

FAILING OUR MOST VULNERABLE

**A Presentation to Ontario's Longterm
Care Commission**

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David N. Fisman and Ashleigh R. Tuite

**Dalla Lana School of Public Health and
Institute for Pandemics, University of
Toronto**



**MARCH 2020: WHAT DID WE
KNOW ABOUT COVID-19?**

**KNOWN HIGH
CFR IN OLDER
INDIVIDUALS
&
PROPENSITY
FOR
OUTBREAKS
IN CARE
SETTINGS**

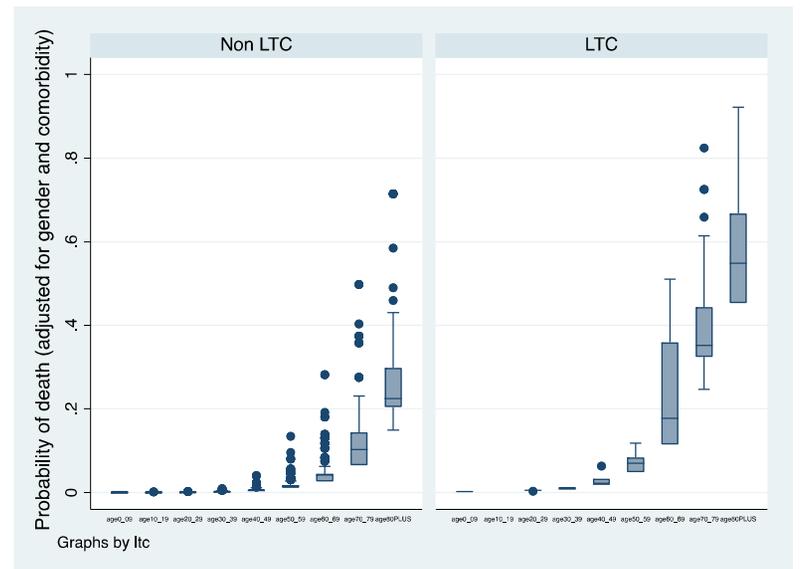
- **Known marked increase in CFR with age (Hubei, February 2020).**
- **Initial recognition of “community transmission” in Washington State and British Columbia: high mortality outbreaks in LTC.**
- **Warnings from other countries.**
- **Known vulnerability of LTCF to communicable disease outbreaks (e.g., influenza).**

**WISDOM
FROM
SOUTH
KOREA,
MARCH
22, 2020.**

“Visitors and nursing persons in these group dwellings are more likely to be infected and/or infecting others as well, given asymptomatic nature of C19...I add this C19 virus is good at having humans to distrust each other, creating ungrounded fear and anxiety, and having us lose the precious elderly, the source of the human wisdom. It attacks everyone yet discriminates those weak and old by hitting them hard. May I suggest Canadians, Koreans and others keep using Trust virus and Mutual Care vaccine to defend this ugly C19 virus? Probably it would be another 12 to 18 months to find a cure for this C19 and exit.”

—Dr. Asaph Young Chun, Director—
General, Korean Statistics Institute

CFR IN ONTARIO, WAVE 1

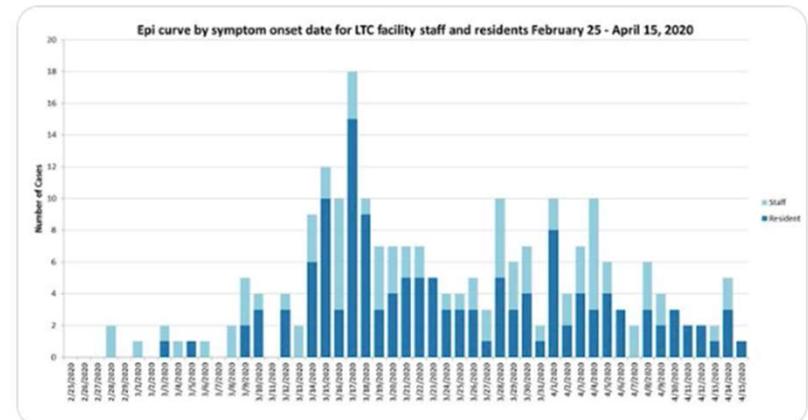


GOOD PRACTICE FROM B.C.

