

Long Term Care Covid-19 Commission Mtg.

Authors of LTC Study: Ontario and B.C.
Experience

on Monday, December 21, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending
remotely, on the 21st day of December, 2020,
1:30 p.m. to 2:21 p.m.

BEFORE:

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

1 PRESENTERS:

2 Mr. Michael Liu, Graduate Student University of
3 Oxford

4 Dr. Irfan Dhalla, Vice President, Physician Quality
5 Unity Health Toronto

6 Dr. Colleen Maxwell, Professor, University Research
7 Chair University of Waterloo

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11 PARTICIPANTS:

12

13 Alison Drummond, Assistant Deputy Minister
14 Long-Term Care Commission Secretariat

15

16 Ida Bianchi, Counsel Long-Term Care Commission
17 Secretariat

18

19 Kate McGrann, Counsel Long-Term Care Commission
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22 John, Callaghan, Counsel Long-Term Care Commission
23 Secretariat

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25 Lynn Mahoney, Counsel Long-Term Care Commission

1 Secretariat

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3 Derek Lett, Policy Director Long-Term Care

4 Commission Secretariat

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6 Dawn Palin Rokosh, Director, Operations Long-Term

7 Care Commission Secretariat

8

9 Jessica Franklin, Policy Lead Long-Term Care

10 Commission Secretariat

11

12 Adriana Diaz Choconta, Senior Policy Analyst

13 Long-Term Care Commission Secretariat

14

15 ALSO PRESENT:

16

17 Janet Belma, Stenographer/Transcriptionist

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1 I N D E X

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3 **The following list of undertakings, advisements
4 and refusals is meant as a guide only for the
5 assistance of counsel and no other purpose**

6

7 INDEX OF UNDERTAKINGS

8 The questions/requests undertaken are noted by U/T
9 and appear on the following pages: 17, 20, 47

10

11 INDEX OF ADVISEMENTS

12 The questions/requests taken under advisement are
13 noted by U/A and appear on the following pages:
14 None

15

16 INDEX OF REFUSALS

17 The questions/requests refused are noted by R/F and
18 appear on the following pages: None

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1 -- Upon commencing at 1:30 p.m.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, if you're all here, we're all here. For
4 the -- we already introduced ourselves to
5 Dr. Dhalla, but I'm Frank Marrocco. There's
6 Commissioner Jack Kitts, Commissioner Angela Coke.
7 We are the Commission.

8 Janet is our transcriptionist who will
9 record the presentation, and, as you know, we will
10 publish a transcript of it on our website.

11 So we have the paper, and you can
12 assume we have some familiarity with it. We're at
13 your disposal. We're ready to proceed when you
14 are.

15 IRFAN DHALLA: Thanks, Commissioner.
16 I'm happy to start. I'll introduce the team, say a
17 few words, and then turn it over to Michael to take
18 us through most of the presentation, which I think
19 will probably only take about 15 or 20 minutes, and
20 then we'll be at your disposal for any questions or
21 feedback that you would have for us.

22 So with me today is Michael Liu, an
23 entering medical student at Harvard Medical School.
24 Michael led the bulk of the work, and
25 Colleen Maxwell, an epidemiologist and professor

1 university research chair at the University of
2 Waterloo.

3 Since you already -- do you have the
4 slides as well?

5 COMMISSIONER FRANK MARROCCO (CHAIR): I
6 think so, yes.

7 IRFAN DHALLA: Yes, okay. So I think
8 Michael will probably be able to share his screen
9 and put them up so we can go through them together.

10 But maybe if I might say a few words
11 about why we did this work, I think in about May or
12 June, it became clear that outcomes in long-term
13 care homes in some provinces in Canada were much
14 worse than outcomes in other provinces.

15 And Michael and I had a couple of
16 conversations about this, and we put together, you
17 know, in my view, an exceptional research team with
18 leaders in geriatrics and long-term care from both
19 British Columbia and Ontario to see if we could try
20 to discern why it was that outcomes in Ontario had
21 been so much worse than in British Columbia.

22 And through the summer, we did this
23 work, and our paper appeared in the Canadian
24 Medical Association Journal, I think, in September.
25 I can't remember the exact date, but you would have

1 it.

2 And so what Michael's going to do is
3 take us through some of the key findings in that
4 paper, and then we can offer some speculative
5 thoughts about why outcomes in long-term care have
6 not been very good in both provinces in Wave 2, and
7 so, you know, that information isn't in the paper
8 itself because the paper was published before
9 Wave 2. But we're happy to share some speculation
10 on those points informed by what we understand is
11 happening in both B.C. and Ontario, and then we can
12 have a discussion with you all. Does that work
13 okay for you?

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 That's fine. Sometimes we will ask -- we've been
16 in the habit of asking questions as things come up.
17 We're amenable to doing it either way.

18 IRFAN DHALLA: I think that's fine with
19 us. We read some of the transcripts, so we know
20 that that's your style, and we're happy to do that
21 so --

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Okay.

24 IRFAN DHALLA: -- please interrupt us
25 any time or interrupt Michael any time.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 All right.

3 IRFAN DHALLA: Okay. Over to you,
4 Michael.

5 MICHAEL LIU: All right. Thank you
6 Irfan.

7 And thank you, Commissioners. Sorry.
8 I'm just going to share my screen. Is that
9 working?

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 It's working for me. Yeah, I think it's working
12 for all of us.

13 MICHAEL LIU: Can you see the slides?

14 COMMISSIONER FRANK MARROCCO (CHAIR): I
15 can. We all can, I think.

16 MICHAEL LIU: Oh, you can? Okay.
17 Great. Sorry. Okay. Perfect. So I'm just
18 getting new to this whole two-screen arrangement,
19 but, great. So thanks. Thanks Irfan.

