

Long Term Care Covid-19 Commission Mtg.

Meeting with Sarah Downey
on Friday, October 2, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending
remotely, on the 2nd day of October, 2020,
10:30 a.m. to 11:30 a.m.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

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10 Sarah Downey, President and CEO, Michael Garron

11 Hospital;

12 Wolf Klassen, Vice President, Program Support,

13 Michael Garron Hospital;

14 Philip Anthony, COVID-19 Outreach Lead, Michael

15 Garron Hospital;

16 Dr. Jeff Powis, Medical Director, Infection

17 Prevention and Control, Michael Garron Hospital;

18 Dr. Jarred Rosenberg, Geriatrician, Michael Garron

19 Hospital.

20

21 PARTICIPANTS:

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23 Alison Drummond, Assistant Deputy Minister,

24 Long-Term Care Commission Secretariat;

25 John Callaghan, Counsel, Long-Term Care Commission

1 Secretariat;
2 Derek Lett, Policy Director, Long-Term Care
3 Commission Secretariat;
4 Lynn Mahoney, Counsel to the Ministry of Health and
5 Long-Term Care;

6
7 ALSO PRESENT:

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9 McKaya McDonald, Stenographer/Transcriptionist.
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1 -- Upon commencing at 10:30 a.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Good morning.

5 SARAH DOWNEY: Good morning.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Just waiting for Commissioner Jack Kitts. I'm

8 Frank Marrocco and Commissioner Angela Coke.

9 COMMISSIONER COKE: Good morning.

10 SARAH DOWNEY: Good morning. Lovely to

11 meet you both.

12 COMMISSIONER COKE: Thank you.

13 SARAH DOWNEY: And Jack Kitts is an old

14 friend, so that's okay. I worked with him.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 Oh, good.

17 SARAH DOWNEY: Yeah. We go way back.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Well, he will be here any second.

20 SARAH DOWNEY: Perfect.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 We were interviewing earlier, so he's --

23 Oh, there he is. So we are here.

24 Ms. Downey?

25 SARAH DOWNEY: Yeah.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 You know, it's a little different than your typical
3 commission, and it's different for this reason:
4 Typically commissions are formed after something
5 has happened, and they look back at it and try to
6 understand it and explain it to the public. We
7 have been created in the middle of something.

8 And so typically the commission
9 investigates, they hold public hearings, and then
10 they write a report. And that takes two/two and a
11 half years.

12 Because our reality is different, we're
13 giving some serious thought to making an interim
14 report and concentrating more on recommendations
15 first, and then we may have a look back at what
16 happened in a different way, in a more traditional
17 fashion.

18 So we're kind of at Phase 1. We're
19 investigating. We're trying to understand if there
20 are recommendations we should make now, and so
21 that's what we're up to.

22 SARAH DOWNEY: Excellent. Well, I
23 think it's absolutely necessary to see what's
24 happened and see if you can make recommendations
25 that will make a difference as this pandemic

1 continues, so thank you for that.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 All right. And there's Mr. Rosenberg, is it?

4 SARAH DOWNEY: Yeah. So I'll introduce
5 you to my part of the team that's here.

6 Good morning, Jack. Long time no see.
7 It's nice to see you. You're looking ten years
8 younger already. I'm looking ten years older, let
9 me tell you. You timed it perfectly, as you always
10 do.

11 So thank you very much. So I guess
12 we're here to tell you a bit about the Michael
13 Garron Hospital response in long-term care and our
14 story in East Toronto.

15 And we've prepared a deck, if you can
16 go to the next slide.

17 As Jack will know, CEOs really don't do
18 very much, but these are the people that were
19 motivated, and I certainly didn't stop them. I
20 encouraged them to respond quickly and very early
21 to the crisis we could see emerging in long-term
22 care at the start of COVID.

23 And so I'm Sarah Downey. I'm the
24 President and CEO of Michael Garron Hospital, and
25 with me today are Wolf Klassen who is the Vice

1 President, Program Support; Jeff Powis who is the
2 Medical Director in Infection Prevention and
3 Control; Dr. Jarred Rosenberg who is a geriatrician
4 at our hospital but who spent nearly the entire
5 pandemic work outside of our hospital in long-term
6 care; and Philip Anthony who is a nurse from our
7 emergency department who stepped in to coordinate
8 our outreach efforts in long-term care.

9 So the way we thought to best present
10 our efforts is to talk to you a bit about East
11 Toronto and what is different, actually, in the
12 quad-integrated system we have in East Toronto.

13 Then Dr. Powis will give you an
14 overview of how, in East Toronto, we have organized
15 our response to COVID. And then Dr. Rosenberg and
16 Philip will talk to you about the very specific
17 COVID response in long-term care, and then Jeff
18 will come back and talk to you about our thoughts
19 going into Wave 2 and how we've organized ourselves
20 to try to keep long-term care homes safe.

21 So let me ground you in East Toronto.
22 I don't know if anybody lives in this area but --

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 Oh, I do.

25 SARAH DOWNEY: Oh, you do. Perfect.

1 Excellent.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 I'll tell you, my daughter is actually an emergency
4 doc and prepared --

5 SARAH DOWNEY: Yes, of course. I
6 wondered and I thought "Yeah."

7 Well, yeah. There you go. The best
8 emerge in the city, for sure. She is a wonderful
9 colleague.

10 But, you know, the Michael Garron
11 Hospital is a community hospital. In East Toronto,
12 it's been here for 91 years, and there's a distinct
13 community, a set of neighbourhoods, around Michael
14 Garron that we serve and have for a very long time.

15 As we say, the area is really Eglinton
16 south to the lake. Sort of from the DVP on the
17 west to sort of Birchmount and sometimes even
18 further east into Scarborough.

19 And when we look at the population that
20 use our programs and services, there's a high
21 affinity of these neighbourhoods to Michael Garron
22 Hospital.

23 We serve 22 different neighbourhoods
24 some of which are incredibly diverse. And 5 of
25 Toronto's 31 neighbourhood improvement areas are in

1 our catchment area which means they're low
2 socioeconomic status, many are densely populated
3 and, I would say, are at high risk for a disease
4 like COVID.

5 Though when you look at incidence rates
6 of COVID, I think we've been actually remarkably
7 successful in preventing what could have been a
8 disastrous spread of COVID in some of these
9 high-risk neighbourhoods.

10 And high proportions in many
11 neighbourhoods of new Canadians. Thorncliff Park,
12 for instance, must be 60 or 70 percent new
13 Canadians with very, very young children. Canada's
14 largest elementary school is in Thorncliff Park.

15 If you can imagine, 65 classrooms vary
16 from Grade 1 to Grade 5. That's 12 to 14 classes
17 per grade, and you can imagine what that is like
18 and the potential for the spread of COVID. And
19 right beside it, in Flemingdon, is the highest
20 proportion of seniors living alone in East Toronto,
21 so a lot of diversity in the populations.

