Long Term Care Covid 19 Commission Mtg.

WRH (David Musyj and Dr Chevalier)
on Thursday, November 19, 2020

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MEETING OF THE LONG-TERM CARE
COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 19th day of November, 2020, 9:00 a.m. to 10:25 a.m.

BEFORE:

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

PRESENTING:
David Musyj,
President and CEO, Windsor Regional Hospital.

Dr. Marguerite Chevalier,
Chief of Family Practice, Windsor Regional Hospital.

ALSO PRESENT:
Judith M. Caputo, Stenographer/Transcriptionist

PARTICIPANTS:

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

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

Adrian Diaz-Choconta, Long-Term Care Commission Secretariat

Jay Bahal, Long-Term Care Commission Secretariat

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

Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care

Kate McGrann, Counsel to the Ministry of Health and Long-Term Care

Ida Bianchi, Counsel to the Ministry of Health and Long-Term Care

-- REPORTER'S NOTE: (Introductions were exchanged before going on the record).

MR. MUSYJ: Okay. Thank you.

Good morning. What we were asked to put together, and we put together a brief PowerPoint to hopefully guide the discussion, and you interrupt us at any point. So, if you don't mind, we would start going through it.

COMMISSIONER MARROCCO: Sure.

MS. MAHONEY: May I interrupt for a second?

David, I spoke with you yesterday. If you wouldn't mind, please, because I have struggled myself with the pronunciation of your last name, so everybody can properly refer to you, would you introduce yourself and pronounce your last name.

MR. MUSYJ: Oh, okay. What, you can't do it by the way it's spelled?

MS. MAHONEY: I know. I'm going to fool it up, David. I don't want to do that, so if you don't mind.

COMMISSIONER MARROCCO: "Musyj", is that right?

MR. MUSYJ: I'm Ukrainian, so you're closer with the pronunciation from a Ukrainian

point of view.

COMMISSIONER MARROCCO: I've spent my whole life spelling my last name for people, so I have some sympathy for this.

MR. MUSYJ: Yes. Yes, you just start with it, David M-U-S-Y-J. So it's "Mooshay" phonetically, M-O-O-S-H-A-Y.

COMMISSIONER MARROCCO: Thank you, Mr. Musyj.

MR. MUSYJ: I'll share my screen here.

COMMISSIONER MARROCCO: We can see it now. At least I can. I think the other two Commissioners can see it. Yes.

MR. MUSYJ: Yes? All right, perfect.

We'll just start. This is the agenda we plan on following. Again, we're wide open, as you stated, to go wherever you want to go, we'll go. But we tried to provide some of the highlights that just focus on this particular issue with respect to the field hospital, and what we were facing in Windsor-Essex.

So to just give you an idea really briefly who we are is we are Windsor Regional Hospital. We're located in Windsor, Ontario. We serve the region of Windsor-Essex, which is

approximately 400,000 people.

We have two main campuses, our Met and Ouellette campus. Even though they're on two campuses, we have specialized services on each of the campuses, meaning we are not two general hospitals; we're one hospital with two campuses with services on each.

In preparations for dealing with COVID, we went back and looked at how March unfolded. We are now part of the West Region, which is on this map, which goes all the way from Windsor to Hamilton and Waterloo.

And what happened back in March is we created what was called a Hospital Table Leadership Structure.

Here is a diagram of what was created back in March, which started with, at the top you have the current CEO of the West Region, former LHIN, is Mark Walton, and Dr. Tom Stewart is the clinical lead.

Then we still use the old LHIN subregions to deal with particular issues and have subregional tables, we call them, that would report into the larger West Region table. So it was similar to an incident management structure or

system in the province.

What we did here in St. Clair is we had what we called a "hospital table", which had sub-tables underneath it that dealt with things like hospital operations, bioethics, communications, critical care.

So on every single one of these sub-tables, we had representation from across Erie, St. Clair LHIN, which goes all the way to London. So it's ourselves, Erie Shores, Bluewater Health, Hotel-Dieu Grace, and Chatham-Kent Hospital, and we all have regular meetings ever since going back to March. At the same time, a little later in March -- I'm sorry.

COMMISSIONER MARROCCO: Mr. Musyj, did you create the region yourselves and the tables, or was that imposed?

MR. MUSYJ: Yes, so it was -- I wouldn't maybe use the word "imposed". More from, okay, how is this going to work?

It started with the discussion of the West Region, the larger region, pulled together, four were CEOs of the larger hospitals from that region. So ourselves, London, St. Mary's and Hamilton. And then we talked amongst ourselves,

saying, okay, how can we create this without being too large but being focused.

And we said, why don't we go back -- because we were in the transition in Ontario Health from the old LHIN regime to the five regional regimes. How can we create focus, and leverage the relationships we had previously, meaning like a year ago? And we landed on creating the subregions, and then it was up to us in the subregion, like myself from a hospital table point of view, to then work with the CEOs in our subregion of Erie-St. Clair, which was the former LHIN, so it was a body, to populate these various teams or tables to make sure there was individuals on them from around the LHIN.

Does that make sense?

COMMISSIONER MARROCCO: It does, to me anyway. I think we're good with that.

MR. MUSYJ: Okay. So later on, in the month of March, we created also a "non-hospital table" for the region because, of course, we didn't want this all to be hospital-centric, and there are far more players in healthcare than hospitals, and the only way we were going to pull those off, or anything in healthcare, is as a collective.

So we did a similar approach in our region, and you'll see the tables are things like EMS, Home Care, Long-Term Care, Mental Health and Addictions, Primary Care.

So all these non-hospital tables met, the hospitals met, over the last couple of months. Now we all meet together. So we're all kind of one. And the chairs of each of these committees report twice a week, probably increased to three times a week shortly. It was three times a week before. Everyone's got access to this website. We minuted all the meetings. It's action items on, okay, what's going on in the region? What can we do to help support each other? So it's very productive.

COMMISSIONER MARROCCO: Does it make this -- sorry, Commissioner Kitts.

COMMISSIONER KITTS: No, I'm just going to ask another question, so go ahead, Commissioner Marrocco.

COMMISSIONER MARROCCO: How do you make decisions at that level? Is it by vote, or how does that work?

MR. MUSYJ: Yes. So what we try to do is give a lot of authority to the various tables.

So, for instance, on the hospital side, we'd have the operations table. That includes primarily the chief nursing executives, as well as the chiefs of staff on that table. And they will review a particular issue.

So, for instance, we had to ramp down surgeries across our region. They work together on their individual plans and on a collective plan and, in effect, signed off on each other's plan. And there's no -- I mean, the goal is, we haven't come across it yet, but it's by, you know, consensus, but we've never had a dispute that needed a resolution by the CEOs.

So once the operation table makes their recommendations, say on how they're going to wind down surgeries individually, and then collectively agree, that is then submitted to the CEOs at the hospital table. And it's technically up to the CEOs of the hospital to say "yea" or "nay", we support it or not. And again, since it's our team members --

COMMISSIONER MARROCCO: Right.

MR. MUSYJ: You know, we haven't had an issue.

COMMISSIONER MARROCCO: Okay, thanks.

Commissioner Kitts.