20 And thank you again for inviting us to
21 speak today.

22 So I was hoping to just take the next
23 little bit to take us through the main findings of
24 our work, provide some further elaborations on
25 points, and discuss how our findings from Wave 1

1 might be contextualized to what is happening now in
2 Wave 2.

3 So as Irfan mentioned, our work was
4 inspired by some informal discussions in the spring
5 and observations that B.C. was doing considerably
6 better than Ontario in controlling COVID,
7 particularly in the long-term care sector.

8 So to investigate this, we performed a
9 case study. We scanned through the gray
10 literature, discussed with some experts just to
11 sort of uncover some factors that might have
12 contributed to these observed differences. And
13 just to reiterate again, our analysis was focused
14 primarily on the first wave in both provinces.

15 And the key points that came out of our
16 analyses was that there was a much higher infection
17 and mortality rate among long-term care residents
18 in Ontario compared to B.C. We found that prior to
19 the pandemic, the long-term care system in B.C.
20 exhibited a number of strengths related to pandemic
21 preparedness, and when COVID hit, we also found
22 that B.C. was faster than Ontario in implementing
23 key policy responses regarding Public Health
24 support, staffing, and infection prevention
25 control.

1 And finally, we found that overall
2 leadership in B.C. was much more decisive and
3 consistent in their communication responses.

4 And so just to review the raw numbers,
5 just prior to the pandemic -- and sorry. I'm
6 sorry. Just prior to the beginning of Wave 2,
7 around September 10th, the infection and mortality
8 rates among long-term care residents were much
9 higher in Ontario compared to B.C. at 7.6% of
10 residents being infected and 2.3% ultimately
11 succumbing in Ontario. These were compared to
12 figures of 1.7% and .6% in B.C.

13 It's important to note that the case
14 fatality rate or percent of people that succumbed
15 once diagnosed with COVID-19 was comparable in both
16 provinces. So crudely, this seems to suggest that
17 it was primarily a difference in COVID-19 entering
18 and spreading in long-term care homes that drove
19 the primary differences during the first wave.

20 It's been several months now, and we've
21 since learned quite a bit about COVID-19 in
22 long-term care. But just to take us back to March
23 and April, actually, quite a bit at that point,
24 earlier reports in February from -- oh, sorry --
25 early --

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Michael, if I can just interrupt for a second?

3 MICHAEL LIU: Of course.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Could you just explain to me, again, why -- the
6 point you made about the mortality rates when
7 some -- with people who were diagnosed earlier and
8 later -- you said it was -- it was comparable.

9 You said the mortality rate was higher
10 in Ontario, which I understood, but then you said
11 something was comparable, and I don't think I
12 caught that quite.

13 MICHAEL LIU: Oh, apologies. So just
14 to clarify, I was talking about the case fatality
15 rate which was what happens when someone does get
16 COVID, be the rate or percent of them succumbing
17 and ultimately dying. And, you know, we can't make
18 any conclusive interpretations, but what we do
19 think is that what we can draw from this is the
20 quality of care that might not have been provided
21 or the risk factors for a resident to ultimately
22 succumb was similar.

23 And so the observed higher rates of
24 infection and mortality were due to the fact that
25 more people were getting COVID -- or more residents

1 were getting COVID in the --

2 COMMISSIONER FRANK MARROCCO (CHAIR): I
3 see. I see. So it's sort of a way of ruling out
4 the treatment? It's a way of ruling out the
5 hypothesis that the poorer outcome was due to
6 poorer treatment.

7 MICHAEL LIU: Yes. Yes.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay. So -- all right. All right. I understand
10 now. Thank you.

11 MICHAEL LIU: Of course.

12 COMMISSIONER JACK KITTS: Michael, can
13 I ask a question as well? We've learned that the
14 highest risk factor for entering the home and
15 having outbreaks is the community spread rate. Did
16 you measure that in this analysis?

17 MICHAEL LIU: No. We did not account
18 for that, and that's something that we will discuss
19 and also come back to. I believe you've already
20 heard from Dr. Stall, and so some of that work
21 is -- and exactly as you mentioned that what we are
22 starting to understand now is that the -- one of
23 the biggest risk factors for COVID entering homes
24 is due to the transmission around the home and
25 community.

1 COMMISSIONER JACK KITTS: Okay. Thank
2 you.

3 MICHAEL LIU: Great. Sorry. So I just
4 wanted to quickly contextualize what we knew back
5 in March. And so there were kind of -- there were
6 reports in February from China that had uncovered
7 the death rate from COVID-19 increased
8 significantly with age, and furthermore, early
9 reporting of outbreaks in the U.S. in Washington
10 State had cautioned about transmission between
11 long-term care facilities and very high case
12 fatality rates, so about 30% similar to what we're
13 observing now in homes.

14 And of course, we've dealt with many
15 infectious and respiratory disease outbreaks
16 before, and the unique vulnerability of long-term
17 care facilities to these pathogens has been
18 extensively documented in the past.

19 So in this table, we just briefly
20 summarize the temporal differences of first wave
21 responses in the two provinces. You can appreciate
22 that in almost all cases, despite COVID-19 coming
23 into the two provinces at roughly the same time at
24 the end of January, B.C. was faster, sometimes
25 several weeks ahead of Ontario in responding to

1 COVID-19 in long-term care homes.

2 So some of these examples include
3 implementing single-site work restrictions and
4 universal masking policies. And although a few
5 weeks may seem like a short time period when
6 there's an exponentially spreading disease, even a
7 few days of delay can contribute to considerably
8 worse outcomes. And so what --

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Can I ask, Michael --

11 MICHAEL LIU: Of course.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 -- we've been told that the lack of personal
14 protective equipment is driving some of these
15 decisions. Did B.C. have a similar -- can you say
16 whether B.C. had a similar problem to Ontario as
17 far as PPE was concerned?

