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.

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

PRESENTERS:
PUBLIC HEALTH ONTARIO:
Colleen Geiger, President & CEO
Dr. Jessica Hopkins, Deputy Chief Health Protection
Dr. Shelley Deeks, Chief Health Protection Officer
Alwin Kong, Chief Legal Officer

PARTICIPANTS:
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat

ALSO PRESENT:

Eric Wagner, Counsel for Ontario

Roopa Mann, Counsel for Ontario

Sunil S. Mathai, Counsel for Ontario

Deana Santedicola, Stenographer/Transcriptionist

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, it is 1 o'clock, so who is speaking at least first on behalf of Public Health Ontario?

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, Commissioner Coke is on the screen, and Commissioner Kitts and myself, Frank Marrocco, and I guess you know Ms. Deeks, and Mr. Mathai is here to make sure that you don't say anything you are not supposed to, so we'll keep an eye out for that.

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

COMMISSIONER FRANK MARROCCO (CHAIR): And we have two of your colleagues from Public Health Ontario; is that right?

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COLLEEN GEIGER: All right.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

COMMISSIONER ANGELA COKE: Yes, thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

And Commissioner Kitts?

COMMISSIONER JACK KITTS: Yes, absolutely yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

So we can all see it.

ALWIN KONG: Okay. Thank you. Colleen, please go ahead.

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

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

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

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COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

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

perspective.

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

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

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

Next slide, please.

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

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

prevention.

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

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

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

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

Next slide, please.

So --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Next slide, please.

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

Next slide, please.

And I will go to the next one.

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

So first off, at the top of the slide

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

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

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

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

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

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

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

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

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

COLLEEN GEIGER: Yes, please.

COMMISSIONER JACK KITTS: Can you go

back to the previous slide?

COLLEEN GEIGER: Yes.

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

COLLEEN GEIGER: Correct.

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

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

COMMISSIONER JACK KITTS: Okay. So --

COLLEEN GEIGER: As -- go ahead, sorry.

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

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Okay. Thank you.

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

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

PHO is a statutory corporation

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

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

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

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

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

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

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

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

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

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

moment ago.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

ALWIN KONG: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

development of policy.

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

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

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

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

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

in long-term care homes.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

ALWIN KONG: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

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

parties would work together to respond.

COMMISSIONER FRANK MARROCCO (CHAIR): And that is a Memorandum of Understanding between the Crown agency, Public Health Ontario, and the Ministry of Health?

ALWIN KONG: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

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

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

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

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

ALWIN KONG: I believe we characterize

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

ALWIN KONG: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

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

sorry, Dr. Shelley Deeks, please.

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

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

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

DR. SHELLEY DEEKS: Yes.

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

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

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

DR. SHELLEY DEEKS: Yes, they --

COMMISSIONER FRANK MARROCCO (CHAIR): Not in a technical sense, but they give you overall direction?

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

ALWIN KONG: I hope that clarifies the matter.

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

ALWIN KONG: My pleasure.

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

I just wanted to flag that the Public

Health Agency of Canada also includes the National Microbiology Laboratory.

If we move to the next slide --

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

Sorry, Shelley, for interrupting.

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

COMMISSIONER FRANK MARROCCO (CHAIR): In terms of the control of -- or

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. SHELLEY DEEKS: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

While it was developing that plan?

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

DR. SHELLEY DEEKS: Okay. If we go on

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

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

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

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

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

So you can see that we interface with

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

So somebody else is dealing with

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Dr. Deeks, you said that since early January they have been conducting tests for COVID-19. When was the decision taken? When did they start thinking about testing for COVID-19?

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, just generally.

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

COMMISSIONER FRANK MARROCCO (CHAIR): So did PHO start to do that on its own because it has got that kind of technical understanding and appreciated the significance of what had happened or what was happening? Is that how that happened? Or were you directed -- was PHO directed to do that or asked to do that?

DR. SHELLEY DEEKS: So these questions

will be ones that Dr. Allen --

COMMISSIONER FRANK MARROCCO (CHAIR): I'll hold the question then until Dr. Allen.

DR. SHELLEY DEEKS: It is important to provide input on, but there is a National Laboratory Network which PHO is involved with.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. SHELLEY DEEKS: Okay. So as I noted, PHO has been conducting testing since early January. The Ministry of Health determines the testing criteria, so which populations are eligible for tests, and that has evolved over the course of the outbreak.

So as test volumes increased, particularly in the first wave of the outbreak, PHO worked with Ontario Health to increase capacity through the development of a COVID-19 diagnostic testing network which was set up as a result of the outbreak, and it is a coordinated system of hospital, private, and public laboratories overseen by Ontario Health.

In addition to PCR testing, diagnostic testing which I have just referred to, PHO is also

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

So the testing strategy as far as

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

DR. SHELLEY DEEKS: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

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

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

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

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

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

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

If we go to the next slide --

COMMISSIONER ANGELA COKE: Could I just ask a question?

DR. SHELLEY DEEKS: Certainly.

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

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

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

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

COMMISSIONER ANGELA COKE: Thank you.

DR. SHELLEY DEEKS: Okay.

If we go to slide 24, to round out the

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

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

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

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

I am now going to turn it over to

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

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

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

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

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

would be assistance on outbreak management and testing.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you there? When you are developing infection prevention and control best practices or PIDAC is with your support, when they have the finished best practices document, where does it go?

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

Okay. So now --

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

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

DR. JESSICA HOPKINS: Thank you, Commissioner Coke.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

Your role is in developing the best practices?

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Next slide, please.

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

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

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

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

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

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

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

And finally, laboratory testing for

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

Next slide, please.

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

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

Next slide, please.

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

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

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

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

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

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

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

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

Do you think that -- and this is just

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

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

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

COMMISSIONER JACK KITTS: Thank you very much.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. JESSICA HOPKINS: Yes, thank you

for the question.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

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

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

brought on new staff as needed.

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

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

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

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

DR. SHELLEY DEEKS: January, yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Thanks. So where are we -- oh, yes. Okay.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, are there any further questions?

No. Well, we don't have any further questions, so thank you very much for the presentation. It helps -- it certainly helps with understanding the roles of some of the participants

a little more clearly than we did before you started.

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

-- Adjourned at 2:15 p.m.

REPORTER'S CERTIFICATE

I, DEANA SANTEDICOLA, RPR, CRR, 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 28th day of September, 2020.

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