Legislative Assembly of Ontario

Assemblée législative de l'Ontario

SELECT COMMITTEE ON EMERGENCY MANAGEMENT OVERSIGHT

FIFTH INTERIM REPORT

1st Session, 42nd Parliament
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The Honourable Ted Arnott, MPP
Speaker of the Legislative Assembly

Sir,

Your Select Committee on Emergency Management Oversight has the honour to present its Report and commends it to the House.

Daryl Kramp, MPP
Chair of the Committee

Queen's Park
February 2021

SELECT COMMITTEE ON EMERGENCY MANAGEMENT OVERSIGHT
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1st Session, 42nd Parliament

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INTRODUCTION

The Select Committee on Emergency Management Oversight is pleased to present its fifth interim report summarizing the Committee hearing that took place on December 11, 2020. In accordance with the Committee's terms of reference, the Deputy Premier and Minister of Health, the Honourable Christine Elliott, appeared as the Premier's designate and provided an oral report to the Committee. The Deputy Premier was joined by two guests: the Chief Medical Officer of Health, Dr. David Williams, and one of the co-chairs of Ontario's COVID-19 science advisory table, Dr. Adalsteinn Brown. This report sets out a summary of the testimony and discussion from that day.

Further interim reports will follow. The Committee's final report will be a compilation of all interim reports.

To review the witnesses' full remarks and all questions posed by Committee members, reference should be made to the official *Hansard* transcript.

COMMITTEE MANDATE

On July 13, 2020, the government House leader introduced a motion to appoint a Select Committee on Emergency Management Oversight. Following debate, the motion carried on July 15, 2020. The Committee was appointed to receive oral reports from the Premier or his designate(s) on any extensions of emergency orders by the Lieutenant Governor in Council related to the COVID-19 pandemic and the rationale for those extensions.

Reporting provisions under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020* include a requirement that the Premier (or a Minister to whom the Premier delegates the responsibility) appear before and report to a standing or select committee designated by the Assembly, at least once every 30 days, concerning

(a) orders that were extended during the reporting period; and

(b) the rationale for those extensions.

Hearings consist of an opening statement from the Premier or his designate(s), followed by Committee member questions. The Committee is authorized to release interim reports summarizing each hearing.

The Committee's mandate is reproduced in full in Appendix A to this report.

STATEMENT AND DISCUSSION

Deputy Premier's Statement

The Deputy Premier and Minister of Health, the Honourable Christine Elliott, appeared before the Committee on December 11, 2020. She opened her remarks by noting that the Solicitor General would appear before the Committee on Monday, December 14, 2020, to discuss the renewal of the emergency orders themselves. The Deputy Premier explained that the purpose of the December 11 meeting was rather to provide Committee members with a deeper understanding of "the rationale guiding the government's decisions" by sharing an update on the province's COVID-19 modelling.

The Deputy Premier introduced her two guests: Dr. David Williams, Ontario's Chief Medical Officer of Health (CMOH) and Dr. Adalsteinn Brown, Dean of the Dalla Lana School of Public Health at the University of Toronto and co-chair of Ontario's COVID-19 science advisory table. She said that the government has "benefited greatly" from the expertise of both guests throughout the COVID-19 pandemic.

The Deputy Premier told Committee members that the guidance and recommendations of the CMOH, the public health measures table and other public health experts, as well as the evidence stemming from modelling and ongoing monitoring of key indicators, have driven and continue to drive the government's decisions around the extension of emergency orders.

The Deputy Premier turned her time over to Dr. Brown to walk the Committee through the COVID-19 modelling, presented through a series of slides.

Presentation of COVID-19 Modelling

Dr. Brown opened his briefing by acknowledging that the work he would present was "the work of researchers and scientists based at McMaster University, the University of Toronto, Queen's University, Public Health Ontario, Ontario Health, the Ministry of Health, ICES and several hospitals in Toronto and elsewhere in the province."

Dr. Brown began by speaking about three indicators that provide a general sense of the spread of the pandemic, being: the number of cases, percent positivity and testing numbers. He noted that when all three of these indicators are increasing, this is "the sign of trouble." When these indicators are "varying," it generally means "that you need to be looking more closely at other indicators."

