Long Term Care Covid-19 Commission Mtg.

Lori Stoltz
on Wednesday, January 20, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 20th day of January, 2021, 9:00 a.m. to 10:23 a.m.

BEFORE:

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

PRESENTERS:

Lori Stoltz, Lawyer Morris+Stoltz+Evans LLP

PARTICIPANTS:

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

Ida Bianchi, Senior Legal Counsel Long-Term Care Commission Secretariat

Kate McGrann, Co-Lead Commission 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

Jessica Franklin, Policy Lead Long-Term Care Commission Secretariat

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Rose Bianchini, Senior Policy Analyst Long-Term Care Commission Secretariat

Angela Walwyn, Senior Policy Analyst Long-Term Care Commission Secretariat

Jennifer King, Gowling WLG

John Callaghan, Co-Lead Commission Counsel Gowling WLG

Jennifer King, Gowling WLG

Lynn Mahoney, Counsel Gowling WLG

Max Libman, Counsel Gowling WLG

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

-- Upon commencing at 9:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I guess, we're -- are we all here? Where is Ms. Stoltz?

LORI STOLTZ: I am here.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, hi. Hello.

LORI STOLTZ: Hello. Very nice to meet you virtually.

LYNN MAHONEY: I think --

COMMISSIONER FRANK MARROCCO (CHAIR): Are you -- are you waiting for anyone?

LYNN MAHONEY: I think we're ready to go, Commissioner. I don't know that -- I haven't seen Mr. Callaghan, but Jennifer King is there, so I think we're ready to go when you are.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, Ms. Stoltz, I'm Frank Marrocco. There's Commissioner Angela Coke and Commissioner Dr. Jack Kitts. We are the Commission.

There is a transcript. A court reporter will take down the presentation, and we will eventually post the transcript on our website so that people have some idea of what we're doing and can follow along with the information that

we're receiving.

And so I think that without any further ado, Ms. Mahoney, are we ready to go?

LYNN MAHONEY: Yes, we're ready to go, Commissioner. And just -- I actually haven't met Ms. Stoltz before, but our team has spoken with her, and we engaged Ms. Stoltz so that she could do a presentation for the Commissioners with respect to the public health Framework.

So we would -- she's had several conversations primarily with Jennifer King of our office, who I believe you've met before who's on the screen. And I think, as we go along -- I think, Commissioners, to the extent that you have questions and clarifications that you're -- that you'd like to ask Ms. Stoltz about, then I think that's why she's here. She's really here to try to bring together some of the things that we've heard about and some of the questions that you've had about how this system is put together and who the various players are.

So please interject with your questions, and so I'll just -- I think Ms. Stoltz is probably just ready to go.

LORI STOLTZ: I am. Thank you.

MS. MAHONEY: Okay.

LORI STOLTZ: Thank you very much. And before I start, maybe just by way of brief introduction, I'll speak a little bit about my involvement in health system from a range of perspectives.

So my -- I first engaged with the public health System Legal Framework, et cetera, as counsel to a group of patients infected with HIV through the blood system before Commissioner Krever, of the Commission Inquiry into the blood system.

After that, I served as chair of the Health Protection Appeal and Review Board, which at that time was the board that heard appeals from orders issued by medical officers of health and public health inspectors under the HPPA, the Health Protection and Promotion Act.

In sort of 2002 to 2004, I was senior policy advisor to Minister Anne McLellan when she was Minister of Health, and that -- my time there coincided with SARS, so I was working with Minister McLellan when she engaged Dr. Naylor (phonetic) to do his report and when she made the

decision to create the Public Health Agency of Canada.

More recently, post-SARS, I coauthored a text with two other practitioners in public health law, Jane Speakman and Rod Blake on the HPPA and public health practice.

And then more recently, pre-COVID and during COVID, I have been engaged to assist some local medical officers of health.

So big picture, I guess what I'm saying is I come at this having looked at the system from a range of perspectives, and my focus here this morning, obviously, is the legal framework.

So I have been asked by Commission counsel to do a review of the Campbell Recommendations, and to the extent that the Walker Commission looked at the HPPA to address those as well and to do a sort of review and audit, if you will, to look at the extent to which those have been taken up and are reflected in the current legal framework. So we are part way through that work. I will speak to that to some extent today, but as I say, that's still kind of a work in progress.

I have reviewed some of the evidence, a

fraction of what you have heard, but I have tried to review those I thought might be germane to what I'm working on, so I have reviewed the testimony of some but not all of the medical officers of health that you have heard from, and the Ministry presentation, et cetera.

So I'm going to try in my remarks not to repeat what you've heard but to maybe highlight what I think might be of interest. So any questions before I start? All right.

Yes, and I guess I'll apologize, I guess, to some -- for a somewhat rudimentary presentation. Instead of slides, I thought this might be a more effective way to present the content. And, obviously, I'm not going to read every word of text, but what I hope to do is to leave you with a little bit of a crib sheet that may be of assistance as you go forward on some important points.

Can everyone see my document? Does that show for you?

COMMISSIONER FRANK MARROCCO (CHAIR): I can. Yeah, we all can, I think.

LORI STOLTZ: Okay. That's great. So just very briefly, page 1, a brief road map, so

I'll speak very briefly to some key insights, if you will, that emerge from the SARS reviews on the public health Legal Framework. I am going to talk in some detail about local public health accountabilities. I will then speak to central public health, so central public health, from my point of view, is comprised of the Ministry and the Chief Medical Officer of Health and then PHO, also part of central public health but a little bit different in its mandate and the scope of its work.

So moving to page 2, The Impact of SARS Reviews on the Legal Framework For the public health System: So I just wanted to flag here some key insights that I draw from review of the SARS Commission Report, and I also see these themes reflected in the Walker Report.