22 We serve a lot of health service
23 providers, which is the way Ontario has not
24 integrated its health system.

25 But 3 hospitals, though Michael Garron

1 is the only acute hospital; 14 home care
2 providers/service provider organizations; 13
3 community social service agencies, 15 community
4 mental health and addiction agencies; 10 long-term
5 care homes; 4 community health centers; and 275
6 family doctors. I've found the largest single
7 practice is probably 40 doctors, so a very diffuse
8 system of care.

9 But you can go to the next slide, Wolf.

10 We are one of the first Ontario Health
11 Teams in Ontario. We were nominated and awarded
12 that in December. And that's because there's large
13 affinity across the agencies that provide health
14 services in East Toronto.

15 And we adopted a model of an anchor
16 partner strategy. We have six anchor partners in
17 our Ontario Health Team, and we are the acute care
18 hospital. Providence represents the long-term care
19 sector. Though they are with Unity Health now,
20 they're still a large long-term care provider.

21 WoodGreen Community Services is both a
22 community social service agency and a community
23 mental health agency -- in fact, the largest in
24 Toronto; VHA Home HealthCare has been a home care
25 partner; South Riverdale Community Health Centre

1 and what we've had in East Toronto, which has been
2 vital to our response to COVID and our response in
3 the long-term care, has been the emergens of a
4 primary care network.

5 The family doctors of East Toronto, in
6 their variety of practices, formed a not-for-profit
7 corporation called East Toronto Family Practice
8 Network just over a year ago, and they are
9 signatories to the anchor partner agreement, member
10 of OHT, and have been vital in designing the
11 response of our Ontario Health Team and in
12 collaborating with us to ensure a community-based
13 response to COVID-19.

14 Across our OHT, we have had a number of
15 successes already. For last two years -- and this
16 will be our third -- we've had an integrative
17 response to influenza.

18 The hospital has invested \$1.5 million
19 in a community-based response to the flu including
20 getting flu vaccines out to vulnerable seniors at
21 congregate settings or living alone. We have
22 funded shelters in order to provide primary care
23 shelters. We've extended our primary care hours
24 over Christmas holidays. We've created expanded
25 mental health and addiction services over

1 Christmastime, and just a variety -- we've provided
2 food to drop-in programs to try to keep people from
3 having to use the emergency department
4 unnecessarily so have really created some great
5 momentum in working together to solve complex
6 system problems which has served as an important
7 substrate, I think, to our successful response to
8 COVID and something I know Dr. Powis will talk to
9 you about and how he organized our response.

10 The other key element in our long-term
11 care work -- so seniors are a major focus as well
12 of our Ontario Health Team as it is for any Ontario
13 Health Team, I think.

14 The other program we've had operating
15 in East Toronto for a long time has been
16 nursing-led outreach teams which are emergency
17 department nurses, a specific program to link to
18 long-term care homes in East Toronto.

19 So we have longstanding relationships
20 built with long-term care homes, the ten in our
21 region, through the NLOT team that when it came
22 time to respond to the problem in the outbreak, we
23 had familiarity with the organizations that were
24 operating in long-term care homes.

25 So with that, I'll hand it over to

1 Dr. Powis who will talk about our COVID response in
2 light of our infrastructure.

3 DR. JEFF POWIS: Thanks. So, you know,
4 in the midst of trying to fare our own organization
5 for what we knew was coming based on the
6 international experience, we took on this role to
7 help with our long-term care partners.

8 And what we have tried to do is
9 instill, well, "What was the philosophy of our
10 approach that led to, what we believe, great
11 success?" And for me, these were the things that I
12 felt in our Command Centre meetings that allowed me
13 to help coordinate and build our response in the
14 community.

15 Now, I think the first thing for us
16 was -- and it sounds simplistic, but as a community
17 hospital, our vision was to build health and build
18 community. And so we wanted to do the right thing
19 for our community. And that, at times, led to
20 challenging decisions where we had to weigh what
21 was right for our hospital versus what was right
22 for our community. Often those things aligned, but
23 we needed to ensure what we did was the right thing
24 for the community.

25 And as a result of that, for me, as an

1 as a infection prevention and control expert, whose
2 major focus before this was on the space inside of
3 my four walls, that gave me the power and the
4 motivation to actually start thinking about the
5 community as my focus.

6 So instead of four walls, I've got
7 Eglinton, the Don, Birchcliff, and the water to try
8 and think about how we focus our infection
9 prevention and control in our region.

10 The other thing that we felt, too, is
11 the response in some ways was slower than it needed
12 to be. And I remember Dr. Mike Ryan from the WHO
13 clearly saying "Speed, not perfection, is what
14 beats a pandemic."

15 And we took that to heart, and we've
16 kind of changed it a little bit. Speed over
17 perfection makes it sound like you're doing things
18 carelessly, but what we wanted to do was we made
19 sure that there were things done quickly.

20 Perhaps we didn't have the perfect
21 complement of staff to do exactly what we wanted it
22 to do. Maybe the model of care needed to be
23 improved over time. But waiting for perfection
24 would lead to inaction which was not the
25 appropriate way to deal with something that was

1 emerging, something that was a crisis that was
2 happening quickly.

3 And the last thing is an institution
4 heavily focussed on improvement. And my other
5 title is in Operational Excellence Quality, and the
6 entire role is focussed on improvement.

7 Dr. Rosenberg and I both have masters in that
8 realm, and we knew that action over perfection
9 needed to come with a secondary principle of
10 iteration and improvement.

11 And so we used that, essentially PDSA
12 cycles, recurringly to continually iterate and
13 change our approach so that we could meet the needs
14 of our community partners and work with them
15 collaboratively to try and address the crisis that
16 they were in the midst of.

17 Next slide, please.

18 So when we looked to take a sense of
19 where we were at and what the needs were in our
20 community, this map provides a -- it's a heat map
21 of where there were cases from our community
22 assessment centre. Those are the -- the blue
23 shading in the background -- you can see certain
24 areas that Sarah mentioned, some of our higher
25 at-risk neighbourhoods with high amounts of health

1 inequity.

2 There were several long-term care homes
3 distributed throughout this space. There were ten
4 long-term care homes that we knew we needed to be a
5 part of.

6 Initially, there were eight that were
7 clearly in our boundaries, and then, afterwards, we
8 found that two others needed our help, and we took
9 those on. They were kind of between the border of
10 traditional Scarborough Hospital and us.

11 And, you know, within this, it's quite
12 a large undertaking to think about changing your
13 scope from a 400-bed acute care hospital to 300,000
14 residents, 10 long-term care homes, 8 retirement
15 homes, 14 shelters, 4 group homes, and many
16 congregate living settings.

17 But holding those principles we talked
18 about earlier, it allowed us to at least vision how
19 we would do this. And really, that was through
20 partnerships with organizations rather than an
21 authoritarian delegative response.

22 Our long-term care homes in the East --
23 next slide, please -- are also diverse. We have a
24 lot of older infrastructure. We have several
25 Class C and even a Class D home which we know are

1 pre-exposed to worsening outbreaks of COVID-19.

2 We also had a various of different
3 structures. Some non-for-profit, some municipal,
4 and some for-profit homes, even some independent
5 for-profit homes which were different than the
6 norm.