18 MICHAEL LIU: Yeah, it's -- and I don't
19 know if Irfan would like to jump in here, but
20 essentially, there were no -- I think there's not
21 much rigorous data or reliable data on the levels
22 of PPE in both provinces early on in the pandemic.
23 There were reports from, you know, investigators
24 that had called on, kind of, a shortage of PPE in
25 both provinces. There were early movements in B.C.

1 with the B.C. care providers and some organizations
2 that had made it their principal goal to procure
3 PPE and prioritise long-term care homes.

4 And -- but it is -- it is difficult.
5 You know, there's no kind of hard core -- hard
6 numbers out there for us to quantify whether or not
7 there was a relative shortage.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Yes, certainly, we've been told that by virtually
10 everybody. You know, that's been what people have
11 told us at the beginning.

12 MICHAEL LIU: Yeah.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 There was a shortage. What nobody has told us is
15 why there was a shortage. The -- everybody's
16 strangely silent about exactly why Ontario found
17 itself in this predicament.

18 But anyway, I just was curious whether
19 the situation was similar, and it sounds like B.C.
20 may have been in a little better position or in a
21 better position than Ontario.

22 Yes, Dr. Dhalla, please.

23 IRFAN DHALLA: Yeah, I don't think I
24 can answer that question with certainty, but there
25 were rumours at the beginning of the pandemic that

1 there was some stockpile of PPE that had expired.
2 Somebody has probably told you that.

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 The Auditor General.

5 IRFAN DHALLA: The Auditor General
6 mentioned that? And I think there was also some
7 news at the beginning of the pandemic how Alberta,
8 in particular, had a much larger supply of PPE due
9 to some decisions that had been made, if I recall
10 correctly, in December or January, just at the very
11 beginning of the period when it started to be
12 perceived that this new coronavirus might make its
13 way into Canada.

14 And again, I don't know how accurate
15 that is. I personally haven't seen any data
16 comparing PPE stockpiles in British Columbia and
17 Ontario or any other provinces.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Okay.

20 IRFAN DHALLA: I think the other thing
21 that happened at the beginning of the pandemic in
22 Ontario -- and I know you've heard this from
23 others -- is that the entire system in Ontario
24 geared up to support hospitals, and so there was a
25 sense that even on issues like PPE, hospitals were

1 sort of the first priority. And, you know, whether
2 that was just a sense or whether that was actually
3 a reflection of policy and practice, I don't know.

4 But as somebody who was practicing on
5 the ward in the spring, you know, we were worried
6 about our levels of -- about our PPE supplies in an
7 acute care hospital. You know, I can only imagine
8 how worried they would have been at long-term care
9 homes who didn't have the support of an acute care
10 hospital behind them.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Okay. Yes, Doctor, Dr. Maxwell.

13 U/T COLLEEN MAXWELL: I was just going to
14 say, I think in both B.C. and Ontario, there were
15 some early media reports where an individual
16 director of care at one site took the initiative in
17 January and started to prepare, and those sites did
18 particularly well early on. So I'm fairly sure we
19 have media reports of that.

20 And so it does -- it does show within a
21 province as well that there was variability in the
22 response, so we could find those for you as well.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 It isn't a case where there's, like, a provincial
25 purchaser. Each individual director can go out in

1 the marketplace and purchase? Have I -- is that --
2 have I got that right?

3 COLLEEN MAXWELL: That was my
4 understanding early on.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Yeah, mine too.

7 COLLEEN MAXWELL: That was -- came, you
8 know, to the fore, things might have been more
9 systematic.

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Okay. So sorry. We keep --

12 MICHAEL LIU: No. No worries. Please
13 keep the questions coming. So we just wanted to
14 focus on two responses that we thought were
15 particularly important. So the first were the
16 single-site work restrictions, and we know you've
17 probably already heard about these quite a bit, but
18 B.C. implemented this policy on March 26, whereas
19 Ontario did so a few weeks later on April 14th.

20 We knew, given a variety of factors
21 related to a lack of economic and employment
22 security, that many long-term care staff were
23 working at multiple homes prior and early in the
24 pandemic which is not optimal given our
25 understanding now of the high rates of asymptomatic

1 infection. And much evidence now shows that staff
2 are the main vectors of COVID-19 into long-term
3 care homes. I know you've heard from Dr. Fisman,
4 but his study in [indecipherable] work open was one
5 of the first to show quantitatively that staff
6 infections preceded resident infection and death.

7 And similarly, Dr. Stall's work, whom
8 I'm -- also believe you've heard from,
9 demonstrated that these single-site work policies
10 were indeed effective, that they reduced the number
11 of connections or movement of staff between
12 long-term care facilities in Ontario.

13 And so the second is universal masking
14 policies within long-term care homes. So B.C.
15 recommended universal masking on March 25th. For
16 context, at this time, recommendations around masks
17 in the general population were really mixed, and we
18 were still trying to understand the mode of
19 transmission of the virus.

20 But in its recommendation, B.C. cited
21 several -- a clinical guideline from Australia and
22 New Zealand about masking among healthcare workers
23 given droplet precautions which is relatively
24 standard for respiratory infectious diseases.

25 And in Ontario, an order for universal

1 masking didn't come until April 8th despite ongoing
2 calls and urges from Public Health experts as
3 already outlined by the Auditor General. And we --

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Michael, can I just stop you for one second?

6 MICHAEL LIU: Oh, sure.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 By April 8, were -- did you do any work to see how
9 bad it was in terms of infections by April 8th? In
10 other words, you know, B.C. acts -- incorporates
11 universal masking March 25th. Ontario, for some
12 reason, doesn't do anything in that vein until
13 April 8th.