So the first is an emphasis on the precautionary principle, and I know you as Commissioners have referenced that already in your interim recommendations, so the principle simply is that reasonable efforts to reduce risk need not await scientific proof.

And that is a principle at the core, I would say, of public health practice, and certainly has been a point of emphasis from every -- you

know, the commissions, the series of commissions that have looked at public health issues in Ontario and Canada starting with the Krever Commission, then Campbell, Walker, and Naylor all referenced this as a touchstone, Justice O'Connor in the Walkerton Report, and again, this Commission has referenced that.

So simply to say that Commissioner Campbell made recommendations around integrating the precautionary principle into the legal framework of the HPPA. That has been done, really, only to a limited extent as relates to Occupational Health & Safety. So that may be something that you as Commissioners wish to direct some attention to.

Other key insights from Campbell and, as I say, Walker, the need to protect and strengthen medical independence, the capacity for leadership, and the power to act quickly and decisively. And Campbell looks at that both at the level of the CMOH and also at the level of local medical officers of health.

He emphasizes in his recommendations and the supporting text the idea that preparedness is essential, so emergency powers are part of the

picture but by no means the whole, and, really, what you need is to be ready for what's coming.

When the -- when the emergency comes, clarity in the emergency powers is crucial. There is -- he spends a considerable time at multiple points talking, you know, basically that time spent in legal wrangling in times of public health emergency is time much better spent, obviously, on delivering care and acting as one needs to.

And then finally, there is an emphasis on transparency and with the notion that increased transparency in scientific advice will facilitate greater accountability.

So my focus is on the HPPO which -- HPPA, rather, which Campbell characterised as the legal engine that makes public health go, and I do think that's a fair description of the Act which really creates the mechanics for the system.

Okay. I'm going to turn to page 3. So focusing on local health -- public health accountabilities, I've just summarized here at the top what local public health is and what -- you know, what I mean and what's generally meant when one refers to public health units. So I think that this structure is by now probably familiar to

you -- to you as Commissioners.

What I wanted to talk in more detail about -- and I'm just going to scroll up here -- is -- are the accountabilities of local public health to central public health. So the independence of local public health has been talked about with some emphasis, but I think it's also important to understand that there are many instruments of accountability that tie local public health to the Ministry and the CMOH. And I've itemized them here.

So each public health unit will have a public health funding and accountability agreement with the Ministry that covers -- governs their receipt of funding from the Ministry and how those funds are going to be used.

A second key point is that boards of health, i.e., local public health units, must provide mandatory programs and services. That's an obligation created in Section 4 of the HPPA, and the actual programs and services are laid out, for the most part, in Section 5.

There are mandatory standards, and I know reference has been made to these. These are the Ontario Public Health Standards, and these

govern the delivery of mandatory programs and services by local boards of health, and one of the areas also covered in the OPHS is the -- is accountability. Accountability is a chapter, and it deals with both accountability within the board of health and to the public, and it also deals with accountability to the Minister.

And then the last key point here is that local public health is subject to the exercise, the potential exercise, of substantial powers by -- held by the CMOH, the Chief Medical Officer of Health and the Minister. And I have simply tried to itemize them here simplifying them considerably but with reference to the Act where you can find them.

So the CMOH can actually exercise, choose to exercise the powers of a board of health or a medical officer of health, may seek a court order to direct a board of health to act, may require information from a board of health and the health unit. It -- the CMOH may issue a directive to any or all boards of health or medical officers of health requiring policies to be adopted or implemented, and the three areas that are specifically identified are infectious diseases,

health hazards, and public health emergencies. And the Minister or the CMOH may -- and this is power reserved more, I would suggest, where there is concern for the functioning of a health unit -- to appoint an assessor to assess the board of health and then to follow up with written directions. And there are measures that can be taken to ensure compliance with the direction. So, again, in sum, many instruments to assure accountability of local public health to the centre.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just -- I -- if I'm getting ahead of you, then please tell me, and I'll wait 'til you get there, but we have a pandemic. Who's -- who's responsible? Like, who's responsible for making decisions? I'm having a lot trouble with this concept.

LORI STOLTZ: Okay. So I think I will come to that, but let me --

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Well, then you get there when you're going to get there.

LORI STOLTZ: Well, no --

COMMISSIONER FRANK MARROCCO (CHAIR): I don't want to take you out of the presentation, but

I --

LORI STOLTZ: No. No. It's -- yeah, it's okay.

COMMISSIONER FRANK MARROCCO (CHAIR): I do want to know what you think.

LORI STOLTZ: Yeah. So -- but what I was going to say is, I will come to elements of that, but let me just say briefly, at the local level, obviously, the local medical officer of health has the capacity and is responsible to make decisions. And in making those decisions, is responsible to deliver the mandatory programs and services, and a component of those is -- relates to infection control and the control of infectious diseases, and we will come to that.

But there is also a decision-making role at the central level, and I would say in one of the areas that I'll speak to is that it is perhaps more implicit in the availability of the kinds of powers, you know, some of which are listed here and some of which I will come to that aren't specific to directing local public health.

But the very existence of those powers implies that there is responsibility for decision making centrally. And if you -- if you look to the

purpose of the Act, which is stated in Section 2 of the HPPA, and I'll just read it: (as read)

"The purpose of the Act is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease, and the promotion and protection of the health of the people of Ontario."

So local medical officers of health are responsible to achieve that as guided, you know, within the framework of the mandatory public health programs and services at the local level. But there is decision making that has to take place centrally to make sure that the system as a whole is delivering on this mandate. And to me, that is -- you know, I would say there is responsibility for decision making at the centre or within central public health to achieve that.