Dr. Brown advised that Ontario is currently in "a bit of a precarious situation." He said that cases are rising, but that percent positivity appears to be flattening, despite very high testing numbers, relatively. Ontario's R, "the reproduction number," is fluctuating above or below 1.0.

Dr. Brown explained that “R” represents “how many people you infect if you yourself are infected.” He said that if R is 1.0, then that means an infected person is only infecting one other person. When R gets above one, the pandemic is increasing. Right now, Ontario’s R “is probably about 1.1.” Dr. Brown said that when R goes below 1.0, this means that the pandemic is “starting to shrink because it doesn’t propagate forward.” With Ontario’s R fluctuating “on either side of one,” Ontario is in a “fragile” situation in which case rates may change quickly and there is “hope that we can get the rates going down.”

Highlights

- Overall mortality continues to increase, exceeding 25 deaths per day within a month. This makes COVID-19 “among the most common causes of death.” While not as significant as cancer or heart disease, “it is more common than virtually every other category” reported by Statistics Canada on a regular basis. Based on forecasting, Ontario’s overall daily mortality will continue to increase.

- COVID-19 intensive care unit (ICU) bed occupancy (a key indicator) is now over 200 and is likely to be over 200 for the rest of December.

- The data demonstrates a consistent pattern: access to suitable housing and employment outside of essential, front-line services are predictors of lower COVID-19 infection growth. If people cannot obtain suitable housing, or have to be in an in-person job, the result is “much faster growth of the pandemic.”

- The current set of restrictions that started in the middle of September has not reduced mobility (and resulting contacts) as much as the spring lockdown. While this is understandable (because the spring lockdown included a more stringent set of restrictions), this is important to keep in mind, because it means that the current restrictions are “not reducing contacts down as fast.” However, it does look like the current restrictions “are having an impact.”

- The data shows “a huge degree of variation” across public health units in terms of the spread of the disease through the second wave. For example, Peel has 197 weekly new cases per 100,000 residents, “down to about 30 in Ottawa.” The very different “picture of spread” across the province reinforces the importance of a region-by-region approach.

- There is also a significant variation in the percentage of new cases that have no known epidemiological link across public health units, ranging from about 70% in Toronto, down to about 6% in London. This is a critical measure of public health capacity. When Ontario “hopefully” enters the declining phase of this second wave, it will be important to identify the source of every case in order to work toward suppression of the disease.

- There is considerable variation across the province regarding the wait time for COVID-19 test results. This is an important measure of public health capacity.

- Overall, it appears that COVID-19 test positivity (i.e., the percent of tests that come back with a positive result) is “flattening.” This demonstrates Ontario’s “very precarious mixed picture.” Because percent positivity is starting to flatten and testing volumes are “reasonably strong,” the province is at the point that “we’re either going to lose control or gain control” of the pandemic.

- Percent positivity by age group is very different for the first and second waves of the COVID-19 pandemic. In the first wave, the most significant spike is seen in long-term care, with relatively lower spikes in other age groups. This reflects the "very significant" restrictions in the first wave which reduced contacts among people who would otherwise be mobile. For the second wave, the data shows a very different picture of community spread "with distribution that's much more consistent across a series of different age groups." The importance of understanding community-based spread also comes back to long-term care, because the single most important predictor of an outbreak in congregate care settings is an outbreak with a high degree of spread in the community (that then finds its way into a long-term care home or other congregate setting).

- COVID-19 cases in long-term care homes appear to be flattening, while deaths remain high. Numbers presented demonstrate the consequence of COVID-19 cases among a very vulnerable population. There has been "an accelerating rate of death" since the summer, with 493 deaths since September 1, 2020 (102 of which have been in the past 7 days). The challenge in thinking about how to bring these numbers down is that death is "a lagging indicator of the pandemic," meaning that even if disease transmission is broken, "you can expect deaths to continue on their trajectory" as a function of existing positive cases in long-term care homes.

