

# Long-Term Care Covid-19 Commission Mtg.

Meeting with Dr. Vera Etches, Medical Officer of  
Health  
on Friday, October 2, 2020



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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held via Zoom, with all participants attending
15	remotely, on the 2nd day of October, 2020,
16	1:00 p.m. to 1:35 p.m.
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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

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8 PRESENTERS:

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10 Dr. Vera Etches, M.D., CCFP, MHSc, FRCPC, Medical

11 Officer of Health, Ottawa Public Health.

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13 PARTICIPANTS:

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15 Alison Drummond, Assistant Deputy Minister,

16 Long-Term Care Commission Secretariat;

17 Dawn Palin Rokosh, Director, Operations, Long-Term

18 Care Commission Secretariat;

19 John Callaghan, Counsel, Long-Term Care Commission

20 Secretariat;

21 Derek Lett, Policy Director, Long-Term Care

22 Commission Secretariat;

23 Lynn Mahoney, Counsel to the Ministry of Health and

24 Long-Term Care;

25

1 ALSO PRESENT:

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3 McKaya McDonald, Stenographer/Transcriptionist.

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1 -- Upon commencing at 1:00 p.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 All right. Well, it's 1 o'clock. You're here  
5 yourself, Doctor. Are you expecting anyone else?

6 DR. VERA ETCHES: It is just me for  
7 better and for worse. I think probably some of my  
8 team members have more detailed knowledge, but I'll  
9 try to convey the big picture of what we've  
10 learned.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 Okay. Well, you know what we're about. We're a  
13 little different than traditional inquiries because  
14 normally those inquiries are called after something  
15 has happened, and they look back at the event, and  
16 then they try to explain it.

17 We've been called together in the  
18 middle of something, and so it changes the  
19 traditional way of going about -- the way --  
20 looking back is you investigate, you hold your  
21 public hearings, and you write a report. It takes  
22 two years, two and a half years, whatever time it  
23 takes, and then you're finished.

24 But, of course, that doesn't work so  
25 well in the world that we're in because the Wave 2

1 is upon us. Maybe there will be a Wave 3, and it  
2 really didn't commend itself to us that we would  
3 report, like, two years from now.

4 So we're trying to come up with or  
5 trying to see if it's possible -- we kind of turn  
6 it upside down to see if there aren't some concrete  
7 interim recommendations that we can make and then  
8 go about the rest of the, you know, inquiry trying  
9 to carry out the rest of our mandate. So that's  
10 kind of where we're coming from.

11 You met us all. There's a  
12 transcriptionist, so there will be a transcript of  
13 this. And we do have a website, and we tend to  
14 post -- we do post as much as we can on the website  
15 so that people have some idea of what we're up to.

16 So, with that, we're ready when you  
17 are.

18 DR. VERA ETCHES: Well, thank you very  
19 much for this opportunity. I think that you  
20 probably have already come with and have gained a  
21 lot of knowledge of the context and the situation.

22 So I don't want to spend a lot of time  
23 speaking about things you already know or have  
24 observed. I can certainly start with describing  
25 some of our experience in the Public Health field

1 in Ottawa where it intersects with the experience  
2 of long-term care outbreak prevention and control.

3 There, certainly, are some things we've  
4 observed and things we've learned and are doing  
5 differently based on the experience of Wave 1 for  
6 Wave 2, and I'm happy to describe that and  
7 certainly open to answering the questions you think  
8 will be most useful.

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Well, we're looking for ways of improving the  
11 response. And we have heard from a number of  
12 people, but I think the best way to go about it is  
13 to tell us what you want to tell us, and if you're  
14 telling us something we already know, we'll tell  
15 you.

16 DR. VERA ETCHES: Okay.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 Okay.

19 DR. VERA ETCHES: Well, let me start,  
20 then, by describing the Public Health work, you  
21 know, with long-term care homes around infection  
22 prevention and control before COVID.

23 So typically what Ottawa Public Health  
24 does with all of our long-term care homes -- and  
25 there are 28 in our area -- is every year we host a

1 session called Outbreak 101. And it's an education  
2 session, actually for retirement homes as well,  
3 where we go over what was the previous years'  
4 influenza season like, what did we learn from  
5 respiratory enteric and outbreak in the last year,  
6 what can we reinforce to prevent outbreaks in the  
7 coming season.

