepared, and the advantages of being prepared, and having established relationships.

So thank you very much for the time and effort. We'll try in our work to do justice to the recommendations that you've given us to think about.

So thank you.

DR. SUTCLIFFE: Thank you for the opportunity. We really appreciate it.

COMMISSIONER KITTS: Thank you.

COMMISSIONER COKE: Thank you.

-- Hearing adjourned at 9:57 a.m.

REPORTER'S CERTIFICATE

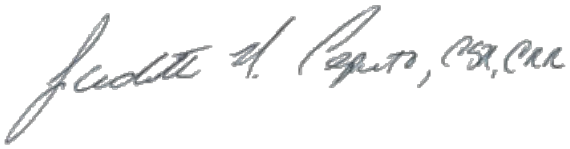
I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

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 20th day of October, 2020.



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