Long Term Care Commission Covid-19 Mtg.

Meeting with Doctor Moore
on Thursday, October 8, 2020

77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 8th day of October, 2020, 1:00 p.m. to 1:55 p.m.

BEFORE:

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

PRESENTERS:

Dr. Kieran Moore, MD, FCFP, FRCPC, Associate Medical Officer of Health, KFL&A Public Health Associate Professor, Departments of Emergency and Family Medicine, KFL&A

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and

Long-Term Care;
Jessica Franklin, Policy Lead, Policy Unit,
Long-Term Care Commission Secretariat;
Dr. Azim Kasmani, Queen's Expert, Health Sciences,
Queen's University.

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, Doctor, let me just sort of tell you, well, we're in a bit of an odd position because typically the Commission of Inquiry is called after something has happened and looks back and attempts to explain it to the public so that there's a complete understanding of the events that occurred.

Our situation is different. We are called to existence in the middle of something which is not over. And so we are not so convinced that the traditional way of doing things -- which is an investigation, public hearings, and a report.

And two and a half years from now is when you'd get the report. Two years to two and a half years is when you'd likely get the report. We thought we should try to communicate something quickly that hits on some key points and then take, perhaps, a more conventional approach with the earlier events.

So that's where we're coming from. We would appreciate any help you could give us. It would be helpful, any perspective. That would be very helpful from our point of view.

We have tended in the past to interrupt and ask questions as we go along rather than waiting until the end, if that's okay with you.

DR. KIERAN MOORE: Of course.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, then we're ready when you are.

DR. KIERAN MOORE: So if it's okay, I did give you a PowerPoint, and I'm happy that you -- I could review that with you, and then please -- happy to interrupt and just make this more of a dialogue.

We basically tried to document our response at a local level in our attempts to influence policy at a provincial level. So would that be of interest?

COMMISSIONER FRANK MARROCCO (CHAIR): That would be very helpful. So if we can get the PowerPoint on the screen, we're ready to go.

Ms. McDonald, you --

There we go. There we are. So I can see the PowerPoint now.

DR. KIERAN MOORE: All right. I'll just --

COMMISSIONER FRANK MARROCCO (CHAIR): And, Commissioner Coke and Commissioner Kitts, you

can both see it?

COMMISSIONER KITTS: Yes, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): So we've got it, so away we go.

DR. KIERAN MOORE: Okay. So I'll just basically run through our experience at a local level and some of the policies that we develop, some of the responses that we've implemented that I think have put it in a good position to date -- and I'm knocking on wood when I say that -- and that could be a model for the province.

So a quick review over KFL&A in our region, our local response to LTC/RH spread of COVID-19, our preparedness, and our approaches, and then some recommendations.

As a Public Health physician, I was a previous emerge physician for over 20 years and moved into Public Health because I do strongly believe in prevention, and certainly long-term care facilities are -- we would love a provincial strategy to keep our elderly ageing healthily and in their own homes and certainly would want a home care strategy as part of an overarching senior strategy.

So I was remiss if I didn't admit to

this in advance in my first slides that we work locally with the AVOID Frailty research network across Canada -- avoid standing for increasing activities; maximizing vaccination; optimizing medications; increased interactions; the "I," so minimizing social isolation; and then working on diet and nutrition in the elderly as a strong frame to minimize the need for LTC.

Certainly LTCs will be necessary, but I think the vast majority of seniors -- and I'm certainly approaching there -- would like to stay many their own home as long as they can. So I know you're targeted on LTCs, but this has to be part of a senior strategy, a stay-at-home strategy, home care support piece.

For KFL&A, this is a map of current outbreaks. As of October 5th, we have no outbreaks in our facilities, so I don't have a lot of outbreak experience to share with you. And KFL&A is over 7,000 square kilometres, so we're a very large region. And resolved outbreaks, we only had one outbreak of one healthcare provider.

We are a vulnerable population, so as you can see, most of our population is below the 401 along the lake, but we have a boom, bust, echo

population distribution with a vast majority of our population, a quarter of which is over 65 and invulnerable.

And so when we saw how COVID was spreading in Wuhan and how the elderly were getting affected in January, we set up strategies to protect our vulnerable, to protect our facilities -- because we were watching in Wuhan how the virus was spreading.

And we set up strategies to protect our correctional facilities, our long-term care facilities, our retirement homes, and minimize the community rate of infection. And that was always our goal, to have a low rate of infection in our community. And that required a very robust strategy, not just an LTC strategy. But we knew if we kept our population rate low, we would protect all our vulnerable populations.