7 And I think that this, broadly, allowed
8 us to see how infrastructure can assist with
9 managing COVID-19 but also how different aspects of
10 corporate structure and the structure of a
11 long-term care home can help.

12 And we'll talk about this later, the
13 difference between some of these different
14 organizations and how they might respond to a
15 crisis and respond to COVID-19.

16 So I'm going to -- the next slide
17 focusses on our approach to seniors care and OHT,
18 and I'll hand it over to my colleague Dr. Rosenberg
19 to speak about that.

20 DR. JARRED ROSENBERG: Thanks, Jeff.

21 So as this next slide demonstrates,
22 really, the structure of our pandemic support model
23 for seniors and our community had three arms. It
24 was an integrated approach that focussed on seniors
25 in long-term care, those living in other congregate

1 environments such as retirement homes or other
2 support buildings, and then those living
3 independently.

4 I would say that the key component in
5 all three arms was really around relationship
6 building and collaboration. And I think, for the
7 focus of today's presentation, I'm going to focus
8 on that first group which is seniors in long-term
9 care homes.

10 So next slide, please.

11 So I think as we mobilized on
12 March 27th to help support our long-term care
13 partners, our strategy really had three arms or
14 three components. The first was a needs assessment
15 and prevention; the second was outbreak management;
16 and the third, really, is capacity building.

17 So in terms of our needs assessment and
18 prevention strategy, when we recognized that, you
19 know, long-term care was going to be the epicenter
20 of the pandemic our area, we reached out to our
21 long-term care partners and we essentially asked
22 them "How can we help you?"

23 We became very apparent that there was
24 a critical need for things like PPE, that there
25 were gaps in terms of infection, prevention,

1 control, or IPAC, resources and expertise. And
2 there were significant barriers in terms of
3 resources and in terms of changing them to
4 implementation in terms of being able to implement
5 Ministry directives and best IPAC practices.

6 So we started having daily phone calls
7 with our -- initially eight and then ten --
8 long-term care partner directors of care, and this
9 evolved into twice-weekly huddles to build,
10 essentially, a community practice and share
11 collective strategies about how to overcome these
12 barriers -- resource ones as well as some
13 logistical challenges.

14 An example would be, for example,
15 cohorting of staff in the face of staff shortages
16 is a significant challenge about what's the
17 recommendation and certainly gold standard in terms
18 of preventing spread of something like COVID.

19 Logistically, that's very, very
20 challenging to implement, and this gave an
21 opportunity for us to go over different strategies
22 that were being adopted at different nursing homes
23 and share our learnings and, from our perspective,
24 also be able to share our expertise and our
25 guidance.

1 We provided seven-day-a-week
2 availability and encouraged our long-term care
3 partners to call us any time. The reason for this
4 is that there sometimes wasn't delay in terms of
5 reaching or getting a response from an
6 organization, which is Public Health, and time
7 really is lives when it comes to COVID.

8 And any time there was concern about an
9 emerging positive case among a resident or staff,
10 we wanted an immediate response. And so whether it
11 was a weekend or an evening, we encouraged our
12 partners to call us so that we could guide them
13 about some strategies to promote containment.

14 And as we were learning new things
15 about this virus, that was a critical piece in that
16 we could hopefully and, in many cases, successfully
17 contain both staff and resident cases by acting
18 quickly which was provided by this, essentially,
19 on-call availability.

20 COMMISSIONER KITTS: Doctor Rosenberg,
21 could I just ask a question?

22 DR. JARRED ROSENBERG: Yes, of course.

23 COMMISSIONER KITTS: Were the eight or
24 ten long-term care homes already members of the
25 Ontario Health Team that you were in?

1 DR. JARRED ROSENBERG: I will let Sarah
2 answer that.

3 SARAH DOWNEY: So they're not an anchor
4 partner. They're called an "engaged partner." So
5 certainly eight of them, I think, are engaged
6 partners to our group. The two in Scarborough, I
7 think, are working with the Scarborough Health
8 Network. But given all the homes that Scarborough
9 had to deal with, we took them on.

10 COMMISSIONER KITTS: Okay.

11 SARAH DOWNEY: But we had done no
12 specific engagement. Other than the nursing-led
13 outreach teams, which are all preexisting models,
14 we've done no specific engagement with --

15 COMMISSIONER KITTS: You had to
16 preexisting relationship or -- that happened
17 because of COVID?

18 SARAH DOWNEY: So we did through NLOT
19 teams, I would say. So we had knowledge of each
20 other, but we had not designed a big, integrated
21 strategy with them yet.

22 DR. JEFF POWIS: And sorry, just to
23 answer that, those eight homes through the NLOT,
24 there were intersections. And, you know, they
25 understood our model of partnership, and there had

1 been a lot of work done between the NLOT team and
2 them trying to prevent admissions and provide acute
3 care.

4 There were also indemnity agreements
5 that had already been signed with those
6 organizations as a part of the NLOT team --

7 COMMISSIONER KITTS: Okay. Okay.

8 DR. JEFF POWIS: -- which we needed to,
9 then, facilitate if somebody expanded to those
10 additional two homes later.

11 COMMISSIONER KITTS: Okay. So there
12 was no difficulty in increasing the partnership.

13 The second question is I think,
14 Dr. Rosenberg, you said March 27th you engaged the
15 long-term care homes. My question is did you go --
16 I don't know the timing, but did you go before the
17 government was starting to get hospitals to get
18 engaged with long-term care homes? Did you go
19 before that or around the same time?

20 DR. JARRED ROSENBERG: No, it was
21 significantly before that time. And Dr. Powis can
22 maybe speak to this more, but Dr. Powis recognized
23 at our assessment centre that there was a
24 significant amount of staff work in long-term care
25 who were COVID-positive.

1 And we recognized that this was going
2 to be how COVID was being, already introduced in
3 long-term care settings, and that's when we decided
4 we needed to reach out to our partners and start to
5 help them. Because some of them didn't even know
6 they had outbreaks emerging, but we knew because we
7 knew their staff were positive.

8 And similarly, after engaging and
9 recognizing that there were critical shortages of
10 PPE, specifically masks, and it was at that time
11 that Dr. Powis recognized that we needed to
12 universally mask all the staff in long-term care.

13 They did not have the PPE to be able to
14 do that, so we chose to share our PPE with our
15 long-term care partners so that they could protect
16 their residents by masking their staff the way we
17 were doing it in the hospital.

18 COMMISSIONER KITTS: So, Sarah, this
19 might be for you, but do you see this hospital
20 long-term care partnership within Ontario Health
21 Team continuing beyond COVID?

22 SARAH DOWNEY: Of course. I mean, it
23 was kind of ironic that we were trying to think of
24 a -- we were saying "We should get everybody
25 together. We should think of something we can do

1 together," pre-COVID, so I think we have massive
2 amounts of momentum.

3 And I would say inherent -- and we put
4 good structures and regular calls into place with
5 all of them. I would say the engagement of any
6 individual long-term care home varies a bit, and
7 the speed with which the organization picks up the
8 phone when we call varies a bit.

9 But we have tried really hard in this
10 model to prop them up to do what's right and not to
11 do it ourselves because, ultimately, they are
12 accountable for the care they provide. We have the
13 is expertise to get them through the pandemic.

