Long Term Care Covid-19 Commission Mtg.

Meeting with Dr. Nathan Stall
on Thursday, November 12, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 12th day of November, 2020, 11:00 a.m. to 12:30 p.m.

BEFORE:

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

PRESENTER:
Nathan Stall, MD, FRCPC Geriatrics and Internal Medicine (Clinical Associate) Sinai Health System and the University Health Network Hospitals Women's College Hospital, PhD Candidate, Clinical

Epidemiology & Health Care Research Institute of Health Policy, Management and Evaluation Women's College Research Institute
Eliot Phillipson Clinician-Scientist Training Program University of Toronto

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat
Sanjay Bahal, Team Lead for Operations, LTCC
Derek Lett, Policy Director, Long-Term Care Commission Secretariat

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

-- Upon commencing at 11:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Mr. Stall, you obviously know Dr. Kitts, and do you know Angela Coke, the other Commissioner?

NATHAN STALL: I know them by reputation only, just like you.

COMMISSIONER ANGELA COKE: That sounds scary.

COMMISSIONER FRANK MARROCCO (CHAIR): Better for them than for me, I guess. All right. Doctor, are you waiting for anybody else?

NATHAN STALL: No. I'm flying solo, and --

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATHAN STALL: And --

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATHAN STALL: Sorry about the -- I'm on a clinical service. I'm in my greens today, so...

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine. Thank you. Thank you for being -- for being here. So you know, I guess -- I don't know if you know the basic drill, but with your

permission, we'll interrupt as we go along. If we have questions, there's a transcript which we will publish on the website.

NATHAN STALL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): We're ready when you are.

NATHAN STALL: Sounds good. So thanks very much for having me. Feel free to interrupt me anytime you need clarification about what I'm going to present.

I'm a geriatrician at Sinai Health System, the University Health Network. I practice acute care geriatrics, and I'm also completing a PhD in clinical epidemiology, and throughout the pandemic, have been very involved in research on COVID-19 in long-term care homes. And I sit on the provincial modelling table as well.

And as you will see, I was involved in helping to lead the clinical operations for my hospitals partnership with a long-term care home that experienced a severe COVID-19 outbreak, so I'm able to speak on several aspects which -- so I've titled my talk, Lessons Learned from Research and Clinical Care.

So I'm going to talk about five things:

What risk factors are associated with COVID-19 outbreaks in Ontario long-term care homes as well as the extent and lethality of outbreaks. I have reviewed in detail the interim recommendations, but I do have some additional insights to provide on this.

What is known about the intensity of care provided to Ontario long-term care residents during the COVID-19 pandemic? Again, we have research on that.

What has been the impact of the COVID-19 pandemic on the health and well-being of long-term care residents? I was very pleased to see the interim recommendations, and I reviewed much of the transcripts of testimony given by groups like the Ontario Association of Residents' Councils. But we do have some data on this as well.

I'll speak about some of the work I have been involved in in promoting and implementing family presence, and I do think it's important to describe our hospital's multi-phase emergency response because there are some learnings that, sadly, might become more immediately relevant as the second wave intensifies in Ontario and in our

long-term care homes.

So I know Dr. David Fisman, my colleague, is going to be speaking to you later today, but I think this was really the first study published in JAMA Network Open that turned people's heads and put data to what we were seeing happening, really, at the end of March beginning of April when it really ignited within the long-term care sector.

So he looked at all -- he just looked at two -- he looked at two things with his group of colleagues here. He looked at using data from the tracker, and you've spoken to my colleague, Michael Hillmer, about the tools that were created to track data.

He looked at what's the -- just the incidence rate ratio, so the risk of death for long-term care residents versus community-dwelling adults, and he looked at how did staff infection correspond with resident death in a lagged manner, so sort of putting data to what we knew was -- was staff were unknowingly importing COVID-19 into homes.

So he showed two things, and again, this went to April 10th but really had a huge

impact, I would argue, in the Province. So he showed that if you look just -- if you compare -- if you compare the deaths among the community-dwelling population and the long-term care-dwelling population, all ages -- there's a 90-fold increase risk of death which we've seen bore out now as the pandemic has gone on.

But I think what was most important was infection among long-term care staff was associated with death among residents with a six-day lag. And this really spurned things like single-work policy, universal masking, recognizing how staff may have been involved in the importation of virus. So that was an early finding.

Now, I'm going to talking about two work -- and I was not involved in that study, but I certainly spoke to Dr. Fisman and his colleagues extensively about it.

I'm going to talk about a study that we published in the Canadian Medical Association Journal that is -- looked at this issue that was coming out about for-profit long-term care homes and how they may have fared differently than non-profit and municipal homes.

So we worked with the Ministry through

my role on the modelling table. We got data for all long-term care homes including data from the Ministry of Long-Term Care Tracker which tracks all the COVID-19 cases and outcomes among long-term care residents and other sources of data the Ministry had. We looked during the really intense period of outbreaks in the first wave, and our exposure that we looked at was the profit status.

So, as you'll know, long-term care, they -- residents get under a publicly-funded long-term care program, get nursing care and personal support as well as subsidized accommodation, but they can be operated by for-profit, not-for-profit, or municipal entities.

And we looked at three outcomes of interest: Whether the home was going to experience a COVID-19 outbreak; if it did experience a COVID-19 outbreak, the size of it, so the number of residents infected, and then the number of deaths among homes with outbreaks.

And we looked at that with the primary exposure being the for-profit status of the homes. The motivation for doing this study was, one, we had known from before the pandemic that for-profit homes have shown generally across a number of broad

outcomes to deliver slightly inferior care compared to non-profit homes.

I think the bigger motivation was we were seeing this play out as a narrative in the media, and we wanted to look at this with a deeper dive.

This is a big chart, but I'm going to focus you on -- so these are the homes by profit status. So these are the things you know in terms of the breakdown of for-profit, non-profit, and municipal.

One thing to focus your eye on here is 53% of for-profit homes as compared to 18% of non-profit and 11% of municipal homes have older design standards. So these are design standards that meet or fall below those set in the year 1972. And we know that homes that have older design standards typically have smaller square footage per room, smaller thoroughfares, smaller common areas. They likely have older ventilation systems. We couldn't capture that in this. And we also know that they're more prone to having double or quadruple occupancy in their -- in their homes.

When you look at chains as well, clearly, the for-profit, they're the ones that have

these large national chains, but there are some smaller chains within the non-profit sector.

So these were the deaths crudely without doing any of the modelling, the statistical modelling that I will speak about. And, again, this is by for-profit sector. You know, on the right-hand side is something called the P-value here, and these -- the ones in the top rows here are not significant. But where you see -- so the statistical significance that we set for the study, a priori, was less than 0.05.

What you'll see is that you do notice, if you just look across the sector, that the ones that are significant -- there was -- there was a higher death rate in for-profit homes, and there was a higher percentage of resident deaths in for-profit homes. And there were -- there were -- it didn't meet statistical significance, but there were homes with any resident deaths tended to be, you know, actually not too different between for-profit status.

But what's really, I think, important here is this case fatality rate early of somewhere between one in four to one in three residents dying in the home who got COVID-19 which is consistent

with international evidence that show that about -- a case fatality rate from first waves in many jurisdictions was somewhere between one in four to one in three.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, if I can, the fact that the for-profit homes are of an older design, is that -- does that control or influence, really, a lot of the other statistics?

NATHAN STALL: I'm going to -- I'm going to show you that in the modelling because this is --

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, that's fine. I'll wait 'til you get there, then.

NATHAN STALL: Yeah. No. This is the -- this is just looking at it crudely without taking into account any of those factors, but I'm going to show you here in this slide, so the first outcome was the odds of a COVID-19 outbreak, so whether or not you're going to have an outbreak.

We had three models here, okay? So the Model 1 is the only thing you put into the model is the for-profit status. In the second model, we adjusted for health region characteristics, and

you'll see that's the COVID-19 incidence in the community and the population size. That was our primary model of interest.

The third model is what your question, Justice Marrocco, got at which was an explanatory model. We looked at things that may be intrinsic to a for-profit home that might explain some of the things that we're seeing.

So if you actually just look at the odds of a COVID-19 outbreak by profit status, you'll see in Model Number 2, if these -- these are confidence intervals. If these cross 1.00, they're non-significant.

