

Long-Term Care COVID-19 Commission

Briefing with Public Health Ontario
on Monday, September 28, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 28th day of
September, 2020, 1:00 p.m. to 2:00 p.m.

1 BEFORE:

2 The Honourable Frank N. Marrocco, Lead Commissioner

3 Angela Coke, Commissioner

4 Dr. Jack Kitts, Commissioner

5

6 PRESENTERS:

7 PUBLIC HEALTH ONTARIO:

8 Colleen Geiger, President & CEO

9 Dr. Jessica Hopkins, Deputy Chief Health Protection

10 Dr. Shelley Deeks, Chief Health Protection Officer

11 Alwin Kong, Chief Legal Officer

12

13 PARTICIPANTS:

14 Alison Drummond, Assistant Deputy Minister,

15 Long-Term Care Commission Secretariat

16 Ida Bianchi, Counsel, Long-Term Care Commission

17 Secretariat

18 John Callaghan, Counsel, Long-Term Care Commission

19 Secretariat

20 Lynn Mahoney, Counsel, Long-Term Care Commission

21 Secretariat

22 Derek Lett, Policy Director, Long-Term Care

23 Commission Secretariat

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

25 Care Commission Secretariat

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ALSO PRESENT:
Eric Wagner, Counsel for Ontario
Roopa Mann, Counsel for Ontario
Sunil S. Mathai, Counsel for Ontario
Deana Santedicola, Stenographer/Transcriptionist

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

2

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, it is 1 o'clock, so who is
5 speaking at least first on behalf of Public Health
6 Ontario?

7 COLLEEN GEIGER: Good afternoon. It is
8 Colleen Geiger. I'm the Acting President and Chief
9 Executive Officer, and I will be starting first.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Okay. Well, Commissioner Coke is on
12 the screen, and Commissioner Kitts and myself,
13 Frank Marrocco, and I guess you know Ms. Deeks, and
14 Mr. Mathai is here to make sure that you don't say
15 anything you are not supposed to, so we'll keep an
16 eye out for that.

17 SUNIL MATHAI: I wouldn't go that far,
18 Commissioner Marrocco.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 And we have two of your colleagues from
21 Public Health Ontario; is that right?

22 COLLEEN GEIGER: I believe we should
23 have three, Dr. Hopkins, Dr. Deeks, who you have
24 already referred to, and Alwin Kong, who is our
25 legal counsel for Public Health Ontario.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 All right. Well, if everybody is here,
3 then, you know, we are ready to go. Deana is our
4 court reporter, so she'll be transcribing what
5 everybody says.

6 And thank you for coming, and we are
7 ready when you are.

8 COLLEEN GEIGER: All right.

9 ALWIN KONG: I am just going to present
10 the presentation. Can everyone see it?

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 I can. Commissioner Coke, can you see
13 the presentation?

14 COMMISSIONER ANGELA COKE: Yes, thank
15 you.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 And Commissioner Kitts?

18 COMMISSIONER JACK KITTS: Yes,
19 absolutely yes.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 So we can all see it.

22 ALWIN KONG: Okay. Thank you.

23 Colleen, please go ahead.

24 COLLEEN GEIGER: All right. We'll get
25 started then.

1 So as I mentioned, I am Colleen Geiger.
2 I am the Acting President and CEO of Public Health
3 Ontario, so I will start, and I will then be
4 handing over to Alwin, who will hand over to
5 Shelley and Jessica as we get -- start more general
6 through this presentation and we get into the
7 details of PHO's role with respect to the long-term
8 care COVID activities.

9 And so that is the way we have chosen
10 to organize this, and we hope that that will be
11 helpful.

12 Next slide, please.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 Ms. Geiger, I should have said, as I
15 started a little hastily, we will ask questions as
16 we go along, so we may interrupt you with
17 questions. It is probably better than us trying to
18 go back.

19 COLLEEN GEIGER: Absolutely. No
20 problem. Thank you for that.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Okay.

23 COLLEEN GEIGER: So I will start with a
24 brief overview of Public Health landscape in
25 Ontario, just so you are grounded from our

1 perspective.

2 Then I will speak very briefly about
3 Public Health Ontario, and Alwin will carry on from
4 there.

5 Dr. Deeks will cover PHO's role in the
6 Ontario COVID response writ large.

7 And Dr. Hopkins will speak to our role
8 specifically with respect to COVID-19 in long-term
9 care.

10 Next slide, please.

11 So in the landscape section, we thought
12 we would start just with a little bit about what is
13 Public Health because we often get questions and
14 confusions about it from members of the public. I
15 think perhaps because our name is Public Health
16 Ontario, and people mix up Public Health with
17 publicly-funded health care.

18 But generally, when we think about
19 Public Health and the sector in which we are
20 working, we think of it as the science of
21 protecting and improving the health of people and
22 their communities. This work is achieved through
23 work in the detection, prevention, and response to
24 infectious disease, a focus on promoting healthy
25 life-style and on research into disease and injury

1 prevention.

2 And we in very simple forms tend to
3 distinguish this from a health care focus where
4 clinicians tend to focus on treating disease and
5 injury with their focus first on the patient and
6 the individual patient. Whereas Public Health with
7 its goal more to prevent disease and injury for
8 populations, we focus first at the community and
9 population level.

10 And when we talk about populations in
11 Public Health, these can be as small as a local
12 neighbourhood or as big as an entire country or a
13 region of the world.

14 And then finally, as Public Health
15 professionals, we focus on identifying the causes
16 and determinants of disease and disability and on
17 the implementations of solutions at the local
18 level.

19 Public Health recognizes the importance
20 of health equity and on social determinants of
21 health. So in the broadest strokes, our intent
22 with this really was to make a distinction between
23 the focus of public health and health care.

24 Next slide, please.

25 So --

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Can I ask you, before you start, where
3 did Public Health Ontario come from or how was it
4 created?

5 COLLEEN GEIGER: So Public Health
6 Ontario -- and we will come to this a little bit
7 further as Alwin speaks about our specific
8 legislation that created us, but just by way of --

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Well, if you want to wait, if you want
11 to cover it then, that is fine. I don't want to
12 take you out of the presentation if you are going
13 to cover it later.

14 COLLEEN GEIGER: No problem, but I can
15 say by general background, we were created in the
16 aftermath of SARS and on the heels not only of SARS
17 but Walkerton and various food outbreaks that
18 occurred in the early 2000s largely and our
19 legislation of creation was passed in 2007.

20 And I will stop there because Alwin is
21 going to pick that up subsequently in the
22 conversation, but just to give you a sense, we were
23 born in the aftermath of SARS.

24 In terms of the overall landscape of
25 Public Health in Ontario, it is busy, but by the

1 nature of Public Health and its population and
2 community level focus, what we wanted to show here
3 were the number of different players and
4 constituencies that are engaged and that we
5 touched.