14 COMMISSIONER KITTS: Thank you.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 If I could just ask -- I think it might be
17 Dr. Powis who is probably the best person, but
18 maybe not -- when did the light first go on?

19 DR. JEFF POWIS: Okay. I mean, I
20 couldn't tell you the exact day. So I have a very
21 close circle of trusted colleagues. I'm sure all
22 of us do with the positions we have, and I would
23 call them every night probably for my own mental
24 health but also to bounce ideas off of each other.

25 And so Jarred gives that very specific

1 date of March 27th. There was a case in another
2 institution that my colleagues -- it was a
3 long-term care home that is part of an acute care
4 hospital. He interviewed the individual. He could
5 not find a way in which that individual got it
6 outside of it being delivered unbeknownst to the
7 staff to the resident.

8 And we had already made the decision,
9 based on evolving evidence, that we needed to mask
10 our own staff in acute care. And I know Sarah and
11 I developed a policy to do that at the Toronto
12 region, so I already felt strongly about universal
13 masking of staff.

14 And so when that case happened, without
15 any clear ideology outside of the staff delivering
16 it to them and the strong belief that universal
17 masking was an invaluable prevention strategy, I
18 think I called Sarah, Wolf, Jarred and said "Okay.
19 We're going to load up some trucks, and we're going
20 to send masks to the homes as our first gift to
21 them to start a relationship of working together."

22 And so we had very limited personal
23 protective equipment. It was a really challenging
24 time for the hospital, but the leadership did
25 support us, appreciating this was the right thing

1 for our community, to distribute masks to everyone
2 so they could begin universal masking and hopefully
3 try to prevent subsequent outbreaks at some of our
4 other homes.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 My question actually -- I didn't phrase it as
7 clearly as I should have, although I appreciate the
8 answer.

9 But in terms of realizing that there
10 was going to be a problem and that it was going to
11 affect long-term care homes -- and I was going to
12 say in our community, but in your community -- can
13 you help me with when --

14 DR. JEFF POWIS: Yeah.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 -- you thought of that?

17 DR. JEFF POWIS: Yeah, okay. So that's
18 a different question, then. So that should have
19 been known to the world as far back as mid to late
20 February. I'm sure we all remember the visions of
21 news clips from Spain where they went into the
22 long-term care homes that were vacated by staff
23 with residents wandering through them.

24 And so we knew this was coming, and I
25 think that the challenge was that I thought my

1 responsibility was within the four walls of MGH.
2 And believe me, that was a large responsibility at
3 that time knowing it was coming and preparing an
4 acute care hospital.

5 But I didn't appreciate long-term care
6 was in my responsibility, and so I delegated that
7 to Public Health. That was my understanding of who
8 was responsible for that, and so it wasn't until we
9 saw that their needs weren't being met that we
10 moved outside of our four walls to have more
11 purposeful strategy outside of the one that we
12 already had.

13 So in my mind, this was knowledge that
14 should have been known to everyone in around
15 mid-February. And again, what I feel I wish I
16 could have done is universally masks needed two
17 weeks/a month earlier because I knew it was coming.
18 It was more so I didn't think it was my
19 responsibility to do that.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Okay. Thank you.

22 SARAH DOWNEY: And just be clear,
23 nothing that is written that actually makes this
24 our formal responsibility. I think we felt very
25 clearly that it was our duty to help. And given

1 our outreach in East Toronto and our longstanding
2 collaborations with many local partners, really,
3 felt the duty to both act within and without.

4 And at times we've called Jeff,
5 jokingly, the "Chief Medical Officer of Health For
6 East Toronto." Just, through all, he has tried
7 very hard to balance between a hospital that, in
8 the end, mercifully did not need all of his time
9 and talent.

10 But we're able and chose always to
11 spread our expertise and resource, where I think
12 it's vitally necessary, into many other settings --
13 long-term care, shelters, retirement homes,
14 schools. Now we're in schools helping them reopen,
15 and we spent a lot of time outside our walls trying
16 to help.

17 COMMISSIONER FRANK MARROCCO (CHAIR): I
18 suppose just to follow that up, that does have a
19 benefit for the hospital in a way to the extent
20 that you can prevent hospitalization or patients
21 that you have to then take into the hospital to
22 care for?

23 DR. JEFF POWIS: 100 percent. And I
24 think that was very critical to our response in the
25 region in that if you look at hospitalizations in

1 our jurisdictions, some of them were heavily driven
2 by long-term care transfers to hospital.

3 And so what we did is -- and again,
4 we'll speak to this a bit later, but a very
5 purposeful hospital "in-home strategy," we called
6 it, to be able to deliver care that residents
7 required in the setting of COVID where they wanted
8 to receive it in their own homes.

9 And I think that allowed us to provide
10 the right care in the right location, but again, it
11 would have probably been the hospital's
12 responsibility, eventually, that they were just
13 transferred to the hospital.

14 But this, in our mind, was meeting the
15 needs of the residents where they needed their
16 needs met. And so we just distributed our impact
17 more broadly by doing that.

18 SARAH DOWNEY: But if I could just add,
19 though, it is our mindset to see it that way, and I
20 can remember speaking to CEO colleagues of much
21 larger organizations in Toronto who have much
22 larger IPAC teams than we have.

23 And, you know, it was the feeling that
24 "Oh, if you do it, then we're going to have to go
25 out and do it," right? Our geographies are not as

1 small defined. You don't feel linked to
2 communities in the same way.

3 And so I think it's very much a mindset
4 of this organization, leaders like Jeff, you know,
5 to care and to do that. All the while there was
6 immense pressure on him and IPAC teams to expand
7 ICU capacity to figure out how to deal with what
8 was an anticipation to lose the emergency
9 department and procure ventilators -- like,
10 everything.

11 The cleaning standards, the staffing
12 redeployment, everything else we had to do was this
13 idea that we had the mindset that we needed to be
14 out early and quickly. And I think, through the
15 pandemic, we've shown it. We're one of the few
16 hospitals helping schools reopen. Because if
17 schools can't stay open, safely we can't contain
18 this.

19 So there is a mindset about it that not
20 every hospital, I would submit, in Ontario has.
21 Many do, but not everyone does.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Do you think, Ms. Downey, that it's
24 possible/workable to order them to do it?

25 SARAH DOWNEY: Of course. You can

1 order them to do anything. It's the passion and
2 energy that you put behind an order versus
3 something you feel is right. And I actually think
4 that the partners that I work with see, now, the
5 sad events in long-term care as being worth
6 mobilizing for and, at times, prioritizing over,
7 you know, some of the things your hospital could do
8 for acute care patients. I think there's been a
9 shift in mindset.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Commissioner Coke?

12 COMMISSIONER COKE: I was just
13 wondering, I mean, you're describing a very
14 integrated system working together well.

15 In some situations, do you think there
16 is still some feeling that the hospitals try to
17 take over that sort of partnership and, you know,
18 there isn't sufficient sort of balance with all the
19 players in it?