COMMISSIONER KITTS: David, do you have functioning Ontario Health Teams in your region? And if so, how did they align with your structure and how effective were they in this environment?

MR. MUSYJ: So Chatham-Kent Health Alliance, or Chatham-Kent region, was the only Ontario Health Team. Bluewater and Windsor-Essex had not been approved.

So what was happening is, they were -- and they continued to work, say in Chatham, together, and tried to feed into these tables. So they're trying to make sure that the same individuals who are sitting on their Ontario Health Team are also involved on these tables, and feed it back and forth.

COMMISSIONER KITTS: Do you think, in the future and at maturity, Ontario Health Teams will be tables unto themselves?

MR. MUSYJ: Yes. As this evolves, we've talked about that, is hopefully the Ontario Health Teams, as they mature, will become the "tables" in effect. It's just right now it's not there yet. And what we're doing is so directly in line with that, that you're exactly right. You're

going to where we've talked we're going to end up going.

COMMISSIONER KITTS: Yes. Thank you.

MR. MUSYJ: So what happens is, on a twice a week -- it was three times a week -- we have this structure where we call it now our G5 leadership, which all of these tables report into technically, and then we report up the G5 to what is called the G15, which is for the whole West Region.

So on an Erie-St. Clair level, these names, this group of individuals, technically we meet daily. We just met at eight o'clock in the morning and kind of just get a -- you know, talk about what's going on in the region, what needs to be done, and then reconnect with individuals in the region.

So when we looked at that org chart, we had the G15, which is the whole region; we have G5, which is this; and underneath it is what I talked about with the various tables: hospital and non-hospital.

It's very fluid in the sense of relationships and discussions, but there is some formal process to it, to ensure information not

only goes up but comes back down from Ontario Health. So it's worked well.

I'll be honest. You know, there's a handful of positive things coming out of COVID, and one of the positive things coming out of COVID is the relationships that have been created. You know, did we have connections with Hamilton previously? Sure. Do we have connections now with Hamilton? Daily.

So the great thing about this is it's forced that relationship on a much broader scale to happen a lot quicker. And now we know everyone by first name, which probably would have taken three years to do previously, took us two months to do now. You know, we know each other's offices and kitchens and whether lights need to be replaced, that's how well we know each other now.

So, this leads us into the particular issue we're talking about today is, in March, we were asked to focus on hospital bed capacity by Ontario Health and Ontario Health West.

We were asked to focus on what's called both "conventional" and "nonconventional" bed capacity, "conventional" meaning your conventional spaces you have in your hospital site.

"Nonconventional" would include, also within your hospital site, where you might have had a boardroom that used to be hospital space or a family meeting room that used to be a patient room, you're now reconverting back to a conventional space.

And also in those discussions at the time, there was this concept of, if you can't create enough "nonconventional" space within your four walls, you need to start looking outward and using this concept of field hospitals. And that's in the middle of March, I would say, that's when we started actively pursuing the concept of a field hospital.

Then I look back and, sure enough, there was the webinar in early April, through the Ministry of Health, that talked about non-conventional "field hospitals" and having to look at that and asking hospitals to look into that.

COMMISSIONER COKE: Can I just ask a question?

It says here that Ontario Health asked you to look at this issue. Were you the only region that they asked to do this, or were others asked to do the same thing?

MR. MUSYJ: I assume it was others. Like, it was our whole West Region was asked to focus on hospital bed capacity, and the webinar in early April was through the whole Ministry. It was on the Ministry side to talk about this.

COMMISSIONER MARROCCO: So the genesis of that, of the idea of nonconventional space, it actually originated with Ontario Health as far as your region was concerned?

MR. MUSYJ: Yes. Yeah. We were asked to look at, within our four walls, what we could create, and if we were concerned about capacity within our four walls, it was "look elsewhere".

COMMISSIONER MARROCCO: Sorry.

MR. MUSYJ: No problem.

COMMISSIONER MARROCCO: Was the motivation because there was a concern that the hospital capacity would be exhausted; is that the idea?

MR. MUSYJ: Yes, for us in Windsor, so what I didn't outline here -- great question -- is we were designated what -- there was discussions at the time to say: Are we going to create designated COVID hospitals, meaning every single COVID patient would go to that particular hospital?

That quickly was eliminated because of the concept of, you don't know you have a COVID patient. If they come into an ED and then they test positive, what do you do? Where do you put them? Do you shift them all? But the hospital already had a COVID-positive, so you can't keep that hospital "clean".

As a result though we are the intensive care unit traditionally for our region, all the way to London. So any patients requiring a higher level of intensive care gets transferred to Windsor Regional hospital, pre-COVID days.

So that was adopted during COVID, meaning if a patient got critically ill and required a higher level of critical care services and they had COVID, they would be transferred to us as Windsor Regional Hospital. So, as a result, us as a hospital had to sit back and say, okay, what type of capacity are we going to need?

Our original thought for the field hospital was: We need a site that if we get that first wave of COVID patients, once they're done their acute phase of COVID, they might not be well enough to go home and/or go somewhere else, but we're going to need a site to create that capacity

for them once they're past their acute phase. That was our initial thought of the field hospital.

And that's why we started looking at that time -- and you have to remember, we're in Windsor, so sitting, for the "Jeopardy" fans out there, sitting north of us is the City of Detroit. So we sit south of Detroit. And they were going through tragedy at this time.

So we're preparing, and we have our staff from Windsor working over there, coming back with stories, and let alone the media stories. So we had to wrap our mind around on we have to create capacity somehow and, hopefully, we never have to use it. But our strategy all along is: Prepare for the worst, pray for the best, be ready for everything in between. And that's worked for us during COVID.

COMMISSIONER MARROCCO: Okay.

MR. MUSYJ: So I pop up this letter, because it summarizes kind of what we did with respect to the field hospital. I believe you can see it.

Basically, what it is, it's a letter from myself to our ADM, Mike Heenan, Assistant Deputy Minister.

And what we had to do in order to get the field hospital approved, we had to do what's called a Section 42 application under the Public Hospitals Act, which the Ministry grants authority to create hospital space outside of the existing campuses.

I recall at the time there was a memo that went out from Ontario Health saying, "If you're going to be creating these, just give us notification. Here are the terms and conditions of creating these types of spaces, 42. Do exactly what we did here". And attached to this was the actual lease agreement.

I'll back up a bit. And the letter explains it. So, middle of March, we're talking about nonconventional spaces, where to create them. And we engaged a retired Lieutenant Colonel, Andy Stewart. He was from the British Army and now he is a major in the Canadian Armed Forces. And we engaged him to help us look for alternative spaces in the community, or field hospitals.

You know, we're not used to doing this as a hospital so, you know, the best thing to do is contact those who have done this for a living. And we came across retired Lieutenant Colonel

Andy Stewart, who was phenomenal, by the way, and he did this for a living when he worked in Afghanistan, etcetera.