This is a distribution of our long-term care facilities and retirement homes, so many are in our rural environment. Many are owned by our municipal partners who co-fund KFL&A Public Health, and they have all been partners long term with Public Health because we work with them. And I'll share some of the work we've done longitudinally

with them.

So we have 11 long-term care facilities, 16 retirement homes, and a significant number of individuals, around 2,600 individuals, living in those environments. And I'll just say for our corrections facilities, we have seven large correctional facilities thankfully with the same number of inmates.

And, if you've seen, all of these congregate settings are high risk, so we had strategies to protect not only our LTC and retirement but also all of our congregate settings, all vulnerable settings in our community.

This is just a list of the directives, and we'll overlay our local action over these provincial directives which came down in response that I'm sure you're very much aware of.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, can I just interrupt you for a second?

DR. KIERAN MOORE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): You said -- so what started the wheels turning for you was your observation of what was happening in Wuhan?

DR. KIERAN MOORE: Correct, yeah. We

were monitoring the epidemiology in Wuhan. We were seeing that the most affected were elderly, those with chronic diseases.

And then we were monitoring the outbreak in Seattle in Washington State. That was a well-documented outbreak. We monitored how they responded in Seattle.

Then we watched the activity in Vancouver when Vancouver -- I think it was Fraser Coastal -- had an outbreak in their LTC and how they managed it. So we were monitoring this risk for this population all along and studied each one of those outbreaks to apply best practices with all of our partners at a local level.

And we did raise awareness at a provincial level that, you know, you have to protect your LTCs and your retirement homes. That wasn't a foundational message to local Public Health agencies, by the way, from Central.

It was only after the outbreak started happening that these interventions were put in place to only allow essential visitors, et cetera. So it --

COMMISSIONER FRANK MARROCCO (CHAIR): When did you notify the province?

DR. KIERAN MOORE: Of our approach?

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah. Well, to say that population in the long-term care homes were at risk.

DR. KIERAN MOORE: Oh, we did that at the very beginning of March. And we did inform the province and our sister health units, all 34 of our protocols that we put in place of our protocol to visit all long-term care facilities, to audit all long-term care facilities. That was shared through the committee of medical officers of health.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

COMMISSIONER KITTS: Kieran, can I just ask a question? I think you said that most of your long-term care homes are municipal, and you have 11 long-term care facilities in your region.

Can you tell us how many are private, municipal, or --

DR. KIERAN MOORE: Oh, sorry. Yeah, Jack, the majority, actually, are private, but each municipality, as per the regulation, is obligated to have a long-term care facility. So we have the Kingston, Frontenac and Lennox, and Addington. So we have three major municipally-owned and operated

LTCs. The rest are private. Extendicare, Chartwell, they're all represented.

COMMISSIONER KITTS: Okay. Thank you.

DR. KIERAN MOORE: So these were the health recommendations that came out recently for the second wave to protect long-term care facilities and retirement homes.

I just want to say that we've had ongoing systems collaborations with our long-term care home facilities, so that wasn't new to us. I'll just highlight that we meet with the medical directors. I met with the medical directors on a weekly basis through teleconference to keep them appraised of the directives, to keep them appraised of risk, to provide with them the local epidemiology.

We had made a cutoff of ten per hundred thousand per week as a risk level that above that count, they should be very much vigilant that there's a risk of a worker bringing the virus or a visitor into their institutions and to heighten awareness.

So we'd set cutoffs; we'd set targets, alert levels. We provided infection prevention and control on-site advice as well as remote advice to

our LTCs from the beginning. We supported any outbreak.

And the one outbreak that we had of one worker in one long-term care facility, we went in and helped them swab everyone in that facility that needed swabbing, so around 100 individuals, and walked them through the outbreak management and how to create a live list, et cetera.

As well, on the management orders, the enforcement side, I'll give you an update of how we used enforcement to bring online some LTCs and retirement homes that weren't meeting our requirements on all of these issues.

So as I said, we had one case of one staff in our one long-term care facility that got ill while at work. Quickly was isolated, and we subsequently tested 100 people and didn't find any transmission.

So we've had no hospitalizations from long-term care facilities from COVID, and quite proud of our institution and partners that we've had no deaths amongst the 2,700 individuals that we protect in our LTCs and retirement homes. So, you know, I got to celebrate the record of our partners in protecting their patients and clients and

families.

So just historically -- I just wanted to put context -- we've had a great partnership with our LTCs. Back in 2012, I created an antibiotic stewardship guide. We were having high rates of C. difficile in our acute care facilities. Many patients were being transferred from LTC to acute care because of C. diff. So we created an antibiotic stewardship practice for our LTC.