6 For convenience, we have put ourselves
7 as the centre. That is not because Public Health
8 Ontario considers itself the centre of the universe
9 in any way, shape or form, but simply for
10 convenience for this presentation. This shows our
11 mandate as scientific and technical advice to
12 support clients working in government, public
13 health, health care and related sectors.

14 And around us on this slide, you will
15 see the Ministry of Health, local Public Health,
16 and there are 34 local Public Health Units which
17 serve varying populations ranging in size from as
18 small as 34,000 to over 3 million, so there is
19 significant variability. And we'll touch on that
20 again in a subsequent slide.

21 The Ministry of Health that I have
22 mentioned. And then various other public health
23 and health stakeholders, as I look at the bottom
24 left of the slide. This encompasses health care
25 providers and institutions across the acute

1 primary, I'll say, tertiary community long-term
2 care sectors. It includes agencies like our
3 Ontario Health, formerly the LHINs, the Public
4 Health Agency of Canada, the National Microbiology
5 Laboratory, Health Canada, and a host of additional
6 associations and groups, as well as academic
7 organizations and non-governmental organizations
8 and some aspects of private sector.

9 And on the other Ministerial side, in
10 addition to the Ministry of Health, the Ministry of
11 Long-Term Care, Office of the Coroner, Ministry of
12 the Solicitor General, Agriculture, Food and Rural
13 Affairs, Community and Social Services, Education
14 and the Environment, Labour, Natural Resources,
15 Housing and Municipal Affairs, and the list goes
16 on.

17 So generally, public health is
18 everyone's business, and we were just demonstrating
19 those -- the breadth of those relationships that we
20 deal in through this slide.

21 What we have not attempted to do on the
22 slide, as you will see in the footnote, is to
23 describe funding relationships or accountability
24 relationships here, and we will touch on those
25 subsequently in the presentation.

1 So with respect to local public health,
2 as I mentioned previously, there are currently 34
3 Local Public Health Units. The legislative
4 authority for the organization of the Public Health
5 system and the duties and powers of its Public
6 Health officials are established by the Health
7 Protection and Promotion Act, the HPPA, and I
8 believe the Commission has been fully briefed on
9 that Act through a different introductory session.

10 But of the 34 boards of health, each is
11 responsible for a specific health unit and each of
12 those Health Units has an appointed local Medical
13 Officer of Health.

14 The funding for Health Units is a
15 municipal and provincial split, generally 70/30,
16 and that we felt was important contextually as it
17 sometimes comes up as people strive to understand
18 drivers from that perspective.

19 The Health Units, as I mentioned
20 previously, vary greatly in the size of the
21 populations they serve. They have different
22 governance structures and different capacities, as
23 you can imagine when you think about the breadth of
24 them varying from a population of 34,000 to a
25 population of 3 million.

1 And I think one of the really big
2 points we wanted to make here, which may be
3 self-evident to you but frequently to members of
4 the public is not, is that Public Health Ontario
5 does not oversee local Public Health Units.

6 Next slide, please.

7 And this slide is a rather broad
8 illustration of the boundaries of those 34 Health
9 Units as at January 1st, and again, this is really
10 just to give you a sense of the depiction of where
11 they are and general sense of difference in their
12 geographic size as opposed to their population
13 sizes, but we do interface with each and every one
14 of these to different degrees, depending on the
15 issue.

16 Next slide, please.

17 And I will go to the next one.

18 As we were preparing for this, we
19 thought and were advised that it might be helpful
20 for you to just see the executive leadership
21 structure at Public Health Ontario, and I thought I
22 would just quickly not review this whole thing for
23 you, but rather just flag for you the individuals
24 as depicted here who are speaking with you today.

25 So first off, at the top of the slide

1 you will see President and CEO acting currently,
2 and that is me, Colleen Geiger. When I am not the
3 Acting President and CEO, I am the permanent Chief
4 of Strategy, Stakeholder Relations, Research
5 Information and Knowledge, which you will see
6 depicted with my name on it in the level beneath
7 that.

8 Alwin Kong, who will be presenting
9 right after me, is our Chief Legal Officer and
10 Corporate Secretary, and Alwin is a key advisor to
11 Board and to the executive and reports in the
12 Executive Committee through our Chief Financial
13 Officer Cathy Campos, who is not joining the
14 presentation today.

15 Dr. Shelley Deeks, who you will see on
16 the left-most of this slide, is, as I mentioned at
17 the outset, our Chief Health Protection Officer.

18 Dr. Jessica Hopkins, who will be
19 speaking about our long-term care COVID response,
20 is the Deputy Chief of Health Protection, and
21 Jessica's focus is on medical and systems support,
22 and Jessica is one of two Deputies within Shelley's
23 area.

24 Dr. Vanessa Allen is also our Chief of
25 Microbiology and Laboratory Science, so Vanessa has

1 been leading our laboratory response to COVID, but
2 Vanessa will not be speaking today. I understand
3 the Commission will in the future have a briefing
4 about the laboratory aspects related to the
5 long-term care COVID-19 situation and in all
6 likelihood Vanessa will have an opportunity to join
7 and speak with you there.

8 And to say that as Vanessa leads our
9 COVID-19 response, it is Shelley Deeks who has been
10 the overall executive lead for PHO's response to
11 COVID-19, and hence, why we have identified her as
12 the speaker for that element of today's
13 presentation.

14 And I will move to the next slide, and
15 I am going to hand over to Alwin Kong, and again,
16 just moving back for one moment to the question
17 that Commissioner Marrocco asked, PHO was created
18 in the aftermath of SARS, Walkerton, and a number
19 of food outbreaks, and our legislation that creates
20 us is the OHPPA Act, and I will turn it over to
21 Alwin to explain that to you.

22 COMMISSIONER JACK KITTS: Before you
23 do, could I ask a question, please?

24 COLLEEN GEIGER: Yes, please.

25 COMMISSIONER JACK KITTS: Can you go

1 back to the previous slide?

2 COLLEEN GEIGER: Yes.

3 COMMISSIONER JACK KITTS: I am
4 interested in relationships and leadership
5 accountability. You said that you have no
6 oversight on the Public Health Units.

7 COLLEEN GEIGER: Correct.

8 COMMISSIONER JACK KITTS: Yet 70
9 percent of their funding comes from Ministry of
10 Health?

11 COLLEEN GEIGER: That is correct, it
12 comes from the Ministry of Health.

13 COMMISSIONER JACK KITTS: Okay. So --

14 COLLEEN GEIGER: As -- go ahead, sorry.

15 COMMISSIONER JACK KITTS: So does the
16 Ministry of Health have oversight over the 34
17 Public Health Units for accountability?