14 How -- were you able to try to
15 determine how many of the people who died were --
16 got sick between -- I mean, I'm using -- I'm using
17 language that I would use rather than what a doctor
18 would, but got sick between March 25th and April
19 8th?

20 U/T MICHAEL LIU: No. That's a really good
21 question. I don't have the numbers in front of me,
22 but I can get them for you, and -- but I do believe
23 that by that point, there were already quite a few
24 homes in outbreaks, and there were already quite a
25 few resident deaths and infection.

1 And I think the key parts of this is
2 that, you know, there were already a lot of urges
3 and reports that masking would be quite effective
4 in reducing spread.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 So if that were the case, then, by April 8th, it's
7 just too late. Like, if that's right, then the
8 problem has started, and the outcome is going to be
9 the death of a certain percentage of those people
10 who got the disease in that period. And the
11 decision on April 8th, in that case, is just going
12 to be too little too late.

13 MICHAEL LIU: Yes, exactly.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Thank you. I'll try to stop -- I'll try to stop
16 asking questions every ten seconds.

17 MICHAEL LIU: No. Please keep going.
18 I just wanted to also say that there are several
19 studies now, although they're not perfect, that
20 have found really strong associations between
21 universal masking and lower transmission at both
22 local and community levels, and just so you had
23 those studies there.

24 So in this next table, we outlined some
25 of the factors that were in place prior to COVID-19

1 related to pandemic preparedness that might have
2 rendered B.C. more prepared to minimize viral entry
3 and spread. The first is that there were
4 significantly more shared rooms in Ontario than
5 B.C. If you look at the data, it's 63% of
6 residents were living in shared rooms in Ontario
7 versus 24%. And there is evidence now, but it
8 should have been -- it should be pretty clear, even
9 without the evidence, that residents sharing rooms
10 would facilitate more spread of virus within that
11 particular room and home.

12 Secondly, a greater proportion of homes
13 were for-profit in Ontario, and we know from past
14 studies that for-profit status is associated with
15 worse process and outcome measures on average.

16 In the context of COVID, I know you've
17 also heard from Dr. Stall's team that profit status
18 is complicated; it's not associated with the risk
19 of outbreak, but the extent of an outbreak is, and
20 the relationship is complicated. It's confounded
21 by factors like design standards and chain
22 ownership as well.

23 Third, we note that inspection policies
24 in Ontario were reactive in recent years with the
25 shift away from the comprehensive RQIs which really

1 precludes assurance that homes are well prepared
2 from an IPAC perspective to prevent and control
3 outbreaks.

4 And finally, we note that the overall
5 health system was less integrated and more in flux
6 in Ontario compared to B.C.

7 We wanted to call particular attention
8 to this last point since we believe it hasn't
9 really been touched upon in detail in past
10 presentations to the Commission. More
11 specifically, B.C., like several other provinces in
12 Canada, has a regionalized health system.

13 In this system, five regional health
14 authorities directly oversee acute care in Public
15 Health and indirectly oversee long-term care. So
16 this integration allows for much more coordination
17 and better mobilisation of support, particularly
18 IPAC support for long-term care homes. And we saw
19 this from very focused interventions from so-called
20 swat teams early on to help quell long-term care
21 outbreaks in B.C.

22 Conversely, in Ontario, Public Health
23 is overseen by 34 Public Health units which
24 govern -- while the governance of long-term care
25 and acute care is more separated.

1 At the same time, we know -- we know
2 from past experience like the 2003 SARS outbreak
3 that poor coordination between Public Health and
4 the rest of Ontario's health system was one of the
5 contributing reasons to poor outcomes.

6 And at the same time, Ontario's health
7 system was also undergoing a lot of flux. The
8 entire health system -- the 14 Local Health
9 Integration Networks were being amalgamated into
10 five Ontario health regions.

11 And also, finally, to add to that in
12 Ontario, there was quite a large exodus of senior
13 leaders from provincial and regional health
14 organizations such as Public Health Ontario and
15 Health Quality Ontario, and due to provincial
16 direction, the budgets for many of these
17 organizations were also being reduced.

18 So all of this is to say that B.C. was
19 better prepared organizationally to respond to
20 COVID-19 in long-term care homes even before the
21 pandemic began.

22 So in this final section, we wanted to
23 just take a quick look at what is happening now
24 given that both provinces are currently in the
25 midst of a second wave. So as you can see from

1 these graphs, the left-hand side represent rates of
2 total cases per 100,000 people, and the right-hand
3 side represent the rate of total deaths per a
4 hundred thousand people.

5 So you can see that B.C. had controlled
6 COVID-19 generally much better than Ontario during
7 the first wave, but both provinces are doing
8 comparatively poorly for the second wave.

9 And this table here shows the raw data
10 for both the overall population in long-term care.
11 I apologize. This is quite a busy table, so I'll
12 takes us through it.

13 So the first two columns are data from
14 the beginning of the pandemic to the end of Wave 1
15 or September 10th. The next two columns are data
16 from the beginning of the pandemic to relatively
17 recently into Wave 2 or December 5th. And the last
18 two columns show what's happened in just Wave 2
19 with the difference between September 10th and
20 December 5th.

21 So as you can see in the first few
22 rows, the rate of infections in the entire
23 population was much lower in B.C. than Ontario for
24 Wave 1 at .4% and .3% of the population
25 respectively.