So I know all the medical directors. We know the nurse managers, the nurse practitioners. We've worked with them longitudinally. And really, if you're going to have success, you have to have preexisting partnerships. And I'm proud of the partnerships we've already had with these institutions and workers.

We also take the standard -- and we read through this standard, the 2018 -- I would suggest that this is a key component that all health units should be held accountable on. It says how you should interact with your long-term care facilities, your retirement homes; how you should manage outbreaks outside of COVID. And we took that responsibility exceptionally seriously

and worked with them year in and year out on prevention and infection management.

We host an annual event to educate our long-term care facilities and retirement homes. We have strong partnerships with them and have strong and high testing within our LTC facilities for respiratory outbreaks as well as GI outbreaks.

So this standard, I think, is a good standard. I would say that all health units should be able to account for whether they've met the key deliverables in this standard. And it's rigorous, and we adhere to it.

So, you know, I just think if you had to boil it down, it's really about strong communication, collaboration, and coordination, the three Cs that we've established longitudinally long before this outbreak.

And we do an annual update where we bring all LTCs, retirement homes, medical directors, nurse practitioners together and review influenza and how to respond to any type of outbreak. We do annual education. We have some of the highest immunization rates in our facilities amongst workers as well as clients and patients. We're very proud of that achievement and generally

have some of the first or second amongst all health units in the immunization rates across all sectors of our community.

We also have assigned an infection prevention and care nurse, coordination nurse, dedicated to our LTCs and retirement homes. She sits on all of their mandatory committees. It's part of the long-term care regulatory framework that they have to have an IPAC committee. We have to prod them to have it on an annual basis.

I will say to this Commission that, you know, to be the IPAC lead within those institutions, you didn't need training; you didn't need skill sets. You just had to be given the title, and I think that certainly needs to be strengthened, that they do need a skill set. They do need the qualifications, the CIC qualifications at a minimum, and that would add a robust response.

But otherwise, we have provided the expertise to all of our LTCs over the years and certainly in COVID.

Fortunately, as well, in 2019, in September, we were monitoring influenza season in New Zealand and Australia, which was severe, and we decided to have a preparedness workshop. So we

brought all of our acute care, EMS, long-term care, primary care partners together to prepare for a potential mild, moderate, or severe influenza season. And luckily that was four months before COVID started.

So we have a history of bringing our partners together to prepare. So I'm an emerge physician.

Jack, you know, you do simulations. I'm used to running simulations, running cardiac arrests, pediatric arrests, and practicing until it's perfect.

So we brought that same mentality to Public Health. You practice outbreak management until it's perfect with all the partners, and you support partners with the three Cs of communication, collaboration, and coordination.

So we've run multiple tabletops. And, by the way, we continue to run those simulations. All summer long, we ran longitudinal simulations with our LTC and retirement homes, medical directors, and nurse practitioners to prepare for this winter where we're going to be seeing a complexity we've never seen -- the co-circulation of COVID-19, other respiratory pathogens, plus

influenza.

And we have a write-up that could be available to you if you're interested in reviewing it because that will prepare -- that is going to set very unique circumstances where they're going to have to have separate cohorts.

So these two significant infectious disease agents -- COVID and influenza -- two different staffing models, separating those patients, building capacity to separate those patients, and it's so important that agencies think well ahead before this circumstance starts.

And I can tell you Influenza B and A is circulating in the Ottawa region. It's already been detected in LTCs as well as COVID-19, so it's there already. And we're only in October, two months before we're going to be seeing it starting to peak.

So all that's to say we have provided IPAC support, ongoing consultation, and we provide a link between the acute care sector and our long-term care sector partners.

We are a trusted intermediary, so if we need extra IPAC support, we'll go to the Gerald Evans, the infectious disease colleagues who have

expertise, and bring them in to do consultation, if necessary.

And the same for patient care. We support our medical directors by having e-health consults, the OTNhub being able to provide consultations in outbreak or outside of outbreak between IV, geriatricians, et cetera. So that's a key, important role.

So I've already talked about how we were monitoring data across the globe. That's an important intelligence-gathering function of Public Health. We assign epidemiologists to look at this data weekly early on, and we also created an educational session.

That's the last time I brought a hundred doctors together was March 5th, 2020. And we brought all of our long-term care physicians, nurse practitioners, primary care physicians together to review the science, the epidemiology, the symptoms of COVID-19.

We reviewed how to do an NP swab for everybody. We reviewed the multiplex. We reviewed how the PCR. And having this Public Health-led educational session early on in the epidemic put us well ahead because our primary care partners felt

comfortable swabbing. They felt comfortable for IPAC.