COMMISSIONER FRANK MARROCCO (CHAIR): At the centre means who?

LORI STOLTZ: Well, I -- well, the Ministry and the CMOH. So there are itemized powers here that deal with powers that can be exercised by the CMOH, but then there is decision

making, you know, maybe not emergency order type decision making, but there is decision making of a different kind that is exercised, for example, in the creation of the OPHS because the OPHS are important, then, because they set the framework for what local public health does including -- and I will come to this -- as relates to long-term care, what their involvement is in the long-term care system.

So the Act gives responsibility for creating those mandatory standards to the Minister, so that's where accountability for that lies, and I guess just a quick point to flag there is that Campbell had recommended that that be a power that be transferred from the Minister to the CMOH. That is not a recommendation that has been taken up.

COMMISSIONER FRANK MARROCCO (CHAIR): So is there a struggle between the Chief Medical Officer of Health and the Ministry of Health? Is there a -- sort of a jurisdictional struggle there?

LORI STOLTZ: I think that -- I mean, I can't speak to the evidence that you have heard. I will speak to what Campbell reported on, and clearly, he identified that there was -- I don't know whether I would call it a struggle, but not

clear -- I think what he was trying to identify is that the CMOH needed a clearer field to exercise independent decision making as relates to medical matters relevant to public health in preparation for and during public health emergencies.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

LORI STOLTZ: His recommendations were directed to achieving that. Some of those have been taken up, and some have not. So to the extent that he was directing recommendations to solve a problem, I guess it's an open question for you to consider whether that problem has been addressed.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, at least as it effects --

LORI STOLTZ: As it --

COMMISSIONER FRANK MARROCCO (CHAIR): -- what happened in the long-term care homes, at the very least, in Wave 1, but probably in Waves 1 and 2.

LORI STOLTZ: Right. Yes. I appreciate that your mandate is specific to what happened in long-term care homes, so...

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

LORI STOLTZ: Commissioner Kitts, did you --

COMMISSIONER JACK KITTS: Yes, can I just ask for clarity? When you say the local medical officer of health or the Chief Medical Officer or -- have the responsibility and/or accountability to act, do they also have the authority to act to make their decisions, or do they have to get permission from others?

LORI STOLTZ: Well, I think the answer to that question would probably -- depends on what power it is they're choosing to exercise. But if you are -- if your question relates to the authority to issue an order, so to issue on order under Section 22, to require a stated actions or Section 29.2 which is an order issued by some MOHs in relation to long-term care facilities, the authority to issue that order lies solely with the MOH. That is an exercise of discretion that must be exercised by the CMOH -- by the MOH, rather, and no one else --

COMMISSIONER JACK KITTS: Okay.

LORI STOLTZ: It will be informed by others, but -- yeah.

COMMISSIONER JACK KITTS: Okay. So

the -- so the local officer has authority to act locally but can be overruled by the Chief Medical Officer or the MOH?

LORI STOLTZ: The Chief Medical Officer of Health does have the ability, and I will come to the triggers.

COMMISSIONER JACK KITTS: Okay.

LORI STOLTZ: But the -- yeah. There is -- well, there is a part in the Act that gathers together what are described as Provincial public health powers, and there are certain triggers that enable the Chief Medical Officer of Health, depending upon the power, to exercise certain powers. One of those powers is the ability to exercise -- to effectively step into the shoes of one or more MOH -- MOHs and issue that power.

COMMISSIONER JACK KITTS: Okay. Thank you.

LORI STOLTZ: You're welcome.

Okay. So moving to the next slide, I wanted to drill down on this question of the OPHS, the Ontario Public Health Standards to address the mandated relationship with long-term care homes because I can see in the evidence that I've read that there is information underlying some of the

testimony you've heard from MOHs that maybe is not clear from your point of view.

So again, the HPPA in Section 7 says that: Minister can create mandatory standards for all boards of health and medical -- well, for boards of health. The Act refers to boards of health, but you can understand that to direct the conduct of boards of health and the Medical Officer of Health.

(As read)

"Those standards address the full range of mandatory programs and services that a local health unit provides."

So I've highlighted two of them here, the infectious disease -- infectious and communicable diseases prevention and control; that's one area of activity. Another area is emergency management, but the OPHS also speak to, you know, immunization, food safety, rabies control, a whole range of activities that are carried out at the local public health level and for which the local MOH and board of health are responsible.

So when we focus in on infectious and

communicable diseases prevention and control, what's important to understand -- and I consider these OPHS as part of the legal framework because they are mandatory. By statute, compliance with them is mandatory.

And Section 7 also permits the standards to refer to protocols, and if you look at the protocols, you will see that much of that language is mandatory. And that informs local public health as to their sphere of activity.

So when you look at the underlying protocols, when you look at the OPHS and the underlying protocols, first of all, what you see is that there is -- there are differences in the way local public health acts depending on the context.

So in relation to personal care settings, so things like tattoo parlors and nail salons, those are settings not otherwise regulated from a health point of view, and you see that there is an express board of health mandate that reads in words of one syllable:

> "The board of health shall inspect and evaluate IPAC practices in personal care settings."

So that is a regular proactive event.

When it comes to long-term care, there is no such express mandate for public health.

COMMISSIONER FRANK MARROCCO (CHAIR): And just to -- sorry to interrupt, but personal care settings, is that -- is that defined?

LORI STOLTZ: Yeah. It -- yes.