- COVID-19 related hospitalizations and ICU admissions continue to rise, with about a 92% increase in hospitalizations since mid-November and about 166% growth in ICU admissions.

- Modelling of ICU occupancy projects that Ontario will remain above 200 ICU beds occupied by COVID-19 patients for the next month, if we are able to control further spread of the pandemic. If Ontario is unable to control spread and we see a 1% increase in growth, then the projection brings the province closer to 300 ICU beds occupied. If Ontario sees growth of 5%, the modelling estimates ICU rates of around 500 to 550 beds occupied by COVID-19 patients by the end of the first week of January. The current ICU bed occupancy is heavily clustered in the regions with the highest case growth, meaning that there is a high concentration of ICU beds being used within a small number of communities. For example, in places like Peel there are now significant challenges in staffing ICUs, which require highly specialized staff.

- Because of the intense nature of care, ICUs operate below 100% occupancy. As admissions rise and patients stay in ICU longer, Ontario may see even more crowding in our ICUs.

- The pandemic has caused a huge reduction in access to health care for people who do not have COVID-19. While there was some readjustment as the pandemic lessened over the summer, access to health care in Ontario continues well below 2019 volumes. This is critical because, instead of making up the deficit from the first wave, "we're actually slowly adding to that deficit." The result will be delay of things like cancer care and cardiac care and loss of ICU capacity needed for motor vehicle accidents or other emergencies. With shutdowns in primary care and a reduction in things like screening and diagnostic imaging, this deficit goes beyond hospital care and it will have long-term consequences.

- As shown in a series of graphs, long-standing structural factors result in certain people being at greater risk of exposure to COVID-19. In order to control the pandemic, it is important to "test, trace, isolate and also support, because these are factors that drive exposure that are beyond people's control." Growth in cases is highest in communities with the least access to suitable housing (i.e., housing that would allow individuals to isolate). Unless support is provided within these communities "you will see this continue to propagate forward." The same pattern is seen in communities with more multi-generational housing. As well, higher growth is found in communities with a high number of people working in non-health care essential jobs (e.g., people working in grocery stores or various jobs in manufacturing and trades): "These are the people who cannot isolate at home; they need to actually work, and often face a very difficult decision whether to go to work or not, or whether to get tested or not." The structural factors that drive high rates of COVID-19 in these communities make it hard for public health restrictions to take effect "unless it is a complete lockdown."

- Under the current public health restrictions, Ontario is seeing "some impact" on mobility during this second wave, "but not as much as we'd like to see."

- According to a simple mathematical model, if R (the reproductive rate) stays at 1.1, the result is a huge increase in infections over a short period of time and "you very quickly lose control." If R stays at 0.9, the result is a huge reduction in infections in a short period of time. Ontario is in "this precarious place" where we are balancing either just above or just below 1.0: "If we can keep it … on the good side, you'll actually see very significant control quickly."

Discussion

Questions from the Committee

The Deputy Premier and Minister of Health, Ontario's CMOH, and Dr. Brown responded to questions on a range of issues from the Committee, including:

- *Vaccination and Herd Immunity* – Witnesses were asked to provide "the health table estimate" regarding when Ontario would "reach herd immunity." The Deputy Premier responded that "it really depends" on when Ontario receives vaccines and in what quantities. She said that Ontario will receive "a small shipment" of Pfizer vaccines first, which will provide an opportunity "to test our system to make sure that we are ready to receive the larger quantities." She noted that a "larger quantity of Pfizer vaccines" is expected before the end of December. The Deputy Premier said that the Moderna vaccines will not be shipped until they receive Health Canada approval, "so it really depends on when that approval happens." She referenced a December 10 discussion with the federal Minister of Health, who was also of the opinion "that it depends." The Deputy Premier also said that health experts "don't even know if there is a herd immunity at this point." The CMOH said that health experts are working to answer a number of questions, such as whether immunization stops transmission of the virus. Regarding when Ontario will "get to a critical mass" in terms of vaccination, the CMOH said that "it depends on all the new products in the queue to be licensed." He commented: "It seems like a long time to the public, but in the world of vaccinology, it's a pretty rapid pace."