8 We also, in pre-COVID times, took a  
9 risk-based approach to supporting homes, and so we  
10 knew before COVID there were homes that,  
11 historically, had more challenge with outbreak  
12 management based on, you know, the length of the  
13 outbreaks they would tend to have, the number of  
14 deaths, and so we would spend more time on site  
15 with homes that needed more support.

16 As COVID was becoming clearly a threat  
17 to our area, we were in regular contact with  
18 long-term care homes to make sure they not only had  
19 the guidance that was emerging from the province  
20 but also understood it and what it meant for their  
21 operations.

22 We were part of what was stood up in  
23 more of an emergency response to oversee the health  
24 system response to COVID. So what I'm speaking  
25 about there is that Ontario Health established a

1 more streamlined expectation that there would be a  
2 regional response with hospital and home and  
3 community care leadership.

4 That built on kind of a pandemic plan  
5 approach in our region already that included what  
6 we call "three-centre decision-making" for a  
7 pandemic response or an emergency response.

8 Ottawa Public Health being a lead for  
9 Public Health response and advising over all the  
10 City were some of the city responses and social  
11 supports needed as well as the healthcare system.

12 And so we did have a way of connecting  
13 amongst those three decision centres. And so when  
14 the Ontario Health request to set up a regional  
15 response was established, we built on that and made  
16 sure that City Public Health and hospitals and the  
17 other health system partners were all linked in.

18 And so under that and through that, we  
19 had different conversations that would have touched  
20 on long-term care home needs and operations and  
21 challenges. Eventually there was a long-term care  
22 home task force established to support homes, and  
23 Public Health was part of the support offered right  
24 on the ground. As well as I was part of the senior  
25 leader table that was getting updates and guiding

1 the response.

2 We did find early on there was more  
3 focus on supports to quickly build up acute care  
4 capacity, and there were definitely pressures  
5 around some of the supplies and guidance around  
6 access to masks and PPE.

7 We advocated to the Chief Medical  
8 Officer of Health on March 18th that there would be  
9 universal masking for all healthcare workers in all  
10 settings, and we found that that was, again,  
11 something we needed to move ahead on locally before  
12 the formal guidance came out, I believe, later in  
13 April.

14 So we saw, definitely, that homes  
15 struggled with controlling COVID-19 outbreaks more  
16 so than they would have traditional respiratory  
17 outbreaks, and I think some of that was related to  
18 the nature of the virus -- you know, needing to  
19 screen people out who have mild symptoms, you know,  
20 where it is previously other symptoms that might  
21 have been more obvious to people.

22 The challenge with some of the new  
23 practices needed that hadn't always been used for  
24 influenza around cohorting, thinking about who's  
25 testing positive and separating them from negative

1 and those who are yet to be determined. We  
2 actually found this was not common practice for  
3 influenza where a control of the outbreak was  
4 facilitated by things like antivirals and more use  
5 of physical barriers that just were maybe not  
6 sufficient given the new virus.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 Doctor, before you go on --

9 DR. VERA ETCHES: Yes.

10 COMMISSIONER FRANK MARROCCO (CHAIR):  
11 -- universal masking was recommended, you said, on  
12 March 18th, but the directive, you said, comes out  
13 late in April.

14 Do you have any sense of what went on  
15 between March 18th and late April given that, you  
16 know, everybody was -- there was a -- it seemed to  
17 me -- right from the beginning, almost -- talk of  
18 social distancing and wearing a mask, at least  
19 optionally anyway.

20 Do you have any sense of whether that  
21 was a long time or not or why it took that much  
22 time?

23 DR. VERA ETCHES: You know, I really  
24 have challenges with how much I can speak to what  
25 others were doing. I really have to --

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Yeah.

3 DR. VERA ETCHES: -- just speak to what  
4 I know directly, and so, you know, that was our  
5 efforts here on the ground was to spread that  
6 message.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Okay.

9 DR. VERA ETCHES: Yeah, right away.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 That's a good reason to avoid answering the  
12 question, so I won't pursue it any further.

13 Dr. Kitts?

14 COMMISSIONER KITTS: Yeah. So, Vera,  
15 can I ask, in Ottawa, you were, early on, promoting  
16 universal masks. Was March 18th a time when there  
17 was still a lot of concern about availability of  
18 PPE and --

19 DR. VERA ETCHES: Yes, yes, absolutely.  
20 So I think while we made the recommendation, there  
21 was a challenge to carry it out, absolutely. And  
22 so I think maybe you've heard about this more, but  
23 the supply of personal protective equipment to  
24 long-term care homes was tenuous. It was something  
25 we heard that was challenging at that time.