20 SARAH DOWNEY: So we tried very hard.
21 There was only one moment where I felt we may have
22 to make the calls to have it taken over. And it
23 was when -- in one of the responses we really could
24 not reach anybody for days. And I remember bumping
25 into our manager of palliative care who said to me

1 on a Friday night as she was leaving "I think I'm
2 just going to drive there on Saturday and see who's
3 around to see who I can help."

4 And there was one moment where I
5 thought "Oh, no, do we need to get --"

6 We have nobody to work with on our
7 side, and it was really because they were -- there
8 was one director of care left standing. You know,
9 60 percent of their staff had COVID. You know, it
10 was, like, impossible for them to pick up the phone
11 or answer in an email.

12 But we, in our own philosophy, felt
13 that that was the worst outcome was -- it's not
14 actually in our expertise, right? We don't do
15 long-term care here, we're an acute care centre.

16 But I know some of my hospital
17 colleagues, when they showed up and saw the amount
18 of devastation, felt that the easiest path -- and
19 maybe it was also who they had to work with -- that
20 the easiest path was to remove that layer and to do
21 it themselves.

22 We never actually formally pursued a
23 management agreement to actually take over
24 long-term care. We were able, ultimately, through
25 perseverance and patience -- and some days were

1 easier than others -- to establish relationships
2 with those homes that kept them accountable for the
3 care and the aftercare that happened.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Commissioner Kitts?

6 COMMISSIONER KITTS: Yeah. Sarah, do
7 you think that your already-established affiliation
8 with community care through your Ontario Health
9 Team was a huge advantage in that this hospital was
10 not interested in taking over? This hospital is
11 interested in working with people.

12 So was the fact that your Ontario
13 Health Team existed and people saw that a factor in
14 how smoothly it went?

15 And the second part of the question is
16 most hospitals aren't in on Ontario Health Teams.
17 Do you think they would have more difficulty?

18 SARAH DOWNEY: Yeah. So I think, in
19 part, it is the longstanding reputation of this
20 hospital, working in communities and being a
21 respectful partner in communities.

22 And it has been the basis of our
23 Ontario Health Team that has six equal partners at
24 the table and, actually, a joint venture agreement
25 across our boards that was signed in the fall to

1 share resources for the benefit of a community. So
2 I think that is probably our reputation as a
3 hospital in this community that has driven the
4 Ontario Health Team.

5 That said, we have no specific Ontario
6 Health Team initiatives with any of these homes
7 yet, you know? It was still kind of consultative,
8 what could or should we do together. But it
9 underlines the philosophy of our Ontario Health
10 Team and, in the end, I think, helped in our
11 response. This is how we do business here, right,
12 you know?

13 COMMISSIONER KITTS: So a direct order
14 to hospitals may not be as smooth as we would like
15 it to be.

16 DR. JEFF POWIS: And, Sarah, the only
17 thing -- I wanted to pick up on the point that it
18 was also the purposeful strategy, when we went into
19 homes in crisis, was not to be authoritarian,
20 delegative presidents.

21 We were there to, as Sarah mentioned,
22 really prop them up to meet the standards that were
23 required. And, you know, it would have been easy
24 to just take over an authoritarian role. Because
25 in crisis and command control, that's the easiest

1 thing to do.

2 But we made a purposeful decision that
3 that would leave us with immediate gains but
4 long-term deficiencies. When this was over the
5 home wouldn't be able to meet the requirements to
6 provide care safely through an IPAC standard.

7 And so that was a very purposeful
8 strategy, and, again, Wolf was very critical in
9 helping frame that for us when we went out to the
10 homes and how we approached their leadership. And
11 often that required us to have our leadership speak
12 to their leadership to frame how we were going to
13 work together collaboratively.

14 COMMISSIONER KITTS: So how does the
15 leadership work? Because you've got Public Health,
16 hospital, and long-term care leadership?

17 How is that working, and is there one
18 overall leader? Or just tell me a bit about the
19 leadership.

20 SARAH DOWNEY: Who wants to talk about
21 that? I mean, we have weekly calls, but they're
22 all differently affiliated.

23 Wolf, is that something maybe you can
24 explain? Wolf is our lead at Michael Garron.

25 WOLF KLASSEN: Yes, thanks. So maybe

1 I'll start and have others join in. It is about
2 working together with everyone. I think there were
3 times when it was unclear what the role was, you
4 know?

5 We have Public Health. We have the
6 LHIN. We have the hospital. We have the nursing
7 home operators and owners. So there were times of
8 confusion.

9 I think it goes back to sort of doing
10 the right thing at the resident level, and our
11 teams going out and working with the directors of
12 care in the various homes really went a long way.

13 So there were other things happening at
14 other levels, but we didn't --

15 (TECHNICAL INTERRUPTION)

16 -- have that to -- (indiscernible) --
17 the needs of the nursing home.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Mr. Klassen, I think the reporter probably
20 missed -- you said "We went out..."

21 WOLF KLASSEN: Sorry about that.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 So the last couple of minutes.

24 Sure. I was just saying that the
25 important thing was that we went out and worked

1 with the directors of care within each of the
2 nursing homes and maintained those relationships
3 while -- there was sort of a myriad of different
4 information and, perhaps, some confusion at other
5 levels.

6 SARAH DOWNEY: And just to add, we also
7 had Philip, who was our dedicated link during the
8 outbreaks, working full time in those homes. And
9 people like Jarred Rosenberg were -- we had teams,
10 like, entirely dedicated to this work outside our
11 organization. And Wolf and I went to visit most of
12 those homes during the outbreak. Jeff was
13 available. We sent IPAC people out.

14 So we really had on-site presence in
15 each of the homes that were in trouble in order to
16 work with them very closely to get this outbreak
17 under -- these outbreaks -- some of them which
18 devastating. We have a slide, and I don't know if
19 we want to go through that. But some of these
20 outbreaks were very serious, and there were a lot
21 of deaths.

22 COMMISSIONER KITTS: One last point,
23 Sarah. Is it sustainable? I've heard that
24 hospitals were down at 65, 70, 75 percent capacity.
25 Now it's up over 100 percent in most.

1 Is it sustainable for hospitals to
2 continue to support long-term care as you have?

3 SARAH DOWNEY: So we were funded by the
4 former LHIN, Toronto Central LHIN, to do some of
5 this work, to have IPAC extenders.

6 I mean, what we didn't do was staff
7 them, except in rare circumstances at the beginning
8 of a crisis. So we made them responsible for their
9 staffing.

10 COMMISSIONER KITTS: Okay.

11 SARAH DOWNEY: It was the
12 infrastructure costs, the IPAC assessments, and
13 people like Philip that were funded to go out and
14 do some of this work.

15 But we didn't, in any significant
16 degree, staff those divisions. We called agencies
17 for them because the agencies wouldn't answer their
18 calls. They answer our calls but wouldn't answer
19 their calls. They're predominantly not our staff.

20 COMMISSIONER KITTS: Okay. Thank you.

21 DR. JARRED ROSENBERG: So maybe before
22 I go into the description of the actual outbreak
23 management of what it looks like, one piece I did
24 want to focus on which I think aligns with, you
25 know, this relationship that we felt was really

1 engaging not only the directors of care but the
2 physicians or the medical directors of care.