And our primary care partners, especially in our rural environments, detected the virus in KFL&A first. And this was amongst healthcare workers that were actively assigned to LTCs.

But they tested, they caught it for us, and we prevented outbreaks because we harnessed the energy of our primary care partners and brought them in to the solution.

And I think, across Ontario, that has been an issue, how to bring primary care into the solution, and how to strengthen the medical directors' capacity to respond to COVID-19.

We -- during the pandemic, so starting in late February -- met and continued to meet with each of the medical directors. And I'd do an hour-long teleconference. We'd review the directives. We'd support them. We'd give them situational awareness. We'd answer their questions. We do the same with the administrators.

At the end of February of this year, I had an hour-long talk with the administrators saying "this is the largest threat you're ever

going to have to the community you serve."

They took it seriously. I read them the riot act, and since then, the partnership is even strengthened with these weekly coordination teleconferences.

March 10th, we set up -- and if you know -- if you remember what the directives were, we set up -- we anticipated restaurants and businesses being closed. We realigned our inspectors and nurses to be -- to work with our LTCs, and they went in to -- I sent them in to the long-term care facilities/retirement homes. I wanted assurance, as the medical officer of health, that all of these false were screening appropriately; they had good IPAC; and that they felt confident to be able to test, isolate, quarantine contacts, and respond quickly.

And so we created a team of a public health inspector -- that's not been done anywhere else in the province -- and a nurse to go in early. And I honestly believe this is a very key and important role for public health.

My colleagues disagree. They don't think they have capacity, but we realigned all of our services to meet this function. I stopped many

other aspects of our business to ensure that this was done and that we protected the most vulnerable members of our community. It seems to have done us well. It's been well accepted by our LTC partners, and it was supervised by our IPAC lead and myself.

And so now we have eight public health inspectors, eight nurses. These aren't funded by anybody. They're coming from the Public Health budget. It's no additional funding. We just realigned our services to meet this need, and we continue to -- we have continued to do it all along.

So if you just look at the time line, we did this March 10th. We visited all homes. We've done 31 repeat visits to 19 homes. I think this is a brilliant role for Public Health because inspectors have the right and ability to write an order against a home. If they find that they're not adhering to public health guidance and/or any directives.

And I'm not aware of many other health units that have done this except, you know, in a lockdown in an outbreak mode. So we did start this very early and were proactive, and many consider this to be the reason why we've had no deaths/no

outbreaks in our region.

This is an example of a checklist. So we've created an evidence-based checklist based on our expertise with IPAC that every inspector went into the LTC. They reviewed all of these. Just as an example, with the LTC, if they didn't adhere to this checklist, we would write an order that they will.

And so we gave them warnings. We used progressive enforcement. First educate and then use the stick, as it were. Warnings and specific time lines to rectify, and then we would put in a Public Health order.

So we put in five Section 13 orders under that Health Protection and Promotion Act, and we put two tickets under the Reopening of Ontario Act to ensure that our population was protected.

These are not easy. The facilities balk. They threaten. But we wanted to ensure that our populations in these facilities were protected.

That's a question you could ask any other health unit -- how many orders did they put in; how many actions on their Reopening of Ontario Act. I think it's very important to be able to use enforcement, and that's the way I think Public

Health is perfectly positioned to work with the Ministry of Labour and the Ministry of Long-Term Care that has oversight directly in their inspectors to do this work longitudinally. I see it. Because we have expertise in IPAC and enforcement, we are perfectly positioned.

I know in the new model, the hospital is positioned to do this or Ontario Health. I honestly believe that Public Health should be given the opportunity to do this work.

We've also been logging -- many of our facilities are short-staffed, and that's true across Ontario. We've been logging to allow our many educational facilities to have their student learners in as long as they have the appropriate precautions in play.

But because of the directives in place, this has not been allowed. But I think we need -- they're going to need staffing, especially if we go into outbreaks longitudinally.

It's also important to know that KFL&A Public Health set up the testing strategy. It wasn't Ontario Health. It wasn't our hospitals. We opened the testing sites in Kingston, and we followed a very aggressive testing strategy that

was a little ahead -- I'll say it honestly to the Commission, ahead of the guidance from the Ministry because we were able to follow the epidemiology a little more closely. And we understand, at the provincial level, there's a bureaucracy to go through.

So if the epidemiology was changing, as it quickly did from Iran to Italy to New York, we would change our testing strategy to ensure that those returning travellers, especially, were tested aggressively, quickly. And because we ran the testing sites, we could be very nimble and responsive in who we tested and how we tested.