1 I want to highlight some other  
2 observations from the first wave. We did notice  
3 that staff worked in multiple locations, and it did  
4 likely contribute to spread of the virus between  
5 location. And then when staff were limited to  
6 working in one home, it was associated with  
7 challenges with maintaining higher staffing levels,  
8 and it often was the homes in the worst situation  
9 that people chose not to work at, and so it  
10 actually made the situation harder in some homes in  
11 outbreak.

12 We definitely observed the challenge  
13 that personal support workers, environmental --  
14 like, cleaning services staff had with maybe not  
15 having access to sick leave or benefits, and so  
16 they were more likely to work when ill.

17 We had quite a few examples of that  
18 happening, and it related to this socioeconomic gap  
19 in the situation, you know, that we actually have  
20 also examples of personal support workers living in  
21 shelters and other situations of congregate care  
22 where, you know, that also increased the risk of  
23 transmission of COVID both within long-term care  
24 coming back to the shelters and the other  
25 direction.

1                   We observed that -- well, certainly  
2 some long-term care homes did not have dedicated  
3 infection prevention and control practitioners.  
4 And it was often a piece of somebody's work, and  
5 that made it harder for homes to take the new  
6 directives and implement them to carry out the  
7 required ongoing infection prevention and control  
8 education and audits.

9                   So our work was certainly to help homes  
10 understand the guidance and go on site and try to  
11 assist with training. And so throughout Wave 1 and  
12 then through into the summer, we partnered with  
13 Public Health Ontario to do more of this work to  
14 provide on-site training.

15                   And our learnings and our observations  
16 were that the training is one piece, but it really  
17 requires ongoing oversight and ongoing  
18 reinforcement. That means leadership and IPAC  
19 supervision really needs to be there seven days a  
20 week if not 24/7.

21                   We found that some homes lacked  
22 clinicians of who were able to provide on-site  
23 support, and this may have contributed to  
24 hospitalizations and more serious outcomes without  
25 the level of medical support that might otherwise

1 have been available.

2 And we definitely heard about negative  
3 impacts on mental health of both residents, staff,  
4 and families. Many, many families reached out to  
5 me about the concern they had for the isolation of  
6 their family members and the impact on themselves.

7 So we needed to pull more people in to  
8 our team that usually works on infection prevention  
9 and control, so we reinforced the team adding  
10 inspectors and nurses from other parts of our  
11 organization where they would have worked with, you  
12 know, other kinds of inspection.

13 So they're not necessarily the  
14 certified infection prevention and control  
15 practitioners that we would, you know, consider  
16 have the highest level of training even on our own  
17 team, but we've continued to build their capacity.

18 We continue to reach out to all homes,  
19 so homes not in outbreak, to try to prevent  
20 outbreak both through on-site visits but also phone  
21 calls and meetings with management. So for homes  
22 that were flagged as red or yellow, having more  
23 concerns for their capacity, those involved  
24 meetings with management to go over what their  
25 needs are and what supports they need.

1           We are finding, through these regular  
2 calls that continue, they're proactive but we also  
3 have responsive calls as well. You know, any time  
4 a home calls us, we respond very quickly. But  
5 we're finding there is still ongoing need to  
6 understand the guidelines and to uphold them.

7           So maybe going back to the Public  
8 Health view of COVID in the community, you know, we  
9 saw first people testing positive in March. Two  
10 weeks later, we saw our first outbreaks in  
11 long-term care homes.

12           So we see the very real connection  
13 between community level of virus and then it being  
14 introduced into homes. We saw in the summer when  
15 the outbreaks were under control and the level in  
16 our community was lower, there was a relaxation of  
17 the measures in the public to decrease our  
18 contacts, to wear masks.

19           And we see, then, again, with COVID  
20 rising in our community, again, it's being  
21 reintroduced into homes. So the sense of  
22 relaxation in the summer related to how active the  
23 screening is to keep people who are ill and showing  
24 symptoms from working, and that -- so, you know, we  
25 see the need again for this ongoing reinforcement.

1 It is really important.

2 The other thing around the screening  
3 and the surveillance testing in long-term care -- I  
4 know there's lots of interest in that. And in the  
5 first wave, we actually didn't find any new  
6 outbreaks through that surveillance testing. Where  
7 we had an outbreak, we found more people infected.  
8 It uncovered more of the spread.