3 And ironically, a lot of the physicians
4 who worked in long-term care actually function in a
5 very siloed way with limited engagement with our
6 East Toronto Family Practice Network and other
7 physicians.

8 And so we also developed a long-term
9 care huddle with these physicians and reached out
10 to them often individually to help them understand
11 our philosophy of hospital coming into the home and
12 help them provide them with, for example,
13 educational resources on advanced care planning;
14 you know, understanding what the treatment options
15 were in COVID so that they could start to engage
16 their families preventatively, for those that did
17 not have an outbreak yet, about what the wishes of
18 the resident and the family were.

19 Again, looking forward that if an
20 outbreak had happened or if their loved one or the
21 resident had become infected with COVID, what their
22 wishes would be and how we could deliver that care
23 best for them in a daily and long-term care
24 environment and minimize unnecessary transfers to
25 hospital and make sure we had the right resources

1 in place.

2 And maybe I'll just speak quickly here.
3 The question was raised before about, you know, are
4 these relationships persisting? Will they
5 continue?

6 I can give two examples of how this
7 physician engagement and offering essentially are
8 on-call service or a secure text messaging platform
9 that physicians could reach out to us -- to
10 geriatrics, internal medicine, palliative -- at any
11 time.

12 In two homes where there were
13 nonactive COVID outbreaks, after we had engaged the
14 physicians, there were two cases of residents that
15 did not have anything related to COVID. One was a
16 gastrointestinal bleed. The other one was a small
17 bowel obstruction.

18 These things are almost always managed
19 in hospital, but in both these cases, the
20 physicians reached out to us and said "The family
21 and the patient wishes for this to be managed at
22 home."

23 And based on some of the things that I
24 described in our outbreak management model, could
25 we try to mobilize these supports to help care for

1 this individual in their home? And both of those
2 individuals were never transferred to hospital, and
3 they did very well in their long-term care setting
4 in a way that prior to COVID we would never have
5 been able to mobilize those supports and care for
6 them in their hospital environment.

7 So just a little bit about our actual
8 on-site outbreak management: I would say, as Sarah
9 and Jeff identified, the key piece was being on
10 site.

11 So the minute when an outbreak was
12 identified, we were on site to do assessments and
13 to develop a response. In many cases, we were the
14 first physicians there since the outbreak had
15 started. And again, you know, there were not
16 Public Health practitioners on site either.

17 And I mention that because I think our
18 physical presence had a massive impact both in
19 terms of being able to understand the root causes
20 of how the outbreak happened and important
21 strategies to prevent its spread, as well as
22 addressing two other key pieces.

23 One was a fear amongst the staff. A
24 lot of the staff in these long-term care facilities
25 were concerned about inadequate PPE. There were

1 knowledge gaps around COVID-19, and I think our
2 presence on the ground provided them some
3 reassurance that, you know, we have their back.

4 And the other piece was leadership. In
5 some cases, as Sarah mentioned, leadership were
6 completely drowning and overwhelmed. And
7 especially having a foot on the ground to assist
8 made a huge difference in being able to help change
9 their models of care collaboratively, identify
10 things that we could help them improve, and
11 evaluate to be able to implement some of the
12 infection prevention and control recommendations.

13 So what did that look like? The first
14 piece was daily huddles that we would have and this
15 ensured good communication and a collaborative
16 approach to those strategies that we were
17 implementing and a daily evaluation of whether they
18 were working.

19 And those huddles would include, you
20 know, our Michael Garron Hospital team but also the
21 local physicians, the directors of care, Public
22 Health, and any other -- sometimes Ministry
23 inspectors, anyone else who was relevant to
24 informing the efficacy of our interventions or any
25 other challenges.

1 We also implemented on-site testing
2 which allowed us to overcome the challenges of
3 delayed swab results and thus expedited COVID
4 diagnoses, minimized unnecessary isolation of some
5 residents and also, of course, you know, the
6 implications of having a delay the diagnosis.

7 Our teams did help with the actual
8 swabbing, and then we processed most of our swabs
9 here at our hospital.

10 As we mentioned, we had a long-term
11 care outreach lead who assisted with things like
12 coordination, clinical assessments, changing
13 staffing and care models, working with agencies to
14 deliver our hospital care in the home.

15 We did mention our NLOT team which, I
16 think, was actually a critical component of this.
17 So we had a preexisting relationship with eight of
18 the long-term care facilities where we had our
19 nursing-lead outreach team who would traditionally
20 help with mostly palliative supports prior to
21 COVID.

22 In the context of COVID, our NLOT team
23 was expanded in terms of numbers, and these nurses
24 would be redeployed, primarily to the outbreak
25 sites but to any long-term care facility, to help

1 with sharing their acute care skills and, in some
2 cases, palliative care skills and knowledge and to
3 be able to care for those residents and do symptom
4 assessments and inform their medical management.

5 They also provided mentorship and
6 training to the other nurses, to the preexisting
7 nurses in long-term care. We had Michael Garron
8 Hospital physicians that were assisting with
9 patient care -- some on site, some with virtual
10 consultations -- some palliative care or
11 assessments with respect to goals of care
12 discussions and geriatrics for management of
13 dementia-related behaviours and infectious disease
14 for infection prevention and control assessments
15 and containment strategies.

16 Other staff that were redeployed --
17 mostly for training and support but, in some cases,
18 to fill staffing gaps -- were environmental
19 services, because cleaning is a critical component
20 to containing COVID, as well as dietary.

21 And the only other piece I will mention
22 is we did haven infection prevention and control
23 extenders that were provided through the LHIN to
24 help provide infection prevention support and
25 education for frontline staff. As well as our own

1 infection prevention practitioners from Michael
2 Garron Hospital did on-site evaluations,
3 assessments, and support.

4 And I think another piece was we really
5 wanted to support the wellness of the nurses and
6 the frontline care providers in nursing homes. You
7 know, they were overwhelmed with high mortality,
8 and so we provided them with bereavement support
9 and an opportunity for them to express their
10 concerns and their fears. And so our Michael
11 Garron Hospital wellness team made several visits
12 over the course of the outbreak to address this.

13 That's really kind of a high-level
14 summary of what our outbreak management on the
15 ground looked like.

16 Moving forward, I think there's two
17 other pieces that we're working on. One is
18 training of long-term care IPAC champions, which
19 Philip will speak about more, as well as some
20 simulation exercises and tabletop exercises with
21 each of our long-term care partners as we enter the
22 second wave.

23 So I think the next two slides, really,
24 we could just briefly look at. This is just a
25 snapshot in time, for example, June 23rd, showing

1 our ten long-term care facilities -- two in red;
2 two in yellow; a few in green.

3 And this was constantly changing which
4 required us shifting resources, reevaluating, you
5 know, who would go where.

6 And if I could just go to the next
7 slide which is similarly showing that, you know,
8 this was a continuous process, and that while an
9 outbreak may have ended on a specific date, we
10 didn't leave on that date.