So testing led by Public Health, I think, worked well in our instance. We have subsequently handed over the testing after the first six months to Ontario Health, and Kingston Health Sciences Centre runs the testing.

But we do all outbreaks in LTCs and retirement homes. We will send our staff in to support testing in those instances. And during the universal testing strategy, we were a very low endemic area, low comminute activities. So we did participate in universal testing and had no cases, no positives detected.

I don't know how fruitful that measure was, and we could have had a new nuanced testing approach given the low epidemiology in our area. I absolutely understand universal testing in a high-risk area. It wasn't fruitful in our region.

We also had worked with many in our community to expand testing. We worked enclosed certain businesses that were high risk, with other outbreaks in the community, and basically have had a strong community response.

So just a rundown, during the pandemic in August, this is the longitudinal simulations of outbreaks in LTCs. We had them go through COVID outbreaks plus influenza outbreaks plus any other viral pathogen outbreak like RSV, which still has significant morbidity and mortality in the elderly, and have done these all summer long getting into the fall.

We also have tried to interact with the Canadian Foundation for Healthcare Improvement. I've done a couple of knowledge-translation activities with them and was interviewed for their report and these patients' safety organizations.

And we basically broke down our response in preparation prevention, working to

increase the capacity and skill sets of the work force, and then we talked about outbreak management and surge response, COVID and non-COVID care, and certainly the requirement for the presence of family.

I'm sure you've heard that social isolation can be devastating to family members and to the individuals affected, and I hope we can have a more nuanced approach going forward as a lesson learned, especially in a low endemic area where we have no community spread.

We've never had significant community spread in the KFL&A in our eight months and wouldn't have had to have directives in place that stopped the presence of family members. It could have been restricted, but it didn't have to be stopped.

And so if I had any advice to provincial leaders and for our commission, it would be have a regional risk-based approach when you have directives in place. I think we can be more nuanced -- and, Jack, I mean, we learned that in SARS. You didn't have to close all hospitals in Ontario because Toronto was suffering.

That was my message to leadership this

time around as well: Please be nuanced. Please have a regional approach.

I wrote the premier about having a regional approach, and I was called "rogue" publicly, but we certainly have a regional approach now to the epidemic.

COMMISSIONER KITTS: Kieran, can I just interrupt you for a second? Can you go back one slide?

So the six key areas, clearly you've talked about preparation and prevention very clearly. Did you have a shortage of workers in long-term care homes going into the COVID epidemic?

DR. KIERAN MOORE: No, we did not. So people in the workforce for us was mainly in augmenting their skill sets in infection prevention and control; protecting them by ensuring, through audits -- so we physically went in and watched them wash their hands, don and doff, ensure they knew how to test efficiently and effectively, knew how to cohort, and that they were screening appropriately.

So we had adequate numbers. And we never had, because we never had an outbreak, any issue with the workforce. I was absolutely

prepared to write an order if there was an outbreak for Kingston Health Sciences Centre or our other community hospital in Napanee to support the long-term care facilities and to mandate that they support them with staffing because I was not going to see what was happening elsewhere occur in our region. And I believe, in Ottawa, an order has been written recently as well under Section 29.2.

COMMISSIONER KITTS: Yeah.

DR. KIERAN MOORE: So we had all the orders prepared, all written in case, and our role from a public health management point was always a supportive role, an educative role.

And we would supplement them in outbreak for outbreak management, for swabbing, for testing, for IPAC, for auditing. But if they had a shortage in staffing, they would have to go to the acute care sector to help them with staffing.

COMMISSIONER KITTS: Okay. And then on the pandemic response and surge capacity, I think we're all aware of the surge capacity created in the acute care sector. Are you talking about any surge capacity in the long-term care homes?

DR. KIERAN MOORE: That's correct, to support them if they need surge. So in particular,

if they're a -- we realize that if they have both COVID and influenza, both staff can't work across those units. So if an LTC has an outbreak, they're going to have to have a COVID floor, an influenza floor. Isolate those patients. Those staff are isolated. They can't cross-mingle, and it adds a complexity I've never had to deal with.

So that is when they're going to need extra staffing, and that was -- it's a very -- it was nuanced to bring that to their attention, but they've clearly and quickly realized that they will be short-staffed if they have two pathogens within one organization.

COMMISSIONER KITTS: Thank you.

DR. KIERAN MOORE: This is the model that's been proposed for supporting infection prevention and control going forward. And you can see there's a dotted line to public health, and this is relevant to, I guess, Central LHIN where we're only involved in outbreak. That is clearly not our structure nor our -- hold on a minute.