9 Now what we're finding with the regular  
10 implemented surveillance, we actually are detecting  
11 staff first through some of that surveillance  
12 testing as well as symptomatic staff going for  
13 testing.

14 And, you know, there's some good news  
15 here that with that identification of the staff, in  
16 14 out of 15 outbreaks, for instance, since August,  
17 it's a staff index case that was identified. And  
18 then in 10 out of the 15, the infection was limited  
19 to staff, so it did not spread beyond into  
20 residents.

21 So homes on the whole are doing better  
22 controlling their outbreaks, and I think I found  
23 some graphs to share with you, for the record, that  
24 show that. The duration of outbreaks in long-term  
25 care homes is coming down compared to Wave 1, and

1 the number of people infected is also coming down.

2 And, you know, it's just quite  
3 different except for when it's not, and so this is,  
4 again, where I think it's important, maybe, to  
5 focus on what's the difference between homes that  
6 do prevent outbreaks or manage outbreaks well and  
7 those where we see ongoing challenge.

8 So I think what we've learned is that  
9 it's very related to the management of the home and  
10 the leadership in the home on the ground that would  
11 instill confidence in staff and support staff to  
12 show up for work, to feel protected.

13 And this is something that, you know,  
14 is a bit qualitative and hard to, you know, think  
15 about our Public Health inspectors and our public  
16 nurses having a role in judging, you know, the  
17 ability of managers in homes. That's something we  
18 really didn't, you know, consider in sort of their  
19 role, necessarily.

20 But it is the case that our Public  
21 Health inspectors and nurses observe things that  
22 challenge outbreak management, like levels of  
23 staffing, and it is linked to leadership in terms  
24 of oversight of you know, how staffing is managed,  
25 the targets that are set. All homes have been told

1 to staff to higher levels given we can predict  
2 there may be some absenteeism, and so this is  
3 something that we've learned.

4 It has led us to use new tools in the  
5 second wave. For example, the Section 29.2 of the  
6 Health Protection and Promotion Act is a tool that  
7 I've used, had never used before, but found that it  
8 is a rapid way to address, you know, more supports  
9 to leadership and management in the homes. And  
10 seeing the importance of that, we've used that tool  
11 twice now.

12 So the difference between homes -- I've  
13 mentioned leadership. It's about having  
14 supervision on site, you know, 24 hours a day,  
15 7 days a week; being able to address the  
16 staffing --

17 The practices that lead to retention of  
18 staff definitely seem to be linked to staff having  
19 access to sick leave, full-time hours. You know,  
20 people are more likely to want to stay and work in  
21 those settings where, then, they build expertise.

22 We also see that some of the  
23 differences relate to the population served. So  
24 where there are more residents with dementia, more  
25 residents with mental health and substance use

1 challenges, then that is likely a riskier situation  
2 and harder, you know, for the homes to control the  
3 outbreaks.

4           The physical infrastructure also  
5 matters, so I think you've probably heard about  
6 that. You know, older infrastructure, shared  
7 rooms, there are physical impediments to cohorting  
8 and moving people.

9           So I think maybe just to get, shortly,  
10 to your questions, I would reinforce, then, that  
11 ongoing oversight and instruction on infection  
12 prevention and control, the importance of the  
13 staffing levels. And another thing I haven't  
14 mentioned yet is the test results need to be  
15 prioritized for long-term care homes in the  
16 laboratory system. And right now, it's not  
17 happening enough.

18           Certainly our laboratory systems are  
19 strained with the volumes of swabs they need to  
20 process through the labs, but we definitely see it  
21 impacting homes' ability to cohort and, you know,  
22 potentially, through those mechanisms, control  
23 outbreaks.

24           The last thing, also, for, you know,  
25 sort of, like, immediate things that could be

1 changed right away, I think sometimes we, in Public  
2 Health, are not getting guidelines that change  
3 before they're released to long-term care homes and  
4 retirement homes. And it makes us need to catch  
5 up, and, you know, it misses the opportunity for us  
6 to do things in a more coordinated way and provide  
7 consistency and direction in messaging. So I think  
8 that is also a quick win.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 Okay. Commissioner Kitts?

11 COMMISSIONER KITTS: You spoke to the  
12 common elements where homes weren't able to contain  
13 the outbreaks, and you really stressed the on-site  
14 leadership 24/7 and basically the IPAC staffing,  
15 that all of that falls out of good leadership and  
16 management. You then said that you used Order 29.2  
17 to ensure leadership and management into the homes  
18 quickly to get them.