11 And there was transition planning. We
12 kind of dialed up and dialed down supports and
13 guidance as needed, and this was an iterative
14 improvement process both from the setting out of an
15 outbreak and for prevention efforts.

16 Okay. I'm going to go to the next
17 slide, please.

18 So very, very briefly, I think this is
19 a very telling -- so this is mortality data from
20 our long-term care facilities. And you can see
21 that this follows -- it's chronologically -- five
22 major outbreaks that happened in our area.

23 And if you look at both "COVID
24 Mortality," the mortality of those who were
25 diagnosed COVID, as well as "All-Cause Mortality"

1 in the nursing homes -- because we saw that
2 increase. Even for those who didn't have COVID,
3 the mortality went up.

4 You can see that there's a dramatic
5 drop in both "COVID Mortality" and "All-Cause
6 Mortality" in the long-term care facilities as we
7 moved chronologically. And I think in just speaks
8 to the importance of that relationship building,
9 the collaboration, and iterative improvement,
10 right?

11 We didn't start out with a perfect
12 formula, and it changed with our outreach, and our
13 efforts changed at every site. But there was
14 significant improvement in the mortality which, I
15 think, speaks to the importance of being engaged in
16 our partners, collaborating with our partners so
17 that we can refine and improve our approach. And
18 certainly, at least in the mortality data, that
19 seems to have happened.

20 So the next slide I'll hand over to
21 Philip just to describe a little bit about our
22 current long-term care IPAC Champion program.

23 DR. JEFF POWIS: And, Jarred, just
24 before we get to Phil, I just wanted to highlight,
25 with that previous slide, that although those

1 changes were related to how we learned to implement
2 what needed to be done in a more efficient and
3 appropriate way -- and what we've appreciated were
4 the appropriate things that needed to be present
5 for a response in a home in crisis.

6 So one of those things was being --
7 Phil being present essentially functioned as a
8 colead with their DOC and to assist to staff those
9 homes at a ratio would be equivalent at an acute
10 care, palliative care unit, or the internal
11 medicine unit. To be able to provide that, we
12 called our hospital in-home philosophy.

13 And I believe, from an ID perspective,
14 that's what drove down the all-cause mortality. So
15 I'll just go on to Phil...

16 PHILIP ANTHONY: Great. Next slide.

17 Yeah. So our long-term care IPAC
18 Champions program, it was created in the response
19 to the COVID-19 pandemic, you know, to provide
20 support and expertise to the long-term care homes.

21 So we wanted to partner with the
22 long-term care homes, build relationships, and
23 prepare IPAC champions in the community of
24 long-term care.

25 We found that, you know, the more

1 people with this kind of knowledge that we could
2 disseminate to, the homes would fare better. So we
3 provided ongoing infection prevention and control
4 supporting guidance through a 7-week curriculum.
5 It was, you know, guided through things that we
6 thought were going to be important moving forward,
7 especially with the second wave coming on.

8 We developed certificates and a
9 graduation, and we really wanted to -- the
10 long-term goal is to train these IPAC champions in
11 a broader IPAC program within the homes to prevent
12 transmission and healthcare-associated infections
13 moving forward.

14 And the more short-term goal was to be
15 able to, you know, have on-the-ground support
16 available for anything to come in the near future.

17 DR. JEFF POWIS: Again, this is our
18 extended fingers when we can't be everywhere at
19 once. The expands our capacity to do the right
20 thing.

21 So next slide, Wolf.

22 So the last two slides, really, are a
23 summary about in retrospect from the first wave.
24 We tried to operationalize when we looked at our
25 approach to the second wave. And so our enablers,

1 we've talked about our community-centered vision of
2 the hospital which, again, really empowered all of
3 us so that we all had the same idea in mind as far
4 as what we wanted to try and accomplish. Nothing
5 about a "partners hip," but we did use a lot of
6 partnership and trust.

7 On-site presence is key. You can't do
8 IPAC from 50,000 feet or via the phone. You need
9 to be present. People need to see that you are
10 willing to be in the trenches with them, and we
11 sent our best people. I picked what I called my
12 "A-team," and that's who went to the homes.

13 We had preexisting indemnity agreements
14 with eight of the homes. It didn't delay things
15 substantially with the last two, but it was
16 something that I would have liked to have had
17 preemptively. There was a subtle delay with that,
18 Wolf, when we had to do that for the last two
19 homes.

20 And to be clear, we were funded. We've
21 submitted a proposal to LHIN for some of this work
22 which allowed me to, again, pick my A-team and do
23 the work that was required.

24 As far as barriers, accountability; we
25 discussed who was actually responsible. I think

1 when you're on the ground and people see that you
2 are the one who wants to be responsible, the
3 accountability becomes a bit clearer. And when we
4 use that collaborative approach, like, "This is
5 your home; we're here to prop you up," it's clear
6 who is accountable. It's the home who is
7 accountable.

8 You know, a lot of the stuff we did --
9 again, Sarah and Wolf kind of let me get started
10 before we had any clear knowledge that it would be
11 funded, again, with that philosophy of protecting
12 our community and doing the right thing.

13 You know, you can't train one of me if
14 you don't have 15 years' lead time. It's a very
15 specific specialty, and there are not a lot of IPAC
16 physicians around. And so we had to distribute
17 that knowledge as best we could, and that's part of
18 the philosophy of the IPAC champion program and
19 also part of the philosophy of me picking
20 intelligent physicians with the right capacities
21 and teammates like Phil and Jarred who I could then
22 bridge that and expand my knowledge and expertise
23 to them who could then expand it further within the
24 rest of the community.

25 Public Health partnership was, at

1 times, challenging. From my perspective, they were
2 overwhelmed. There was no on-site presence, and we
3 were able to meet those needs that were not being
4 met by the homes.

5 I had very great conversations with the
6 OMH related to Public Health and long-term care,
7 and I did that almost immediately saying "Listen,
8 you are too busy. There's too much on your plate.
9 We don't need to do the same job. We both can work
10 together in trying to do the best we can for the
11 entirety of our community."

12 What I kept saying to them was "I've
13 got East York. Just let me do that. I'm the CMOH
14 of East York for now. I've got these homes. I'll
15 protect them, and I think that if you want to be
16 involved you can, but leave it to me. I've got
17 it."

18 And then the last thing we did talk
19 about is the staffing within long-term care, and we
20 talked a little bit about our formal
21 recommendations in the last slide, but staffing
22 models in long-term care were challenging going
23 into this. Many part-time staff were in many
24 different homes.

25 And medical support for those homes, at

1 times, was not on site, as Jarred mentioned. Him
2 and I were often the first physicians that had been
3 in the home when they were in crisis.

4 So these are our considerations for
5 Wave 2. Again, appreciating that you are
6 synthesizing so much information to come up with a
7 formalization, these are the things that we think
8 are important.

9 And we think it's really important that
10 we align with a shared goal, and we need to
11 remember that, ultimately, we're doing this for the
12 residents and family. And doing the right thing
13 for them is what must guide our decision-making.
14 Financial and reputational implications should, of
15 course, be secondary to the needs of our residents
16 and families.