COMMISSIONER FRANK MARROCCO (CHAIR): I just wondered why it didn't include a long-term care home because just looking at the words --

LORI STOLTZ: Yes, I --

COMMISSIONER FRANK MARROCCO (CHAIR): -- you would think --

U/T LORI STOLTZ: Right. I understand what you mean, and I will get you the actual definition of that term. There is one, but it relates to things such as tattoo parlors --

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

LORI STOLTZ: -- nail salons, that kind of thing.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

LORI STOLTZ: Okay? When it comes to long-term care homes and other institutions, and institutions is a term that is defined in the -- in

the HPPA, what you -- there is a mandate. I'm not trying to say there is no board of health mandate. There clearly is, but it is framed differently.

The mandate to inspect and evaluate IPAC for long-term care, focusing on that, is a more limited responsive kind of role. So it is responsive to complaints, and you see that in what's called the IPAC Complaint Protocol. And there is a clear role in relation to outbreaks.

And you see the role for long-term care spelled out in -- the role of local public health is -- you know, there is some content that you will find in the OPHS, but then when you look at these protocols, it -- they are much more granular. And the two that are relevant to outbreak in this context are the Institutional Facility Outbreak Management Protocol and the control of respiratory infection outbreaks in long-term care, which is not a protocol but a guideline, as I understand it.

COMMISSIONER FRANK MARROCCO (CHAIR): So let me stop you there, if I can, if you don't mind.

LORI STOLTZ: No.

COMMISSIONER FRANK MARROCCO (CHAIR): We know there's outbreaks of COVID-19 in long-term

care homes. So that -- am I correct, that engages the authority of the local medical officer of health?

LORI STOLTZ: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Now, can the Chief Medical Officer of Health tell the local medical officer of health, Dr. Williams and Manns, what he wants the local medical officer of health to do? Or does Dr. Williams have the authority to do what he wants -- to order what he wants done regardless of the local medical officer of health?

LORI STOLTZ: So first of all, the OPHS provide some -- provide the framework for how local public health will engage in outbreak situations in the long-term care setting and institutionally.

In a given situation, the -- in a given local situation, the medical officer of health, as I understand it, will typically engage informed by that framework and their understanding of their responsibilities, and they will exercise and make -- you know, they'll exercise their authority, and they'll make their decisions as they deem appropriate engaging their powers if and as they feel they should meeting statutory criteria,

et cetera. If --

COMMISSIONER FRANK MARROCCO (CHAIR): So when they're -- sorry. Go ahead. No don't -- let me -- finish your thought.

LORI STOLTZ: Yeah. If there were a situation where the Chief MOH had reason to believe that an individual situation was not being handled as it should, then we'll come to the various powers, but you'll see that the power is there to intervene on a one-off basis, okay, if there were concern in a situation like that.

And then I guess the other question is at a -- forgetting about individual situations and concern about -- yeah, forget about concern about individual situations. If the MOH wanted to set some -- establish some further guidance around how outbreaks should be managed, there are tools to do that. We will come to those tools. But there are tools in the hands of the CMOH.

COMMISSIONER FRANK MARROCCO (CHAIR): So you correct me if I'm wrong. When there's an outbreak in a long-term care home, the person who should show up making decisions in the public interest is the -- first, the local medical officer of health, and if the Chief Medical Officer of

Health isn't satisfied with the way the local medical officer of health is handling the matter, the Chief Medical Officer of Health can make his will felt on the local medical officer of health; is -- have I got that right or no?

LORI STOLTZ: Yes. And -- but I guess the reason for the hesitation you may hear in my voice is that there is not automatic reporting up from the local medical officer of health to the Chief Medical Officer of Health whenever an order is issued, so it's not that linear a relationship.

But should circumstances arise such that the Chief MOH had reason to be concerned, yes, there would be -- there would be an ability on the part of the Chief Medical Officer of Health to intervene.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, and I can understand why you wouldn't report up every time you made an order, but, here, you know, you have all kinds of people sick, people dying. I think -- I think one would expect that that would get -- whether there's an obligation to report or not, that's the sort of thing that would get reported. I'm not asking you that, but that's just the way it seems to me.

So in terms of the accountability for making decisions to deal with the problem, this is the -- is there anybody else that has decision-making authority in that -- in the situation where there's an outbreak and people are either seriously ill, dying, or both --

LORI STOLTZ: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- in the long-term care home?

LORI STOLTZ: So it's an important question because the -- to go back to -- the role of the medical officer -- the local medical officer of health as currently conceived by these protocols, if you read the language, you will see that it is different -- like, in a personal care setting, for example, the MOH, the responsibility lies with the health unit to manage the outbreak. They -- that is, they go in. They take over. They manage.

In the context of an institutional or facility outbreak, you will see that the language in those protocols speaks to -- the primary responsibility for managing that outbreak lies with the institution. So, for example, if it's a hospital, the hospital has primary responsibility.

If it's a long-term care home, the long-term care has primary responsibility, and the language as relates to the role of public health is sort of assist, support. But, obviously, at a certain point, if things aren't being done that need to be done, local public health and a medical officer of health has the capacity to issue orders, exercise authorities to make sure that things get done.

But in the first instance, responsibility for managing the outbreak is placed with the institution.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you for a minute? The institution, if you're dealing with a for-profit long-term care home, is the institution the owner or the Minister of Long-Term Care?

LORI STOLTZ: It's the owner. It's the -- it's the entity, the facility. You know, if it's a --

COMMISSIONER FRANK MARROCCO (CHAIR): And then -- okay.

LORI STOLTZ: -- a hospital, if it's a long-term care, it's the owner/operator.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Got it. And what's the responsibility of

the Ministry of Long-Term Care in this situation where you have a COVID outbreak and you have people sick and people dying?

So I get the fact that the owner has a responsibility, and I think I understand that the local medical officer of health has a responsibility, and that the Chief Medical Officer of Health can impact -- can really force the situation to go in a certain direction.

What is the Ministry of Long-Term Care's responsibility in that situation, if they have one?