19 Where do you feel the leadership and  
20 management comes from? And in Wave 2, can you get  
21 the leadership and management into the homes before  
22 the outbreaks?

23 DR. VERA ETCHES: So in Wave 1,  
24 long-term care homes turn to hospitals for more of  
25 the expertise and support both around infection

1 prevention and control and medical support.

2 And so when I issued the order, I did  
3 turn to a hospital to provide that support to the  
4 homes, and I do hear from my team that long-term  
5 care homes are still turning to hospitals seeking  
6 support from hospitals for some of these aspects.  
7 I've seen a difference in Wave 2 in the ability for  
8 hospitals to provide that support.

9 So I am concerned about that not being  
10 a solution that's as available at this time given  
11 hospitals' need to address growing pressures around  
12 other critical healthcare needs.

13 And so to me, I would be interested in  
14 a model that actually draws on learning within the  
15 sector. There were many homes and are homes now  
16 that are managing outbreaks well and so taking a  
17 look at, potentially, leadership within other homes  
18 that are doing well to support homes that are  
19 struggling.

20 In terms of trying to have that happen  
21 before there's an outbreak, absolutely a good idea.  
22 And so, you know, the place we're looking to start,  
23 of course, these conversations we're having with  
24 the management of homes that is the yellow homes  
25 and the red homes.

1           And so as we've gone out and had those  
2           conversations with management, we have not found  
3           any others at this point where I feel that it's  
4           likely we need to get into an order situation. So  
5           we are trying to assess that in our phone calls and  
6           our meetings.

7           COMMISSIONER KITTS: You have 28 homes  
8           in your Public Health unit catchment area. Do you  
9           know what state of readiness each of those 28 homes  
10          are in, and how many are you concerned about?

11          DR. VERA ETCHES: Yes, we do. Through  
12          these, with the outreach we've done, you know, we  
13          have a good idea and, again, a historical pattern  
14          of who struggled.

15          You know, we have a list of 14 where  
16          they've had at least two outbreaks, so recurring  
17          outbreaks, so those were the ones we start with.  
18          In some of those cases, management has changed  
19          since the first wave and we have, you know, a lot  
20          of confidence.

21          And, you know, I think that that's the  
22          list that we're working off of because of these  
23          other aspects too, the nature of the physical  
24          layout that help us predict where people could run  
25          into trouble.

1                   COMMISSIONER KITTS: And you haven't  
2 assigned a hospital to those homes at this point?

3                   DR. VERA ETCHES: No. And I'm not sure  
4 I have the authority to do that either, but we are  
5 continuing to work in partnership with, again, this  
6 regional structure. But that's not the  
7 understanding right now, I think, in terms of what  
8 could be accomplished by the hospital.

9                   COMMISSIONER KITTS: Thank you.

10                  COMMISSIONER FRANK MARROCCO (CHAIR):  
11 Commissioner Coke?

12                  COMMISSIONER COKE: I just wanted to  
13 ask a little bit more about your relationship with  
14 the Province. One of the things you mentioned  
15 before was the issue of not getting the guidelines  
16 in advance that would be more helpful.

17                         Are there other things that you feel,  
18 based on lessons learned out of Wave 1, that would  
19 improve where there's information flow or any other  
20 interactions with the provincial level?

21                  DR. VERA ETCHES: I think what is  
22 happening now is useful in terms of a daily report  
23 to the Emergency Operation Centre. This allows us  
24 to flag the current situation and any  
25 recommendations or requests or support on a daily

1 basis, and I'm finding that is useful.

2 It goes to the Emergency Operation  
3 Centre, but we can flag things for the Ministry of  
4 Health, the Ministry of Long-Term Care, and Public  
5 Health Ontario.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 As you look forward to Wave 2, what do you think is  
8 the most significant vulnerability that needs to be  
9 addressed?

10 DR. VERA ETCHES: So I've already  
11 spoken about the leadership and the oversight.  
12 After that -- and they're related, but more homes  
13 are struggling with staffing than with leadership.

14 So "staffing" meaning personal support  
15 workers, other healthcare staff, just having the  
16 ability to have more people on site to deal with  
17 the greater demands in an outbreak. This is a real  
18 need, and we know there are plans underway to  
19 address that to try to recruit more people.