So you'll see that both -- so the reference group here is non-for -- is the non-profit, so we're comparing for-profit to non-profit. You'll see that it actually is not significant, meaning there is no effect of profit status on whether a home is going to experience an outbreak or not which is important.

But what's really important here is that the factor that's most explanatory of whether a home is going to experience an outbreak or not is the COVID-19 incidence in the public health unit region surrounding a home, and that's really

pertinent now as we see surging transmission in the second wave. People keep asking, why are homes experiencing outbreaks? We know that the strongest risk factor for whether a home is going to experience an outbreak is the -- is the transmission of COVID-19 in the communities' surrounding homes. And I'll get to some of the reasons how we can try and prevent that, but as I'll show you later on and as I'll speak to, these are not impenetrable environments despite, you know, the most world-class IPAC measures. And so suppressing community transmission of COVID-19 is really essential if you're going to prevent outbreaks.

These findings, the fact that for-profit status did not impact whether a home is going to go into outbreak or not have been cited by decision-makers, but I will say that they only focused on this outcome, so specifically Minister Fullerton on the -- in the -- actually cited this on the floor of the Government stating that this study specifically showed that for-profit status did not impact how -- home having an outbreak or not which is a true finding, but I would say that what was not discussed in those

comments was the latter two findings of this; is that when you do have an outbreak -- so this is the extent, the size of the outbreak -- those for-profit homes had outbreaks that were twice as large as non-profit homes when you took into account things like the incidence of COVID-19 in the health region.

And then, again, if we move over to the Model Number 3, you'll see that the things that were explanatory here -- so you'll see that actually, you adjust away the effect of for-profit status in this third model. It is no longer significant.

That doesn't mean it's not important, but what it shows is that these findings down here having chain ownership and older design standards, those were the explanatory factors for why we're seeing such large outbreaks in the for-profit homes.

Shown a different way, we plotted all the homes -- this is non-profit, for-profit, municipal. Now, you'll see a bunch of orange triangles at the top. So what are the orange triangles? The orange are the homes that are older design standards, and the triangles are the ones

that are chain ownership. And you'll see a clustering of the older homes with -- old -- the homes of older design standards, again, those that meet or fall below the year 1972, and chain ownership.

But what's important for this is -- and speaking to the motivation of the study, it's not all for-profit homes that did badly. As you'll see, there are many homes that are clustered at the bottom that did reasonably well in terms of containing outbreaks. And similarly, there are some non-profit homes that also had worse outcomes. But it tends to be that there are more homes that have older design standards and chain ownerships that had larger outbreaks, and the majority of those tend to be for-profit homes.

And stop me at any time if I'm confusing you. Yeah, go ahead.

COMMISSIONER JACK KITTS: Yes, so I think what you said is that the factors associated with large outbreaks --

NATHAN STALL: Yes.

COMMISSIONER JACK KITTS: So all homes are susceptible to outbreak because it's what -- what the prevalence and spread in the community

determines --

NATHAN STALL: Yes.

COMMISSIONER JACK KITTS: -- whether it gets into the home. So that's fine.

Once it's in the home, the for-profit status had a much -- twice the size of outbreaks than others, right?

NATHAN STALL: Yes, compared to non-profit, yes.

COMMISSIONER JACK KITTS: Okay. And you're saying that the likely cause and effect or what seems to be a cause and effect is chain ownership and old design homes?

NATHAN STALL: Yes.

COMMISSIONER JACK KITTS: Chain ownership, is that because their homes are much bigger, more crowded, or what's the chain ownership got to do with it?

NATHAN STALL: So it's a good question. You know, we don't have several sources of data that could further illuminate that reason. We do know, from before the pandemic, research shows that homes with chain ownership tend to have lower levels of staffing.

We also wondered, as I'll show you,

whether there was more mobility of staffing amongst homes that had chain ownership where they shared workers within a chain which might have contributed as well.

And furthermore, we wondered as well whether, when you're dealing with a home that has a large national chain, whether there was sort of policy or practices that might have been implemented centrally which may not have worked as a one-size-fits-all solution and the smaller, sort of, tailored-to-the-home solutions were required.

Of course, those are all hypothetical reasons, but this was -- you know, that was the observation we had had.

I'll show you with the number of deaths as well actually quite similar findings. So there were, in homes that had outbreaks, the for-profit homes had 78% more deaths than non-profit homes.

And, again, if I draw your attention to the bottom right corner, older design standards and chain ownership seem to explain that as well.

And similar plot, again, you see a lot of clustering of the orange and the chain homes when you look at homes that had deadlier outbreaks. And this is showing the proportion of residents in

a long-term care home who died of COVID-19, so you see the highest was about 45%.

But again, it's not -- it's unfair to paint the entire for-profit sector with the same brush. It is a reality, though, that there are more older homes than those with chain ownerships in the for-profit sector and that likely explains some of the reasons that they had worse outcomes when it came to COVID-19 outbreaks.

Any questions before I move on to the next major study we did?

COMMISSIONER JACK KITTS: I guess -- I guess just to follow up, so would you -- I can't remember when the visitor policy was implemented, but you'd have to think that the transmission into the home must have been by staff?

NATHAN STALL: It's a good question. I'm going to show you a study coming up where we actually used anonymized cellphone data to track mobility patterns between homes.

The -- we know from outbreak analyses in -- early on in Washington State that staff were definitely importing -- importing COVID-19 into homes unknowingly. The issue of the visitor policy and, you know, the family caregivers, there was

actually no evidence -- there's been two rapid -- actually, three rapid reviews in the literature that have found no evidence that family caregivers or visitors were or have been importing the virus into homes. But, of course, an absence of evidence is not evidence of absence, and so -- but that has been a point of contention.

We do know also early on, which was reported in the media in the outbreak in Bobcaygeon, there was a visitor who actually contracted COVID-19 in the home and expired. Whether they were the -- you know, the original vector into the home, it's unknown at this point, but we definitely -- and as I'll show you later on, we definitely know that staff are very important vectors for COVID-19 into homes.

Okay. So the next -- this was actually published this week in another large General Medical journal called JAMA Internal Medicine. We looked at a different -- it's actually the same data cohort and cut with dates, but we looked at a different factor here.

So the first study looked at for-profit status. It looked at the older design standards chain ownership.

Here, we wanted to know -- and this is actually motivated by clinical work we were doing and really just, I think, fundamental infection prevention and control knowledge that it's probably a bad idea to have a lot of people sharing a room and a bathroom especially when you're in the middle of a pandemic with a highly transmissible infectious agent.

So we looked at something very simple. We said, okay. Let's look at outcomes by something we called the crowding index. So if you just look at what is the average number of residents per room and bathroom in your home. So if you had a home where everyone has their own room and has their own bathroom, your crowding index would be 1.

If you had a home where everyone's in a four-person room and with a bathroom, crowding index goes to 4.

So but, you know, we know that in some homes, they have different formulations of that, so some may have half single rooms and half semiprivate, et cetera, et cetera. So we built a crowding index to be able to assign some sort of -- some sort of measure of how crowded a home was before the pandemic.

We looked at, really, three things. The cumulative incidence, so over that time period of COVID-19 infection and of mortality, and we did what we call a -- or what we called a prespecified falsification analysis or a negative tracer. We had an outcome which a priori we did not think would be influenced by the crowding index, and that was introducing virus into the home.

So much like, you know, we showed that for-profit status didn't impact the virus getting into the home, there's no reason to think that having a more crowded home is going to impact the chances of having a virus come in, but we did think that once it did get in, having a more crowded home was going to lead to more -- to, you know, more widespread transmission and deaths within the home.

Sorry. There's an overhead announcement in my hospital.

So this is the distribution of the crowding index. So if you actually look across the province, and we know at the onset of the pandemic, as is usual in pre-pandemic times, our long-term care system was at or very near capacity.

And so of the resident beds, 36% were -- almost 37% were single; 37.3% were double;

and 25.8% were quadruple bedded rooms, okay? And this is the distribution of crowding index. You'll see that there is no home in our province that has a crowing index of 1 of only single rooms and only single washrooms. And we categorize them as a crowding index less than 2 was a low crowded home, and a crowding index of 2 to 4 was a high-crowded home. And you'll see there are some homes in our province was -- actually have a crowding index of 4, which may not be a surprise to you.