18 COLLEEN GEIGER: The Ministry of Health
19 sets the Public Health standards, and they do hold
20 the Public Health Units accountable through their
21 medical officers of health and their boards of
22 health for the delivery of the programs required by
23 those standards.

24 COMMISSIONER JACK KITTS: And I believe
25 we are going to hear it from Ms. Hopkins, but then

1 the Public Health Ontario holds a similar
2 relationship with long-term care homes in terms of
3 Public Health compliance and oversight?

4 COLLEEN GEIGER: We do not have any
5 role in compliance or oversight in long-term care
6 any more than we do in compliance or oversight of
7 local Public Health Units.

8 COMMISSIONER JACK KITTS: Okay. So you
9 are independent. There is a total independence
10 between Public Health in the -- outside of, I
11 guess, Public Health in the Ministry of Health?

12 COLLEEN GEIGER: We do not have any
13 accountability relationships with the Ministry of
14 Long-Term Care at this time.

15 COMMISSIONER JACK KITTS: Okay. Thank
16 you.

17 ALWIN KONG: So good afternoon,
18 Commissioners. My name is Alwin Kong, and as
19 Colleen mentioned, I serve as the Chief Legal
20 Officer here at Public Health Ontario.

21 Over the next few slides, what I hope
22 to do is just take you -- introduce you to PHO from
23 a statutory and governance perspective, and we'll
24 start with the legislation that creates PHO.

25 PHO is a statutory corporation

1 established under the Ontario agency for Health
2 Protection and Promotion Act, 2007. I'll just read
3 the purpose of the Act.

4 It is to enhance the protection and
5 promotion of the health of Ontarians and to
6 contribute to efforts to reduce health inequities
7 through the establishment of an agency, to provide
8 scientific and technical advice and support to
9 those working across sectors to protect and improve
10 the health of Ontarians and to carry out and
11 support activities such as population health
12 assessment, public health research, surveillance,
13 epidemiology, planning, and evaluation.

14 PHO operates since 2011 under its
15 business name Public Health Ontario. Under the
16 OHPPA, PHO is established as an agent of the Crown.
17 It is also an independent Board-governed
18 operational services agency, as designated under
19 the agencies and accountabilities directive.

20 PHO is governed by an independent Board
21 of Directors. Each Director is appointed by
22 Lieutenant Governor in Council.

23 The leadership of the Board is
24 discharged by the Chair and Vice Chair who is
25 appointed by the Board.

1 The Act that creates PHO also mandates
2 three standing committees. Each of the committees
3 focus on different aspects of the organization.
4 One is the Governance Committee that obviously
5 looks at board governance.

6 One is the Strategic Planning Committee
7 that is a subcommittee of the Board that focuses on
8 strategic planning and focus of the organization.

9 And the other one is Audit and Finance,
10 which obviously focuses on the financial compliance
11 and financial aspects of the organization.

12 I also wanted to highlight that while
13 the Chief Medical Officer of Health is not
14 designated as a Board member of PHO, the Chief
15 Medical Officer of Health is entitled to attend and
16 participate in Board meetings but does not vote,
17 but the Chief Medical Officer of Health as well is
18 designated as a member of the Strategic Planning
19 Committee. So it really has a focus on assisting
20 the agency and its strategic plans.

21 Section 6 of the enabling legislation
22 sets out PHO's mandate. At a high level and as a
23 chief focus, we provide scientific and technical
24 advice and support to the Ministry of Health and
25 other key stakeholders, as Colleen just described a

1 moment ago.

2 We focus on providing knowledge and
3 best practice and research. PHO operates the
4 Public Health laboratory and many of its programs
5 aim to bridge infection control and occupational
6 health and safety, a focus on emergency response --

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Excuse me, Mr. Kong. Emergency
9 response, would that be like COVID? Would that be
10 an emergency to which you would respond?

11 ALWIN KONG: That's right. Yes, that
12 is one example. COVID is a disease of public
13 health significance and --

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 And what -- oh, sorry. Pardon me. Go
16 ahead.

17 ALWIN KONG: PHO has been called on by
18 the CMOH to assist the CMOH in responding to this
19 pandemic.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 No, I guess my question is a little
22 different. The slide says that section 6 sets out
23 your mandate, and the slide says that one of the
24 mandates is emergency response. And I guess my
25 question was going to be, what is the mandate in

1 relation to emergency response? Are you
2 responsible for managing the emergency? Or what is
3 the mandate?

4 ALWIN KONG: So I think, you know --
5 and my colleagues who are involved with the
6 emergency response itself will have a more detailed
7 explanation, but our mandate really focuses on
8 supporting the CMOH and assisting in the command
9 structure of the Ministry in responding to the
10 pandemic.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 So the Chief Medical Officer of Health
13 is responding to the pandemic, and you are
14 supporting the Chief Medical Officer of Health; is
15 that the idea?

16 ALWIN KONG: That's right.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Okay.

19 ALWIN KONG: Yes. Okay. If there is
20 no other questions, I was going to discuss as well
21 PHO's role in assisting in policy development.

22 So as Colleen mentioned, the domain of
23 public health policy is that of the Ministry of
24 Health and not PHO, but we do provide scientific
25 and technical support that supports their

1 development of policy.

2 A key focus -- and my colleagues will
3 explain in greater detail momentarily -- is our
4 focus on population health, surveillance, and
5 epidemiological data. We are a key provider of
6 professional development and education to public
7 health professionals here in Ontario, and we assist
8 the CMOH, again, very pointedly with providing
9 scientific and technical advice and operational
10 support in the event of an emergency or --

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 What is operations support?

13 ALWIN KONG: Shelley or Jessica? If I
14 could just defer to one of my colleagues who could
15 better describe it?

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Oh, sure, and if they are going to make
18 a -- they want to answer. I was just curious what
19 it was. So if it is convenient to answer now,
20 fine. If not, then answer it during the
21 presentation.

22 DR. JESSICA HOPKINS: It is Jessica
23 Hopkins. I happy to speak to you about it more
24 when I get to the long-term care section, but an
25 example would be our support for IPAC assessments

1 in long-term care homes.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 All right.

4 ALWIN KONG: I just wanted to also
5 highlight, as part of our governance structure, a
6 key agreement that we have with the Ministry of
7 Health is our Memorandum of Understanding.

8 The MOU sets out our accountability
9 relationship with the Ministry of Health. From a
10 governance and structural perspective, PHO's Chair,
11 who leads the Board, is accountable to the Minister
12 of Health for the performance of the agency, and
13 its CEO, obviously who has management oversight of
14 the agency, is appointed by and reports to the
15 Board of Directors.