So we went around, we connected with a bunch of different organizations, school boards, etcetera. I'll be honest, at the time in our head we were thinking, okay, we just have to pick a school gymnasium, you know, like an elementary school gymnasium should be fine. He's the one who said, "No, no, no, you've got to look bigger. You only want to do this once. You don't want to do this multiple times. You want to pick a location that has the ability to grow and is almost larger than, hopefully, you need because you don't want to have to replicate this multiple times in your region. You don't have the bandwidth to do that. You don't have the infrastructure to do that. You don't have the time to do that".

So we connected with a bunch of organizations and connected with St. Clair College. Literally, we pulled out a map. We just went around a map and looked at different large places. And St. Clair said, "Yes". You know, we explained what we were thinking of using it for. And they said, "Sure, come and look at it". The minute

Lieutenant Colonel Andy Stewart showed up at St. Clair was the minute he said, "This is your spot".

It is what's called a "sportsplex", and in my opinion, I mean, I haven't researched it, but I assume many colleges and universities across the Province of Ontario have similar facilities, indoor facilities. If you picture it, what it is, it's a sports arena that, you know, they play their basketball, volleyball, etcetera, in. It has about three or four courts in it and it has a walking path along the top, but it's an arena.

Then, on the outside of the arena is the lobby area to get into the arena. So it's a nice, neat separation between the two. And it has, you know -- I'll go through what it has: It has a back-up generator, etcetera, all sorts of positive things that we needed.

So this was, you know, middle of late March. We went back, connected with St. Clair again and we said, "Can we take possession as early as April 1st?" They said, "Yes". We got a lease done like in 24 hours. They charged us $1; I still haven't paid it.

And from my point of view, these are provincial assets at the end of the day. They're

available in many jurisdictions to be used. And chances are, our theory all along was, when they need it back is when we're no longer going to need it. Meaning, if things are good enough or well enough for them to go back and play basketball and volleyball, that means we're probably not going to need a field hospital if they're back to that. And sure enough, it's followed that path where they've cancelled sports for the spring as well, for the upcoming spring.

So I'll back up first to talk about what was happening simultaneous to the field hospital. Then I'll jump in to what the field hospital offered to us. Just to give a snapshot of --

COMMISSIONER MARROCCO: Can I just interrupt for a second?

How long did it take? You said you signed the lease April 1st, I think it was. How long did it take to build the field hospital or convert the complex to a field hospital?

MR. MUSYJ: We took possession April 1st. We had the residents move in April 18th.

COMMISSIONER MARROCCO: 17 days?

MR. MUSYJ: Yes, and Easter fell in between there.

COMMISSIONER MARROCCO: Okay, thanks.

MR. MUSYJ: I'll explain kind of what happened. And the teamwork, it's a community, it really is a community that made this happen.

Just to give you a snapshot of what was going on at the time. We opened up our assessment centre in the middle of March, to do the swabbing. I think we were one of the first ones in the province to open, so that was similar timing across the province.

Early April we started seeing positive staff members -- and I'll focus on two long-term care homes in Windsor-Essex region -- starting coming back positive. In early April there's multiple long-term care homes in Windsor-Essex, it's an outbreak. When I say "multiple", it started at seven and I think it popped up to ten real fast, like, it started taking off, right?

April 10th, I've been able to find is when Heron Terrace alerted through our Public Health and then, by then, that non-hospital structure was in place. Through the non-hospital lead, that they were in a staffing crisis. Heron

Terrace is a long-term care home, approximately 140 residents.

Multiple calls and meetings occurred to try to stabilize the staffing and get testing on the residents in a more aggressive manner. And where the multiple calls were is that G5 group I showed you before. That's who had the calls. So, again, we're just feeling our way around this time in the sense of who's doing what and how do we work together.

We then immediately have, I recall, calls over April 10th, leading all the way through Easter, calls with Heron Terrace, saying they're in trouble.

EMS was engaged by Public Health. EMS is our ambulance service. They have done a ton of work in our region with respect to going out and doing swabbing, be it on agri-food farms or into long-term care retirement homes. And the results started coming back -- they went into Heron Terrace, and the results started coming back the early week of April 13th.

Just to back you up a bit. April 1st, we take possession of the field hospital. I remember around April 5th, I went to the field

hospital because we were looking at the different types of rooms we were going to build in the facility. They literally had set up in the field hospital three or four different examples of modular units that you could buy prefabricated, or lease. And then there was one that was built by a company we work with, by a construction company that had built one themselves.

So we went through all of them. You know, I went through the first one and told, "Okay, this one's going to be a million bucks and delivery in four to six weeks". "This one is going to be an $800,000 lease, delivery, you know, next week".

And then they were -- they were nice, but the walls were shorter and just didn't really fit. And then came the one that was built by the construction company and our team, said, "Okay, this one is going to be $30,000".

And I said, "Oh, 30,000 for each of them?" And we had already plotted out that we could do a hundred rooms in the sportsplex. We already drew it out. And I said, "So 30,000 for each?" And they said, "No, 30,000 to do all 100". And I'm like, "What?" And they said they're only doing it at cost and they'll build them all. And I

said, "How long will it take?" And they said, "Maybe a couple of weeks". And at the time I'm like, "Great, that's easy, let's go". So we started immediately.

Then I remember, as April 10th started heating up, hearing about Heron Terrace. I went back in. Because they had asked me at the time, our folks said, "Okay, how much time do we got?" And I said, "Well, probably two to three weeks, you know, so near the end of April, we should be fine".

And I went back in and said, "Listen, things are heating up. There's a good chance we might be shifting our focus and we might be having to help out some of these long-term care homes. We need this done the week after Easter. We got to get it done".

So we targeted the Thursday, I think it's April 16th, after Easter, and I said, you know, "Sorry, we've got to work". And they said, "It's 24 hours". I said, "Let's go".

So they pulled it off, and it was a full team effort: our hospital team; this construction company; St. Clair College, their own resources were invaluable because they had their own electricians, etcetera, who knew this building,

and plumbers, and they knew how to get, you know, the services around the exterior. We had to bring it in to the interior of the sportsplex. So it was quite impressive.

So there was another long-term care home, including Heron Terrace, that was in crisis at that same time, showing a massive majority of their residents positive. They decided to remain in place. And we had around the same time discussions with them about even extracting their negatives into our sub-acute facility, and they decided not to at the time just because they had so many positives. I think the number was 70 to 80 percent. They decided to stay in place.

It became obvious that Heron Terrace couldn't sustain their operations, even with some staffing support from home and community services, and discussions started rather rapidly about decanting the residents, for safety concerns. I mean, it's been shared with us: For the 140 residents, at one point they had three staff taking care of 140 residents.

So on April 15th, the Director of Care of Heron Terrace -- all during this, from April 10th to April 15th, it's ongoing discussions

between this G5, myself, the Director of Care at Heron Terrace. She attended the field hospital with her team, and by that point we were getting close to -- it was almost close to completion, and she made a decision to decant the residents as early as the 17th, which is the Friday. But we picked the 18th, to make sure -- we didn't want to do it later in the day on the 17th, we wanted her to have a clear day. So we started taking on the 18th.

And construction, basically, was completed by the 16th.

COMMISSIONER MARROCCO: This is really off the topic, and I don't want to get too far off, but did Heron Terrace indicate what was the cause of the staffing problem, why the staff were not showing up? I appreciate the nature of the disease and everything, but I'm just curious if they said why they were having the problem.