So as of May 20th, we knew that five -- fifty-two -- 5,218 residents developed COVID-19 infection. We knew that 1,452 died, and that case fatality rate was 27.8%. We showed that in the last study.

But what was -- what you may also know is that COVID-19 infection was distributed unequally across the province's home, so 86% of infections occurred in just 63 homes or 10% of homes, which is, you know, quite disproportionate, so these are some of -- some of the outcomes.

Just on a descriptive level, okay, so if you actually just look, okay, if you look at low-crowding versus high-crowding homes, okay, in terms of the home, there are more residents

infected, and there are more residents who die in the high-crowding -- high-crowded homes. And the high-crowded homes, unsurprisingly, have more quadruple occupancy than the low-crowded homes. So that -- that's, again, without doing any modelling, okay?

Now, if you look again, just -- if you just ranked the outbreaks, so compared to homes with low crowding, homes with high crowding, again, had a crowding index of 2 to 4, had a higher COVID-19 incidence of 9.7 versus 4.5%, and homes had a higher mortality rate of 2.7% versus 1.3% meaning that homes that were high crowded, nearly 10% of the residents were infected versus low-crowded homes, 5%. And similarly, you know, nearly 3% died in homes with outbreaks versus 1.3% in low-crowded homes.

And this is shown in a graph as well in terms of the outbreak size, and the high-crowded homes are in the darker colour, and you'll see the outbreak size is clearly lower -- or clearly higher -- I'm sorry -- in the high-crowded versus the low-crowded homes.

Now, we did statistical modelling here, and what I'm showing you here is that compared to

homes with low crowding, those with high crowding had a significantly increased risk of COVID-19 incidents and mortality.

So if you look down here, these are our three outcomes. These are the incidents of infection, so whether you're going to have infection. This is mortality, and then this is the COVID-19 introduction that pre -- that negative tracer or that prespecified falsification analysis.

And you'll see that as the home becomes more crowded -- and these are unadjusted and adjusted. So in the adjusted, we take into account factors like we did in the first study and some resident characteristics.

As your home becomes more crowded, you monotonically increase your risk of having a higher COVID-19 incidence and similar to mortality. So if you look -- if you compared the highest crowding-index homes, they had twice the level of mortality and twice the level of COVID-19 incidence as low-crowded homes, but importantly, our negative tracer analysis showed that crowding didn't impact whether you were going to introduce COVID-19 into the home at all which was what we had hypothesized early on.

Now, what we did was, then we've simulated. And we said, so what would have happened if you had actually converted -- and this just shows -- so in the graph again, you have that relationship that's very clear between cases and deaths as it comes to the crowding index.

But we did a simulation. So what had happened at pre-pandemic, we've actually converted all the four-bedded rooms to two-bedded rooms. We would have averted nearly a thousand COVID-19 cases and 263 deaths, so almost 1/5th of cases and 1/5ths of deaths in our province had we decrowded our long-term care homes before the pandemic, but of course, that would require about 5,070 new two-bedded rooms. So that -- that's the crowding study. I'll wonder -- I'll pause there and see if you have questions.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, can you -- in looking at this, to what extent would you say it's hindsight, it's an analysis based on something that happened versus foreseeable?

NATHAN STALL: I think it's totally foreseeable. I mean, the new design standard in 1999 has had construction of homes with no more

than two residents per room. The homes that were the older design standard that had these multiple occupancy rooms needed to be upgraded for years and were not upgraded over a period of more than 20 years. So -- and I think anyone -- the basic infection prevention and control 101 says having multiple residents per room is bad -- and there's evidence for all sorts of any other -- or all sorts of other infectious outbreaks that multiple residents per room leads to worse outcomes. So I don't think it was hindsight.

The other thing which I'll speak about is not only is your, what's called, secondary attack rate higher, so you infect more residents quicker and easier when you have crowding and more residents per room, but one of the things we're really seeing now, and it's unfortunately playing out again in the second wave, is that when your home is more crowded, you actually have no space to isolate and cohort residents.

And so they were doing things like erecting, you know, simple barriers and sheets between multi-occupancy rooms. And so that led to the directive at the beginning of June that no longer permitted admissions to rooms that had three

or four residents. The Government, to their credit, issued that directive.

The challenge was, as has come out, was the directive did not pertain to existing residents, so many of the homes retained their crowdedness throughout the summertime. And subsequent to that, we've learned that some of the hardest-hit homes in the second wave have had their three -- have had their multi-occupancy rooms fully occupied.

COMMISSIONER FRANK MARROCCO (CHAIR): So then, obviously, you can't build, what is it, 5,000 --

NATHAN STALL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- beds in a few weeks.

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): But so what would you do, you know, given this reality, and it's foreseeable --

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- what should you do to deal with it, do you think?

NATHAN STALL: Yeah, so one of the

things we have been calling for -- yes, you can't just -- it's people's homes. You can't move them out. But one of the things we've been calling for is you need to create temporary space in the system to give homes a chance to be able to isolate and cohort residents.

So other jurisdictions have appropriated underused space whether it's hotels, convention centres. This has actually been done in Windsor where they had a field hospital at the onset of the pandemic. And there was a huge need to be -- to urgently decrowd these homes because we know not only is the outbreak going to be much larger in a crowded home, but it's also going to be impossible for them to implement any mitigation strategies when they have no space to actually move residents and isolate and cohort them.

So if you look at the -- at some of the worst outbreaks that have happened, you know, Fairview in Toronto during the second wave, most communication that was uncovered by Jessica Smith Cross in the Toronto Star from Queen's Park briefing, they reached out to them and said that all of their multi-occupancy rooms were all -- were fully occupied with three or four residents per

room.

So that's the suggestion, and it has been done in other jurisdictions, to take your homes that are crowded and particularly, they're the ones, I would argue, that are in the community, situated in communities with the highest incidence of COVID-19 need to think about decrowding those and maybe temporarily moving people to other locations to decrowd these spaces.

COMMISSIONER FRANK MARROCCO (CHAIR): So if you think of the Province as 34 health units or whatever the correct number of health units are, then the challenge -- then what should have been happening -- correct me if I'm wrong -- but in your opinion, what should have been happening is over the last several weeks, they should have been searching in the health unit to find ways to move -- to decrowd, to use your phrase -- word -- to decrowd these crowded homes?

NATHAN STALL: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): And that's really all -- that's what you have to do in order to be able to do something.

NATHAN STALL: Yes, and what we are actually hearing --

COMMISSIONER FRANK MARROCCO (CHAIR): You're forced to, you know --

NATHAN STALL: Sorry to interrupt you, Justice.

COMMISSIONER FRANK MARROCCO (CHAIR): No. No. No. We're both -- that's what you have to do in order to do something about the problem.

NATHAN STALL: Yes. And what we are actually hearing is that because the new admission policy has created a contraction of beds in the system, that limitation to two residents per room, hospitals are now facing increasing pressure to clear their ALC wait times, and we are hearing that -- and I've heard this from the OLTCA -- that hospitals are pressuring homes to admit residents, and regional coordinators, more specifically, are pressuring homes to readmit and -- to homes and fill them up again beyond -- you know, fill them up to dangerous levels of crowding, and there have been -- there have been -- the OLTCA also informed me that there are incidences of homes where they will admit the resident to a two-bedded room and then two weeks later, move them to a three or four-person room because the original writing in June was it was a limit on admissions.

They have subsequently, when this came to light in October, changed the wording to also make it apply to existing occupancy. But there is this competing pressures of making space in the hospital system but also not crowding to dangerous levels again.

COMMISSIONER FRANK MARROCCO (CHAIR): So -- but that's the same -- the only thing that alleviates that pressure is creating additional space, temporary space somewhere.

NATHAN STALL: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

NATHAN STALL: Yes. Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke.

COMMISSIONER ANGELA COKE: Yeah, I just was curious. Obviously, we had had this notion of decanting in our recommendations, but I'm just trying to figure out, from your point of view, what are some of the risks of that. And if you've got staffing challenges, you may find space, but how do you get the people to be able to deliver the care?

NATHAN STALL: Yeah, it's a huge challenge. And as you know, that 70% have

dementia; 90% have cognitive impairment. They have to be spaces that are safe for residents, so it's not a simple as saying just put them in a hotel. You need to set up a hotel or a space like that with the appropriate safety measures.