16 Finally, what I just mention in the MOU
17 is that the MOU itself contains provisions dealing
18 with outbreak situations, and as I mentioned a
19 moment ago, Commissioner Marrocco, it is in this
20 MOU that identifies PHO's role in an outbreak
21 response situation and how we assist the MOH in
22 discharging our function, as well as supporting the
23 Ministry through its chain of command.

24 PHO's role in an emergency and outbreak
25 support include -- similar as I just mentioned in

1 terms of our mandate, but specifically enumerated
2 in our MOU the provision of scientific and
3 technical advice, a provision of surveillance and
4 epidemiological data and analysis, much more
5 details will come out momentarily, conducting
6 relevant research and providing field support.

7 The MOU also discusses financial
8 aspects of obviously extraordinary costs involved
9 with a pandemic response. I would just highlight
10 that from a public communications perspective, it
11 is at the Ministry of Health that leads those types
12 of operations, and as well as I mentioned earlier,
13 the CMOH may request or direct PHO to provide
14 assistance in responding to the outbreak.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 Where you describe your role in
17 emergency and outbreak support and communication
18 and so on, is that all set out in the Memorandum of
19 Understanding?

20 ALWIN KONG: Yes.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Okay.

23 ALWIN KONG: Yes. The Memorandum of
24 Understanding specifically contemplated an
25 emergency and outbreak situation and how the

1 parties would work together to respond.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 And that is a Memorandum of
4 Understanding between the Crown agency, Public
5 Health Ontario, and the Ministry of Health?

6 ALWIN KONG: That's right.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Thank you.

9 COMMISSIONER JACK KITTS: Does the
10 Ministry of Health include the Ministry of
11 Long-Term Care?

12 ALWIN KONG: So just -- specifically
13 our MOU actually dates back to 2008, and it was
14 entered into between the Ministry of Health and
15 Long-Term Care as it was then known.

16 When there was a separation of the
17 Ministry of Health and the Ministry of Long-Term
18 Care, it was determined that PHO would remain
19 accountable to the Ministry of Health, so there is
20 no specific accountability relationship with
21 Long-Term Care.

22 COMMISSIONER JACK KITTS: But I guess
23 in these situations you would include Long-Term
24 Care as part of the partnership?

25 ALWIN KONG: I believe we characterize

1 the Ministry of Long-Term Care as an important
2 stakeholder, but the accountability relationship is
3 with the Ministry of Health.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 So technical support for the Ministry
6 of Long-Term Care is determined by -- the extent to
7 which you can do that is determined by the Ministry
8 of Health?

9 ALWIN KONG: So I will defer to my
10 colleagues who can describe the operational
11 aspects, but I believe what often happens is they
12 receive a request from the office of the CMOH
13 and -- with a request for support, and then we
14 provide support under that request or direction.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 But if the Ministry of Long-Term Care
17 asks Public Health Ontario something, the way in
18 which that is responded to is determined by your
19 relationship with the Ministry of Health?

20 ALWIN KONG: Yes.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Okay.

23 ALWIN KONG: If there are no more
24 questions, at this time I would like to turn the
25 presentation over to my colleague, Dr. Jessica --

1 sorry, Dr. Shelley Deeks, please.

2 DR. SHELLEY DEEKS: Okay. Thank you
3 very much, Alwin. If we go on to the next slide,
4 this slide basically is a repeat of a previous
5 slide and just denotes Public Health Ontario's
6 primary clients and partners and stakeholders.

7 So as both Alwin and Colleen has
8 described, our primary client or stakeholder is the
9 Ministry of Health, and specifically within the
10 Ministry of Health, it is the Chief Medical Officer
11 of Health and the office of the CMOH.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Can I just stop you there?

14 DR. SHELLEY DEEKS: Yes.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 The use of the word "clients", why do
17 you call them "client"? Like, what is the -- they
18 are a primary client. Why that terminology, or
19 what does that mean?

20 DR. SHELLEY DEEKS: They are our
21 primary stakeholder, the people for whom we
22 interact most closely.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Does that mean they give you
25 instructions? They tell you what to do?

1 DR. SHELLEY DEEKS: Yes, they --
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Not in a technical sense, but they give
4 you overall direction?

5 DR. SHELLEY DEEKS: Yes, the office of
6 the CMOH will often ask us for advice, and we would
7 then respond to that advice.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 So are you subject to the Chief Medical
10 Officer of Health or independent of the Chief
11 Medical Officer of Health?

12 DR. SHELLEY DEEKS: Alwin, I am going
13 to get you to answer that question.

14 ALWIN KONG: Sure, yeah. PHO is an
15 independent Board-governed agency, so our
16 accountability relationship as an organization is
17 with the Board of Directors.

18 The CMOH has certain powers, as you
19 are, I am sure, aware under the OHPPA, but there is
20 no specific accountability relationship to the
21 CMOH.

22 And just to clarify, our use of the
23 word "client" is really a more informal
24 characterization. I think it really focuses on
25 PHO's service delivery model, and while we might

1 describe the MOH as a client as well as local
2 Public Health Units, our accountability
3 relationships are quite different, as an example.

4 So while we provide services both to
5 the Ministry of Health and Health Units, we are
6 really only accountable through our Memorandum of
7 Understanding to the Ministry of Health.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay.

10 ALWIN KONG: I hope that clarifies the
11 matter.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Well, I will have to think about
14 whether it clarifies it or not, but I appreciate
15 your response.

16 ALWIN KONG: My pleasure.

17 DR. SHELLEY DEEKS: So then other
18 stakeholders includes health system partners, which
19 include other government ministries, as Alwin was
20 referring to before, including the Ministry of
21 Long-Term Care, Ontario Health, and at the federal,
22 provincial, territorial level, the Public Health
23 Agency of Canada and other agencies across the
24 country.

25 I just wanted to flag that the Public

1 Health Agency of Canada also includes the National
2 Microbiology Laboratory.

3 If we move to the next slide --

4 ALWIN KONG: Sorry, just before we do
5 that, I just wanted to also clarify that the use of
6 the word "partner" is not indicative of a legal
7 relationship or partnership, but how, again, we
8 describe our relationship with our stakeholders.

9 Sorry, Shelley, for interrupting.

10 DR. SHELLEY DEEKS: That is okay. If
11 we move to the next slide, this slide just denotes
12 the areas of expertise within the organization, and
13 so we -- people within PHO have expertise in a
14 number of different areas, including infection
15 prevention and control, communicable disease
16 control, as well as outbreak control, microbiology
17 and laboratory operations, environmental and
18 occupational health, health equity, health
19 promotion, chronic disease prevention, emergency
20 preparedness, surveillance and epidemiology, data
21 analysis, knowledge synthesis, training, education
22 and professional development, information
23 management, and research, ethics and evaluation.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 In terms of the control of -- or

1 infection prevention and control, would Public
2 Health Ontario devise responses, for example, for
3 long-term care homes in the event of an infectious
4 disease outbreak? Would that be something you
5 would do?