LORI STOLTZ: Yeah, they do -- they do have one, as I see it, and I will say I am not intimately familiar with the ins and outs of the Long-term Care Homes Act. There is a clear provision in the Act that creates an obligation on the part of every home to have adequate IPAC. And my understanding is there is an inspection regime built around that. As to how they fulfill that and -- you know, I can't -- I can't speak to that in detail.

But I guess what I can say is, my read of it is is that it would seem to make sense that the underlying rationale or a somewhat differently

tasked role to public health as relates to long-term care is predicated on the assumption that you have long-term care inspectors who have responsibilities to inspect as kind of a first line, and so that public health, in that case, is, in effect -- back up is the wrong expression, but it's -- they're supplementary, but long-term care has a primary responsibility to do the investigative work.

So if we could just turn to the next slide because I -- or I'll just bring you to the next page because I wanted to anticipate the possibility that, you know, should this Commission form, you know, the view that public health -- IPAC and long-term care homes should be more fully integrated into local public health responsibilities. And in addressing this issue, I think I'm trying to respond to having read the testimony from some of the MOHs you heard from, so Dr. Kyle, for example, Dr. Moore, Dr. Sutcliffe. I think I understood all of them to say that there is a good fit.

Okay. I'm just going to let you know, I've just got a message that my Internet is unstable, so I hope I don't fail here, but the --

you know, there is a good fit for a stronger, more comprehensive mandated relationship.

COMMISSIONER FRANK MARROCCO (CHAIR): You did freeze. You froze on our screen. We'll wait 'til you come back.

(BREAK)

LORI STOLTZ: Okay. I'm back, can you hear me?

COMMISSIONER FRANK MARROCCO (CHAIR): We can, yes.

Janet, where was -- what's the last thing you have?

Just so you know -- Ms. Stoltz, just so you know where you were.

LORI STOLTZ: Yes.

LYNN MAHONEY: You're on mute, Janet.

COURT REPORTER: Sorry. (By reading)

"-- so I hope I don't fail here, but, you know, there's a good fit for a stronger, more comprehensive mandated relationship."

LORI STOLTZ: Okay. And -- but before I -- as I was unfreezing there, I just -- it occurred to me that I should emphasize -- I do want

to be clear that it is not as if -- it is not as if the protocols that I'm speaking to don't provide any role for public health in long-term care.

It is there, but as I say, it's differently cast. It's in a more supportive kind of -- more of a supportive and then episodic kind of role. But you did have MOHs who said, look, there is a good fit here, and, you know, we've got the expertise. We've got the relationships, and it's very efficient to have local public health be -- have more of a -- you know, like the personal care settings, have the mandate to do proactive IPAC inspections, that it not be an episodic thing.

But if that's to be better -- you know, give us the -- I think Dr. Kyle said give us the mandate and give us the resources.

So if you wanted to do that, what would your -- how might that -- how could that be approached? The mandate, you know, my point here is the mandate and related authority should be express in the legal framework to eliminate the potential for dispute.

You know, it's great when things work well, but as Campbell points out repeatedly, clarity is absolutely essential to clearing the

field for decisive action especially in an emergency context.

So, you know, an ongoing public health unit mandate to proactively inspect and evaluate IPAC practices, public health unit authority to communicate with and involve others as maybe necessary because you can find stumbling blocks there, and what obligation, if any, to publicly report outwards the results of inspections and findings of lapses, if there are any.

So options for recommendations: You can make -- you could recommend that such a mandate be expressed in the Ontario Public Health Standards. That's one place that could be done.

COMMISSIONER FRANK MARROCCO (CHAIR): If you're referring to your presentation, it's not on the screen.

LORI STOLTZ: Oh, okay. That's a problem. Let me --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I mean, we can follow along too, you know. There was a world before slide decks.

LORI STOLTZ: True, there was. There was. Okay. But here. I can -- I think it's going to be easier if I share it, though I just need to

figure out how to do that again. Just one second.

MS. MAHONEY: Do you see the icon at the bottom of your screen?

LORI STOLTZ: Yeah, I've got it. I've got it.

LYNN MAHONEY: Okay.

LORI STOLTZ: All right. Do you have it now?

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, we have, Options For Recommendations.

LORI STOLTZ: Good. Okay. So express Board of Health Mandate in the OPHS, that's one option, to recommend that. Another option is to recommend that that mandate be included right in the HPPA. So I'm just going to take you to the next screen where I have excerpted part of Section 5 so you can get a sense of what that looks like, and, you know: (as read)

"Mandatory health programs and services: Every board of health shall superintend, provide, or ensure the provision of -- "

-- et cetera, and you see a list; 1.1 is, I am fairly certain, post-Walkerton, okay? And then 2, which I've highlighted, relates to control

of infectious diseases, and the -- everything -- the current wording goes to the word adults, and then I've just added in brackets here and underlined where you might -- could think about including something. Now, this wording isn't probably what you would want to use. You would likely want to be broader, but it gives you the idea.

Another point just to flag quickly is Section 29.2 of the HPPA is a section that various medical officers of health have used to engage and require action on the part of long-term care facilities including allowing hospitals to come in and work with them as partners on IPAC.

And I just wanted to identify an issue for you here that I think was touched on in, I believe, Dr. Kyle's presentation, but I may be wrong, that there is, arguably, a shortfall in the power in Section 29.2 which is fine as long as you have a willing partner to send in with supplementary services to long-term care but could be a problem if you had to require the collaboration and support of a partner.

So if you look at the language here, you see that the capacity to issue an order tells

the medical officer of health they can make an order requiring a public hospital or any institution to take actions for the purposes of, et cetera, responding to an outbreak of communicable disease at the hospital.