- *Vaccination and Other Public Health Measures* – Given that vaccination may not prevent transmission, a Committee member asked whether it was fair to say that "the vaccine is not the only public health intervention we will need in the coming months." The CMOH said that the main focus of the vaccination program is "to stop people from getting very ill and to stop them from dying or getting admitted to hospital." In order to bring case numbers down in the coming months for the population at large, the CMOH agreed that the focus will continue to be on other public health measures "well into April-May."

- *Vaccination and Clinical Ineligibility* – Witnesses were asked what percentage of Ontario's population is clinically ineligible for vaccination, and what plans are in place for individuals who want to receive a vaccine, but cannot. The Deputy Premier responded that the issue of comorbidities that might prevent certain people from being vaccinated is still being explored. The CMOH said that the companies bringing vaccines forward are "trying to keep expanding their clinical trials to get to different age groups." He advised that, even for the Pfizer vaccine, "their final monograph" with "all the stipulations" is not yet available. The National Advisory Committee on Immunization is "reviewing the products" and "this is going to be very much learn as we go." The CMOH emphasized that Ontario will take a cautionary approach, including watching developments in Canada and in other countries.

- *Vaccinating Children* – Witnesses were asked whether there is "a specific plan for children and students with regard to vaccination." The Deputy Premier said that, at this point, neither of the Pfizer or Moderna vaccines are to be used on children. She noted that five or six other vaccine candidates are "in the pipeline." The CMOH echoed the Deputy Premier's comments, noting that Ontarians would have more information "as it comes forward." He said that the priority for vaccination was for those at higher risk, meaning adults and particularly older adults who are "suffering more mortality."

- *Plans to Address Vaccine Hesitancy* – A Committee member asked about the government's plans to address vaccine hesitancy. The Deputy Premier emphasized that vaccination will be on a voluntary basis. She said that there is one category of people that are opposed to vaccination "under any circumstances," while there is another category of people who want to be vaccinated, "but don't want to be in the first group because they want to see the effects it has on other people first." She said that the task force is working on communication and community involvement "to calm people's anxieties," as well as "catering responses for different groups." She commented on the need to engage with Indigenous communities, as well as people who are new to Ontario and may face language barriers.

- *Plans for Vaccine Distribution* – Witnesses were asked whether there is a plan to ensure that long-term care staff and residents receive the vaccine on a priority basis, including whether residents would be transported to hospitals or other sites for vaccine administration. The Deputy Premier responded that there is a

plan in place. She said that because the Pfizer vaccine must be kept at extreme cold temperatures, experts have advised that the vaccine "needs to stay at the place where it's delivered." Pfizer will deliver doses to specific sites and then long-term care staff will be asked to come to those locations to receive the vaccine. She noted that, due to concerns about transporting long-term care home residents, it is more likely that they will receive the Moderna vaccine, which is more transportable.

- *Leadership of Vaccine Distribution* – A Committee member asked whether local public health units would be leading the vaccine distribution in each region, noting that the vaccine task force in Ottawa has been structured so that public health is "the lead." The Committee member said that public health units have experience with vaccination campaigns and can be a "trusted voice regionally." The CMOH responded: "It's a partnership." During the first phase of vaccination, he said that Pfizer would only allow two sites and the sites the government selected, with the appropriate "ultra-low freezers," are hospitals. He said that this initial phase is being led by the vaccine distribution task force, not necessarily by public health or Ontario Health or by hospitals. He said that the task force "will allocate more and more" and that "as it gets out wider and wider, it'll change." The Committee member asked that the government consider public health leadership "going forward on the vaccine task force and regionally."

- *Vaccines for Peel Region* – A Committee member questioned why Peel, with "some of the highest per capita case counts" has been excluded from the first batches of vaccines. The Deputy Premier said that the government would be announcing the exact locations, but noted "we are looking at including the areas that are in lockdown, because we know that those communities need extra help and we of course want to protect the long-term care residents." She clarified that long-term care residents would likely receive the Moderna vaccine "because of the difficulties in transporting the Pfizer vaccine."