1 By Wave 2, or December 5th, B.C. and
2 Ontario have similar rates at .59% and .56%.

3 And furthermore, when you look at the
4 last two rows in long-term care, which focuses
5 specifically on long-term care, resident infection
6 mortality were much lower in B.C. during Wave 1,
7 but by Wave 2, B.C. has now done relatively worse
8 than Ontario with infection and mortality rates of
9 4.8% and .9% versus 3.7 and .7% in Ontario.

10 And so we haven't done --

11 IRFAN DHALLA: Maybe, Michael --

12 MICHAEL LIU: Yeah.

13 IRFAN DHALLA: -- is it worth just
14 asking the Commissioners if they have any questions
15 about this slide because there's quite a bit of
16 data on it.

17 MICHAEL LIU: Yeah. Sorry.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 The only -- the only question, I guess, is by the
20 Wave 2, would you say both provinces have
21 comparable policies when Wave 2 starts?

22 MICHAEL LIU: So, I mean, we were
23 going -- we were going to get to this, and in many
24 ways, I think that Ontario had made some meaningful
25 steps, and some of that is coming out of, I

1 believe, from the recommendations that the
2 Commission has made and a lot of other steps that
3 were taken --

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 That was not the reason I asked the question.

6 MICHAEL LIU: No. No. No. But you're
7 correct in that, you know, Ontario was not doing
8 nothing in the months before the first and second
9 waves and that there was progress being made. And
10 so -- and we'll get to this a little bit more as
11 well. But you're right that many productive or
12 more productive policies were being implemented in
13 Ontario prior to the wait.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 So does that suggest that the infections are now
16 occurring in a way that no one understands? I
17 mean, if both -- if both -- if both -- and I'm
18 really asking this as a layperson, but if both
19 parties are engaged in similar practices, how does
20 one account for the difference between B.C. and
21 Ontario now, I guess is --

22 IRFAN DHALLA: It's probably a good --

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 -- better way of saying it.

25 MICHAEL LIU: Yeah.

1 IRFAN DHALLA: It's probably a good
2 segue to your next slide, Michael, and then I
3 think -- but I wouldn't say that we have no idea.
4 So I'll let Michael go through the first three
5 points, and then I might add a little bit of colour
6 commentary, if I might.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Sure.

9 MICHAEL LIU: Sure. And that's a great
10 question, Commissioner, and I think this is where
11 we're trying to get a little bit at -- at a bit of
12 this. We haven't done a thorough analysis, and so
13 we can't, kind of, explain all the potential
14 factors. But we can think of, kind of, three main
15 categories. And so the first, as we said, was that
16 Ontario has taken some quite meaningful steps to
17 improve and emulate B.C. before and during the
18 second wave such as enlisting more IPAC support,
19 starting to reduce the number of residents sharing
20 rooms.

21 And furthermore, one key strength
22 that's also been identified in Ontario is that
23 they -- we've taken quite an active testing and
24 screening strategy for staff, residents, and
25 visitors, which allows us to -- and I believe it's

1 that most staff need to be tested every 14 days in
2 some regions and seven days in more severely hit
3 regions. And that actually allows us to capture
4 more symptomatic and asymptomatic cases before they
5 can enter homes.

6 And the third is that there is, as
7 you've also pointed to, a relatively higher
8 community transmission in B.C. now, and we know
9 from Dr. Stall's work that this is a major risk
10 factor for long-term care infection and death.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 M-hm.

13 MICHAEL LIU: And speaking to some of
14 our partners in B.C., Dr. Schwandt also
15 mentioned -- who's -- who sends his regrets and is
16 a medical health officer in B.C. has said that much
17 of this community transmission has overwhelmed the
18 highly engaged hands-on Public Health approach that
19 B.C. took quite early on. And so it's sort of
20 reached this critical mass where Public Health
21 staff are finding it difficult to focus as much as
22 they did on single homes and provide the high-level
23 support that they did in Wave 1.

24 IRFAN DHALLA: I think it's more that
25 than it would probably be just an unknown, so I

1 think it's not quite accurate to say we have no
2 idea how COVID is getting into long-term care
3 homes. It's probably more accurate to say that
4 staff continue to be the portal of entry, if you
5 will, but that long-term care homes and the system
6 as a whole is struggling from a resource
7 perspective to do the things that we know need to
8 be done to prevent transmission.

9 So, for example, I was speaking with a
10 colleague over the weekend about why test
11 turnaround time in Ontario appears to be
12 increasing, not just in long-term care but across
13 the system as a whole. And her response to me was
14 that a lot of it has to do with long-term care
15 homes sending screening specimens all on the same
16 day of the week instead of sending them in on the
17 day they're collected, long-term care homes not
18 sending specimens in at the time of collection even
19 for diagnosis as opposed to screening, but rather
20 than sending them in, you know, in batches.

21 So this was all focused on test
22 turnaround time, but I think what it made clear is
23 that we haven't provided long-term care home staff
24 with the support they need to be able to reduce
25 risks as much as we know they can be reduced. And

1 when -- you know, we know Public Health units in
2 the hardest hit regions like Toronto and Peel are
3 so overwhelmed that they can't keep up with contact
4 tracing, so it probably indicates that they are
5 also so overwhelmed that they can't manage
6 outbreaks as closely as they would like to be able
7 to manage outbreaks. And we've heard that
8 firsthand from our colleague Michael Schwandt in
9 B.C., where he has basically told us -- I think --
10 you know, I spoke with him earlier this morning,
11 and he said that, you know, they like to talk about
12 an at-the-elbow approach, so the long-term care
13 home staff would be obviously doing the direct
14 work, but the Public Health unit staff would be at
15 their elbow providing them with support, guidance,
16 answering questions, et cetera. But as the number
17 of outbreaks has increased, they haven't been able
18 to provide that "at-the-elbow support."