So if the long-term care facility is the institution with the problem, clearly, you can direct an order under 29.2 to that facility, but arguably, you can't use -- you can't rely on this section to compel a local hospital to engage and to provide support to that facility. So that was just the issue I wanted to flag there.

Okay. I am almost out of time. I'm sorry to have been so long.

COMMISSIONER FRANK MARROCCO (CHAIR): No. No. We were asking a lot of questions. You know, just go ahead.

LORI STOLTZ: Okay. And well, I'll just move more quickly through the next slide. So emergency management under the OPHS, so just to say that there is content in the Ontario Public Health Standards that addresses what a board of health should be doing to prepare for emergencies, and you see here, I've bolded, in accordance with Ministry policy and guidelines.

So you then, to understand the framework fully, turn to that guideline, and the -- when you look at that guideline, to my reading, and you may have had medical officers of health and others testify as to their understanding, but the focus really appears to be the continuity of board of health programs and services. Certainly, there is no express reference to long-term care homes.

And when you contrast that with the SARS Commission recommendation, for example, it's -- they're not the same. I -- that this does not -- I would say that the current language of the OPHS do not fully give expression to what I understand Commissioner Campbell to have recommended here.

COMMISSIONER FRANK MARROCCO (CHAIR): Can you -- can you go back to -- just go back to the previous page? There. Just -- so 29.2, if you have COVID-19 patients at a hospital and COVID-19 residents at a long-term care home, wouldn't that allow the local medical officer of health to make orders respecting both institutions?

LORI STOLTZ: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): So in that situation, they can order -- they can

order them to do things.

LORI STOLTZ: Oh, I wasn't suggesting that 29.2 couldn't be used in relation to a hospital. What I was focusing on was that if it was to be relied upon to order a hospital to do something, the wording of the provision suggests that the underlying reason for the order should be a problem at the hospital.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that's what I was asking. The problem at the hospital is the COVID-19 patients and the presence of the disease --

LORI STOLTZ: Oh, I see.

COMMISSIONER FRANK MARROCCO (CHAIR): -- in the hospital.

LORI STOLTZ: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): And there's also the presence of the disease in the long-term care home, so can they not make, then, I mean, I'm not --

LORI STOLTZ: Yeah. I --

COMMISSIONER FRANK MARROCCO (CHAIR): Why can't you just make an order, then say, look, you've both got the same problem; I'm ordering you to do this?

LORI STOLTZ: Well, but if the problem is -- if the fundamental issue is inadequate IPAC practice in a long-term care home, I think, arguably, that's a different situation.

So I guess what I would say is this is one example of an ambiguity --

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

LORI STOLTZ: -- that could do with some clarification because that at least raises the question. I mean, interestingly, you know, Section 29.2 is new. There used to just be Section 22, and I would have thought, really, that you didn't need 29.2, that 22 gave you all the powers you needed to have.

But 29.2 has now been added, and so it does raise a question, to me, anyway, that there is a little bit of ambiguity there.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

LORI STOLTZ: And I do want to point out, where you have a willing partner, the medical officer of health does have the power to issue directions that will engage that partner and empower them in -- to assist in giving effect to

his or her order.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

COMMISSIONER JACK KITTS: That's what I was going to raise because I think what we've seen in our interviews is that where the hospitals have come in to help the long-term care homes, they -- there's been a voluntary management order from the local public health officer. And I think in a couple of occasions when that wasn't seeming to work out, there became a mandatory management order which I think came from either the Ministry of Health or the Chief Medical Officer of Health.

LORI STOLTZ: Yes, that may be. Okay. So moving, then, to central public health, and here is where -- so -- and I'm going to deal with -- so central public health, I think, is fairly understood to include the Ministry, the Chief Medical Officer of Health, and Public Health Ontario.

But Public Health Ontario is fundamentally different. You know, it's a source of technical expertise, scientific expertise. Its functions are quite different, so I have separated them, and here, just some general points: So, you

know, broad central powers for policy, direction, guidance, and oversight of local public health units, so that's really what I covered in part 2.

Then here is where I was just going to review for you the broad central powers to act in response to risks to health. And so post -- pre-SARS, some of these powers pre-existed SARS. Some have been added since, some immediately post-SARS, and some more laterally.

They have now been collected together in a new Part IV, Provincial Public Health Powers, and there are a lot of them. So what I've done, I won't read through every one, but I'll just -- I'll highlight them for you. So just so that you know, I have included them all here and attempted to summarize them on key points. So in bold type is the substance of what -- whether it's the CMOH or the Minister is empowered to do, and then I've identified the trigger.

And you will see that there is variation in the triggers, which I must say standing back and looking at it, which I'm not sure I understand the rationale because they do seem to vary, and I'm not sure what the reason, in some cases, for the variation is, but that's how I've

organized it, and, really, I've just gone through the Act section by section.

> "So there is an ability to investigate and act as the CMOH considers appropriate to prevent, eliminate, or decrease identified risk. This includes exercising the powers of a board of health or medical officer of health but is not limited to that."

So that's a very broadly stated power. There is an ability for the CMOH to seek a court order to direct a board of health to act. The CMOH can require the board of health -- a board of health to provide information to the CMOH.

The Minister may require an occupier to deliver premises for public health purposes, so if there's a need to -- there's been discussion about whether field hospitals should have been set up to facilitate cohorting by long-term care homes. There is an ability to require that premises be delivered up to do that.

> "The Minister may, by order, require the procurement, acquisition, seizure of medication

and supplies."

PPE comes to mind. Then moving to the next page:

"A CMOH can require a health information custodian to supply information. A CMOH may trigger a directive to any healthcare provider or entity."

And those terms are actually defined in the section, and this is the section that has been used to ground the directives that have been issued by the CMOH.