6 DR. SHELLEY DEEKS: So we are going to
7 get into the specifics of our involvement with
8 infection prevention and control with respect to
9 long-term care, but as I think Colleen mentioned,
10 in terms of the policy, the policy is set by the
11 Ministry of Health, health policy.

12 We at PHO would provide scientific and
13 technical advice to that policy in terms of --

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 So the Ministry of Health would, in
16 this hypothetical situation, have to say to you, We
17 want to create a protocol for long-term care homes
18 responding to infectious diseases, and when the
19 Ministry of Health asked you for support, you would
20 provide your support to the Ministry of Health?

21 DR. SHELLEY DEEKS: Yes.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 While it was developing that plan?

24 DR. SHELLEY DEEKS: Yes, we would
25 provide support when asked.

1 In addition, there is a Provincial
2 Infectious Disease Advisory Committee called PIDAC
3 that focuses on infection prevention and control
4 and sets out best practices for infection
5 prevention and control.

6 So that is a long-standing advisory
7 committee, and there are a number of best practices
8 that have been developed by PIDAC. It is a
9 multidisciplinary committee of health care
10 professionals with expertise in infection
11 prevention and control.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 And I don't want to ask you -- I mean,
14 I know you are here to talk about what you do. Is
15 it under the Ministry of Health as well?

16 DR. SHELLEY DEEKS: No, PIDAC advises
17 PHO on prevention and control of health
18 care-associated infections and produces best
19 practice documents that are evidence-based.

20 Then the advice that PIDAC gives to
21 PHO, the CEO would then provide that advice to the
22 CMOH, who may change policy, who sets the policy.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 Okay.

25 DR. SHELLEY DEEKS: Okay. If we go on

1 to the next slide. Colleen also mentioned that we
2 run the Public Health laboratory.

3 So I thought it was important to
4 identify core functions of public health
5 laboratories because people often get confused
6 between a public health lab versus a hospital lab,
7 for instance.

8 So functions -- core functions of a
9 public health laboratory include disease
10 prevention, control and surveillance, integrated
11 data management, reference and specialized testing,
12 public health preparedness and response, and Public
13 Health's related research.

14 If we move to the next slide, what I am
15 going to do now is I am going to give you an
16 overview of our role in Ontario's response to
17 COVID, and then I am going to turn it over to my
18 colleague, Dr. Hopkins, who is really going to take
19 a deeper dive or a deeper focus in what our
20 response has been to long-term care.

21 So this slide just shows you our
22 relationship with the other key organizations that
23 have been involved with the Public Health COVID-19
24 response in Canada.

25 So you can see that we interface with

1 the Ontario Government, and that is the medical
2 officer -- sorry, the Ministry of Health, as Alwin
3 has explained.

4 We also interface with the local Public
5 Health Units and then with the Public Health Agency
6 of Canada, who has a number of scientific tables,
7 and we sit on some of those tables.

8 If we move to the next slide, basically
9 we have been functioning in an IMS since the
10 beginning of the response, and our work in
11 supporting Ontario's response can be divided into
12 two primary streams of activity.

13 The first one is laboratory testing,
14 and then the second one is the Public Health
15 response with scientific and technical advice and
16 support.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 So when you say "laboratory testing",
19 that doesn't have anything to do with gathering the
20 samples? It has to do with testing the samples; is
21 that it?

22 DR. SHELLEY DEEKS: It is testing the
23 samples, yes, once they get --

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 So somebody else is dealing with

1 testing, but they can send the tests -- you are
2 coordinating what happens if they send the tests
3 taken to one of the public laboratories?

4 DR. SHELLEY DEEKS: Yes. So an
5 individual will do a nasopharyngeal swab, let's
6 say, so do the actual test, and then once the test
7 gets to a PHO laboratory, we are responsible for
8 doing the testing and then reporting the
9 information out.

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Okay.

12 DR. SHELLEY DEEKS: If we go to the
13 next slide, it actually focuses a little bit more
14 on laboratory testing.

15 So PHO laboratory has tested more than
16 a third of all the COVID-19 molecular tests in the
17 province, so that is the PCR test that you have
18 probably heard a lot about.

19 As of mid-September, the provincial
20 network had conducted more than 3.4 million
21 COVID-19 tests, of which PHO's laboratory had
22 conducted more than a million of them.

23 The PHO has been conducting tests since
24 early January. Initially, they were validated
25 through the National Microbiology Laboratory, which

1 is part of the Public Health Agency of Canada that
2 I was --

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Dr. Deeks, you said that since early
5 January they have been conducting tests for
6 COVID-19. When was the decision taken? When did
7 they start thinking about testing for COVID-19?

8 DR. SHELLEY DEEKS: I believe if you
9 want specific dates, we would --

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Well, just generally.

12 DR. SHELLEY DEEKS: I think it was
13 right at the very beginning. As soon as the
14 disease was identified in early January, there was
15 work both in PHO as well as at the NML or the
16 National Microbiology Laboratory in developing
17 tests.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 So did PHO start to do that on its own
20 because it has got that kind of technical
21 understanding and appreciated the significance of
22 what had happened or what was happening? Is that
23 how that happened? Or were you directed -- was PHO
24 directed to do that or asked to do that?

25 DR. SHELLEY DEEKS: So these questions

1 will be ones that Dr. Allen --

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 I'll hold the question then until

4 Dr. Allen.

5 DR. SHELLEY DEEKS: It is important to

6 provide input on, but there is a National

7 Laboratory Network which PHO is involved with.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Okay.

10 DR. SHELLEY DEEKS: Okay. So as I

11 noted, PHO has been conducting testing since early

12 January. The Ministry of Health determines the

13 testing criteria, so which populations are eligible

14 for tests, and that has evolved over the course of

15 the outbreak.

16 So as test volumes increased,

17 particularly in the first wave of the outbreak, PHO

18 worked with Ontario Health to increase capacity

19 through the development of a COVID-19 diagnostic

20 testing network which was set up as a result of the

21 outbreak, and it is a coordinated system of

22 hospital, private, and public laboratories overseen

23 by Ontario Health.

24 In addition to PCR testing, diagnostic

25 testing which I have just referred to, PHO is also

1 leading Ontario's COVID-19 serosurveillance program
2 to better understand what proportion of the Ontario
3 population has COVID-19 antibodies, so it is
4 looking at serology, to identify hot spots and high
5 risk groups.

6 If we move on to the next slide, now I
7 am going to identify some of the areas under which
8 we provide scientific and technical advice and
9 support.

10 So we have been talking about
11 laboratory science, and that is a key area for us
12 in providing scientific and technical advice. So
13 Ontario's COVID-19 Provincial Diagnostic Network,
14 PHO acts as a reference laboratory, as we have
15 indicated. It validates -- we validate new
16 laboratory technologies and approaches to ensure
17 they are effective.

