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.

BEFORE:

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

PRESENTERS:

Sarah Downey, President and CEO, Michael Garron Hospital;
Wolf Klassen, Vice President, Program Support, Michael Garron Hospital;
Philip Anthony, COVID-19 Outreach Lead, Michael Garron Hospital;
Dr. Jeff Powis, Medical Director, Infection Prevention and Control, Michael Garron Hospital;
Dr. Jarred Rosenberg, Geriatrician, Michael Garron Hospital.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
John Callaghan, Counsel, Long-Term Care Commission

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

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 10:30 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning.

SARAH DOWNEY: Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): Just waiting for Commissioner Jack Kitts. I'm Frank Marrocco and Commissioner Angela Coke.

COMMISSIONER COKE: Good morning.

SARAH DOWNEY: Good morning. Lovely to meet you both.

COMMISSIONER COKE: Thank you.

SARAH DOWNEY: And Jack Kitts is an old friend, so that's okay. I worked with him.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, good.

SARAH DOWNEY: Yeah. We go way back.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, he will be here any second.

SARAH DOWNEY: Perfect.

COMMISSIONER FRANK MARROCCO (CHAIR): We were interviewing earlier, so he's --

Oh, there he is. So we are here.

Ms. Downey?

SARAH DOWNEY: Yeah.

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

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

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

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

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

continues, so thank you for that.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. And there's Mr. Rosenberg, is it?

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, I do.

SARAH DOWNEY: Oh, you do. Perfect.

Excellent.

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

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

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

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

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

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

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

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

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

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

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

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

But 3 hospitals, though Michael Garron

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

But you can go to the next slide, Wolf.

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

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

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

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

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

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

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

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

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

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

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

So with that, I'll hand it over to

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

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

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

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

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

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

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

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

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

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

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

And the last thing is an institution heavily focussed on improvement. And my other title is in Operational Excellence Quality, and the entire role is focussed on improvement. Dr. Rosenberg and I both have masters in that realm, and we knew that action over perfection needed to come with a secondary principle of iteration and improvement.

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

Next slide, please.

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

inequity.

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

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

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

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

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

pre-exposed to worsening outbreaks of COVID-19.

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

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

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

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

DR. JARRED ROSENBERG: Thanks, Jeff.

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

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

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

So next slide, please.

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

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

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

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

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

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

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

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

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

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

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

DR. JARRED ROSENBERG: Yes, of course.

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

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

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

COMMISSIONER KITTS: Okay.

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

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

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

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

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

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

COMMISSIONER KITTS: Okay. Okay.

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER KITTS: Thank you.

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

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

And so Jarred gives that very specific

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

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

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

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

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

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

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

DR. JEFF POWIS: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SARAH DOWNEY: Of course. You can

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

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke?

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts?

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

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

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

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

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

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

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

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

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

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

thing to do.

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

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

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

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

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

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

WOLF KLASSEN: Yes, thanks. So maybe

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

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

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

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

(TECHNICAL INTERRUPTION)

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

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

WOLF KLASSEN: Sorry about that.

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

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

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

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

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

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

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

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

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

COMMISSIONER KITTS: Okay.

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

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

COMMISSIONER KITTS: Okay. Thank you.

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

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

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

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

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

in place.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PHILIP ANTHONY: Great. Next slide.

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

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

We found that, you know, the more

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

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

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

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

So next slide, Wolf.

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

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

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

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

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

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

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

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

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

Public Health partnership was, at

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

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

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

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

And medical support for those homes, at

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commissioner Kitts?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And, Ms. Downey, we may be back.

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

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

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

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

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

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

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

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

SARAH DOWNEY: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): And good luck.

-- Adjourned at 11:30 a.m.

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.

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