Other jurisdictions have done it. They have set up field hospitals, and again, there's local expertise from St. Clair College in Windsor that did this early on. But also, there are other jurisdictions that in Massachusetts that have reappropriated spaces like hotels.

Of course, it would require, you know, the necessary health-human resources in the face of a staffing crisis. It would -- it would necessitate an operations team and command to be able to do this. It has been done, though.

And I would argue that leaving homes crowded like this in the face of surging transmission is just leaving them as lame ducks. Like, it's -- we've shown how many deaths could have been averted.

And, you know, I saw, as I'll show you early on, when you have this many residents and you have no vacant rooms, it's impossible to be able to properly implement the mitigation measures to put

out an outbreak.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, and so what we've had is several weeks where things were relatively quiet, and the number of cases was not growing in a significant way.

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): And that was the period of time in which to do this.

NATHAN STALL: Yes, and the commitments that were made by the Government over the summer focused on rebuilding and building new beds in the system, that 30,000 number. But we -- you know, it was always known that those beds weren't going to help the people for the second wave of the pandemic. It was going to help people in years not days or weeks or even months.

COMMISSIONER FRANK MARROCCO (CHAIR): Jack, did you -- you're on mute.

COMMISSIONER JACK KITTS: Yes. Dr. Stall, I want to come back to your comment about the foreseeable. We've talked about what to do in the middle of it if it wasn't foreseen. But I want to go back to your decade or two, the long-term care status.

And as you know, you look very young, so I'm not sure how long you've been in practice, but for some time now there has been a very strong focus on keeping our elders as well and safe at home, and we know that that's not a crowded area.

We've also known that the long-term care homes, as you say, that four beds and three beds is not a good thing, and we've known that for a long time.

I'm just trying to rationalize how when it's elder care and it's keeping them at home and comfortable and safe and they're moving to what many referred to as their last home. Were they somehow forgotten in the home first and home care initiatives, or how did that work?

NATHAN STALL: Yes. So, yeah, I mean, we could, as you know, and I think as has been told earlier in the Commission, we have, you know, quite low funding for home care per capita compared to OECD countries. And other jurisdictions have done, you know, remarkably well to reduce need for their long-term care system by investing in their home and community care systems.

The challenge is that the limits on home and community care for the types of people

that are being admitted to long-term care homes which we know over the last 15 years have increased in complexity, increased in age, need -- have more dementia diagnoses have -- need more assistance for -- extensive assistance for cognitive and functional abilities.

The limits that people can get when I look after patients, when you're talking to families, and they can get, you know, one or two hours a day of care is wholly insufficient for people. And so, really, they don't have a choice between long-term care and community because we don't give them the choice.

So, yes, absolutely, had all these residents not been in congregate care settings which are outdated, crowded, with staff who are underpaid, living often in the COVID hotspots of our city and coming and unknowingly importing virus and facing difficult decisions themselves about whether to work or not because an absence of sick pay, I'm confident we could have avoided hundreds if not thousands of deaths.

But I do think, though, that the knowledge of the homes that had not been rebuilt, that had not been updated, that were left in -- you

know, with design standards that met or fell below the year 1972, that was foreseeable.

I mean, if you look back years and years and years, talking about the beds that are slated for redevelopment, this has been known. So that aspect of it was foreseeable.

The issue of reinventing our long-term care system and, you know, shifting resources to home care, I think, is a valuable conversation, was probably foreseeable but would have required more creative and imaginative thinking over a longer period of time to be able to implement that.

I mean, Denmark is a classic example that's often used about not having to build new long-term care beds because they properly apportioned resources and invested in home and community-care services.

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): But in the reality that we're in, really, you somehow had to create the additional space. And as Commissioner Coke was saying, you had to somehow find people whether they were retired workers or whatever to --

NATHAN STALL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- help you through this crisis.

NATHAN STALL: Yeah, I actually think we need to be doing this now as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, yeah, I didn't mean to imply.

NATHAN STALL: Yes. Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): But it does strike me that what you're saying is that several weeks have gone by --

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- when this is what should have been happening.

NATHAN STALL: Several months, right? I mean, we really cooled off in June in our province, right? We've had June, July, August, September, five months already, right?

COMMISSIONER FRANK MARROCCO (CHAIR): Right. Right. Do you know how long it took to erect that field hospital in Windsor?

NATHAN STALL: No, I don't, but it might be an interesting thing for the Commission to explore. No, seriously, because I --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, I know. We will.

NATHAN STALL: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke.

COMMISSIONER ANGELA COKE: I just wanted to ask the question, you know, following up on what you've described as been some of the history of how we've gotten to where we are, if you -- your thoughts about the -- whether we do have some public policy or funding bias against older people.

NATHAN STALL: Yes. So I think in many ways, this has been exemplified during the pandemic. Early on, you know, early on in the pandemic, I would argue we had what Scott Halpern at University of Pennsylvania classified as an identifiable lives bias.

So our response to the pandemic was so lopsided because it prioritized the lives that we most identified with, which at the time were young people on ventilators in New York city and hospitals being overrun in Bergamo, Italy.

At the same time, if you read the news reports, the Spanish military were coming across long-term care homes totally abandoned with residents in their -- dead in their bed. And this

happened in Italy as well.

It's a matter of cognitive biases in public health policy that made us prioritize our responses to those lives that we most identify with. And frankly, for clinicians, the lives that most of us treat when it comes to patients, and most people don't work in long-term care.

So this is why you saw things like tents being erected outside of hospitals that never ended up got -- being used to some degree. And you found this totally lopsided response when it came to long-term care.

I think if you go back into your question, absolutely, long-term care is an easy sector to neglect. The majority of people who live in long-term care with 70% having dementia and 90% having cognitive impairment, are not necessarily able to advocate for themselves. Most of them may not vote, and a lot of them may not be alive for the next election.

So they really are the people who are most vulnerable and also have the least, you know, political power in some ways. And I think that's reflected in things you've heard in this commission that, you know, 21 reports over 30 -- you know,

things that Doris Grinspun has highlighted and things like the Nurse Wettlaufer inquiry that should have, you know, upended the system for fundamental and transformational change, and, yes, it's early from when that commission undertook its work, but absolutely.

And I think, you know, if we think more recently in terms of what's going on in the second wave, you know, the first time, they said they didn't know better which I would argue is not entirely true because, again, we saw concurrently what was going on in Italy in terms of their ICUS, we also saw happening in their long-term care homes.

I think we -- in the second wave, we knew better, but again, it was -- it was a -- really, a choice or a matter of priorities when it came to the second wave. I think we became a little myopic over the summer and focused, again, on one issue for a long time which was schools and schools re-opening which, of course, is very important, but we lost, I think, a little of the focus on long-term care.

And I think now, as I'll speak to later on, there's the challenging issue of trying to

balance the economy with -- with protecting older people, and I think, you know, there's this dangerous fallacy about being able to shield the most vulnerable, which there is no empiric evidence from any jurisdiction that you are able to effectively shield your vulnerable population, contain outbreaks in that setting, while allowing transmission to rage in other parts of society and community.

So I absolutely think that there is a bias, that identifiable lives bias. I think there is the bias -- you know, the people in long-term care have several intersecting forms of discrimination that plague them.

They have the agism, so which was, you know, described as one of the last socially accepted forms of discrimination. There's dementia-related discrimination. We cannot forget that the majority of people who live in long-term care are women, and the majority of people who work there are women.

And then, of course, the issues which you have heard much about on the Commission about why we have not acknowledged and properly remunerated the workforce is the majority of people

are not only women, but many of them are people of colour as well.

So the long-term care sector in many ways is a real, you know, microscope or a laboratory for all the social inequities that -- for many social inequities in our society and a real display of how when these things are left and neglected, things can go very wrong.

I will show you a bit more of the work. I know -- do we have a hard stop at noon?

COMMISSIONER FRANK MARROCCO (CHAIR): Not exactly.

NATHAN STALL: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): We've got -- I think we're scheduled again at 1 --

NATHAN STALL: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): -- if I'm not mistaken.

NATHAN STALL: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): So we've --

NATHAN STALL: Yeah, I will -- I will --

COMMISSIONER FRANK MARROCCO (CHAIR): I suppose all of us can be -- not you, but the rest

of us can be on a diet without any real adverse consequences.