Insights from Dr. Michael Schwandt (@michaelschwandt), posted on Twitter, May 2, 2020.
<https://twitter.com/MichaelSchwandt/status/1256728638243790848?s=20>.



If anyone tells you that massive and deadly #COVID19 outbreaks in #LongTermCare are "inevitable," please tell them otherwise. We've managed 17 LTC outbreaks in Vancouver Coastal Health and have developed some useful measures, which we think are life-saving. 1/





Michael Schwandt
@MichaelSchwandt



Replying to [@MichaelSchwandt](#)

When it comes to LTC staff, monitor symptoms closely, test early, and test broadly, and support workers from immediately staying off of work for any compatible symptoms. It is well-known that symptoms can be very low-grade... 4/

GOOD PRACTICE FROM B.C. (2)

9 FUNDAMENTAL ERRORS

1. Denial of community transmission in Ontario, March 2020.
2. Failure to acknowledge transmission by asymptomatic, presymptomatic and minimally symptomatic individuals (ongoing).
3. Application of influenza outbreak protocols (3 tests and done) to COVID-19 outbreaks in LTCF: Rule of Rescue, absence of vaccine or prophylaxis.
4. Failure to emulate successful strategies from B.C. in a timely manner.

9 FUNDAMENTAL ERRORS (2)

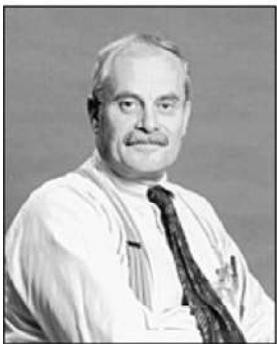
5. Failure to "decouple" LTCF network by restricting staff to single facilities, resulting in a killer network.
6. Failure to provide adequate PPE to LTCF staff, and thus failure to create bidirectional protection for staff and residents.
[<https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1270/5898577>]
7. Failure to create economic security and dignity for part time workers at LTCF, which would obviate the need to work at multiple facilities (again, could follow BC's lead: fair pay, benefits).
8. Failure to apply high throughput tests to identify presymptomatic infection in PSW and other LTCF workers (ongoing).

9 FUNDAMENTAL ERRORS (3)

9. Failure to apply precautionary principle.

"Your job is to make it stop".

–Dr. Jonathan Freeman



1939-2000

Jonathan Freeman was a faculty member at the Harvard School of Public Health from 1990 until his death in May 2000. This symposium honors his many contributions to the Department of Epidemiology and the Infectious Disease Epidemiology program that has evolved since his time here.

D.F. EMAIL TO COLLEAGUE IN CMOH OFFICE, MARCH 24, 2020

“Why is [Dr. Yaffe] doubling down on the community transmission stuff? Have you seen the poppycock she’s been spouting in the globe? [Name], we are admitting people to twh whose exposures are raves and Bay Street tax seminars. No travel.

What [Dr. Yaffe] is doing is awful. It undermines public health messaging and is patently false. We have a long term care outbreak now where staff worked with mild respiratory symptoms because it couldn’t possibly be covid. These psw joked about it. But they hadn’t travelled and didn’t know anyone with covid, so according to [Dr. Yaffe] that’s unlikely covid. I’m assuming you’re all up to speed on what mortality of covid looks like in long term care...that is coming.”