- *The Lockdown and Small Businesses* – Committee members asked why large retailers and "big box stores" are able to remain open for in-person shopping, while small businesses are restricted. The CMOH said that many large retailers carry food and other essential items. He also commented that larger retailers "have bigger square footage to spread the people out." He noted that stores must limit the number of people allowed inside, with "supervision at the door" and take steps to control the direction of flow in the aisles. He said that shopping at small retail stores tends to result in more people "out on the street going back and forth," which can make mask wearing and distancing difficult to control. While retailers have attempted to impose restrictions, they are having difficulty preventing customers from coming into close contact. Dr. Brown commented that "this is a really hard question, because it requires weighing so many things." He showed the Committee mobile phone data from the United States (specifically, Chicago) for March 1 to May 2, 2020. He explained that researchers had used this data to link where people lived with where they had been, and then used a complex process of mapping and algorithms "to see what seems to be

associated with more infection," and specifically to "figure out where the infection likely happened." Dr. Brown explained that it is "very, very clear" that restaurants, gyms and snack bars have a significant risk of increasing infection. He said: "It does come down, with different types of stores, to much lower." Dr. Brown echoed the CMOH's comments that, if a store is open and adherence to public health interventions is low, this could result in crowding and in a "super-spreader event."

- *The Situation in Toronto* – A Committee member referred to a slide in Dr. Brown's presentation showing the percentage of weekly new cases with no epidemiological link across different public health units. She asked for an explanation of "what is going on with Toronto," noting: "Toronto is an outlier in an extreme way." She said that, despite money for extra contact tracers, Toronto "has never been better than 50% on this score." The CMOH agreed that "a lot of contact case tracers" have been added in Toronto. He also noted that staff are being deployed "to assist all the health units as they start to get overwhelmed." He said that respondents answering the contact tracers' questions may either not recall "or they don't want to share" where they have been or what contacts they have had. He said, "If they can't recall, we can't do much about it." As well, he pointed out that in Toronto the answer to the question "were you in a crowded place for a period?" is more likely to be yes. For example, Toronto has more "high-rise-type locations" where people have "multiple high-contact risks all the time that they have very little control over," such as being on an elevator.

- *R Rate and Public Health Interventions* – A Committee member said that, according to Dr. Brown's presentation, Ontario is currently at an R rate of approximately 1.1, with fluctuations above and below that level. She asked Dr. Brown whether it would be correct to assume that, without the public health interventions that have been put in place, Ontario's R rate would increase significantly, resulting in "all kinds of problems." Dr. Brown agreed, noting that Ontario saw very rapid growth of COVID-19, "and now that has actually come down." He said: "So that's likely the impact of the interventions that we have in place." He explained that modelling indicates that, had interventions not been put in place "with the type of explosive growth we saw in the spring," the result could have been ICUs very quickly becoming overwhelmed and a much higher mortality.

- *Paid Sick Days* – Dr. Brown was asked whether paid sick days would have made a difference for the high number of positive COVID-19 cases found among non-health care essential workers and whether anyone is looking specifically at case numbers among groups of workers who have, versus those who do not have, paid sick days. Dr. Brown responded that, to his knowledge, Ontario does not "collect information that could be linked like that." He said that, while he could not provide "trial-based evidence," he strongly believed "that comprehensive packages of interventions that allow people to stay at home safely," including sick days and protection against eviction, among other things, are critical to supporting such workers.

- *Christmas Holidays* – Committee members asked about challenges heading into the holidays and whether Ontario can expect to see "a bump" in cases (potentially leading to some of the projected worst case scenarios). The CMOH said that "holiday sessions" are always a risk. The question is whether people have "learned the lesson" regarding restricting mobility and limiting gathering to their own households. He said that the government is providing messaging about shopping ahead of time, ordering online and reminding people "that you don't always have to order from the … big companies." Regarding the modelling, Dr. Brown explained that there are competing forces: on the one hand, people are at home more and schools and businesses are closed; on the other hand, families may want to get together. If there is no traffic outside of the home (and no gathering of multiple households), "you would probably see a reduction in cases." However, if there are significant private gatherings indoors, this could result in super-spreader events. The CMOH emphasized that messaging will continue to remind people to stay at home with their own households and engage in virtual visiting with others: "It's a different Christmas."