19 COLLEEN MAXWELL: I was just going to
20 add, Irfan, that the tipping point is there in both
21 provinces. I mean, both provinces are doing poorly
22 now. And it's just -- it's similar to the tipping
23 point you see with ICU bed care.

24 At some point, the community outbreak
25 is such that it doesn't matter how prepared or how

1 timely or how responsive Public Health has been in
2 the past. It's just overwhelming the system, and
3 the shortages of staff are overwhelming the system,
4 the low morale, et cetera.

5 So, you know, Ontario has possibly
6 improved in many ways given our article, but both
7 provinces are not doing great right now.

8 COMMISSIONER FRANK MARROCCO (CHAIR): I
9 don't know if you've looked at this, but --

10 Well, Dr. Kitts, you had a question?

11 COMMISSIONER JACK KITTS: Yeah, I was
12 just going to ask whether you have data that might
13 be able to show, like you said, that the belief is
14 that the vectors into the home are staff. But
15 you'll recall that for some time, visitors and
16 caregivers were allowed in. Then they weren't, and
17 then they were again.

18 And I'm just wondering if you have any
19 data to suggest whether the visitors, caregivers
20 were a -- also a factor in bringing it into the
21 homes or contrary.

22 IRFAN DHALLA: I don't think we have
23 data on that point.

24 Do we, Michael?

25 MICHAEL LIU: Oh, I think Colleen was

1 going to say something.

2 COLLEEN MAXWELL: No. No, I don't
3 believe we do. I mean, there's data from Europe
4 showing that letting visitors in did not cause
5 additional spread, but I don't believe we do. And
6 I don't know the difference in testing with family
7 caregivers in Ontario versus B.C.

8 So if there was more testing in
9 Ontario, that might have played a role when both
10 provinces had, you know, open doors to visitors.

11 MICHAEL LIU: And I also believe that
12 the Ontario policy now does apply also to
13 essential -- to the visitors that --

14 COLLEEN MAXWELL: M-hm.

15 MICHAEL LIU: -- that it's a 14-day --
16 a report of a 14 -- a negative test within 14 days
17 is needed for visitors as well. And so a lot of
18 these -- a lot of the benefits that have come from
19 these general active screening strategies has also
20 been applied quite broadly.

21 COMMISSIONER JACK KITTS: Thank you.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Can I just return to this delay in ordering
24 universal masking? And the reason I do that is
25 I'm -- I remember now having seen a photograph of

1 two children being sent to school during the 1918
2 flu, Spanish flu, and they had masks on.

3 And so I -- I'm wondering in terms of
4 the decision to order universal masking how big a
5 mystery it was on March the 25th that masking was a
6 good idea. I mean, how well-known -- how
7 obvious -- is it -- would that have been obvious
8 on -- at that time? Or is this some revelation?

9 MICHAEL LIU: I don't think it's a
10 revelation, and, you know, applying the
11 precautionary principle, as you've heard again and
12 again that masks are -- you know, even in the
13 absence of evidence to show that it was effective
14 at the time, for SARS-CoV-2, with our past
15 experiences with respiratory pathogens that -- and
16 it was generally agreed upon at the time that it
17 was -- that there was at least droplet precautions,
18 that masks should have been a good idea.

19 I think there were -- there was a lot
20 of rhetoric at the time whether or not masks were
21 needed in the general population, and I think that
22 was mainly a cause of concern because there was a
23 lack of shortage for healthcare workers, for
24 high-risk settings, but I believe long-term care
25 homes applied very much under that umbrella. And

1 so I think that rhetoric at the time should not
2 have confused or led to hesitancy within the
3 context of long-term care homes.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 So if I understood you correctly, even a perceived
6 or real shortage -- let's say real shortage of
7 personal protective equipment should not have
8 affected ordering universal masking with respect to
9 long-term care facilities, not enough masks to, you
10 know -- if you're -- if you don't have enough -- if
11 through some sort of error, you do not have enough
12 masks, then -- and why you don't want to tell the
13 entire population that they should wear a mask,
14 it -- you can't because you don't have the masks.

15 But that -- if I understood you,
16 Michael, that same dynamic is not working with
17 respect to long-term care facilities.

18 MICHAEL LIU: Right.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 That's a concern.

21 MICHAEL LIU: Right. I believe, and,
22 you know, I believe that shortages are definitely
23 practical limitations, but I think that the idea of
24 prioritising or at least trying to prioritise more
25 supply of PPE to long-term care homes and requiring

1 to whatever extent possible or practically possible
2 should have been made.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Yeah. Yeah.

5 IRFAN DHALLA: I think it may -- I
6 mean, we -- I don't -- I don't think we are capable
7 of answering this question, but it may be
8 interesting to better understand whether the
9 shortages were similar across the country or
10 whether they were more severe in Ontario, and if
11 they were more severe in Ontario, why that was the
12 case.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 Well, yes, that -- the last question is definitely
15 of interest. Actually, the whole thing is because
16 that's why I was asking about B.C. and Ontario
17 earlier on. I was trying to get a sense of whether
18 that portion of it was the same in both provinces,
19 and I recall what was said. Anyway, thank you.
20 Carry on.

21 MICHAEL LIU: Great, sorry. I just
22 have one more slide. Apologies for dragging along.
23 But so in light of everything we've talked about, I
24 think our team just had a few more recommendations
25 which we think would supplement the really

1 incredible recommendations that have already been
2 made by the Commission, many of which we believe
3 have already contributed to the better outcomes
4 observed in Ontario.

5 So further, we believe that there needs
6 to be more economic security and support to staff
7 within long-term care homes particularly for care
8 aides and personal support workers.

9 Second, we think the Province should
10 also look at formalizing structures and processes
11 to ensure the integration between Public Health,
12 long-term care, and acute care in Ontario.

