TORONTO STAR

STAR COLUMNISTS OPINION

'It's a mutiny. Wow.' Ontario's public health units are acting to protect their regions — and the province has to listen

By **Bruce Arthur** Columnist

Thu., May 28, 2020 | 5 min. read

The province has to embrace this, and fix this. On Wednesday, Ontario's 34 public health units, in the face of an inflexible approach and insufficient leadership amid a pandemic, decided to take some control for themselves.

"It's a mutiny," says Dr. Andrew Morris, a professor of infectious diseases at the University of Toronto, and the medical director of the Antimicrobial Stewardship Program at Sinai-University Health Network. "They're actually outlining a strategy. That's pretty amazing. That's unbelievable. It's a mutiny. Wow.

"I'm going to say great for them, like about bloody time. The real issue is going to be whether the province agrees to this or not."

A document, which was prepared by the medical officers of health and obtained by the Star, lays out several specific categories that should be considered together before different parts of Ontario reopen businesses or organizations, or decide to reinstitute restrictions.

Note: On desktop, use "+" and "–" to navigate this document. On mobile, pinch to zoom

Ontario Public Health Unit Core Indicator Framework for COVID-19 Monitoring

Provincial Framework

	Virus Spread and Containment		Health System Capacity		Public Health System Capacity		Incidence Tracking
Purpose	Ensures loosening of measures is appropriately timed with the progression of the epidemic in Ontario		Ensures there is an effective response to any potential case resurgence		Ensures there is an effective public health response to any potential case resurgence		Ensures that any potential resurge identified prompt
Dimensions	• A consistent two-to-four week decrease in the number of new daily COVID-19 cases • A decrease in the rate of cases that cannot be traced to a source • A decrease in the number of new COVID-19 cases in hospitals		• Sufficient acute and critical care capacity, including access to ventilators, to effectively response to potential surges • Ongoing availability of personal protective equipment (PPE) based on provincial directives and guidelines		• Approximately 90 per cent of new COVID-19 contacts are being reached by local public health unit (PHU) officials within one day, with guidance and direction to contain community spread		• Ongoing testing of suspected C especially of vulnerable populat outbreaks quickly • A shift to new and other ways o tracing to promote widespread
Indicators and Rationale for Local Monitoring	**Indicator**	**Rationale**	**Indicator**	**Rationale**	**Indicator**	**Rationale**	**Indicator**
	7-day moving average of daily new COVID-19 cases (non-institutional / congregate care setting) by specimen collection date[1]	Measures ongoing transmission in community settings	Per cent of acute care beds occupied[2]	Measures reserved capacity to accommodate future need	Per cent of newly reported COVID-19 cases (confirmed and probable) reached within 24 / 48 hours of reported date[1]	Measures ongoing public health unit ability to ensure timely case isolation and contact identification	Per cent of positive COVID-19 tests with a turnaround time (duration between specimen collection date and reported date) of 24 / 48 hours[1]
	Per cent of new COVID-19 cases that are non-epi linked (no link to confirmed case, outbreak or travel)[1]	Measures the degree of transmission from unknown sources	Per cent of intensive care unit beds occupied[2]	Measures reserved capacity to accommodate future need			COVID-19 per cent positivity[3]
	7-day moving average of daily new hospitalized COVID-19 cases by admission date[1]	Measures severity and state of infection in the community	Per cent of intensive care unit beds with ventilators occupied[2]	Measures reserved capacity to accommodate future need			
	New and cumulative number of institutional and congregate care settings in COVID-19 outbreak[1]	Measures the degree of transmission in vulnerable settings; potential future impact on Health System Capacity	Days of personal protective equipment stock in reserve	Measures reserved capacity to accommodate future need			

Data Sources: 1) iPHIS, CORES, The COD, CCMtool; 2) Ontario Ministry of Health COVID-19 Command Dashboard; 3) Chung H, Fung K, Ishiguro L, Paterson M, et al. Characteristics of COVID-19 diagnostic test recipients, Applied Health Research 2021 0950 080 000. Toronto: Institute for Clinical Evaluative Sciences; 2020.
Notes: Monitoring by PHUs may be influenced by local capacity, data availability and other influences. Data source for 'Days of personal protective equipment stock in reserve' to be determined by public health unit.