- *Isolation Centres for Essential Workers* – A Committee member asked, based on available data regarding COVID-19 and non-health care essential workers, whether providing a place for those workers to self-isolate would help. Dr. Brown confirmed that providing a safe place to isolate would improve the chances "of not only closing the prevention gap that happens in those communities, but we'll actually reduce the impact across the entire province as well." The Committee member also asked whether the provincial government would be willing to fund isolation centres, noting two existing such centres are funded federally. The Deputy Premier said that the government has identified 14 neighbourhoods within the lockdown zones that require "extra help" and that she has had several conversations with the federal minister to obtain assistance with more quarantine isolation zones "so that we can start getting the numbers down—because we know in many of these communities, it's very difficult." She said that the federal government has been a very willing partner. However, "if, for whatever reason, the money is not coming from the federal government, absolutely, it's something we would consider doing as a provincial government."

- *Targeting Resources in Hard Hit Communities* – A Committee member asked the Deputy Premier to provide a timeline as to when "hard hit" communities, such as the Committee member's riding in northwest Toronto, "will receive additional isolation options." The Deputy Premier advised that, while she could not provide an exact timeline, "this is an item of priority for us because we know that communities such as yours need extra help." She noted that there have been discussions with the federal Minister of Health regarding federal assistance in this area.

- *Restricting Travel Between Zones* – A Committee member expressed concern about members of the public traveling from lockdown areas to less restricted regions in order to shop and dine. She asked: "What guidance do you have for these people and for the business people in my community?" The CMOH

explained the messaging to the public is that there are no “real barriers” to travel within the province. He said that the goal is to discourage people from traveling from high-risk to lower-risk areas, except for essential reasons. If travel is essential, people should “maintain precautions and be respectful to the local community.” Regarding shopping, he said: “we’re going to have our groups continue to use their enforcement, as well as limiting crowds and numbers.” He commented that, if people do their planning ahead of time, then “that crush for the shopping should not occur.”

- *Curfews* – A Committee member asked whether the government would consider curfews and other measures employed in some jurisdictions, “if asking people to respect the rules” does not work. In response, the CMOH emphasized that “a large part of our public are staying the course.” He said that the government was not looking at imposing a curfew at this time, noting that the government needs co-operation from the public, rather than having “to police it, because we can’t watch everywhere, every person, every moment, and we need them to participate.”

- *Intensive Care Unit Occupancy* – A Committee member commented that when she speaks with ICU staff, she hears that they are working very hard with patients who are acutely sick. She asked what it will look like when Toronto ICUs are full. Dr. Brown said that the Committee member was correct that “it is a very, very challenging situation.” He noted that, according to the modelling, when ICUs become full, “you would see challenges in other types of care.” For example, people having to forego cancer and cardiac surgeries and motor vehicle accident victims having great difficulty getting care: “You would see overall growth in death, not just growth from COVID-19.” The CMOH said that Ontario Health sometimes deals with ICU occupancy issues by moving “certain cases and patients.” He said that another concern ICUs are dealing with is staff becoming infected in the community, which has an impact on available health human resources.

- *Disparities between ICUs* – The Committee member also commented that ICUs across the province do not all have the same facilities and so “are not all created equal.” She noted that some people in northern ridings rely on Toronto hospitals and asked whether Toronto hospitals may soon be unable to take northern patients (because they will be full). Dr. Williams responded, “That would be how the system starts backing up.” He noted that when this happens, the idea would be to try to use capacity in different ICUs around the province, “but it becomes more and more stressed” because of both outbreaks and staff shortages. He emphasized, “That’s why we’re trying to tell the public that while these numbers don’t seem big at the moment, they are having an impact, because they will back up the system.”