(BRIEF INTERRUPTION)

COMMISSIONER FRANK MARROCCO (CHAIR): I know the feeling.

DR. KIERAN MOORE: Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, mine almost always rings right in the middle of these presentations.

DR. KEIRAN MOORE: I hope it's not an LTC.

COMMISSIONER FRANK MARROCCO (CHAIR): No.

DR. KIERAN MOORE: So in our model, we would be -- you know, the hospital is still -- in the case of health sciences in our region, Ottawa General and Ottawa Civic -- Ottawa Hospital, would be the clinical IPAC lead.

We would be a coordination role. We would be the agency that goes into the field. And I do think we're perfectly positioned because we have inspectors, nurses, and the ability to enforce the Health Protection and Promotion Act. You know, Public Health does have a key role.

And we're not pulling out. I'm not going to pull out until Ontario Health can guarantee that they can replicate the service that we're currently providing to our LTCs and retirement homes and the expertise that we add and the support of the medical directors and nurse practitioners and staff.

Yes?

COMMISSIONER COKE: Can I just ask a question in terms of the way you've positioned yourself as a leader and a coordinator in your area? The capacity and resources in the public health units, is there more of an issue in other ones?

DR. KIERAN MOORE: Well, it really is having the vision and the direction in outbreak mode to make this happen. We didn't ask for any extra cash. We just realigned our services and our staff. I shared this model with others. They didn't want to be involved. They didn't -- other health units. They didn't want to do this type of work, but I thought it was key, central, and core to our role in outbreak management to do this work.

But you're absolutely right. Ours is probably an abhorrent approach, and I couldn't get consensus from my sister health units. I shared our approach, and I shared our audit tools. Public Health Ontario eventually created audit tools for LTCs and retirement homes. I badgered them, and I shared ours with our partners.

And I didn't see a direction from the CMOH office or the Ministry of Health or Ministry

of Long-Term Care or endorse a model and/or a direction for Public Health agencies to take. We just took it. It worked for us. We believe we've had success to date.

But if you're looking at gaps at a provincial level, I would say that's a gap, the strategic from direction from on high either mandating or enabling or directing Public Health to have this role. Any local public health agency could have done this. They would just need to have business continuity planning and realign.

COMMISSIONER COKE: Okay.

COMMISSIONER KITTS: Just to follow up, Kieran, I recall vividly when with the SARS, it was Public Health needed to have a stronger leadership role in epidemics, pandemics, whatever.

And the governance of the Public Health units was an issue in terms of not being in the Ministry of Health but more in the municipal. Is the governance a problematic or an asset?

DR. KIERAN MOORE: The governance in ours -- so we're an autonomous board, so to me, that's wonderful. I don't have to work within a municipality. I don't report to a CAO and then to a board. I report directly to a board.

The board is primarily municipally led, so our funders plus the citizens in the community. So I find autonomous boards are very responsive. They give you the flexibility to get job done.

I think working in a more rigorous, bureaucratic-structured municipal government would have been much more difficult, I think, to get the job done. If we're going to continue to have boards, autonomous boards, to me, is the direction to go.

COMMISSIONER KITTS: Do you know what the other 30 units/32 units have in terms of boards?

DR. KIERAN MOORE: Yeah. The vast majority, I think 23, are autonomous boards. And then the large ones -- Toronto, Peel, Ottawa -- are integrated within regional structures and so a little more complex governance model.

COMMISSIONER KITTS: Okay. Thank you.

DR. KIERAN MOORE: And so I talked briefly about our plan for COVID and influenza. I think that's key heading into the fall. As you're seeing, we're just constantly thinking ahead and anticipating the need and building capacity so that they, at least, have thought through how their

agencies can respond to the two pathogens. And again, it's having space, having staffing capacity.

And if we had recommendations, again, being proactive, follow the EPI, follow data, operationalize, have the relationships with your acute care, long-term care.

Public Health really can be that middle ground, that trusted partner, between acute care services, community services, long-term care, and primary care.

In our instance, we are the neutral, trusted ground. People come to us to discuss problems and get solutions. And also, what's worked well for us is the inspections of the properties within LTCs, and these are some of the documents that were core to our functioning down the road.

So that was a brief intro. I'm happy to have further questions.

COMMISSIONER FRANK MARROCCO (CHAIR): You indicated that the local Public Health unit is sort of uniquely positioned to drive this kind of arrangement. What's the alternative?

Like, was there an alternative suggested that would -- because it does seem rather

logical that --

DR. KIERAN MOORE: Yeah. So most Public Health physicians -- I'm a program director for a residency program, so I train public health preventive medicine specialists, and I've been doing so for eight years.