MR. MUSYJ: Yes. And Dr. Chevalier, you can jump in. But this was early on in COVID, a lot of anxiety, a lot of nervousness. No one exactly knew the extent of this.

Again, we're in Windsor, right across from Detroit. They're seeing a substantial amount

of positives in residents. Staff is testing positive. Then, on top of it, you have staff that are, quite rightfully, very nervous and are saying, "I'm not showing up to work, I'm concerned". I don't know if Dr. Chevalier...

DR. CHEVALIER: Yes, I think we have to -- you know, we have the pleasure right now sitting in November and we have eight months of learning behind us. But, you know, back in March and April, people were very, very scared, and there was very little information and we were hearing and watching what was going on in Italy and New York, and Detroit right across the way.

You know, most long-term care homes did not have appropriate PPE. They did not know how to use their PPE, the PSWs. They were scared, and they were just not showing up. They thought, "I'm not getting paid enough to do this", quite frankly. And there was very little support for them.

You know, the physicians were not making rounds to show anybody any leadership in the long-term care homes. It was a very fearful time for everybody. And some of them were sick as well, and of course, you know, they weren't going because they were sick, but most, I think if you look back,

most of it was fear.

COMMISSIONER KITTS: Can I just ask. So when it was moved to the hospital tent, I assume that there was sufficient PPE and probably a sense for the staff that they would be safer. And so did you notice many coming back? Or was that noticeable?

DR. CHEVALIER: So Dr. Kitts, so I'm a hospitalist in the hospital. I travel between both campuses. I'm well-known amongst the staff. The field hospital was staffed by -- I was the lead physician, the clinical lead. I was there rounding on patients, but I was there every day as the lead physician, and I took that responsibility very seriously.

The staff that joined us at the field hospital, some volunteered; many volunteered to go there to work. And some came because they, you know, they were float nurses and that was part of their role, etcetera. But we had lots of PPE. We never had a concern for that.

I will tell you that I was a bit of a hound dog with PPE use, from day one. And David is going to laugh at one of my pep talks that I gave in the beginning. And I will tell you that I

watched people put their PPE on, and I didn't care who it was, if it was David, if it was our Chief of Staff, if it was the dietary staff or one of my colleagues coming in, nursing staff, if I didn't like how they put it on, I told them. You know, nicely, obviously, and respectfully, but I would take them out and I'd say, "I don't like how you did you that. Can we go back over your PPE use?" And that was donning and doffing.

I will say again, you know, the history, it feels kind of funny to go back through all the history, when we came to the field hospital, but I think it's extremely important because I think it was a storm that was happening. You know, in March, when we were seeing all of this unfold, you have to remember the anxiety in the hospital. Just doing rounds, you could feel the palpable anxiety from staff about -- you know, we were not wearing masks in the hospital yet at that time. There was no mandatory masks. I'm going to tell you, I stuck my neck out as a chief and I walked around and I said, "Put your masks on, everybody. Get your masks on".

We had some physicians -- one of my colleagues, actually, one of the doctors that

worked with me at the field hospital, her husband was making 3D printed shields because we didn't have shields at the time.

I was being very aggressive, I guess, and very protective of the staff, whether that's physicians or nurses or whoever it was on the floors. You know, I went every morning, and this is before we went to the field hospital, to kind of give pep talks to calm the staff and say, "Guys, we're going to get through this, but we're going to get through this together".

So when we moved to the field hospital, I think that everybody certainly knew that we cared. It was very important for them to know that I recognized their risk of stepping into that arena, if you would, or that gymnasium. You know, we had staff living in hotels. We had staff living in trailers on their front yards so that they wouldn't affect their families. Anxieties were high, and they needed to know that they were safe. And they did know that, I know that they knew that.

COMMISSIONER KITTS: Right. So you brought medical leadership and an abundant supply of personal protective equipment.

The question is: Did many of the staff

who left the long-term care home because of anxiety and fear come back, or were they invited back to the tent?

DR. CHEVALIER: So the staff from long-term care never worked at the field hospital. The staff that, if you would, walked away from Heron Terrace, they are employees of Heron Terrace, not of Windsor Regional and not of the field hospital.

Remember, again, historically, it was only at the time really when we were launching the field hospital that hospitals were given, you know, the mandate of going into long-term care to help with all of that. Prior to the field hospital, that was not our purview as an organization.

MR. MUSYJ: So what we had to do, the concept of decanting was to, of course, extract the positives. Because to this day we think when you -- our theory, you can see it later, is if you have five positives in long-term care, you've technically got ten. You're chasing your tail at a certain point. Especially in a lot of these facilities, there's no way they can cohort safely in place.

So the issue was to get them down to a

level of residents, that their staffing they had could safely take care of the remaining residents of Heron Terrace safely and from a proper IPAC point of view. So at the same time we came into Heron Terrace with our IPAC teams. And the long story is you get into April, that's when the hospitals and our region and across the province divided up the long-term care retirement homes and really got in with respect to prevention measures, working as partners. And if there's one thing coming out of this, too, is that needs to continue.

Eventually, when COVID goes away, if it goes away, we got to continue those relationships. We cannot lose the relationships that have been formalized between hospitals and retirement homes and long-term care homes regarding prevention partnerships and dialogue. It's been phenomenal.

And we've seen recently, when we've had other outbreaks, those relationships allow us to immediately go back in. We go in all the time now anyhow, but to go back in, help stabilize and avoid larger outbreaks and avoid eventual deaths.

COMMISSIONER MARROCCO: Right. Does that have an effect on terms of staff then in terms of them staying?

MR. MUSYJ: Exactly. So by having those "SWOT" assessments -- and I can tell you personally, I went into the long-term care retirement homes, part of it was selfish because I want to pick my future house, but I went in to be there for support and to show we're all in this together, which we are.

We've had subsequent Zoom calls with staff who weren't there at the time, didn't show up to be part of it, to ask questions, to talk to them, to provide that, hopefully, that confidence, and to deal with what Dr. Chevalier stated.

Our most nervous time as an organization was before we started getting positive COVID patients. We were walking on eggshells. We were scared to death, our staff was. But we did the training, the education, the tabletops, the ongoing support, that once we started getting COVID patients in the hospital, then all that kicked in. And our team's done an amazing job.

To this day, even though we're a pretty large hospital, knock on wood, we've only had 14 positive staff members, and all from the community and not one spread within the hospital to another staff member or to patients. And that goes back to

what Dr. Chevalier stated. It's continually reiterating that we're there for you.

I mean, I went into the field hospital. Dr. Chevalier made sure I had proper PPE on, and when I came out, I took it off properly. Again, it's to show we're all in this together and we can do this together and it's, knock on wood, going to work.

COMMISSIONER MARROCCO: Do I understand it that all of the long-term care homes in the region are partnered with a hospital, so now they have access to the expertise that's resident in the hospitals, which the public spends all kinds of money creating in the first place?

So now the homes can access that because the partnerships exist?

MR. MUSYJ: Yes.