"The Minister may issue an order to any healthcare provider or entity directing information to be provided to the Minister.

The CMOH can collect previously collected specimens or -- "

That should be or information about their analysis, not of.

"The CMOH may issue a directive to any or all medical -- boards of health or medical officers of health requiring the adoption or implementation of policies or

measures including as related to -- "

And there are specific areas there.

So you see there are -- there is a broad range of powers, and that doesn't include, you know, the powers to look into the affairs of a board of health that I canvassed at the beginning. But in terms of the "emergency powers," that is -- that is the list.

And so just going to page 10, some key points here: These powers each have their own, as I said, somewhat differently expressed triggers, but none of them are limited to or specific to a declared provincial emergency.

So these powers exist whether the Premier has declared an emergency or not, and, you know, there's good reason for that. He may -- there may be a -- you know, you may have a public health issue that exceeds the capacity of a given health unit or that spills over multiple boundaries of individual health units, and it may not be a situation of provincial emergency. It may not reach that threshold, but nonetheless, there are risks to help that needer -- that need broader powers to address them.

I wanted to emphasize the advantage to addressing system-wide issues at the central level in the context of an emergency, and it's probably an obvious point, but, you know, it does have the potential to clear the field for local MOHs on issues that might be ambiguous or might be controversial.

For example, you know, I guess it's possible we may have a question that emerges around mandatory vaccination. It doesn't make sense for 34 local medical officers -- local MOHs to be, you know, sort of trying to wrap their heads around an issue that is system wide in its implications, highly complex. That's a good example of a system-wide issue that could be addressed at the central level very usefully, and, you know, there -- I'm sure there are lots of others.

Another important point is that -- I think it's been addressed before you already -- that every order issued by an MOH can be appealed. There is a right of review to the Health Services Appeal and Review Board, and that is -- you know, it's a -- it's a wide-open review of the issuing of the order.

So there's no entitlement that anyone

has to be heard by a medical officer of health before an order is issued, but when the matter comes for review before HSARB, there is a full on review.

So by way of example, there was an order issued by a local medical officer of health, I believe, in the Windsor area that addressed migrant farm workers. I may not have the health unit right, actually. I think it was a different health unit. But, in any event, it was in the western part of the province, and that was -- that was appealed, and it was a five or six-day hearing before the board with another day before Divisional Court.

So it is an advantage that if the CMOH acts at a system level, you don't have to deal with the diversion of resources to deal with an automatic right of appeal or review.

In terms of the capacity for enforcement, there are provisions in the Act that allow the -- you know, provide authorities for the orders and directions of the Chief Medical Officer of Health and Minister to be enforced, and the potential for an application to the Superior Court. And actually, I see I got -- it should be 102(2),

not 102(1); (1) is for the Medical Officer of Health.

So I just had some quick observations to share with you as related to role and responsibilities of the CMOH, and these don't -- you know, my starting point is not the evidence before you, but rather, looking at the SARS Commission Recommendations and the -- you know, how those have been translated into the current legal framework.

And, you know, just by way of a general point, the SARS recommendations emphasize the need for a robust role and responsibilities for the CMOH and clear accountability.

There is emphasis on independence in relation to medical matters pertaining to public health and primary authority as relates to the public health aspects of provincial emergency.

So we will have -- you know, I am undertaking a detailed review of the individual recommendations, but just some quick observations.

When you look at the HPPA, we have limited provisions in the Act to define the role and mandate of the CMOH.

So by comparison, a local medical

officer of health understands their mandate because they know they are responsible under the Act -- and the board of health -- they are responsible under the Act to deliver the mandatory programs and public health services as expanded upon by the OPHS.

But when you look at the defined role and mandate of the CMOH in the Legislation, there really is not a lot that is expressly stated. So:

> "The CMOH must report annually on the state of public health and may make other reports, must keep informed on matters of occupational and environmental health."

And what I wanted to -- yeah, sorry, may make other reports, right, so there's an obligation to report annually and a permissive ability to make other reports.

When you look at the role -- the legislative provisions in the B.C. Public Health Act, they have, I would suggest, a more robust explanation of this role. So first of all, in paragraphs -- in Section 64, a very clear statement:

> "The Provincial Health Officer

is the senior public health official for British Columbia."

And then scrolling down to Section 66, you see in (1):

"The Provincial Health Officer must monitor the health of the population of British Columbia and advise in an independent manner the Minister and public officials on matters that include -- "

-- you know, health promotion, which is sort of the other big area of public health activity and health protection. And then you see other matters canvassed there.

In (2), somewhat stronger language around the obligation to make other reports. So:

"Where the Provincial Public Health Officer believes it would be in the public interest to make a report to the public, the Provincial Public Health Officer must make the report to the extent and in the manner that he or she believes will best serve the public interest."

And then, in (3) and (4), there are

provisions that deal with annual reports.

So not to say that you need to look at this as the -- you know, as the last word on the issue, but it is an interesting example of a more expressly stated mandate that, then, kind of helps understand one of the first questions you asked, Minister -- Commissioner Marrocco, is, you know, who's responsible for making decisions in relation to what?

That could be answered, to some extent, in the Legislation more fully at the central level.

Second point that I wanted to make here as relates to the CMOH powers, and here, again, as with Section 29.2, I think I'm really just pointing out an ambiguity, but potentially an important one, that seems to be, at least as I read it, somewhat at odds with what Commissioner Campbell conceived of as the role of the CMOH in an emergency.

So:

> "In a declared emergency, the Premier has a power under Section 7.0.3 which is not specific to the CMOH, but includes the power -- gives to the Premier the power to exercise the statutory powers of any

Crown employee."