And, you know, outbreak management is 101. You can't leave my program without being an expert in outbreak management, understanding testing, and understanding communication collaboration coordination are your key tools. And foundational to that is having to bring in all health system partners to any dialogue in outbreak management, especially pandemic.

We do yearly pandemic training amongst our residents. They have to graduate with that expertise and competence to lead an agency response.

So the competence of the medical director, the medical leader of the Public Health agency, is key. The desire to be the leader in an outbreak, I think, is exceptionally important. There's no one better than a Public Health physician to lead this.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, from your perspective, you have the order-making function.

DR. KIERAN MOORE: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): So it's fairly efficient if you're looking for reasonable and probable grounds because you need an order.

DR. KIERAN MOORE: Oh, for us to be involved in LTCs and retirement homes is brilliant because of the Health Protection and Promotion Act. In its capacity, it's very, very nimble and a trusted legislation.

We didn't have to go to Ministry of Labour. We didn't have to go to the inspector. We always kept the inspectors, the Ministry of Long-Term Care inspectors informed, and we know who they are. But many of the times, they hadn't been to facilities in quite a while.

We are the eyes and ears on the ground. If we don't see something that we like, we can write the order. We can be immediately responsive. The order is in place to -- we give them a week to remediate, and then we go back in. If it's not there, they're financially in charge.

And as I pointed out, we've done that

numerous times, and I don't think any Justice of the Peace or a Court would, at the time of an outbreak, question Public Health's direction. And I think the long-term care facilities knew it, and so they were very quick to remediate and to improve and to respond to our suggestions.

So you need honey, but you also need to be able to sting when necessary.

COMMISSIONER FRANK MARROCCO (CHAIR): Is there a resistance to this model, like, up above you?

DR. KIERAN MOORE: Yes. I think there -- I haven't seen it embraced by my sister health units nor by the leadership. You know, if you compare us to BC where Public Health is very much integrated with the acute care sector -- they're part of a regional health authority, and LTCs report to the same leadership -- you're at the same table. That works very well as well.

We basically function like a regional health authority. David Pichora, the CEO of the hospital -- I'm on all their committees. We report and discuss on a daily basis what's going on.

So I do like the regional health authority model where Public Health is a partner

integrated with acute care and long-term care, but we also have the authority to implement and inspect and to penalize if you don't adhere to the basic recommendations.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, Ms. Coke?

COMMISSIONER COKE: Yeah. You said, you know, there's some resistance to this approach, so I guess I'm just trying to understand what is that resistance grounded in?

Is it just I don't feel I have the capacity to take on a larger role, the fact that -- you know, does it matter depending on where you are locally in terms of having the capacity and ability to manage this way?

DR. KIERAN MOORE: Yeah, I can't answer for all 34 health units, but when I brought these subjects up, many didn't want the role. They don't -- they said they did not have capacity. It is my belief, given a direction from the CMOH office, they could have made capacity.

Just, for instance, all restaurants were closed, all bars were closed, March 17th in Ontario. Our inspectors -- I wasn't going to have them sitting around not doing work in the middle of

a pandemic. So we just repurposed them.

They have expertise in infection prevention and control. We did do some education with them on this role, but they embraced it. They wanted to be a part of the response and took on this role brilliantly within our agency, and so did our nurses in supporting these facilities.

So it's clearly within their education, within their skill sets. It just needed a little improvement in terms of reviewing best practices in LTCs, and they were very easy to adapt and adopt this new role. So it could have been put in place in any jurisdiction.

COMMISSIONER FRANK MARROCCO (CHAIR): And do you have the authority, as the local officer, to make orders directed at restaurants and --

DR. KIERAN MOORE: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): -- bars and that sort of thing?

DR. KIERAN MOORE: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah. So it's a simple thing to deal with some place that has too many Queen's University students on a patio, if it comes to your attention.

DR. KIERAN MOORE: Don't get me started. Yes, so we -- oh, I didn't mention. We formed a whole enforcement committee. So we brought -- and this was back in March. We brought our bylaws officers from our municipal partners. We brought our Kingston Police, the OPP, our enforcement officers together just so we could have the same universal approach to these issues.

Whether it's an aggregation of students and/or someone, you know, not wearing a mask going into a long-term care facility, we were all on the same page.

I wrote an order for our community that you must wear a mask very early on in this outbreak in any public setting going to any business. We were well ahead of that provincial direction which just came out. All businesses were to have masking and hand hygiene product. So we had a strong emphasis on prevention very early on.

COMMISSIONER FRANK MARROCCO (CHAIR): Jack?