DR. CHEVALIER: Commissioner, in our region we have 19 long-term care homes and 25 retirement homes, and they're split up regionally. So Windsor Regional is partnered with a group of those for IPAC supplies, practice, any outbreaks, early intervention. Hotel-Dieu Grace Healthcare, who is our sub-acute hospital, they have a proportion, and then Erie Shores, which is our

other small community hospital out in Leamington, they have a proportion of those as well. So yes, they --

COMMISSIONER MARROCCO: No, go ahead, Doctor. I didn't mean to interrupt. You finish what you were going to say.

DR. CHEVALIER: I think that's been a very, very important piece in prevention and education for the staff and confidence for the staff to know, and the families and patients there, that they have appropriate education around what to do to prevent COVID. They can help with cohorting suggestions, they can help with PPE supply, which of course was a huge issue.

You know, quite frankly, you had PSWs walking around with the same pair of gloves they had put on for you, they would take off and then they would use for Dr. Kitts in the next room. And they didn't understand. They didn't understand infection control because that's not been a big focus of their training as a PSW, pre-COVID, which of course will change in the future.

MR. MUSYJ: So Windsor Regional has responsibility for 21 of those long-term care retirement homes. Physically, our team goes in

twice a month physically. We have weekly phone calls with every single one of them, and we're on speed dial.

By going through all 21, part of that was not only the education and training, and so we looked at the homes to say, if this home has a positive, there's going to be an issue in this particular home. When we went in, we developed plans with them to say, okay, if you get a positive, where are you going to cohort them. And some of them had places, segregated spots, that they could do it in. A lot of them don't.

So they're on our hypersensitivity list, meaning, if positives start, lights go off because we say this could wind out of control really fast in this particular home.

COMMISSIONER MARROCCO: Was the partnering or the pairing -- I guess pairing is probably the better word -- was the pairing voluntary, or how did you do that?

MR. MUSYJ: Yes, and it took some trust. So what we did is the three hospitals just went through the list and divided them up, as Dr. Chevalier said, proportionately or equitably, based upon the size of the hospital. And

geographically we tried to do it that way so they're close to the hospitals.

COMMISSIONER MARROCCO: Right.

MR. MUSYJ: But it was trust. We had to make it very clear when we were making that first phone call to say we want to come in is we're coming into help, which we were, and we're doing this from a partnership point of view.

Again, that's why I felt it important for me to go to try to express that, that we're all in this together, that we cannot do this alone. And this is not meant for us to criticize your operations, we're here to help. If you want to tell us to stop, we'll stop.

In general, it was fine, 95 percent had no issues. There was 5 percent it took a little bit of, you know, convincing to get the invite in, but they did eventually. And now it's 100 percent because the relationships have developed, the trust has developed. But you got to earn that trust.

So we couldn't come in, you know, guns blazing and saying, "We're here to tell you how to run your place". We're here to help.

COMMISSIONER MARROCCO: Was Heron Terrace private, municipal, or provincial?

MR. MUSYJ: Private.

DR. CHEVALIER: Private.

COMMISSIONER MARROCCO: Does it matter, in terms of the model, whether you're dealing with profit, not for profit, in terms of the preparing and that sort of thing?

MR. MUSYJ: No, not as concerned the pairing. I know there's studies and things about people have said the differences in the outbreaks, etcetera. We haven't seen that.

Clearly, in municipal homes, it's funded differently. We used to run a long-term care facility at Windsor Regional Hospital and we know what the funding is and to operate it, what you're operating at. So the municipal homes are funded and staffed differently than private, or other homes, so...

COMMISSIONER KITTS: Can I ask a question about the cohorting? So I understand that the tent was created to help cohort COVID-positive patients from long-term care.

MR. MUSYJ: Well, it wasn't created, and just Dr. Kitts will just -- we've heard that before. It's not a tent, it's a building, the field hospital. Just so it's on the record, people

don't think it's a tent in the middle of a field.

But it was originally created, in our mind, to create additional space for patients past their acute phase in the hospital that had nowhere to go but still needed care.

In early April, it shifted. When this started happening, we said -- we got together as a team and said, "Okay, we're starting to see this long-term care thing break loose. Why don't we shift gears and use it for this?" And immediately everyone said, "Yes, let's go. It's the right thing to do".

COMMISSIONER KITTS: We now know that cohorting is an important IPAC measure. A lot of the homes don't have the ability to cohort. So my question is, when you're in those homes and now that everybody has seen how good it was for the Heron Terrace, is there pressure to move patients from long-term care homes who have outbreaks and cohort them at the hospital facility? And if so, who makes the decision as to whether they cohort in place or cohort at the hospital facility?

MR. MUSYJ: So the way it's worked is, right now the process would be Public Health Medical Officer or Health would work with the

medical director of the particular home, along with the director of care at the particular home. And they would collectively make the decision. They might, you know, ask us for advice or suggestions, but we'd leave it up to them to agree on the transfer to the field hospital.

The retirement homes, which a lot of them don't have -- you know, each person has their own individual physician. There might be a physician over the top of it for the corporation. They've indicated the same thing, if they start getting outbreaks, they got us on speed dial. And we're, right now, hours away from ready to go, if needed.

COMMISSIONER KITTS: And does the field hospital have significant capacity, or is that filling up as well?

MR. MUSYJ: The field hospital has capacity for 100.

COMMISSIONER KITTS: Okay. So you're not using it right now?

DR. CHEVALIER: No.

MR. MUSYJ: As of right now, we are not, but by the time we hang up this call, we could. We have one home in our (overspeaking) --

DR. CHEVALIER: So Dr. Kitts, after we cleared Heron Terrace and returned their patients, we have not had to go back to the field hospital for any of the local outbreaks. They have been managed because of that relationship and our ability of healthcare organizations to go in with their IPAC suggestions and practice and cohorting.

We have had a number of outbreaks in our community since we actually, if you would, turn the lights out at the field hospital. It's still all there, ready to go at a moment's notice. But we've done all these other things in the meantime with all those other outbreaks and have managed quite well, to be honest with you.

COMMISSIONER KITTS: Yes.

DR. CHEVALIER: So it's a combination, and I think that's what's really important for us all to remember, it's a combination of things to help our communities in long-term care and retirement home care.

The IPAC, the prevention, is so very important. And then, you know, you go down your list of prevents and tests. And, of course, now we can get testing on turn-around much quicker than we could back in the springtime.

So you can effectively cohort if you have the capacity in the long-term care home. And most of them have scaled back their patient numbers, so they have left themselves, if you would, some wiggle room to cohort, which has been helpful. Of course, maybe if you're not trying to get into long-term care because there's not as much capacity, but... And then the field hospital or extrication of the patients, when you've got an outbreak that's too big, is really of paramount importance, I think.

COMMISSIONER KITTS: Thank you very much. That's very, very clear. Thank you.

COMMISSIONER MARROCCO: Commissioner Coke.

COMMISSIONER COKE: May I just ask the question.

In terms of when that decision is made that we're going to transfer somebody out to the field hospital, does that require the resident or the family's approval or permission to do that?

MR. MUSYJ: Yes.

COMMISSIONER COKE: Okay.

MR. MUSYJ: Yes, that takes place -- so with Heron Terrace, it took place, and some of them

initially said "No". And then once they heard about what was happening at the field hospital, they would say "Yes". And some of them stayed in place. So I don't know.