NATHAN STALL: Okay. Well, we need to let the commissioners eat. That's quite important. I think that my friend David Fisman's coming on, I believe, sometime this -- he might be at 1 o'clock. Anyways --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

NATHAN STALL: This is -- you know, this is -- you will know that this is -- this is other work we did working with colleagues at BlueDot who have access to anonymized mobility data from cellphones. So we looked at -- you know, there was this limiting -- I've talked about the motivations for limiting workers to one site.

So on April 22nd, an emergency order came in that restricted employees of long-term care homes from working in more than one long-term care home, congregate care setting, or healthcare setting within a 14-day period. Importantly, it didn't apply to temporary agency staff or other contract staff.

So we used anonymized mobile device location data, and we looked in the time -- the six

weeks before -- the seven weeks before, excuse me, the order came in on April 22nd and the seven weeks following. And we visualized the connectivity and looked at how many homes had connections. And a connection was, so what -- they drew geoboundaries around the homes, and we could know if a home was pinged within one of those geoboundaries or had a check-in, a digital check-in within in two contiguous half-hour periods.

So we knew that they were there throughout the duration of an hour, and we then looked -- were there -- were there individuals with that unique mobile device who had that check-in at another home within a 14-day period. And we then looked at the mobility and the connections between homes throughout these two time periods.

So this is -- this is the table, and I'll show you the graph. So these are homes with a connection. So before that order came in on April 22nd, 42.7% of all homes in the province had a connection which would have lasted at least an hour within a 14-day period.

So see, the public policy was actually quite effective. Afterwards, 20 -- 12.7% of homes had a connection, so there was a 70.3% reduction.

And similarly, the number of connections, so the homes on average had almost four connections, so connections, there were four homes within that network. Afterwards, there was less than 1, so an 80% reduction.

You'll see that the connectivity was highest in the for-profit and non-for-profit homes compared to municipal homes. And the residual connectivity afterwards remained highest at 14.7%.

I think it's actually important to note that still 12.7% of homes after that order came in had mobility that was documented.

And I'll show you -- this is actually a neat network diagram. So this plots all the networks, okay? And the red dots are ones that had an outbreak. The greenish ones, they did not have an outbreak. You'll see there was quite a bit of connectivity. So all these dots are homes, and the lines between them are connectivity. And you'll see there's a marked reduction of connectivity after the -- the order came through.

But I think that 12.7% is quite important to focus on because we know there's a loophole within that public policy that permits temporary agency staff to be able to travel between

healthcare settings. And we have heard that homes are -- you know, in order to close that, you would have to have only full-time staff.

And we have heard that homes are choosing to hire temporary staff and -- rather than have full-time employment, and this is leading to some residual connectivity.

Of course, the other reasons why there could be residual connectivity are people like delivery persons who are going between the homes, but that's why we limited it to that -- at least one hour that they had to spend in each of the locations which I think is less likely.

And the other group of people who are exempt from that order are physicians as well, so it's possible there are some physician contributors, but because of the fact we have heard about and we know that it's a loophole within this policy, that the fact that still 12.7% of our homes in the province have a connection with another home in a 14-day period where someone spends at least an hour in each of those homes is concerning considering what we know about how staff may be vectors for COVID-19.

And you've heard much about, you know,

what could be done to promote more full-time employment and retention in the field which would reduce the reliance on temporary agency staff and then lead to mobility between homes.

Any questions about that study?

COMMISSIONER FRANK MARROCCO (CHAIR): No. Just so I'm clear, what you're suggesting is that if you're trying to prevent outbreaks, you would deal with a temporary staff, the ability of the temporary staff to be in multiple locations?

NATHAN STALL: Yes, within a 14-day period, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

COMMISSIONER JACK KITTS: So just to be clear, so because the staff are vectors into the home, you're supporting the one site only for staff?

NATHAN STALL: I mean, this clearly shows that there was a strong reduction of 70% in connectivity, and that was an important and successful public policy. It was probably implemented too late. When you look at when it was implemented in other jurisdictions like British Columbia, it was clearly successful, but

the fact that there's this residual connectivity and this known loophole in the policy is something that I think is another immediate target for action to try and reduce risks in these homes.

COMMISSIONER JACK KITTS: So in the risk-benefit analysis of this, we've heard that the risk was a significantly increased shortage of staff because of this policy, but you feel the risk-benefit ratio is implement this policy and find the staff?

NATHAN STALL: You know, these are the competing crises of trying to, you know, address the long-term care sector. Obviously, you need someone to be able to care for the people at the end of the day. This is empiric data showing this. We know that it's a risk factor. We don't have a comparative analysis showing that you're going to contract the amount of available staff by 'X' much and it's going to lead to this much harm.

But in terms of, you know, immediately identifiable things that could be done now -- you know, we can't build 30,000 new homes -- you can say, well, it's very hard, Dr. Stall, to actually, you know, train up the staff you would need to do that. That's a fair point, but this is just

something that we've identified that's an immediate target. I can't comment specifically on the risk-benefit ratio of that.

COMMISSIONER JACK KITTS: Thank you.

NATHAN STALL: Okay. The last -- the latter studies are -- I know we're just on Item 2 of 5, but I promise you Item 1 was the longest and pithiest.

So this was something that actually came out of reading some of the transcripts of the Commission, specifically the Chartwell Commission. So we know that, and as I spoke about, Canada has the highest proportion of COVID-19 deaths in long-term care residents, about 78, 80% depends when you look. And I've talked about the concerns about a skewed pandemic response that focused on acute and critical care.

There was no official policy denying hospitalizations for long-term care residents with COVID-19, but media reports and testimony from this own commission suggested that resident transfers to hospital were strongly discouraged especially at the onset of the pandemic.

So to investigate this, we looked at whether there were temporal variations in

hospitalizations, and we have compared community dwelling adults to those in long-term care during the first and second waves of the pandemic.

One of the things that I will say that I think was detrimental as well that may have motivated the lack of transfers was early on, there was a triage document that was leaked that has actually never been officially released. And early on, that document, which was in draft form and was later edited to not include this, suggested that in surge levels, residents should not be transferred to hospital. And that was actually taken out. That would be in the spirit of -- it was actually, should not be transferred to hospital to receive critical care. But I think this made the news.

There was also these conversations and letters going out from homes to families strongly discouraging transfers, and this was something I heard -- I read in the Chartwell testimony from your own commission. So we wanted to look at this.

So this is all the people who died of COVID-19 in our province from March to October 2020. There was 3,114. We went to October 28, so relatively recent data. In the left column, the left notes are the dates and some of the

demographics, we had community residents and nursing home residents.

Now, you would always expect community-dwelling residents to be hospitalized at a greater rate than long-term care residents. For the most part, they are more well off because they can still live independently in the community. And many people in long-term care have goals of care or advanced directives that may not include transfer to the hospital.

But what we noticed, in March -- so if you look here, and I'll show this graphically. The proportion of community-dwelling people who were hospitalized prior to death is relatively constant throughout. Somewhere between, you know, 75.9% to 88.8%. But, you know, relatively stable even during March and April when we had the real surge in COVID-19 admissions and use of our acute-care hospital system.

Interestingly, among long-term care residents, we saw that in March and April, it was only 15.5% of all -- out of 1,028 people who died that were transferred, and this has gone up.

In May, it was 26.9%. In June and July, it was 41.2%. And there's limited numbers,

but in August to October, it's 30.8%.

When you look, you can say, well, maybe it's an age thing. It's actually not. So when you look by age as well, the rates in the community-dwelling cohort were relatively, again, stable in the high 80s for community dwelling and low in the -- low -- much lower in the nursing home population.

And what we did find, which is actually consistent with other literature, was that men were more likely to be transferred to hospital than women. And I've shown this pre-pandemic, and it's been known that men, there's gender-based biases where men are more likely to be offered aggressive care.

So this graph -- this shows it that, you know, there is these really large discrepancies and technical variations in the intensity of care that's provided. And so March and April, you know, a really small number of all nursing home residents who died were transferred. That went up once the system was loosened up. Hospital partnerships were made, and it was clear that that first wave was not going to -- not going to overwhelm our hospital system.

I think this is important because that very well may have contributed to the large concentration of death we saw in the first wave, and people were not being transferred to hospital who not only may have benefited from medical care that may have saved their life, but also people were not being transferred for just basic care when homes were in crisis, and people aren't being transferred for palliative care to help them die with dignity during the first wave when homes were totally overwhelmed.