13 Third, now that we've been talking
14 about this idea of PPE, there should be more
15 transparency, we believe, surrounding staffing
16 levels, e-stock (phonetic), hours of direct care,
17 and staffing mix in long-term care homes both to
18 facilitate management and these research questions.

19 Fourth, there should be a phasing out
20 of shared rooms in homes, particularly in homes
21 with older designer standards.

22 And fifth, now that we know that
23 community transmission is able to overwhelm or
24 contribute quite highly to long-term care cases and
25 overwhelm prevention and response efforts, reducing

1 community transmission is likely one of the best
2 methods to protect our residents in long-term care
3 from COVID-19.

4 And just finally, learnings in
5 long-term care should be applied to other
6 continuing care settings, and Colleen can speak to
7 this more, such as supportive or assisted living
8 facilities. We know that these are directly
9 outside the purview of the Commission, but these
10 facilities have also been hit incredibly by COVID,
11 but they've received much less attention.

12 And also important to note that there
13 are unique issues that are faced each in different
14 settings, and those are important to take into
15 account as well.

16 And so that's all the slides I have.
17 Thank you for bearing with me, and we're happy to
18 answer any other questions.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Well, Commissioner Coke.

21 COMMISSIONER ANGELA COKE: I'm just
22 curious. Because B.C., you know, has a more, sort
23 of, integrated structure, did they have -- do you
24 know if they had, sort of, the issues with staff
25 moving across different parts of the healthcare

1 system like PSWs? Or do they have some consistency
2 in the way these staff are treated and paid that
3 would mitigate against that happening?

4 IRFAN DHALLA: I think they have more
5 consistency than we do here. Long-term care homes
6 are not -- or before the pandemic at least, they
7 were not formally part of the Regional Health
8 Authority, so, you know, a staff member who worked
9 at a long-term care home could quit their job at
10 the long-term care home and go work for an acute
11 care hospital.

12 But relatively early in the pandemic,
13 and I don't know the details of how this worked
14 exactly, but the Provincial medical officer of
15 health there instituted an order that effectively
16 gave her full control over staffing in long-term
17 care homes, I think, throughout the Province. And
18 so I don't know the details of exactly how that was
19 implemented, but I know that, you know, obviously,
20 that led to the single-site restrictions. It also
21 led to a greater level of pay, and I think part of
22 the reason for that was to avoid the problem that
23 you've just alluded to.

24 MICHAEL LIU: And in addition to that,
25 it also led to a greater centralization of ensuring

1 that staffing levels were appropriately high. I
2 believe that same directive allowed the medical
3 health officer to -- I'm sorry -- the Provincial
4 health officer to monitor and directly, kind of,
5 move staff around such that homes were
6 appropriately staffed as well.

7 IRFAN DHALLA: Yeah. So, I mean, one
8 of the things that's happened in Ontario that has
9 been very interesting to see is some long-term care
10 homes have received much greater levels of support
11 than other long-term care homes.

12 You know, I work -- I'm on the
13 executive team at Unity Health Toronto, and we have
14 a long-term care home as part of our health system,
15 and so we've been able to provide, I think, a much
16 greater level of support to that long-term care
17 home than has -- than -- you know, than other
18 long-term care homes in Ontario have received.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Can I just ask about a couple things that you
21 didn't touch on but which we've heard about? And
22 the first one is, you know, moving residents who
23 test positive out -- offsite or to a field
24 hospital, that sort of thing. We heard about the
25 effects of it in Windsor, and it seemed to be very

1 positive, and Windsor wasn't the only example.

2 Did your research -- did you look at
3 that strategy at all? Or are you able to comment
4 on that?

5 MICHAEL LIU: I don't know if --

6 IRFAN DHALLA: No. We didn't look at
7 that. I mean, I think that this -- I think -- I
8 mean, at the risk of stating the obvious, a
9 long-term care home is someone's home, and so
10 transfers out of the home should be done carefully.
11 And I don't -- you know, it probably can work well
12 in some situations, but it can also probably go
13 quite badly if the place that the resident is being
14 transferred to doesn't offer the kind of care and
15 support that that individual needs. So it was
16 probably very context specific.

17 So, I mean, even if --

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Oh, they were field hospitals --

20 IRFAN DHALLA: Yeah, so I --

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 -- for all practical purposes.

23 IRFAN DHALLA: Yeah, that term does
24 make me nervous because when I think of a field
25 hospital, I tend to think of a place that is, you

1 know, temporary, doesn't provide a high degree of
2 personal support; staff tend to have generic
3 training rather than the training that is needed to
4 take care of people with the kinds of behaviours
5 that sometimes people living in long-term care
6 homes have.

7 I'm not speaking about any specific
8 example. It may be that we've had some really
9 great examples of field hospitals being used to
10 take good care of people in long-term care homes in
11 Ontario, but that strategy does make me nervous.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 And the second question dealt with the rapid
14 testing and whether any of your -- whether any of
15 your research affected or looked at that. There's
16 an article in The Globe this morning that, you
17 know, a number of the major firms in downtown
18 Toronto are now proposing really massive rapid
19 testing so that their employees can go back to work
20 in the office towers.

21 And I was wondering if there was any
22 resort or anything you saw in relation to rapid
23 testing in the work that you did because it does
24 seem rather obvious that if you can test and get a
25 result rapidly, that that would be a good idea.

1 IRFAN DHALLA: It does.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Apart from me asking you that, did it come up in --
4 is there any -- did you notice anything or come up
5 against anything like that or an observation about
6 that?

7 IRFAN DHALLA: I think Michael's
8 smiling because he and I are doing some work
9 separately on rapid testing.

10 Rapid testing right now isn't used very
11 widely in either B.C. or Ontario in the public
12 system as far as I'm aware. I mean, I think the
13 example that you're talking about is in the private
14 sector. I think, you know, could we be using rapid
15 testing more in long-term care homes in Ontario in
16 December 2020? Probably.