Dr. Chevalier?

DR. CHEVALIER: I was going to say, the other issue, they need consent, of course, to move there. There were some patients that I felt -- because all those calls would go through me so that I would know who was coming.

You know, in long-term care, it's not all just seniors, you know, that have complex -- some of them are younger people with Down Syndrome, etcetera. If they were clinically very unwell, needing high oxygen already, and their family wanted them to be a full resuscitation, it is not appropriate, in my medical opinion, to have them go to field hospitals. So we would divert those as they came up to the acute care facility, where the care needs would be better met if someone was needing ICU, for example.

So the family has to consent, but you do have to know the clinical scenario and the goals of care and expectation for resuscitation and whatnot of the patient prior to moving to a field

hospital.

COMMISSIONER MARROCCO: So part of it is whether the person's condition can be --

DR. CHEVALIER: Managed.

COMMISSIONER MARROCCO: -- if necessary, managed at the field hospital, it's part of the -- so you make that decision?

DR. CHEVALIER: Yes. I made those decisions when we were having the intake of the patients, yes. I mean, we did have to move some out to acute care. That's why you have to have someone who's seasoned and willing to make those decisions.

When people with COVID start to do poorly, they crash fairly quickly, so you don't necessarily have time to move them. So everybody needs to know at the outset what the goal is with that patient's care. And, of course, coming from long-term care, many patients are not full resuscitation. They are, you know, aggressive medical management but not to go to ICU.

We do know, of course, that patients with COVID that were -- of course, back in March time or April, remembering, you know, we didn't have much experience with intubating COVID-positive

patients, but at this stage in your life, if you're requiring intubation, you are not going to survive, quite frankly.

MR. MUSYJ: So we have to remember again at this time a lot of the families hadn't seen their loved one or talked to their loved one, there wasn't enough time for like four to six weeks. So those were the stories we were getting once they moved to the field hospital.

So I just outlined some of the things on this slide. It gives you a photo of what it looked like, all the benefits of being in this facility, aside from the price. It had overhead sound for music; it had a back-up generator; a separate area for hot and cold, meaning hot zone being where COVID's at, cold zone being outside in the lobby area. Making sure we have proper donning and doffing areas; easy access in and out for food supplies, residents, to come in and out, through ambulance. We had our own lab and pharmacy in there. It was basically a satellite hospital facility.

If you look at this, what we did is we brought electricity and water into the middle, so there's sinks with running water. There's Pyxis

machines for drugs, the hospital computer system. If someone called the hospital main switchboard, you could ask for the field hospital and you would get directly dropped over here.

We created it as if it was just an individual hospital site.

It has WiFi. Why that's important -- and we enhanced it -- is we could run a hundred iPads, and we bought iPads for every single resident so they could communicate. It was on a stand and our staff would help; they could communicate 24 hours a day, if they wanted to, with their family. From a resident point of view, we had some circumstances where residents were passing away and the family just wanted to watch and be with them remotely. We set that up.

At the same time as things evolved, some of these residents really liked their TV and they were into Netflix and TV. We had it going. And they thoroughly enjoyed that as the time evolved. And they had that, stuff they were not able to have at their long-term care home.

For those, and we talk about that, I know because at the time we were hearing about it, is you shouldn't move the residents to these

facilities, they should stay in place as best you can. Yes, that's great, but they were staying in place, and I'll be blunt: They're going to die in place. The goal here is to survive.

The team did it in an amazing fashion, not only survive but survive within a very warm and caring environment. And if they did pass away, they passed away in that same warm and caring environment. That's no disrespect to the long-term care home at the time, but they just couldn't do it. And some just can't do it. It just starts unwinding so quickly, they can't do it.

I don't know, Dr. Chevalier, if I heard that properly.

DR. CHEVALIER: You know, there was a lot of heavy-handed comments. One in particular that was very, I thought was hurtful, actually, from a geriatrician in Toronto, about moving this population into the field hospital.

But I'll be honest with you, Commissioners, those patients -- you know, we had 53 patients of that 150-bed facility, and had we not moved them, that whole facility would have been infected. Truly, those patients die of neglect, and that is just horrific, in my opinion.

While we moved them to a gymnasium, yes, we had wonderful staff, the patients were cared for. And I think, in Canada, I think our citizens deserve that. If they died, they died with dignity and their family being able to at least know what was going on, and we were with them that whole time. You know, we had nurses sit with patients. And I promised every family member -- I mean, I spoke to them every single day and I -- no one will die alone if they were going to pass with COVID at the field hospital.

I think at the time it was the best thing that we could have done for our community. I really feel strongly that I think that, for $50,000, you guys, with the healthcare expenses that we waste, I think that if this health community survive a COVID outbreak in long-term care, that is -- I think it is well worth and I would do it again, and that's why we only have the lights off, and I'll go there tomorrow if we need to. I --

COMMISSIONER MARROCCO: Go ahead, Doctor.

DR. CHEVALIER: No, that's all right. You go ahead, Commissioner.

COMMISSIONER MARROCCO: I have some difficulty with the idea that for the patient's own good, and this notion that for the patient's own good, don't move them.

That just seems to me to be a very, if you'll pardon the gender-specific term, a paternalistic approach. Each one of these families, or the individuals, if they were competent, were asked to consent, and they consented. And I don't understand, quite frankly, why their consent doesn't -- it seems to me, in terms of what you were doing, their consent counts for something. If they agree to go there, why would somebody come along and say it's not good for them? I just think that that disregards their control over their own affairs.

I think it's an excuse, quite frankly. It may very well be an excuse for not doing something that needs to be done.

DR. CHEVALIER: I would totally agree with you. I think the other thing is, I think it really is almost ignorance of what the fear was at the time and of the inability to stop this thing. Once it gets into a home, it's like wildfire, without the proper help. And at the time we

definitely did not have the proper help to get them, other than this. And this worked wonderfully. Honestly, it did. And the relationships that were built.

The patients were very, very, well cared for. Had my mother been sick, I would have been happy for her to have been there, really. I can honestly say that. Yes.

COMMISSIONER MARROCCO: On the staffing side, one of the things we've heard is that the hospitals were able to staff because of the anticipated wave of people that didn't show up, or I'll put it differently. The hospitals are gearing down in certain areas, created a kind of surplus that could be employed in the field hospital. Is that kind of a necessary component to this?

MR. MUSYJ: Yes. Yes, at the time we were ramping down surgeries. So, as a result, we had staff "available", a lot easier back then.

However, even through today, we've continually planned ahead. And one of the issues that we came across was this concept of tuition fee set-aside. It's for colleges and universities. I guess, when you sign up to be in a college or university, the college or university holds back a

certain amount of the tuition and then reinvests it in work-study programs, etcetera, for the students.

So what we worked very closely with is St. Clair College, in order to increase, aside from hiring, is using -- it's not additional monies, it's existing monies -- is using these monies to hire these nursing students back into the hospital, to help support our staff.

You have to remember, a lot of these nursing students are working as PSWs in long-term care retirement homes as we speak. And a lot of them are looking for jobs, in addition. Aside from those working there, which stay there, there's more out there looking for jobs. So you have to do creative things like that in order to help support your staff.