So I'll talk about the conditions I witnessed in the outbreak that I assisted with, but there was clearly this huge temporal variations in the intensity of care that raises concerns that they were unofficially triaged out at the beginning of the pandemic for a number of reasons and although it was never officially said that they shouldn't come to hospital.

Questions about that?

COMMISSIONER FRANK MARROCCO (CHAIR): I don't think so.

NATHAN STALL: Okay. Okay. What has been the impact of the COVID-19 pandemic on the general health and well-being of Ontario long-term

care residents? Again, Commission has done a fantastic job with capturing some of the voices.

My role in a lot of this is to capture the data to corroborate the things that we're hearing.

So one of the things we were hearing was that there was increased prescribing of things like psychotropic medication, so things like antipsychotics, benzodiazepines, antidepressants, that they were, you know, drugging people up, in the most colloquial sense, to allow them to tolerate the conditions of lockdown or because homes were in crisis; there was no one to provide care for them, and they were responding with chemical restraints for these residents. So these were things that we had heard in the news that families had reported, and we wanted to look at.

So we examined the monthly proportion of long-term care residents who were dispensed psychotropics -- I'll describe what those are -- from April 2019 to September 2020. And we looked -- the pre-pandemic period, so, you know, obviously, our first case in Canada was the end of January, but Feb. 26 was the time that we had our first documented case of community transmission in

Ontario, and March 14th is when restrictions on visitors, absences, and congregate dining came into effect.

So the pre-pandemic period was February 2020 earlier, and then we looked March 2020 forward. We looked at the dispensation of four psychotropic medications, so antipsychotics, antidepressants, benzodiazepines, and trazodone. So all these medications are psychoactive. Some of them have -- many of them have sedating properties, and many of them are used to treat what are called responsive behaviours in people with dementia which are also known as the behavioural and psychological symptoms of dementia, things that are known to have been exacerbated during the pandemic because of the lack of interaction, social isolation, the physical activity, fresh air, et cetera, that people endured during the pandemic.

Again, much like other studies, we had a falsification analysis. So we looked at two drugs, metformin, which is used to treat diabetes, statins, which are used to treat high cholesterol, and we did not expect those to change or to go up during the pandemic.

And then again, we looked -- we

looked -- January to February 2020 was the pre -- that was the start of the pre-pandemic period, and then we looked March to September 2020 being the -- being the post-pandemic or pandemic period, apologies.

So what we find for these drugs are some very interesting trends. So antidepressants is in the top left. This is the -- you know, the linear trend of what you expect going back again from -- all the way back from April 2019. So the linear trend, if you were just to draw a line, there's been a general increase, and you'll see the proportions are small, but we're dealing with 70,000 residents. About 50% of all long-term care residents are on an antidepressant, which may surprise you, but this is known.

The general trend has been increased prescribing, but you see this really sharp uptick in that that line here is the start of the pandemic in the prescription of antidepressants. Similarly, also known that trazodone antidepressants and antipsychotics have generally been going up in prescribing where benzodiazepines have been going down. That's been noted pre-pandemic.

But you see for antidepressants,

trazodone and antipsychotics, there's sharp upticks in the -- in the proportion of residents that are being dispensed these drugs.

Benzodiazepines continues on that downward trend, but even so, there is an uptick in prescribing during that time period. Interestingly, the metformin and statins, there's a sharp decline. And you may say, well, there's less residents in long-term care; that's why. We actually controlled for that in the denominator. We looked at the proportion of residents who were prescribed any medication.

So either this means that those medications weren't refills because of the collapse of medical care; the people who are on metformin and statins were the ones who were more likely to die, which is the possibility because they're more -- diabetes and high blood pressure and cardiovascular risk factors are known cardiovascular risk factors for COVID-19 outcomes.

But clearly, there are some sharp increases in the prescribing of psychotropic medications, again, giving evidence to things that family members were telling us were happening during this time. Questions about that?

Okay. So I'm just going to speak -- that's sort of the end of the -- you know, data, data part of the talk. A lot of this you've seen, so I will -- I will go quicker, but I'll just talk about specifically what I have been involved in when it comes to promoting and implementing family presence because I think there are some important additions to be considered to the interim recommendations that have been made.

So, you know, these photos, I've showed to many people. This is from Winnipeg, right? These are sort of the tragic -- I hate to use the word iconic, but the photo that typifies the experience of long-term care residents through glass barriers.

I don't know if you've seen this one. Someone hired a bucket crane at Baycrest in Toronto to be -- because, you know, obviously, window visits disadvantage the people who are in upper levels of the building. Usually, people want to be on upper levels of the building. This is one time you don't want to be, so they hired a bucket crane.

This photo always gets me, and I show it in many talks I do which is the hugging curtain. This is a couple in Barcelona, and, you know, this

is supposed to be an innovation in family presence and connectivity, but honestly, almost makes me choke up every time that I -- that I see this photo.

And then this is sort of someone from Montréal just looking longingly out the window at, really, the rest of the world that was re-opening over the summertime.

We -- there's actually a new disorder that's been characterized. I don't know if someone's described this term to you, the confinement syndrome in the course of the testimony you've heard. But this letter in JAMDA, which is one of the leading long-term care journals, was from French physicians who noted that the confinement disease is probably more deleterious than the COVID -- the coronavirus disease itself.

And what we saw and what I have seen are the collateral damages of this confinement syndrome of the conditions of lockdown that were imposed for months on long-term care residents had really extreme collateral damages. So we saw -- this is a news report. You may have heard that there was actually a resident where the coroner concluded died of malnutrition in our province, so

dehydration and malnutrition.

I've seen people who went from walking who are now wheelchair-bound who needed help with minimal activities who now require help with multiple activities. Certainly, exacerbation of chronic medical conditions and mental health disorders. I have spoken to caregivers who, when they were finally allowed back in, their loved one no longer recognized them anymore. There's been worsening of responsive behaviours; you know, pandemic loneliness and social isolation; and, of course, psychological distress, depression, and anxiety.

So we were really --

COMMISSIONER FRANK MARROCCO (CHAIR): You know, Doctor, on that topic, there's been a lot of -- I don't know if you -- if there's any collateral or analogous connection, but solitary --

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- confinement cases --

NATHAN STALL: Yes. Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- there's a lot of evidence to suggest that more than five days --

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- in solitary confinement is a problem.

NATHAN STALL: Absolutely. And that's where this term comes from, right, which is really insane when you think about it that we're applying terms that are -- you know, there's been the multiple Supreme Court rulings -- I don't need to tell you. It's embarrassing for me to tell you something -- that solitary confinement is unlawful, but this became the default response for our long-term care residents in many ways.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, one of them is mine.

NATHAN STALL: Yes. Yes. Sorry. What do you mean by that, one of them -- one of the rulings, yes. Yes, sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): One of the rulings.

NATHAN STALL: Sorry. I thought you meant you had a loved one. Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): No. No. No.

NATHAN STALL: Yes, absolutely. That's why I said it's embarrassing for me to tell that to

you.

So -- yeah, so one of the things that we did -- and I don't know if you've seen this document, is with my colleague, Samir Sinha, who I know was the first person to testify at this commission, or -- I keep using the word testify; it's not sworn; it's a presentation -- but who gave a presentation.

We worked really hard over the summer to present to government and the world, really, and the province, but actually, this has led to international work -- really, to find a better balance for how we can mitigate what we saw going on.

And we laid out some principles. A lot of this has been captured now in the -- in the -- but we did this in July -- has been captured in your commission. So really, the need to differentiate between family caregivers and general visitors leaving the authority for an autonomy to determine who is essential to support them in their care, that should be the resident substitute decisionmakers and their families.

You know, restricting access to visiting has to balance the risk of social

isolation with the benefits you're getting from -- from preventing COVID-19 infection; having some equity in policies, not just a quality, which was something that was important; recognizing that, you know, the conditions for visiting may be very different for very -- for different residents, and some people may need more, and some people may need less.

I think having regular transparent and evidence-based communication about what's dictating these policies, it's often spoken about, you know, that these are evidence-informed decisions, but really, as I told you, there's an absence of evidence to suggest that visitors or caregivers have been involved in transmission which has been a huge source of frustration, that have data, collect data when you reopen homes, which, unfortunately, hasn't been done in the way that we're aware of so that, you know, our caregivers and visitors, are they being implicated in outbreaks.