17 In particular, the -- you know, the
18 rapid tests are not as sensitive as the lab-based
19 PCR tests, meaning that there is a higher number of
20 false negative tests. But the tradeoff is you get
21 the result immediately.

22 And so right now in Ontario, the
23 turnaround time on lab-based PCR can be two days,
24 can be three days, in some places can be even
25 longer. And so you're trading off a more accurate

1 test that has a several-day turnaround time against
2 a less accurate test that you have the result in
3 15 minutes. And the modeling study suggests that
4 once the turnaround time on the lab-based PCR
5 grows, you know, too long, you're better off using
6 a rapid test even if it's less accurate and doing
7 it every few days or every week.

8 In addition to that, you know, the
9 usage of lab-based PCR tests in long-term care
10 homes in Ontario particularly to screen visitors
11 has, to some degree, gummed up the laboratory test
12 processing system for the -- everyone else, right?
13 Because -- and that is actually part of the reason
14 why our test turnaround times are so long.

15 So if we were screening visitors with
16 rapid tests, we would be getting faster results
17 there, and we would also be getting faster results
18 for people who have symptoms or who are close
19 contacts and living in the community, essential
20 workers, so on.

21 So, I mean, I think that's actually --
22 it's a really good question, and it's an example of
23 where, if we were taking a holistic view of the
24 whole pandemic response and using an improvement
25 mindset, we might have switched to rapid tests

1 particularly for visitors to long-term care, you
2 know, two or three months ago.

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 M-hm. Well, the -- can I just pursue this a little
5 bit further? The false negative, that means people
6 think you don't have it, and you do.

7 IRFAN DHALLA: Correct.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Well, that probably means you don't have any
10 symptoms, in which case you would probably have
11 slipped through the system anyway. You show up at
12 the long-term care home, and somebody asks if you
13 have a fever, and they take your temperature, and
14 they ask if you've been outside the country for 14
15 days. You give all the appropriate answers, but
16 you're asymptomatic, and you're -- well, the -- so
17 you're going to get -- that type of person is going
18 to slip through whether they falsely test negative
19 on a rapid test or not.

20 IRFAN DHALLA: Yeah, I think you're
21 generally correct.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 It's the -- but the other people, the people who
24 test positive who are positive, they're not going
25 to get in under the -- I --

1 IRFAN DHALLA: Yeah, and I think you're
2 generally correct. There are multiple lines of
3 defence, right? So for visitors going into
4 long-term care homes, first of all, there's symptom
5 screening. Then they're supposed to have a
6 negative test, and they're also, of course,
7 supposed to physically distance and wear a mask and
8 wash their hands.

9 And so, you know, even if they have a
10 false negative, if they have no symptoms and they
11 physically distance and wear a mask, the risk of
12 that individual transmitting COVID-19 into the
13 long-term care home is going to be very low.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 M-hm. Okay. Thank you. Any other questions?

16 Oh, Commissioner Coke.

17 COMMISSIONER ANGELA COKE: I'm just
18 wondering in terms of, sort of, broader context if
19 you observed or had any observations about
20 differences they may have had with respect to home
21 care or community care for seniors, and did that
22 have any impact on, you know, what might or may not
23 have come into the long-term care homes in terms of
24 more people being able to stay out.

25 IRFAN DHALLA: Colleen, do you want to

1 comment on that?

2 COLLEEN MAXWELL: I'm actually not sure
3 of the data for B.C. I know in Alberta, for
4 example, there has been a shift from long-term care
5 to assisted living, and home care plays a very
6 large role in assisted living. In some regions,
7 they do view it as a substitute for long-term care.

8 In B.C., there has been quite a move to
9 assisted living as well, but it's been private, so
10 it's possible, but I don't know of the data for
11 B.C. I know of Alberta.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Well, I think that's -- that exhausts our
14 questions, I think. Thank you very much for taking
15 the time to come. I think we found it very helpful
16 in terms of what we're thinking about. And I
17 really -- we really do appreciate it.

18 U/T If you should do any more work that
19 gets to a publishable form before we're finished,
20 please let us know. We'd be very eager to read it.

21 But anyway, thank you. Thank you for
22 the presentation, and thank you for taking the
23 time.

24 COMMISSIONER JACK KITTS: Yeah.

25 COMMISSIONER ANGELA COKE: Thank you.

1 IRFAN DHALLA: Thank you very much for
2 having us. Thank you for having us, and thank you
3 for everything you're doing.

4 COLLEEN MAXWELL: Yes. Yeah. Thank
5 you very much.

6 COMMISSIONER ANGELA COKE: Thank you.

7 COMMISSIONER JACK KITTS: Take care.

8 COLLEEN MAXWELL: Take care, everyone.

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Bye.

11 COLLEEN MAXWELL: Happy holidays.

12 -- Adjourned at 2:21 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, JANET BELMA, CSR, Certified
4 Shorthand Reporter, certify:

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth;

9
10 That all remarks made at the time
11 were recorded stenographically by me and were
12 thereafter transcribed;

13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.

16
17
18 Dated this 22nd day of December, 2020.

19
20 

21
22 _____
23 NEESONS, A VERITEXT COMPANY

24 PER: JANET BELMA, CSR

25 CHARTERED SHORTHAND REPORTER

1 Clarification: One small typo found on page 10:
2 The resident and mortality rates among long-term
3 care residents were much higher in Ontario compared
4 to B.C. at 7.6% of residents being infected and
5 2.3% ultimately succumbing in Ontario. The bolded
6 word should read "infection".

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