- *Surgical Backlogs* – Witnesses were asked whether Ontario is tracking the health effects of the surgical backlog, such as “who dies from not getting their surgery.” Dr. Brown advised that there are two studies underway: one looking at cancer

care and one looking at cardiac care. Currently, results are preliminary. He noted that further analysis will likely shed light on this and other health effects, such as immunization for diseases other than COVID.

- *Transportation Support* – The Deputy Premier was asked whether the government would commit to providing additional funds to transit operators, such as the Toronto Transit Commission, to supply additional buses on busy routes. The Committee member said that buses, in which people stand "shoulder to shoulder" in high transmission communities, are "places where people are at risk of catching COVID." The Committee member also asked whether COVID-19 transmission on public transit had been discussed "at the health table." The Deputy Premier said that she would "discuss it with Minister Mulroney and Minister Surma," as this concern would be within their jurisdiction. Regarding discussions at the health table, she noted: "We haven't had that specific discussion with respect to buses, but we can certainly do that."

- *Public Health Measures in Other Jurisdictions* – Witnesses were asked to share with the Committee how they compare Ontario's public health measures with those taken in other jurisdictions and to discuss "some of the lessons learned" from other jurisdictions. The CMOH responded that "our national federal/provincial/territorial committee" as well as the Public Health Agency of Canada and Health Canada are "doing lots of jurisdictional scans" looking at different measures that are "succeeding and not succeeding." Questions are then brought to the science advisory table in terms of whether different approaches would or would not be "valid in our setting." He stressed that this is an ongoing learning process. Regarding lessons learned, Dr. Brown said "you either have to do the work early or you have to do it late, and if you do it late, it's a lot harder." For example, he noted that in parts of Australia and in other places, "as the cases got really out of control," measures included curfews, "police on the streets," travel restrictions and "exactly the type of strict, strict, strict stay-at-home orders that you saw us not even get to with our first-wave activities." He further noted that a variety of jurisdictions, including Canada, "delayed and delayed and delayed, and then it takes you to a place that is much stricter and much harder." Dr. Brown concluded by informing Committee members that the experience of other jurisdictions has demonstrated that, the more that governments do "that support part of the work, the better it goes."

- *Making COVID-19 Modelling Data Public* – A Committee member asked whether any other province releases modelling data or provides regular updates on modelling projections to the public, as Ontario does. The CMOH said that some other provinces "have released their modelling data at different times and in different ways." He noted that Ontario's science advisory table monitors this information. Dr. Brown said that providing transparency by publicly releasing data "is really critical." He advised that modelling is an effort to look forward and "is always inexact." Dr. Brown explained that members of his team "actually do model progress and look at progress" in other provinces. He said that this is important "because it gives us a sense of both, first, how we can advance our

methods, but also, second, how we're doing relatively in terms of the predictive efficacy of our models—but also what the impacts are in those other jurisdictions." He told the Committee: "I tend to think that the more that you can have strong, independent modelling, the stronger position you are in to respond."

- *Percent Positivity* – Dr. Brown was asked why percent positivity is an important metric. He responded, "If you see growing testing and you see growing cases, the question always comes up: Are you just finding cases because of the testing or are you actually seeing the spread of the disease?" He explained that if testing and cases are increasing, but the percent of tests that are positive is decreasing, then "what you're probably doing is finding more cases. It's not that you're actually seeing spread, necessarily." However, if cases and testing are increasing, and the percent of those tests being positive is also increasing, "it tells you that you're looking at spread." He said it is important to look at numbers of cases, testing and percent positivity together in order "to understand the actual course of the pandemic."

- *Local Public Health Restrictions* – A Committee member asked how important the ability for local public health officials to "tailor restrictions" for their communities under section 22 of the *Health Protection and Promotion Act* might be to Ontario's COVID-19 response framework. The Committee member also asked for an explanation of how Ontario's response framework helps people "to anticipate where their area might be going." The CMOH responded that each level of the framework establishes "the platform" which local medical officers can add to, based on situations that may be unique to their jurisdiction, but cannot reduce. Regarding how people can use the framework, the CMOH said that it allows the public to take ownership in terms of needing to "get your numbers down" in order to move to a lower level of restriction because "you can actually see the metrics in front of you."