And I think something that really frustrated people was have a mechanism for feedback in an appeals process when there was disagreement. People felt like they had no one to go to except the media when it came to what they were seeing

with their loved ones.

I won't go through all of this, but we really spelled out and we looked across the country at what were some of -- and we looked internationally as well at what policies were.

In the end, one of the things I think was really -- and sorry -- we created separate guidance for family caregivers and for visitors.

So one of the things that I think was really to the credit of the Government that they did was they took these recommendations that we had made to heart. And the policy they came out with at the beginning of September really aligned with our recommendations on caregivers in terms of the ability for them to designate their own caregiver, the ability not to place time limits to allow them into homes under conditions of outbreak. That was something -- I would say we have one of the most progressive caregiver policies in the country. Could we do more? Absolutely. But, you know, the things that came out, I think, were very positive from that work.

Now, where do I have ongoing concerns, and I think to add to the work that the Commission has already done, in many ways, I feel that the

course that our government has chosen to pursue with respect to management of our pandemic has been one of trying to, without saying it, segment or shield our vulnerable populations while allowing the rest of society to live their life with some basic hygiene measures.

And so what do I mean by that? You may have heard the Great Barrington Declaration that came out last month where this -- this is a proponent of the shielding strategy where you try and shield these vulnerable individuals and let the people who are less vulnerable to bad outcomes from the disease go on and live their life, so you don't shut down the economy, and you try and get the best of both worlds where you protect those who are most vulnerable.

The counterpoint to that was the John Snow Memorandum which I am clearly more in agreement with which is that shielding is impractical. It's impractical in the Province of Ontario because shielding long-term care residents would require shielding the more than 100,000 long-term care workers who live in the community. And we spoke about how they, themselves, often live in COVID hotspots where -- and often live in

multi-generational households, may not have sick benefits, all the conditions of labour that you have heard about.

But I think it's really unethical. It's also -- sorry -- ineffective. There's no empiric evidence, importantly, from any part of the world that has been able to let COVID-19 transmission continue on without suppressing it, keep their economy open, and be able to prevent deaths disproportionately among older adults and specifically those in long-term care. And it's unethical.

So to segment a community without their consent, really confine them to these indefinite and harmful conditions on confinement, for people who have limited life expectancies and are most susceptible to these conditions of the confinement syndrome is unethical.

So where I see the caregiver policy was a huge -- was a -- was a really big and, I think, important thing, and -- but I think there's really still a need for more balanced and nuanced infection prevention and control.

So right now, what has happened is they've shut -- they've stopped short-term

absences. And again, it's like the visitor policy. There's a difference between people, the caregivers who are going in to feed their loved ones and people like my 3-year-old twins who are going to visit my grandmother who lives in a retirement home for social reasons. Is the latter important and vital? Absolutely, but there's a need to distinguish between these policies.

So one of the things is they're no longer allowing people to go outside for fresh air and walks in the immediate vicinity of homes because they've closed short-term absences. So there can be more balance and nuance, and we could have more humane, you know, public health measures that, you know, okay, we don't want you going to your loved one's house to have dinner indoors, but walking around the block and getting fresh air is a human right I think we should all have.

Similarly, many of the homes that are in the high-alert status, which, you know, if you think about Peel or Toronto are probably with the current strategies that we have in place are going to be on high-alert status indefinitely. And many of them have moved to shut down things like congregate dining and social activities and suspend

them and go back to dining in rooms and not having social things that promote wellness and well-being and quality of life for these people. So again, I think we can have more nuance and balance.

If your home's under outbreak, clearly, you want people in the rooms, and you need to start isolating and cohorting people. But to indefinitely serve people meals in their rooms and not allow them to socialize, again, reflects a lack of balance and nuance.

Similarly, in some of these homes, if a home -- if a unit's on outbreak, and they're totally separate from the other units with no -- with staff being cohorted, you need to think about whether you actually need to shut down the congregate dining and social activities for the whole home as well.

And I think one of the things that was sad to see and personally sad to see -- so -- and I think it's not covered in the -- not necessarily the purview of the Commission, but many of the -- many of the infection prevention and control measures that are for long-term care have been applied to retirement homes.

And they're sort of the lost, I would

say, child in all of this. You know, they have had better outcomes, but the people who live in there are usually a little less functionally dependent -- a little more independent, I should say. They have almost exclusively private rooms and private bathrooms, but they've had much better outcomes.

But these really draconian measures have been also imposed on them, so I think what has been really -- and I'm not sure why this was done, was they stopped outdoor visiting for long-term care homes which we know being outdoors is lower risk. And they were asking people to be masked and distanced. And I think that's another easy thing that can be re-implemented.

So, for example, I'm no longer allowed to see my grandmother who is in a retirement home because we were visiting outdoors because that was -- that was implemented. That was in the fall when cases started to pick up, which I think is something -- again, I can understand why they don't want people going into the homes. Yes, it's impractical to have outdoor visits in Canada in the wintertime, but we're managing to find creative solutions for people to do this for things like restaurants on patios. We should be available to

do this for people in long-term care.

Questions about that?

COMMISSIONER FRANK MARROCCO (CHAIR): No. We're good.

NATHAN STALL: Okay. In the last part, which I've -- again, I think -- I don't think you've heard about this, and I think it's important, is how we executed a response to a home experiencing a COVID-19 outbreak.

So you'll know on April 22nd, also when the order came to limit staff to one home, the Government asked hospitals to develop and deploy these specialized COVID-19 SWAT teams to provide additional staffing, IPAC occupational health and operational support. There was no road map for this. We weren't really told what we needed to do specifically other than to help.

And so we -- I took -- you know, we wrote this up, actually, in the Journal of American Geriatric Society. Actually, we wrote it up in May. The work was done in April and May. And a huge team of individuals who contributed to this -- and I'll show you.

The home we became involved in when we became involved in mid-April, almost the entire

cohort of residents had been infected, 85.8%. We ended up, 1/5th were admitted to acute-care hospital, and 1/5th of all the people ended up dying. So -- and this is the epidemic curve, so it was a really severe outbreak that was experienced by this home.

What we did in the first 72 hours, and I think this might -- and other people have reached out to us to share what we did, and I'm not saying it's the best way or the right way, but it certainly worked, and there was a structure here.

We built -- so we had an environmental scan in our hospital, and their -- what their clinical expertise was, what their staffing was, what their supplies were, and what their equipment needs were.

We built a team with geriatric medicine that I led, one of my palliative care colleagues, and our IPAC or infection prevention and control clinicians. We evaluated their staffing shortages. We determined they're PPE stockpile, their supply chain, and their expected burn rate of personal protective equipment, and we assessed their shortages and expected needs.

My IPAC colleague did -- they reviewed

the outbreak line list that I showed you part of in the last slide, plotted that epidemiological curve I showed you, did a rapid assessment of what the IPAC gaps were. Widespread testing was done of the remainder of the residents.

We built a team, and I think one of the things was we actually drew a lot on the literature of disaster management response, and we came at this from one of team building and trust building and collaboration rather than the hospital was taking over the home as has often been described.

So we built a team, and I'll show you that team -- a clinical and operations team which had senior leadership from our hospital, administrators, nurses. We had -- we were really fortunate to have our hospital fully onboard with clinicians and geriatrics, palliative care, psychiatry, pharmacy, and infection prevention and control.

And one of the things we immediately did was we decanted 15 residents to the acute-care hospital. That speaks to that crowding thing I was speaking about earlier on where there was -- we realized it was so out of control in the home, there was no vacant rooms. There was nowhere to

cohort and isolate people, and they had such a collapse in staffing that there was no one to look after the residents.

So we made the extraordinary decision with the support of the hospital to actually send 15 residents that they chose the home to our hospital and admitted them to Mount Sinai Hospital.

This was the clinical and operations team. We had four, really, arms of this working. There's the clinical team, the IPAC team, the health human resources team, and the PPE supply team.

So in the clinical team, which I help lead with a palliative care physician and the senior nurse administrator, we established the infrastructure for provision of virtual care. So we actually donated iPads to them and had a secure video-conferencing technology.

We rapidly, as I'll show you, went through the home and triaged and assessed all the nursing home residents to figure out whether they wanted to go to hospital, whether they wanted active medical management, or palliative care.

We had a lot of goals of care discussions and advanced-care planning discussions.