18 PHO is also home to Ontario's COVID-19
19 Testing Strategy Expert Panel, which recommends
20 changes to the testing strategy to the CEO of PHO,
21 who then recommends those -- takes those
22 recommendations forward to the Chief Medical
23 Officer of Health.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 So the testing strategy as far as

1 long-term care facilities is concerned would be
2 determined by the Chief Medical Officer of Health?

3 DR. SHELLEY DEEKS: Yes.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Okay.

6 DR. SHELLEY DEEKS: Another key area
7 where we provide technical advice and support is in
8 terms of data and surveillance.

9 So since 2011, PHO has been conducting
10 surveillance on diseases of public health
11 significance as an agent of the Ministry of Health.

12 So as Alwin mentioned, COVID-19 is a
13 disease of public health significance or reportable
14 disease, so all Health Units collect information on
15 COVID-19 and report it through our reportable
16 disease information system, and at PHO, we conduct
17 the data analysis on behalf of the province. So we
18 are conducting the provincial analysis, and we
19 report back on those findings.

20 We are currently doing a daily -- we
21 produce a daily epidemiologic summary for COVID-19.
22 We produce a weekly epidemiologic summary, as well
23 as more detailed, what we call, ad hoc
24 epidemiologic summaries, which are a deeper dive in
25 a specific area of focus.

1 If we go to the next slide, this
2 denotes some of our work in advice and
3 consultation. So we provide expertise to the
4 Ministry of Health and other government Ministries
5 to support provincial decision-making and policy
6 developments.

7 We also provide support to Public
8 Health Units to assist with their local
9 decision-making, policy development, program and
10 service delivery and support of organizations and
11 sectors in their community.

12 So an example of this would be if a
13 health unit has a particular challenging question
14 or issue that they are dealing with with respect to
15 COVID-19, they then contact either us directly or
16 us through the Ministry. We then will arrange a
17 teleconference and provide them with our advice and
18 consultation.

19 An additional bucket of activities is
20 under the category of knowledge synthesis. So we
21 have throughout the pandemic conducted synopses or
22 critical appraisal of COVID-related peer-reviewed
23 literature.

24 We have also done a suite of products
25 called "What We Know So Far", which summarizes the

1 current state of knowledge related to specific
2 COVID-19 topics, and then we also conduct evidence
3 summaries in response to requests, typically from
4 the Ministry of Health, as well as other Ministries
5 and the Public Health Units.

6 If we go to the next slide --

7 COMMISSIONER ANGELA COKE: Could I just
8 ask a question?

9 DR. SHELLEY DEEKS: Certainly.

10 COMMISSIONER ANGELA COKE: Are any of
11 these summaries specific to information about
12 long-term care home issues?

13 DR. SHELLEY DEEKS: Yes, some are
14 specific, and then others would be related just
15 because of the general nature of disease control.

16 COMMISSIONER ANGELA COKE: Okay. And
17 are any of these summaries available for us to look
18 at?

19 DR. SHELLEY DEEKS: Absolutely, and we
20 will be getting to that in the next section, and we
21 have also provided at the end of the slide set some
22 links to some of those summaries.

23 COMMISSIONER ANGELA COKE: Thank you.

24 DR. SHELLEY DEEKS: Okay.

25 If we go to slide 24, to round out the

1 additional two aspects of our scientific and
2 technical advice, one is infection prevention and
3 control best practices. I mentioned earlier that
4 Public Health Ontario hosts PIDAC, and we provide
5 resources, training materials and support to public
6 health, health care organizations, health
7 practitioners, for the implementation of best
8 practices in infection prevention and control for
9 PIDAC.

10 So there is a suite of products dealing
11 with infection prevention and control best
12 practices on our website, but Dr. Hopkins will be
13 getting into the specifics for the ones related to
14 long-term care that are specifically COVID-related.

15 And then finally we produce public
16 health guidance, so we provide input to the
17 Ministry of Health on the development of public
18 health guidance based on the best available
19 scientific evidence. So we do that on request but
20 also organically if there is a situation where we
21 feel that the current advice needs to be updated.

22 Although the policy directives are
23 determined by the Ministry, we will provide the
24 input when asked by the office of the CMOH.

25 I am now going to turn it over to

1 Dr. Hopkins who will discuss further our role with
2 respect to long-term care.

3 DR. JESSICA HOPKINS: Thank you so
4 much. So I am going to speak in more detail about
5 the specifics related to the long-term care
6 setting.

7 But before I go through this next set
8 of slides, I just wanted to remind the Commission
9 of some significant changes in the health care and
10 public health system since the beginning of 2019 as
11 they may provide some helpful context for the
12 discussions.

13 So early in 2019, Ontario Health was
14 operationalized, and then in mid 2019, the Ministry
15 of Health and Long-Term Care was split into the
16 Ministry of Health and the Ministry of Long-Term
17 Care.

18 Where I am going to start is with what
19 Public Health was doing with long-term care prior
20 to COVID, so these are part of Public Health
21 Ontario's regular activities. So we were providing
22 scientific and technical advice to the Chief
23 Medical Officer of Health in Public Health Units on
24 long-term care relevant issues under the Ontario
25 Public Health standards. So an example of that

1 would be assistance on outbreak management and
2 testing.

3 We were supporting the Provincial
4 Infectious Diseases Advisory Committee on infection
5 prevention and control in the development of
6 infection prevention and control best practices,
7 and I will share the -- we can share the links
8 later, but, for example, this would be best
9 practices for IPAC programs in Ontario which are
10 very relevant to the long-term care setting.

11 Developing resources to support
12 long-term care homes' implementation of IPAC best
13 practices, so we have a suite of different
14 resources, as Dr. Deeks mentioned. These would
15 include things like videos on hand washing and how
16 to put on and take off personal protective
17 equipment correctly, and these are publicly
18 available.

19 Building capacity for IPAC best
20 practices through communities of practice. We also
21 have IPAC core competencies training, which covers
22 the essentials that people working in health care
23 settings would need to know.

24 Laboratory testing of communicable
25 disease outbreak-associated samples from long-term

1 care homes is part of our regular practice as well,
2 and this is particularly evident, for example, with
3 respiratory virus season outbreaks and influenza.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Can I just stop you there? When you
6 are developing infection prevention and control
7 best practices or PIDAC is with your support, when
8 they have the finished best practices document,
9 where does it go?

10 DR. JESSICA HOPKINS: Yes. Thank you,
11 Commissioner, for the question. So those documents
12 are posted publicly on the Public Health Ontario
13 website. We have a specific section for PIDAC, but
14 other sections for other Public Health
15 Ontario-produced resources.