- *Public Reporting on Vaccination Progress* – The Deputy Premier was asked whether there were plans to provide regular public updates regarding the progress of the vaccination campaign. As the Deputy Premier had to be excused from the Committee session before it finished, the CMOH responded that the government is "putting in systems" to collect information, such as who has been vaccinated. He said that information is needed to ensure that individuals receive the two required doses, as well as to monitor "any adverse events."

- *Use of Existing Capacity in Long-Term Care* – A Committee member asked whether the CMOH and the public health measures table have considered or would consider using provisions under public health legislation to enable admissions to empty long-term care beds. The Committee member referred to 120 empty single-bed ward rooms in his riding, noting: "it's putting pressure on our hospitals and it's putting pressure on our community." He said that "there are provisions in public health under other circumstances to admit people during an outbreak, given certain conditions." As the Deputy Premier and CMOH had been excused, Dr. Brown said that he could not "comment on the public health

measures table or the government." He said that, while he was not familiar with the particular situation in the Committee member's riding, "outbreaks in a nursing home are largely determined by the level of infection in the community. Mortality within the nursing home is largely determined by the age of the home, whether or not it's crowded and whether or not it's in chain ownership." Dr. Brown advised that he would "pass on" the Committee member's comments to the CMOH.

- *Vaccine Public Information Campaign* – With regard to vaccination and vaccine hesitancy, Dr. Brown was asked whether he knew "when the public information campaign is going to start or how we're going to roll that out." Dr. Brown advised that he did not know the answer and that this would be a question best directed to the CMOH. He said, "I agree entirely on the importance of public education."

APPENDIX A:
TERMS OF REFERENCE*

That a Select Committee on Emergency Management Oversight be appointed to receive oral reports from the Premier or his designate(s) on any extensions of emergency orders by the Lieutenant Governor in Council related to the COVID-19 pandemic and the rationale for those extensions; and

That the Committee shall have a membership of up to eleven Members, comprised as follows:

- Up to seven members of the Government party
- Up to three members of the Official Opposition
- Up to one Independent Member; and

That the House Leaders of each of the Recognized Parties shall indicate in writing to the Clerk of the House, their Party's membership on the Committee; and

That the Government House Leader, in consultation with the Independent Members, shall indicate in writing to the Clerk of the House, the Independent Member on the Committee; and

That the deadline for indicating Committee Membership with the Clerk of the House shall be Thursday, August 20, 2020; and

That the Committee shall meet at the call of the Chair as follows:

- Up to 30 minutes for the Premier or his designate(s) to make an opening statement
- Up to 60 minutes for Members of the recognized Parties to pose questions to the Premier or his designate(s) in 3 rounds of 10 minutes for each Party
- Up to 10 minutes for the Independent Member to pose questions to the Premier or his designate(s) in 2 rounds of 5 minutes each
- Report writing in closed session; and

That the Clerk of the Committee shall convene the first meeting of the Committee no later than Thursday, August 27, 2020 to elect a Chair and Vice-Chair of the Committee, but no Sub-committee shall be appointed; and

That for business conducted under this order of reference, the provisions of Standing Orders 38 (b), (c), and (d) and 134 (c) and (d) shall be suspended.

That the Committee is authorized to present interim reports summarizing each hearing to the House, or deposit interim reports with the Clerk if the Legislature is not in session; and

That the Committee's final report shall be a compilation of all interim reports; and

That the Committee shall be dissolved 30 days following the Government House Leader indicating in writing to the Speaker that the Committee is no longer required; and

That the Committee's final report shall be tabled in the House, or deposited with the Clerk if the Legislature is not in session, before the Committee is dissolved; and

That if the Committee fails to meet this deadline the cumulative interim reports shall be deemed to be the Committee's final report and deemed to be tabled on the date that the Committee is dissolved; and

That an Order shall be placed on the *Orders and Notices Paper* for discussion of the Final Report of the Select Committee on Emergency Management Oversight following its presentation to the House.

**Votes and Proceedings, July 15, 2020, 42nd Parliament, 1st Session*