As I'll show you, we provided active medical management, palliative care within the home. We provided psychiatric support and care for the residents and psychosocial support for the frontline staff. And we worked with our pharmacists and colleagues of the home to ensure they had access to medical equipment, drugs, and supplies.

I mean, before we came, they were using coat hangers to hang up bags of normal saline. They didn't have enough oxygen tanks. They were looking on Amazon to secure concentrators for the oxygen. So this is -- you know, this is happening in Canada, so this was the level of crisis that this home was in when it came to supply.

There was a really detailed IPAC assessment that was done around education and training that was provided. They coordinated the rooms that they moved residents between, coordinated the cleaning of the room to show -- to advise them this is where you should move this resident and that resident so that we were properly cohorting and isolating. The health human resources team worked with staff at the home to identify who was sick and when they could come back

to work.

We actually deployed from our hospital a dozen RPNs and PSWs and one clinical nurse specialist for a one-month assignment at the home to help with their staffing crisis. And a lot of personal protective equipment was sent over there as well as medical supplies from our hospital.

So in the first seven -- in that -- in the next seven days after we established -- as I showed you, we established that team, everyone was tested. We decanted the residents.

For the people in the home, we actually set up -- because many of us were working in the hospital and doing this as well, and we couldn't travel between the sites, a lot of this was done virtually.

So we -- there was donation of iPads. So we established the infrastructure for virtual care. We brought in the family physicians who were working and who would join the virtual rounds to be able to advise on the care of their residents.

The first 72 hours we got access to their electronic medical record, we triaged all the residents. We laid eyes on all of them, and we made, as I'll show you this, sort of, pandemic

assessment and triage tool. One of the things we found, which is not unique to this home, was that they were screening for COVID using the typical symptoms, the fever and the cough, whereas we know that long-term care residents are more likely to have atypical symptoms. They're more likely to be confused, delirious, not eating.

So we made this tool, and we flagged all the residents that -- they flagged for us who they thought was sick. We laid eyes on all of them, and then we made these decisions in real time often speaking with their substitute decisionmaker, did they want to remain in the home or go to hospital? If they wanted to remain in hospital, we coordinated to take them to Mount Sinai Hospital so there was a smooth transfer of care.

If they wanted to remain in the home, did they want active medical management or palliative care? And we provided both of that to them. We provided -- we arranged stat and in-home laboratory and imaging services. We taxied over a lot of oxygen tanks from Sinai to give them oxygen. One of the fears they had was that low-flow oxygen might aerosolise COVID-19 which has been shown that it cannot.

We used a lot of hypodermoclysis, which, instead of putting it in the intravenous, you actually put the needle subcutaneously, and we rehydrated a ton of residents that way. And we were available -- my colleague Dr. Ramona Mahtani and I were available 24/7 over a period of two months to respond at any time to them for clinical concerns or emergency situations, so we were basically on call for them.

We provided high-quality palliative care. My IPAC colleagues went there and did actual onsite training of donning and doffing, education about modes of transmission. We had talked about the room changes and terminal cleans, setting up donning and doffing stations, and then the occupational health measures.

What I think was really essential about this -- and I think as we think about this wave and the future of long-term care in connection with acute-care hospitals, is we didn't just leave once the -- once the outbreak was declared over. So, yes, we gave them -- there was the deployment of hospital-based staff. I'll just speak about the final things that we did.

We actually had a pharmacist who

consolidated and streamlined medications because if people are getting medications three times a day, it would necessitate the careworker to go in three times a day and don and doff their equipment, so we streamlined medications to twice or once a day, got rid of unnecessary medications.

Our geriatric psychiatry team was phenomenal in providing support for their residents who were having the things I showed you, the exacerbation of mental health conditions, worsening of their responsive behaviours.

One of the things they did and continued to do is they provided support for the frontline nursing home staff who were traumatized, understandably so, by what had gone on.

And then we provided stabilizing IPAC interventions which continue to go on to this day with the home to oversee what's going on with their IPAC procedures and to make sure that they're following the necessary things. To their credit, they have not had another outbreak during the second wave.

And we transitioned care back to the nursing-home staff and physicians, and they actually used the virtual care infrastructure that

we had built. One of the things that had happened and that I think your commission has also heard is that the medical model which was already -- and I'll speak about that in my last two slides -- entirely collapsed in many homes. And in this home, you know, many of the long-term care physicians, they, themselves, are older adults. They were advised by their own physicians not to go into homes, and many of them work at multiple homes that were each experiencing catastrophic outbreaks. So they, themselves, were totally overwhelmed for the most part and unable to capably assist in all of the homes they were involved in.

The final thing I'll say is there was a paper by long-term care physician colleagues on improving medical services in Canadian long-term care homes. They've put out some recommendations which I think are actually essential, some of them at least, about how to improve medical services. One of them is the time commitment, four hours a week for every 25 to 30 residents they've established as a reasonable practice cohort for a physician to have. As I said, many physicians have practices at five, six, long-term care homes where they may be responsible for hundreds of residents.

The necessity of physical presence during outbreak management, that you cannot rely solely on virtual care, that there is a time and a space where you need to actually have boots on the ground to get in there and assess what's going on. They talked about some remuneration that might be required particularly for the medical director role to reflect the increased work during pandemics and outbreaks that that's required.

I think maintenance of competency is a huge thing. A lot of people who work in long-term care don't have care of training -- or don't have training of care of the elderly. They may not have training for long-term care. They may have learned it on the go, but there's also no real -- there's no real maintenance of competency or continuing medical education. And there may be no added training for medical directors to be able to assume this role of leadership, the medical director.

Many of the homes simply rotate the medical director role, and that has to do with rotation of the -- of the extra stipend that they get for the medical director role, not necessarily to rotate leadership to, you know, have fresh leadership. They -- if there's three or four

physicians in the home, they may rotate the medical director role quarterly so that they split the stipend.

I think one of the things we really saw is, you know, often the default is to send somebody to hospital, and that's because there was not -- you know, not availability of things that we were struggling with but were able to secure which is lab services, timely diagnostic imaging, medical supplies. We were lucky -- very fortunate that the staff at the home had just been trained in how to give subcutaneous hydration prior to the pandemic starting, so we were able to literally rehydrate and save the lives of people just by rehydrating them with the expertise that the staff at the home had done.

And I think credentialing, there needs to be a standardized credentialing process because we saw the collapse of the medical model of care and the fact that, you know, physicians in many homes stopped coming in to provide care and were totally overwhelmed. They need to be better trained specifically in care of the elderly and long-term care but also in -- clearly in outbreak management as it relates to the COVID-19 pandemic.

So I know I've talked a lot, and I went over time, but I'm really happy to take questions, and I sincerely appreciate you listening to what I've had to say today.

COMMISSIONER FRANK MARROCCO (CHAIR): I think we asked -- I don't see either of the Commissioners wanting to ask any further questions. I think -- I think we asked the questions as we went along.

And, Doctor, you thanked us for listening, but thank you for the preparation and the obvious work that went into this. It will be a help to us going forward, and thank you for taking the time to do that.

NATHAN STALL: No. Thanks for having me, and I did share my slides, so, please, those can be publicly posted and used as need be.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. And thanks again.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): And we may be back.

NATHAN STALL: Okay. Be happy to.

Did you have something to say, Commissioner Kitts?

COMMISSIONER ANGELA COKE: Just thank you.

COMMISSIONER JACK KITTS: I was just going to say that that was extremely clear, and I'm so impressed on how up to date it is. It's -- it was a very good presentation. Thank you, Dr. Stall.

NATHAN STALL: Oh, thank you. That's a benefit of being young.

COMMISSIONER FRANK MARROCCO (CHAIR): We're trying to -- I think you wanted to put an end to agism, so --

NATHAN STALL: I know.

COMMISSIONER JACK KITTS: I'm not sure I was ever that good.

COMMISSIONER FRANK MARROCCO (CHAIR): Goodbye, Doctor. Thanks again.

NATHAN STALL: Okay. Thank you so much. Take care.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Thanks.

NATHAN STALL: Bye-bye.

-- Adjourned at 12:30 p.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, 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 13th day of November, 2020.

NEESONS, A VERITEXT COMPANY
PER: JANET BELMA, CSR
CHARTERED SHORTHAND REPORTER

Page 6: Jama Network open? Should be JAMA Network Open.

Page 76: Should be "imaging services" and not "emery services"

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