Last updated: May 26, 2020

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On virus containment it spells out a two- to four-week decline in new daily cases, a decrease in unsourced cases, a decrease in hospital admissions; a seven-day decline in community cases; and more. It also lays out indicators in health-care capacity, public health system capacity, and incidence tracking capacity. And it explains why.

All 34 medical officers of health signed it, and as much as they tried to present the plan as a complement to the provincial reopening plan, the provincial version was considered maddeningly light on actual data thresholds. This is polite, firm mutiny in the name of the public's health. Some had already considered something similar.

"As public health practitioners we're obliged to follow the data, and do what makes sense to best protect the health of the populations that we serve," said Toronto's Dr. Eileen de Villa, who spearheaded the effort with Ottawa's Dr. Vera Etches and Peel Region's Dr. Lawrence Loh.

The plan's exact numbers haven't all been established. Dr. Irfan Dhalla, the vice-president of St. Michael's Hospital, said it may expose gaps in the data we have. Dr. David Fisman of the University of Toronto called it right and coherent. Morris called it wise. Dhalla said it just made sense.

"Today feels like a win, and I haven't felt that in about 10 days," says epidemiologist Dr. Nitin Mohan, who teaches public and global health at Western University, and who co-founded a public health consulting firm called ETIO. "This is exactly what we're looking for. This is a very logical document, and they do really well to say, here are the minimum requirements, and here are our suggestions to go further. I'm really impressed.

"I don't want to play Monday morning quarterback and look back, but had we had these parameters from the beginning we probably could have hit a sustainable opening by now, and we could be talking about a Phase 2 opening."

The province started reopening some businesses in Phase 1 without having met concrete benchmarks, and it neither embraced nor rejected the document. Health Minister Christine Elliott said the province was listening, and said the document would go to the expansive Ontario health command table. Premier Doug Ford argued Wednesday people might travel among regions.

"I always say, we need to stick together as a province, and I think we're moving along pretty well," said Ford. "Everyone's listening, everyone's following the protocol of their local medical officer of health, people are still self-distancing, we're ramping up testing, and thank goodness, you saw the numbers, I know they're up and down like a yo-yo, but last two days have been positive, under 300 (new cases). So there's positive things that are happening.

"So why make a big divide now, when we're getting through this?"

The point is that the province's medical officers of health have powers to make their own decisions, and do not necessarily think we are all doing very well. And epidemiologists agree.

"I've been aware of at least three (medical groups drafting letters), outside the medical officers for health, saying we're better than this, we can do better, we're going in the wrong direction," says Fisman. "And the most productive ones don't just say fire the chief medical officer of health. They say, here's what a different way would look like, and who are some of the people who have that skill set and experience to actually lead that effort and turn this flaming dumpster-fire clown car around?"

Dr. David Williams's job as Ontario's chief medical officer of health has been a topic of discussion in medical circles for some time. Williams, for his part, said he considered the plan a complement to his existing framework. He said, "I saw it as much more of a positive thing ... My overall approach, I think it's a good thing they're doing, and they're keeping me informed." That may be a good thing.

"What should have happened is David Williams, along with Public Health Ontario, should have brought together the medical officers of health and said guys, what should we do?" says Morris. "And they would come up with this document and everyone would be on the same page and it would work perfectly. Instead, for a variety of reasons, they have taken it upon themselves to outline a strategy that is in my mind really thoughtful.

"But is this going to advance the cause? I don't know, because people might be really confused. What happens if the premier says one thing, and all these medical officers of health say something different? Who's the public going to listen to now?

"And what's David Williams going to be saying? Because he should be aligned with these guys, but he's employed by the premier. It's unclear if the premier needs to go along with any of this.

Morris says he figures the only quick fix is to appoint somebody to quarterback all this, with diplomacy and communication skills and administrative ability.

"If you consider a pandemic to be a health-care equivalent of a war, you actually do need a command-and-control structure," says Dr. Sacha Bhatia, the chief innovation officer at Women's College Hospital, and its chief of cardiology. "You have to be a competent general to run it. Bonnie Henry in B.C. — even the premier deferred to this one person.

"I think at the end of the day, a very strong CMOH makes a lot of these problems go away."

The province needs to embrace this, and fix this. The revolution, as it turns out, was local. But then, most revolutions are.

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