So we're ready to go again. If we have to flip the switch again, we have staff ready to go from our various areas, even though our hospitals are at 100 percent capacity, to go back in very swiftly for the first 30 patients that go in.

It gets tighter after that, but part of it as a result of having the nursing students available to help support our acute care hospital staff, as well as the staff here, at the field

hospital, taking care of quote, "long-term care retirement home patients".

COMMISSIONER MARROCCO: And that piece was worked out during the period from March to today, somewhere in there you address this problem that way?

MR. MUSYJ: Yes. So as, you know, we started ramping back up surgeries and, of course, the hospital started filling up, we have to think about, okay, where are we going to find the staff to restart the field hospital? How are we going to do this?

And working with our college, who is amazing, St. Clair College, Patti France, she said "Hey, what about this?" We're like, "Bingo, perfect". And it's existing dollars, it's not new dollars. It's existing programs. And, again, everyone should be taking advantage of it and, you know, working and getting these students in to the hospitals and to the long-term care retirement homes.

COMMISSIONER MARROCCO: Okay.

MR. MUSYJ: So this slide here shows the statistics that we talked about. I mean, some examples, pre-COVID, we had patients that couldn't

walk. Came into the field hospital, clearly in wheelchairs and/or stretchers. They walked out of the field hospital. So that's the level of care that Dr. Chevalier and the team provided is, they weren't walking, it had nothing to do with COVID; they started walking again.

So our focus, you know, lessons learned, the first one is communication is critical. What we made sure is we communicated, as stated, about the consent and getting consent. I called every single POA that her family member moved in.

Dr. Chevalier called them first, the clinical team, to say "They're here", boom, boom, boom, "This is what we're going to do. Here's the game plan". As Dr. Chevalier stated -- and I state it for the record, she should be sainted as a result of this because she called the families every day, which was critical. And I called them when they came in, to say, "Thank you for trusting us".

What we did, here is a photo of a patient's room. We wanted them to send us all the photos they had of their loved one and their family members, and we plastered it as wallpaper in their

rooms so the resident can see that. And also you'll see a photo there: We made it look as if there was a window or windows, and each of the rooms had two of these. They could look out and look at an outdoor field or garden, so it made it look like they were in a house or in their room.

Of course, like I said, we had the iPads, etcetera. But communication, communication, communication. And we called on discharge, unfortunately, when they passed away, called as well, and to a person.

First of all, they all wanted to thank Dr. Chevalier and the team, but to a person, even when they lost their loved one, they said they were able to spend time with their loved one. And they knew going in -- and there's some that went in and are shocked to this day their loved one's alive.

DR. CHEVALIER: True.

MR. MUSYJ: And they can't believe it, because they knew going in, their loved one was not in a good spot.

So our second point on lessons learned is physician leaders like Dr. Chevalier and others. I mean, it's endless, but you need that.

Again, when we did the costing on this,

we were staffed "rich"; it was 700 bucks a day. So we're not talking about a considerable amount of money for taking care of individuals in the field hospital. It was an amazing thing.

Goals of care, I don't know if Dr. Chevalier wanted to talk about the importance of that.

COMMISSIONER MARROCCO: Just before you do that, two things. First of all, Dr. Chevalier, we all heard what was just said. There's a transcript in case you need it in the future to prove what was said.

Secondly, what did it cost -- I think you gave us this figure a few minutes ago, but I just want to be clear about it. What did it cost per bed to do this? What did it cost to do this?

MR. MUSYJ: Yes. So our cost was, per patient, $700 per day. Right now, you use a cost -- Dr. Kitts would know this, it's about -- the Ministry uses about $1,300 a day for acute care, about $500 a day for sub-acute/ALC. So we were at $700. And that's with, you know, staff beyond appropriately, far greater than of course what they would get at a long-term care home, but again they were sick.

And we wanted to make sure the trust and the confidence, to say, number one, there's going to be communication; number two, you're going to be able to see your loved one, via virtually; and number three, you're going to be confident of the staffing. From a physician point of view, as well as a nursing point of view, that you're going to be confident they were going to be taken care of. And again, for $700 a day, I think it was an amazing investment. Aside from the construction costs.

COMMISSIONER MARROCCO: Okay.

DR. CHEVALIER: So, following along our lessons learned there. The goals of care, you know, to make the transition of patients smooth required some thought-out efforts, actually, which is well worth it and, quite honestly, you guys are looking at long-term care overall, and these things truly should be already in patients' charts and updated regularly. But clear goals of care, or resuscitation wishes by families.

There needs to have updated medications lists, and their complex medical history list should all be updated in a concise way, to be handed off to either acute care or a field hospital

or wherever they're going.

So every family member needed to have that goals-of-care conversation prior to coming to us while they were getting consent, because that did make a difference.

I did ask that every patient have somewhat of, if you would, a friendly summary of who they were. So, you know, if David came into the hospital, I wanted to know what did he go by. Did he go by "Dave"? Did he go by "David"? Who was his contact, where he grew up, what he liked to do. So that when we quickly walked into a room and they were scared and they were being moved, that we could quickly communicate with them in a friendly sort of way, as we were all new team members to them.

We pasted those right on the outside of the doorway on your way into the patient's room, so that everybody had access to that, whether that was the dietary staff delivering breakfast, lunch or dinner, or an ambulation person, or me as a physician, or the nursing staff.

So I think it provided us with a warm environment so that we could, you know, talk to them about things that they liked. Remember, many

of these patients had dementia. So you had to quickly make some ground to be friendly and make them feel safe and cared for, comforted.

We did have to move one patient out from the field hospital that rapidly deteriorated and he was a full resuscitation, but only one, actually. So that was good, I guess.

The second or fourth point there is to make it friendly, so that was with our family pictures, and we had a big colour printer. Of course, we were receiving patients all the time so this was an ongoing thing to be pasting up pictures. And we had young man who was mid-fifties, developmentally delayed. So he was a big draw'er. So we had endless stacks of paper and magic markers, and then his room was literally plastered with his pictures that he would create for all of us.

And then again five is our "prevention is key". Our SWOT teams that went in to, you know, Heron Terrace to help them clean up, because it took 50-some days for them to get out of outbreak, which, you know, that was a long time. And we were still receiving patients in waves from them as they were trying to clean up and cohort their patients

so they could get themselves out of outbreak.

Again, Commissioner, you have to remember, when we look back at April, now moving into May and June, we were not yet as a province, our Public Health was not making a statement of how we clear these patients and decant them. So what do we do with them? Even when they were in the hospital, how do you clear them of their infection? Do you need two negative swabs to send them back to long-term care? Do we need just time-based?

That was still up for debate, which was a part of our dilemma, if you would, at the field hospital. Because now we had this cohorted patient at the end, and what do we do with them? And Heron Terrace was still in outbreak.

So we've moved a long ways from that knowledge base back in May and June to where we're at now. And now we have time-based clearance. You know, if you had COVID now, 14 days and you're cleared, and then you can go back to your nursing home or long-term care retirement home, or wherever it is; go back to work, if you're working. But we didn't have that back then. So family members were anxious still about their family member still being, you know, deemed not well enough to go back

to long-term care.