16 In addition, we share those widely
17 through the networks of stakeholders that we have.
18 So we have stakeholder connections through
19 long-term care, as well as many long-term care
20 homes participate in our communities of practice,
21 and we will hold meetings and/or webinars with
22 those communities of practice to help share that
23 information. So there is a knowledge translation
24 plan that is built into the development and launch
25 of those products.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Okay.

3 COMMISSIONER JACK KITTS: Is there a --
4 are these standards, or is there anything that
5 ensures that the field follows this? I don't think
6 they are practice standards. I don't think you
7 have oversight or authority. So how do these get
8 taken up?

9 DR. JESSICA HOPKINS: Thank you,
10 Commissioner, for the question.

11 Yes, there is no oversight by Public
12 Health Ontario to ensure these are taken out.
13 However, there is -- within the Ontario Public
14 Health standards, the oversight for outbreaks of
15 diseases of public health significance, including
16 respiratory and gastro-intestinal outbreaks within
17 long-term care homes, are under the authority of
18 the local Public Health unit.

19 As well, the Ministry of Long-Term Care
20 has inspectors who have authority with respect to
21 safety within the long-term care homes as well.

22 Okay. So now --

23 COMMISSIONER ANGELA COKE: I have
24 another question. Just in terms of -- I'm
25 assuming, as you are developing training or

1 products, that you have done some sort of a needs
2 assessment, so I am interested in your
3 observations. Did you think or have a sense of
4 what the IPAC sort of capacity or expertise in
5 long-term care homes was even before COVID?

6 DR. JESSICA HOPKINS: Thank you,
7 Commissioner Coke.

8 So, yes, there was an awareness of the
9 importance and the need for IPAC within the
10 long-term care setting, and so the document best
11 practices for IPAC programs in Ontario was written
12 specifically with that thought in mind, the need to
13 understand governance, accountability, and
14 oversight for IPAC within long-term care homes and
15 other studies within Ontario.

16 The uptake of that and the
17 accountability to ensure uptake does not rest with
18 Public Health Ontario.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 And so is the video dealing with
21 putting on and taking off PPE, how would you -- you
22 developed that best practice, and where does it go?
23 How does it get out?

24 DR. JESSICA HOPKINS: Yes. Thank you
25 for that question.

1 So in terms of the development of best
2 practices, the Provincial Infectious Diseases
3 Advisory Committee will often conduct literature
4 reviews, and Public Health Ontario provides that
5 secretariat support in order to conduct those, as
6 well as jurisdictional scans of other best
7 practices so that we ensure that what is being
8 recommended is evidence-based.

9 Those are then published on the Public
10 Health Ontario website open to the general public,
11 and we use our pre-existing networks. So we are
12 connected very closely with acute care, long-term
13 care, the Public Health Units in Ontario. We share
14 the information when we launch new products so that
15 they are aware it is available.

16 We often also accompany this with other
17 mechanisms of knowledge sharing such as webinars.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 So in terms of making employees in
20 long-term care homes aware of what you have done,
21 you have done those things, but there is no
22 compulsion to this? This is advice. It is
23 voluntary. Is that right?

24 DR. JESSICA HOPKINS: That is correct,
25 Commissioner. Public Health Ontario does not have

1 the authority to compel long-term care homes to act
2 on this advice.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 So what would have to happen is that
5 the Ministry of Long-Term Care would have to take
6 up the best practices and then enforce them through
7 whatever enforcement mechanism was available to
8 them.

9 Your role is in developing the best
10 practices?

11 DR. JESSICA HOPKINS: Yes,
12 Commissioner, that is correct.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Okay.

15 DR. JESSICA HOPKINS: If there are no
16 more questions on that section, I will move on to
17 the work that Public Health Ontario is doing in
18 response to COVID-19 specifically in the long-term
19 care setting.

20 So our initial work back in the very
21 early months of January 2020 and into February was
22 really focussed on our pre-COVID-19 roles in which
23 we were responding to requests from stakeholders,
24 primarily the Ministry of Health and Public Health
25 Units.

1 We are also building relationships with
2 new stakeholders, including the Ministry of
3 Long-Term Care and Ontario Health.

4 We participated in a number of
5 long-term care-specific tables, including the
6 long-term care planning and response table, as well
7 as the long-term care retirement home COVID-19
8 action table.

9 We have also established within our
10 incident management structure long-term care
11 setting work, and so we have divided this into two
12 different areas. So one is around provincial level
13 supports and the other is local level and community
14 setting supports, which I'll speak to more on the
15 subsequent slides.

16 So if we begin with provincial level
17 supports, Public Health Ontario has been providing
18 scientific and technical advice to Ministries to
19 inform decision-making and policy development.

20 So one example of this would be
21 recommendations around prevention and control
22 measures such as restricting long-term care staff
23 from working in multiple homes.

24 We have also been involved in data
25 collection, analysis and reporting. So, for

1 example, we report on long-term care cases and
2 outbreaks as well -- and that is on a regular basis
3 in an in-depth way.

4 We also conducted an enhanced
5 epidemiologic summary report which compares case
6 fatality of seniors in long-term care versus
7 community dwelling, along with a number of other
8 factors.

9 With respect to knowledge synthesis, we
10 have provided a number of different products to the
11 Ministry of Health, including an evidence summary
12 on universal masking in health care settings and
13 retirement homes, and long-term care would be
14 considered part of this.

15 And with respect to capacity building,
16 we have been involved in training, professional
17 development, and education, and one of the things
18 that we were asked to do was develop modules for
19 the long-term care setting covering direct care
20 staff, non-direct care staff, family and
21 caregivers, as well as inspectors. So that would
22 be Public Health inspectors and Ministry of
23 Long-Term Care inspectors.

24 These launched at the beginning of
25 September, and between September 2nd and 23rd, we

1 had more than 48,000 registrations for these
2 training modules.

3 As well, we have been involved in
4 developing a network of laboratories across Ontario
5 for COVID-19 testing.

6 Next slide, please.

7 This slide describes our local level
8 and community setting supports. So with respect to
9 scientific and technical consultation, we have
10 provided that to Public Health Units and long-term
11 care homes on testing and outbreak prevention and
12 management.

13 So I know there was a question
14 previously around what support have we been
15 providing directly, so we have been providing
16 infection prevention and control assessments, both
17 virtually and on-site, to different homes in the
18 province, particularly those that are in need
19 because of challenges with outbreaks where they are
20 having trouble stopping transmission, and we have
21 been engaged in well over 100 of those to date.

22 We are involved in data collection,
23 analysis, and reporting. So Public Health Ontario,
24 for example, provided lab and analytical support to
25 Public Health Units for the testing pilot.