Incidence per 1000

**CATASTROPHE
OBSERVABLE AT OUTSET
(EMAIL TO LOCAL MOH'S
APRIL 11)**

11mar2020 18mar2020 25mar2020 01apr2020 08apr2020
Date



From: **Risk Factors Associated With Mortality Among Residents With Coronavirus Disease 2019 (COVID-19) in Long-term Care Facilities in Ontario, Canada**

JAMA Netw Open. 2020;3(7):e2015957. doi:10.1001/jamanetworkopen.2020.15957

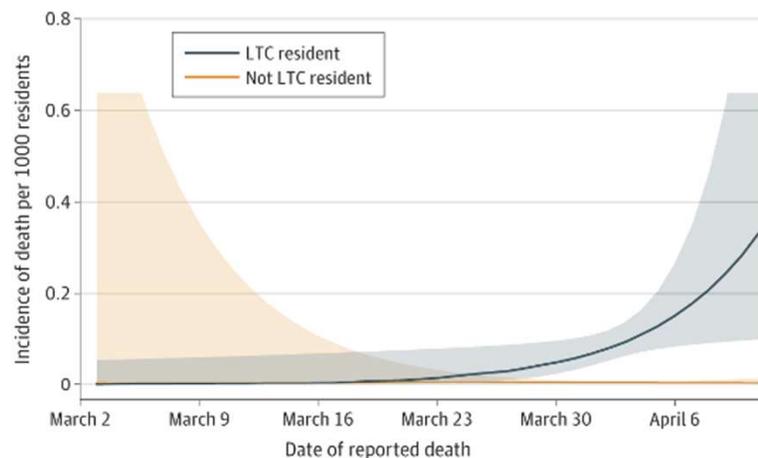


Figure Legend:

Model-Based Estimation of Coronavirus Disease 2019 Death Risk in Ontario The 2 curves represent modeled deaths per 1000 individuals in the long-term care (LTC) population and the community-dwelling population older than 69 years in Ontario. Shaded areas represent 95% CIs.

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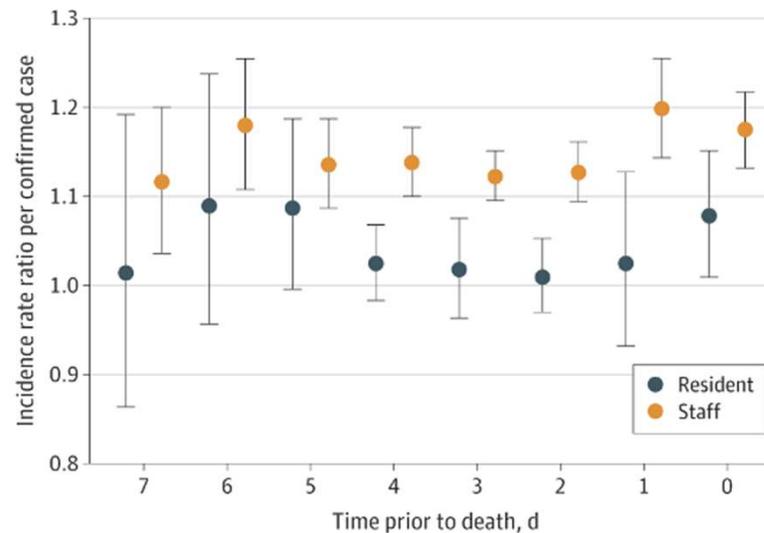


Figure Legend:

Incidence Rate Ratios for Death in Long-term Care, by Lagged Infections Among Residents and Staff
 Incidence rate ratios from Poisson regression models evaluating lagged associations between staff and residents with confirmed coronavirus disease 2019.

CONCLUSIONS (PREPRINT DRAFT, APRIL 13, 2020)

“In summary, we document that the rapid movement of COVID-19 through Ontario’s LTC system has resulted in a marked surge in mortality in that population, as compared to community-living elders. We find evidence that links mortality to infection in LTC staff, highlighting the urgent need for improved infection control, more widespread testing, access to personal protective equipment, and economic protections and support for those who do this important work.”

-Version from April 14, 2020 available at

<https://www.medrxiv.org/content/10.1101/2020.04.14.20065557v>

THANK YOU

Questions?