20 Also, there's interest in our region to  
21 actually create quick training programs through the  
22 colleges. So we have La Cité and Algonquin College  
23 in Ottawa, and both of them have said that they  
24 would be able to set up rapid programs to bring  
25 people in to that personal support worker training

1 that would lead to certification but could get  
2 people into homes more quickly. And they do need  
3 funding to be able to run those programs, but that  
4 is an option that's being discussed here.

5 COMMISSIONER FRANK MARROCCO (CHAIR):

6 It seems to me the difficulty with putting a person  
7 in a course is that that doesn't put them in the  
8 home. And are they talking about some kind of  
9 on-the-job working and ongoing education?

10 DR. VERA ETCHES: That's correct. So  
11 it would be an initial short period of training and  
12 then training on site and then the option to return  
13 to the classroom to finish, you know, the  
14 certification.

15 There are others. Of course, I think  
16 we'll be interested in returning to personal  
17 support work when they have the right incentives,  
18 and I think some of that work has also been  
19 announced recently. I think it will make a  
20 difference.

21 We actually saw when personal support  
22 workers, especially, had the pandemic pay, it made  
23 a difference to their ability to meet their needs.  
24 And so going again to extend their income so that  
25 it's an incentive to work, that is important.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):

2    Okay.  Anything further?

3                   Okay.  Well, I don't hear anything.  So  
4    well, thank you very much for coming here  
5    unguarded.  It was very helpful to us.

6                   DR. VERA ETCHES:  I would maybe like to  
7    make a comment, then, overall about the --

8                   COMMISSIONER FRANK MARROCCO (CHAIR):  
9    Go ahead.

10                  DR. VERA ETCHES:  -- you know, the  
11    governance of the health system.  I think that what  
12    we've put in place as emergency response structures  
13    are voluntary and collaborative, and everyone's  
14    trying to do their best.

15                  But we still have, you know, people who  
16    are most responsible and accountable to run their  
17    organization's operations, and it's harder to move  
18    people and resources to where they're most needed  
19    when there are, you know, different  
20    accountabilities and reporting structures.

21                  So I just would make that observation  
22    that it's getting harder now that all organizations  
23    are under pressure to move resources around.

24                  COMMISSIONER FRANK MARROCCO (CHAIR):  
25    Who should make that decision?  Who should

1 decide -- let's assume you switched it from a  
2 consensual model to the command model. Who is the  
3 commander, do you think?

4 DR. VERA ETCHES: I think that's part  
5 of the question. It's not necessarily obvious. We  
6 have Ontario Health that funds agencies, but we  
7 have agencies that also have boards and owners.  
8 And it's not clear that Ontario Health has the  
9 authority to direct in all of those instances.

10 COMMISSIONER FRANK MARROCCO (CHAIR): I  
11 mean, yeah, I appreciate that the current situation  
12 makes it unclear, perhaps, whether you or anybody  
13 else has the authority. But if you were setting --  
14 who should have the authority? That's what I'm  
15 trying to understand.

16 DR. VERA ETCHES: Yeah, I'm not, you  
17 know, the best person to say necessarily what  
18 should happen. I can make observations that in  
19 other provinces where there's a regional health  
20 authority and everyone is an employee of the  
21 regional health authority that people can be moved  
22 around more easily, and there is one accountable  
23 person. So that's a different model entirely, but  
24 there may be some advantages to that.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 That kind of a change would take a long time?

2 Yeah.

3 COMMISSIONER COKE: Oh, yeah.

4 COMMISSIONER FRANK MARROCCO (CHAIR):  
5 Okay. Anything further?

6 DR. VERA ETCHES: No, thank you. I  
7 just thought I would add that. I appreciate the  
8 opportunity, and thank you for this. It's  
9 important work that you're doing.

10 COMMISSIONER FRANK MARROCCO (CHAIR):  
11 Well, thank you for taking the time to help us  
12 understand this a little bit better and get a  
13 little bit more improved perspective on it. So  
14 it's very helpful from us, and thank you.

15 COMMISSIONER COKE: Thank you.

16 DR. VERA ETCHES: Bye-bye.

17 COMMISSIONER KITTS: Bye, Vera.

18 -- Adjourned at 1:35 p.m.

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1 REPORTER'S CERTIFICATE

2  
3 I, MCKAYA MCDONALD, 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 2nd day of October, 2020.

19  
20 

21  
22 \_\_\_\_\_  
23 NEESONS, A VERITEXT COMPANY

24 PER: MCKAYA MCDONALD, CSR

25 CHARTERED SHORTHAND REPORTER

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