COMMISSIONER KITTS: Kieran, clearly leadership accountability and authority to act are the key ingredients for this success.

This may sound like an odd question,

but do most Public Health officers in the various units believe that, in a pandemic, they are the leader, that they are accountable, and that they do have the authority to act?

DR. KIERAN MOORE: I mean, that's a very good question. I have always considered that to be a key role of Public Health, and I've always considered it at the CMOH --

COMMISSIONER KITTS: Yeah.

DR. KIERAN MOORE: -- our position in Ontario. You are the lead, and you tell the acute care sector what you want of them and the LTC and retirement homes.

Leadership isn't always embraced, but I do think it's foundational to our practice, that we would be the leads of any outbreak.

You know, Ontario Public Health Standard clearly states our role and responsibility for LTC outbreaks in influenza or other, and we've followed that to the T. We've embraced it, and it is essential.

COMMISSIONER KITTS: So your class at Queen's, I take it they get that in spades. I know you well enough that they don't leave there without knowing that they're the leader, they're

accountable, and they have the authority to act. But it doesn't sound like it's widespread.

And the second part is is there any leadership training involved in becoming a Public Health Officer?

DR. KIERAN MOORE: Oh, great question.

So we do leadership training. We do risk communication training at Queen's. The OMA runs a leadership course which leads to a certificate. I have encouraged all my residents to take that longitudinal, one-year leadership training, six long weekends, to teach the skills of leadership. So we have done that. We've done that through the School of Business here at Queen's as well.

Foundational. Leadership can be learned, and it certainly can be taught. But if we learn, those skills can be adopted.

COMMISSIONER KITTS: So is it as easy as getting the new Public Health Officer manual? The first line says:

> "In any pandemic or outbreak, you are the leader."

DR. KIERAN MOORE: You're the general. You're running the show. This is your

responsibility. And honestly, it starts from the top down. And if your CMOH, like Bonnie Henry, is saying "you are the leader," "you're the spokesperson," "I'm going to be the communicator on behalf of all public health within my jurisdiction. No one else speaks except me, and the authority comes from me and is distributed to all of you. You're going to do X, Y, and Z."

Yeah. That's paramount, responsibility and authority, being recognized and being replicated across the province.

COMMISSIONER KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm just not sure that that can be learned. I think you can teach it, but I'm not sure it can be learned by anybody who hears you.

DR. KIERAN MOORE: I did find the course that I took instrumental. It did improve my understanding of the qualities of leadership. And yes, you have to practice it, and you have to be in a position to utilize the skill sets, but --

COMMISSIONER FRANK MARROCCO (CHAIR): But you have to embrace it.

DR. KIERAN MOORE: And if you're going to become a medical officer of health -- so I'm a

CEO. I have 200 something staff. By its nature, you're a leader. You may have variable styles in your leadership, but by its nature, you're a leader of that organization, and you have to take charge.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, unless there are -- this, I must say, for me -- and perhaps less so for Dr. Kitts, but for me, anyway -- and I can't speak for Ms. Coke -- this clears up a sense of how the lines of authority flow.

I'm familiar with the Act, and I read it very much the same way that you enforce it. But when you read something on the page, how it plays itself out is different. But this was very helpful for me; I can tell you that.

DR. KIERAN MOORE: I mean, it would be good in hindsight to review how many local Public Health agencies use Section 13, use Section 29.2, implemented orders to protect the health of vulnerables within these settings, how many audited.

I don't think this activity was widespread, but that could be done in a survey to local Public Health agencies fairly quickly.

I have spoken to the auditor general as

well and discussed some of those opportunities to improve the care of the vulnerable heading forward.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think unless there's anything else, Doctor, thank you very much for your time and for your insight. It's extremely helpful to us.

DR. KIERAN MOORE: If you want to have any further information, you know how to contact me.

COMMISSIONER FRANK MARROCCO (CHAIR): No, you shouldn't have said that. We may very well be back.

DR. KIERAN MOORE: Honoured. And I'm little more familiar with the regional health authority model because I reached out to Bonnie on their structure. I do like that model of integration with Public Health with partners in a governed way, although it can happen naturally as it's occurred in our region.

But thank you very much for your time as well and for the work that you're doing.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

COMMISSIONER KITTS: Thank you, Kieran.

COMMISSIONER COKE: Thank you very

much.

DR. KEIRAN MOORE: Thank you.

-- Adjourned at 1:55 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 8th day of October, 2020.

_____

NEESONS, A VERITEXT COMPANY
PER: MCKAYA MCDONALD, CSR
CHARTERED SHORTHAND REPORTER

WORD INDEX