And then further in that section:

"There is an ability that the Premier has to delegate those powers to the Minister, and the Premier can either directly delegate to the Commissioner of emergency management, or a Minister could, in turn, delegate to the Commissioner."

There is a section later on in the Act that has language to the effect of: (as read)

"Nothing in this Act abrogates the powers or should be understood to abrogate the powers of the CMOH except to the extent that they conflict with an order, like an emergency order."

And I'm not sure that adequately protects the CMOH powers from encroachment under Section 7.0.3. So I just wanted to highlight that because it is different from what Commissioner Campbell conceived which is that you would have a CMOH who is the primary lead authority on public health matters in an emergency, on the medical aspects of public health matters in an

emergency.

And then the last point that I wanted to highlight is in the CMH [sic] role as currently conceived by the Legislative framework as CMOH has limited authority to direct PHO, and so I'm just going to cover that very briefly on my last slide. There's lots of text, but I don't propose to walk through it all with you.

But just to say that both SARS -- the SARS Commission and Walker recommended that the CMOH have the responsibility and ability to direct the agency that is now PHO.

The current Legislative framework does not provide for that. The current Legislative framework for PHO is set out in the Act that I have identified here, the Ontario Agency For Health Protection and Promotion Act.

And very briefly, what you see is that it has a board of directors comprised of up to 13 people appointed by Cabinet. A CMOH is not a director. He has the entitlement to notice of the meetings and to attend and participate in the meetings, but he doesn't vote. He is a member of the Strategic Planning Committee, but whatever PHO strategic objectives are, they are subject to the

Minister's approval, it is not the CMOH who is directing those strategic objectives.

And the CMOH does have the power to issue directives to PHO, but it is somewhat limited, and I've included that language fully here:

"To provide scientific and technical advice and operational support to any person or entity in an emergency or outbreak situation that has health implications."

So that is the conclusion of my prepared remarks. I would be happy to answer any other questions that you have. Oh, I can't -- I can see that you're speaking, Commissioner Marrocco, but I think you're muted.

COMMISSIONER FRANK MARROCCO (CHAIR): Sorry about that. So then who has the authority to direct Public Health Ontario if the -- who is in charge of it? I appreciate that it has a board of -- it has directors, but who's in charge?

LORI STOLTZ: Well, who's in charge? The -- I can't really take you -- I mean, it is an independent agency -- well, it's a Crown agency.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

LORI STOLTZ: But a board appointed by Cabinet. Their strategic objectives must be approved by the Minister of Health, so I would say the Minister of Health has considerable power over Public Health Ontario.

COMMISSIONER FRANK MARROCCO (CHAIR): So then the original thought in the SARS Commission, in the Walker Report, that Public Health Ontario would take its direction from the Chief Medical Officer of Health got -- I don't want to say subverted, but got redirected. That authority got redirected to Ministry of Health?

LORI STOLTZ: It's not -- I guess the way I would say it is it's certainly not fully reflected here. I mean, because even in Justice Campbell's report, the CMOH is part of the Ministry. He recommended that the CMOH hold the position of Assistant Deputy Minister.

So to that extent, you know, there was -- there was always going to be integration of PHO and connection to the Ministry as part of the public health infrastructure, if you will, of the Province of central public health, but what is missing is clear role and responsibility to the

CMOH over direction of PHO.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

Commissioner Coke.

COMMISSIONER ANGELA COKE: Yeah, just for clarity for me a bit more, I'm trying to understand if the concept was that the Chief Medical Officer of Health would be out from under the Ministry and independently heading PHO or the opposite, that PHO be inside under the direction of the Chief Medical Officer of Health?

LORI STOLTZ: Are you -- you mean in terms of the SARS Commission recommendations?

COMMISSIONER ANGELA COKE: Yes. I'm trying to understand, you know, if this was to be an independent body, and the Chief Medical Officer the head of that, why would they still remain under the Ministry as an ADM? I'm just confused with which structure was really being recommended.

LORI STOLTZ: Yeah. So, yeah, I'm struggling a little bit here because there is -- I think, as I read the recommendations, the intention was that there be some level of integration. It's just the how that is different.

So Public Health Ontario is a separate

corporate entity, but with accountabilities to the Ministry. I believe that is consistent with what the SARS Commission recommended, but the conception was different in the sense that the -- that the CMOH was intended, I believe, to have a stronger role and authority in directing the -- in directing PHO.

Let me just look and see if I can find -- if you can just give me one second. I just want to see if I can put my hands very quickly on Commissioner Campbell's actual language, which may help.

COMMISSIONER FRANK MARROCCO (CHAIR): Is it in Volume IV?

U/T LORI STOLTZ: I've actually -- I've got a -- I've got them reproduced in a different place, and it was in Volume V, although he, I think, probably talked about it in multiple places.

You know what, I am -- I think probably the better thing for me to do, Commissioner Coke, is to get back to you with some clear information on that because it's -- it is a little bit confusing, and I want to faithfully relay to you what the Commissioner actually recommended, so I will provide --

COMMISSIONER ANGELA COKE: That's fine.

LORI STOLTZ: -- through Commission counsel.

COMMISSIONER ANGELA COKE: That's fine. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I don't think we have any further questions. On behalf of us, thank you very much. This has been very helpful in -- for us to get a more granular sense of the framework that we're dealing with and to try to understand what the accountabilities are in long-term care which is, of course, our remit, so thank you very much.

LORI STOLTZ: You are very welcome.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Thank you.

-- Adjourned at 10:23 a.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, 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 21st day of January, 2021.

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CLARIFICATIONS:

P.6 line 24 – “she” not “we”

P.11 line 12 – “in” not “and”

P.14 line 9 – “sum” not “some”

P.49 line 7 – “role” not “local”