17 There needs to be clear
18 accountabilities for IPAC in long-term care. At
19 the beginning of this, there were many people
20 involved. It was challenging to know whose job it
21 was. As I said, I didn't know this was my job at
22 the start of it, or I would have been doing it in
23 January.

24 And long-term care homes -- what I hear
25 from their leadership is they are always told what

1 to do, and I think we need to engage them on how do
2 we actually do this while involving them in the
3 decision-making process.

4 We've talked over and over about this
5 relationship building and building capacity. And
6 we need long-term care homes to know what to do on
7 their own, but also, we need to appreciate that we
8 have to prop them up to do so.

9 And again, as I've mentioned, you can't
10 do IPAC from 50,000 feet. You can't coordinate it
11 through a Zoom call or by over the phone. You must
12 be present because, over and over again, we heard,
13 "Yeah, everything's fine; everything's fine."

14 And then you go in and you appreciate
15 there is so much subtlety that needs to be improved
16 to get up to the baseline appropriate standard of
17 practice.

18 And the last thing, again, Sarah
19 mentioned we are not long-term care experts. One
20 thing we noticed is that the staffing plans and
21 practices probably need to be changed in long-term
22 care.

23 Again, we don't issue those and know
24 the staffing aspects of long-term care, but our
25 sense was that there were a lot of part-time

1 employees; wages were lower than they were in acute
2 care hospitals; many did not benefit, and as a
3 result, they wanted to work many jobs to try and
4 make a decent salary. And as a result of that,
5 there wasn't really a culture to build staff up to
6 be the best at each home.

7 And we feel that there needs to be more
8 leadership development and on-site physician
9 presence. We think that's very key. And although
10 there were many of our homes that did extremely
11 well through this, we did see during crisis that --
12 and one of the major reasons we brought Phil in was
13 so assist with that leadership during crisis.

14 And we do think that, perhaps, a shared
15 staffing pool, which the LHIN did discuss in
16 concept, might be a good solution for staffing in
17 the future in an outbreak setting. So I'll stop
18 there unless anybody wants to weigh in with this
19 real conclusion slide as far as our thoughts,
20 again.

21 These were kind of appreciations. This
22 last one on the left was St. Clair O'Connor. They
23 did this tear-jerking video to appreciate us. They
24 were in crisis, and we pulled them out from the
25 fire.

1 And the other is one of our homes that
2 didn't have a substantial outbreak, and it was a
3 matter of how we approached and worked with this
4 clinician to build the best possible prevention
5 strategies within their home.

6 So I'll stop there and see if anybody
7 else wants to add anybody else about the
8 conclusions piece especially.

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Any questions? Any further questions?

11 Commissioner Kitts?

12 COMMISSIONER KITTS: Just a question on
13 the IPAC leadership because I agree with you. It's
14 confusing as to who is responsible or held
15 accountable or has the authority to make IPAC
16 measures exist.

17 My question is one of the most
18 important IPAC measures is the physical distancing,
19 and so my question is in your homes that you are
20 responsible for, are you able to meet the IPAC
21 measures particularly where homes may have three
22 and four-bed rooms?

23 DR. JEFF POWIS: Some of our homes,
24 especially the ones that are Class C and D, are
25 extremely challenged in meeting the recommendations

1 to keep occupancy down to double occupancy only in
2 traditional four-bedded rooms. So we have not been
3 able to meet that require in all of our homes due
4 to the extreme limitations of their infrastructure.

5 COMMISSIONER KITTS: And do you have to
6 take any special measures because of that to try
7 and prevent spread?

8 DR. JEFF POWIS: What I say is that,
9 you know, keeping COVID out of homes is a complete
10 package. I think what you're talking about,
11 really, is the back-end mitigation should you let
12 it in the front door.

13 And one of the retrospective insights
14 from the first wave is that one of the homes that
15 has horrible physical infrastructure did quite well
16 for the first wave. And trying to distill what
17 they did well was it was actually an investment in
18 their staff in training on how to protect
19 themselves and building really robust mechanisms
20 for their staff.

21 They were one of the first homes to use
22 our cloth masks and donate them to their staff to
23 use in the community, really robust
24 self-identification symptoms and preventing work as
25 a result, and purpose with strategies around break

1 rooms and physical distancing in those spaces
2 appreciating that staff were the ones bringing it,
3 unbeknownst, into long-term care.

4 COMMISSIONER KITTS: Are you convinced
5 that going into Wave 2, at least the long-term care
6 homes you know, are far better prepared than they
7 were for Wave 1?

8 DR. JEFF POWIS: I'm quite comfortable
9 to say yes, they are far better prepared. I have
10 been clear with the leadership and my team. Even
11 the homes that we're working with -- this is like
12 trying to grab air.

13 Many people are asymptomatic. You can
14 transmit pre-symptomatically, and we have to build
15 really robust systems that are universal in how
16 they're applied in order to have a chance. There
17 will be cases in long-term care despite everything
18 we do.

19 And what our goal is, what we've kind
20 of tried to take, is it's not so much the number of
21 outbreaks, it's about the size of the outbreaks
22 that we feel we can mitigate for appropriate
23 relationships and interventions.

24 And so our modular focus, to be honest,
25 is on syndromic surveillance so we can hopefully

1 find and mitigate cases. We had numerous homes
2 that had a single case. We tried to learn from
3 their lessons, about what they did right, so we
4 could apply it the second time.

5 So that's my predominant quality of
6 metrics that I'm using for our team is what are the
7 size of outbreaks and the number of secondary cases
8 and whether there's transmission.

9 But I do think there will be outbreaks
10 despite everything we are doing because it took
11 me -- and I took on the role of infection
12 prevention and control in our hospital in 2016, and
13 it took me four years to build a team and a right
14 culture across our organization to deal with this.

15 It's really hard to build that in --
16 what did I have? -- three or four months to prepare
17 them for it. We've done our best, but I do have to
18 be realistic in what I'm expecting for the second
19 wave.

20 COMMISSIONER KITTS: Thank you for
21 that. Very good. Thank you.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Well, thank you pretty much concludes. This has
24 been very informative for us.

25 And, Ms. Downey, we may be back.

1 SARAH DOWNEY: Come back any time, but
2 don't bring your daughter.

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 I'll leave her out.

5 SARAH DOWNEY: And I was going to say,
6 Jack, you'll like Jeff Powis. He's from Ottawa.

7 COMMISSIONER KITTS: Oh, excellent.
8 All the best come from Ottawa.

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Well, apart from that outbreak of regionalism, I
11 want to say again that the transcript of this and
12 some of the practices will be very helpful for us.

13 So thank you very much for taking the
14 time to do this, and thank you for the thoroughness
15 of the presentation.

16 SARAH DOWNEY: Any time. If there's
17 more information you're requiring, you can just
18 reach out. We're happy to provide it.

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

21 SARAH DOWNEY: Thank you.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 And good luck.

24 -- Adjourned at 11:30 a.m.

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REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, 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 2nd day of October, 2020.



NEESONS, A VERITEXT COMPANY

PER: MCKAYA MCDONALD, CSR

CHARTERED SHORTHAND REPORTER

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