1 We have continued to be involved in
2 knowledge synthesis, and so Public Health Ontario
3 has taken the IPAC best practices which were
4 developed by PIDAC, and we reformatted those for
5 long-term care into a more user-friendly checklist
6 that long-term care home administrators, as well as
7 Public Health unit staff, could use to conduct IPAC
8 assessments on-site for long-term care homes.

9 We have continued to build capacity.
10 For example, we have increased our community of
11 practice meetings and provided updates to our
12 long-term care participants on current COVID-19
13 guidelines and best practices.

14 We have also worked with Ontario Health
15 and developed what is called an IPAC Extenders
16 Training Program.

17 So during the first wave of the
18 pandemic, you will recall that hospitals and other
19 health care settings in the community were not
20 working to the same level that they normally would,
21 and so there were underutilized staff. Those staff
22 could be trained using this training to help
23 provide further preventive support to long-term
24 care homes to prevent outbreaks.

25 And finally, laboratory testing for

1 long-term care settings. So Public Health Ontario,
2 for example, performs testing for the majority of
3 outbreak-associated samples in long-term care
4 homes.

5 Next slide, please.

6 This is a screen capture of the landing
7 page for Public Health Ontario's COVID-19 long-term
8 care resources, and so you can see we have a number
9 of different categories that can be accessed,
10 including surveillance reports, guidance and best
11 practices, fact sheet, info-graphics, videos. So
12 lots of different resource there for our long-term
13 care home partners.

14 And as of September 15th, these
15 resources have been accessed more than 100,000
16 times.

17 Next slide, please.

18 So that brings us to the end of the
19 presentation. As Dr. Deeks mentioned, we have put
20 together some different references that are
21 available as links for you to access, and we are
22 happy to take questions.

23 COMMISSIONER JACK KITTS: I have a
24 question about the IPAC extenders. I think it is a
25 great idea.

1 My question is who trains them,
2 certifies them, and how long does it take?

3 DR. JESSICA HOPKINS: Thank you for
4 that question, Commissioner.

5 So this is not a certification program.
6 This program is designed for people who already
7 have health care experience, the preference ideally
8 being community and long-term care experience.

9 And so Public Health Ontario developed
10 the training module for this. The Ontario Health
11 region that we worked with was required to provide
12 oversight through hospital IPAC specialist and
13 infectious disease physicians, so that if there
14 were challenges that these IPAC extenders
15 encountered in the field, they would have a ready
16 resource available.

17 There are certified programs that are
18 available through post-secondary institutions and
19 national certification with respect to infection
20 prevention and control that is available.

21 COMMISSIONER JACK KITTS: No, I think
22 the idea to get the local hospitals' IPAC experts
23 to train them, I agree, in a crisis, you do the
24 best you can.

25 Do you think that -- and this is just

1 an opinion. Do you think that that's a model that
2 should be carried through in terms of IPAC for
3 long-term care homes, the hub should be at the
4 hospital and the spoke should be in the long-term
5 care homes?

6 DR. JESSICA HOPKINS: So in terms of
7 some -- there are some things that are happening
8 with respect to that, and I would defer perhaps to
9 you following up with the Ministry of Health and
10 Ministry of Long-Term Care with what is happening
11 there specifically.

12 But, you know, certainly we have
13 communicated to both the Ministry of Health and the
14 Ministry of Long-Term Care the importance of taking
15 practices that are already in place and scaling
16 them across the province as there is a very urgent
17 need within long-term care.

18 COMMISSIONER JACK KITTS: Thank you
19 very much.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Is there a way of introducing
22 foreign-trained professionals into the public
23 support worker -- into the field through the public
24 support worker portal or entrants?

25 DR. JESSICA HOPKINS: Yes, thank you

1 for the question.

2 So I think that this question would
3 best be posed to the province. There is a --

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Okay.

6 DR. JESSICA HOPKINS: There is a
7 HealthForceOntario workforce matching portal where
8 Ontarians were encouraged to put in their
9 applications if they had skill sets that could be
10 used to support long-term care homes.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Okay. Commissioner Coke?

13 COMMISSIONER ANGELA COKE: I am just
14 curious, in terms of your own organization, if you
15 had sufficient resources and capacity to deal with
16 this emergency?

17 DR. JESSICA HOPKINS: I'll defer to
18 Dr. Deeks.

19 DR. SHELLEY DEEKS: Yes. So I think
20 that that's a very challenging question in terms of
21 resources and capacity.

22 We have been operating in an IMS, and
23 that has been happening since January. We have
24 basically deployed staff from throughout the
25 organization to assist with the IMS and have

1 brought on new staff as needed.

2 And now that we are going into the
3 second wave, we are looking at our human resources
4 and seeing if we need additional staff to be able
5 to continue to respond to the outbreak.

6 Sustainability is an ongoing challenge,
7 given that we are now in month 10 of the outbreak.

8 Would we like to have -- in an ideal
9 world, it would be great to have more staff.
10 However, we have been functioning in the IMS and
11 have deployed staff as needed.

12 COMMISSIONER ANGELA COKE: Thank you.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 So you have said, in answer to
15 Commissioner Coke's question, month 10. That takes
16 us back to January and December?

17 DR. SHELLEY DEEKS: January, yes.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Okay.

20 DR. SHELLEY DEEKS: Mid-January was
21 when -- well, not even mid-January. The second
22 week of January we started to increase our
23 response. Initially, we functioned with just our
24 routine staff, but as time progressed, we
25 implemented the IMS and had to bring more staff in.

1 We also went from basically a
2 five-day -- Monday-to-Friday organization to a
3 seven-day-a-week organization.

4 Even when we were five days, we have
5 always had an on-call system, but quite quickly in
6 January and February, particularly after our first
7 case, I think it was January 22nd, on call on
8 Saturday and Sundays became very, very busy for the
9 small number of people that were on call.

10 So we decided to move to a seven-day
11 work week so that we could support the sector.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Thanks. So where are we -- oh, yes.
14 Okay.

15 ALWIN KONG: Commissioner, actually,
16 this is the end of our presentation, so of course
17 we would invite any further questions from the
18 Commission or leave it here for now, for the time
19 being.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Well, are there any further questions?
22 No. Well, we don't have any further
23 questions, so thank you very much for the
24 presentation. It helps -- it certainly helps with
25 understanding the roles of some of the participants

1 a little more clearly than we did before you
2 started.

3 So thank you very much for that. We
4 may be back with your permission asking for a
5 little bit more assistance. But thank you.

6
7 -- Adjourned at 2:15 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, DEANA SANTEDICOLA, RPR, CRR,
4 CSR, Certified Shorthand Reporter, certify:

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

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

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

13
14
15
16 Dated this 28th day of September, 2020.

17
18 

19
20
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22 NEESONS, A VERITEXT COMPANY

23 PER: DEANA SANTEDICOLA, RPR, CRR, CSR
24
25

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