So it was important for us to, of course, care for them and make it an enriching environment for them, which we did, and it was fun, actually. Those were nice times to celebrate, quite honestly, after coming through that dark time.

MR. MUSYJ: Yes, so Dr. Chevalier had tea parties, balloon parties.

DR. CHEVALIER: Oh yes. We had birthdays to celebrate.

COMMISSIONER MARROCCO: Were you able to do testing at your own lab?

DR. CHEVALIER: No. Unfortunately, Commissioner, Windsor does not have a public health testing facility here. That was closed, unfortunately. I don't know how many years ago, David, maybe seven years ago here.

So all of our testing has to go to London. Of course, that was part of our problem with all of the outbreaks at the beginning. The backlog and the turn-around time for testing was extraordinarily long. So that was part of Heron Terrace's problem. They would test and they wouldn't get their test results back for five days.

Well, in the meantime, the virus is just replicating in the long-term care home.

So we don't have any testing available locally in Windsor. It all goes to London. And at the time, I don't even think they were going to London, David, back in April. I think they were going to Toronto. So London wasn't even an option for us.

So that, you know, it was just -- it was the perfect storm for a lot of problems.

COMMISSIONER MARROCCO: Did your lab at the hospital have the capability of doing the test?

DR. CHEVALIER: No.

MR. MUSYJ: No, no. At the time you needed, I forget the levels, I think it was Level 3 lab. We don't have that.

COMMISSIONER MARROCCO: Okay.

MR. MUSYJ: So I mean, now we've acquired a PCR machine, because since then they've developed the stand-alone machines. We've acquired it. Just like everyone else, we're waiting on test kits now to use it.

But London is a great partner. Their turn-around time on the hospital side right now is very tight. You know, within 24 hours basically,

36, we get turn-around time.

The Public Health side to which long-term care runs through has struggled from the start. And that's .6 is, because there's delays -- you know, the approach we've taken is: You get a positive, you go in and test everybody, cohort test, cohort test.

There's multiple studies on this across the world that it works; if you can't cohort, you extract. And I know, you know, there's studies, you know from Hong Kong, let's say, you just extract, forget about cohorting. And you know, I think we lean towards that, too, because again, as stated in point 6, our position is: If you have five positives in long-term care or retirement home, you have to assume you've got ten.

We indicate there, yes, moving creates risk. However, the conditions in which they're in, the goal is survival, and that's our focus.

COMMISSIONER MARROCCO: It wouldn't only be an assumption. I mean, there is a precautionary principle that has been suggested as an approach and that you're supposed to apply, which would be you assume ten and you don't wait for the science. You make the assumption.

MR. MUSYJ: Yes. As I stated, plan for the worst. So that's the purpose.

Sorry, Dr. Chevalier.

DR. CHEVALIER: I was just going to say, and again you have to kind of go back in time. But Heron Terrace was having such a hard time getting their testing turned around quickly enough, that I remember our VP in charge of the field hospital, Karen Riddell, who is the lead for our IPAC and the SWOT team, and I am also in charge of the testing centre, the COVID assessment centres, as the lead physician.

I remember Karen and I being so frustrated trying to track these tests that were getting done at Heron Terrace. And I said, "Karen, we need to stop and we need to put them all through the hospital, put them all under my name and make them as if they're a hospital patient", because we could get priority in the broken system at the time.

And that actually helped because we would get the test results back quicker, as opposed to just having them go through the normal testing of long-term care patients at the time. And that did, I think, swing the tide a little bit because

we could actually get the tests and get the patients out. Because at one point, honestly, it felt like we were in a sinking ship because we could not get them out of outbreak. But it was largely because of that long turn-around time in the testing.

MR. MUSYJ: So, Commissioners, that's the end of our "formal presentation". And if you have any more questions, we can talk, we can answer, try --

COMMISSIONER MARROCCO: Commissioner Coke?

COMMISSIONER COKE: I'm just curious, given the success that you've had with this model and how you've approached it here, if there's been a lot of sharing with your colleagues across the Province or through some mechanism in terms of lessons that others can learn?

MR. MUSYJ: Yes. So we received phone calls from various jurisdictions about it, about the field hospital, how it was created, how it works. And Dr. Chevalier and I trying to recreate, remember history, it was late June we got a call from the Ministry, and I think maybe the pressure in the system alleviated a little bit and now we're getting far more calls about the field hospital and

the concept. But again, unfortunately, I'll be frank, is I think some of those comments out there of not moving were very strong and have not allowed people to really aggressively look at this. So, hopefully, that goes away.

COMMISSIONER MARROCCO: Which Ministry?

MR. MUSYJ: It was Health reached out early. Long-Term Care reached out recently.

COMMISSIONER MARROCCO: Did you ever hear back from them?

MR. MUSYJ: Just I don't know, Dr. Chevalier, the phone calls were, you know, positive. We shared all the information we had, basically shared what we shared here, and we haven't heard anything. You know, other municipalities have called, other provinces have called. So we shared exactly what we shared here and how we set it up and all that type of information.

Chatham-Kent Health Alliance has built one themselves, used the same contractor we did, got the same price. So good for them. And so they're ready to roll, too, if needed.

Again, our goal is we hope to never have to go back into the facility, to care for

long-term care patients or retirement home patients, or any patients for that matter, because we're really focusing on the prevention phase, and that's been relatively successful so far in our region. But we're ready to go, if need be, and it's there. And we know it works. And I know the minute we say to staff this time, "Are you interested in going to work in a field hospital?", we'll probably have 5,000 hands in the air, saying, "Let's go". Because they know how successful it was.

COMMISSIONER MARROCCO: Well, I don't think we have any further questions. It was a very complete presentation. It's very helpful to us. We have been struggling with this, and it's very helpful to actually talk to someone who actually did it, and understand the results. It's very, very helpful, makes it real.

So thank you very much for the time, and with your permission, we may circle back if we're missing a piece of information.

DR. CHEVALIER: It's been my pleasure, Commissioner, to share this.

I think there's a lot of changes that need to come to long-term care that COVID has

uncovered. So they're a long time coming. So you have great responsibility on your shoulders, and if I can ever be of help, please don't hesitate, I would love to participate in it. And I wish you the best pulling together your report.

COMMISSIONER MARROCCO: Well, there's a transcript of that comment, too, Doctor. We'll remember that. Thank you for the offer. Much appreciated.

DR. CHEVALIER: You're welcome.

MR. MUSYJ: Thank you, everybody. Please stay safe. And we're there for you if you need anything; just holler, we'll respond.

COMMISSIONER MARROCCO: Thank you.

-- Concluded at 10:25 a.m.

REPORTER'S CERTIFICATE

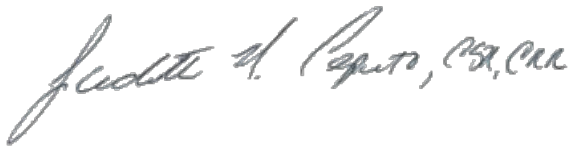
I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed at my direction;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 20th day of November, 2020.



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