

Ministry of Health's Pandemic Response Structure and Actions Briefing

Meeting of the Long-Term Care Commission
on Tuesday, September 8, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants
attending remotely, on the 8th day of September,
2020, 2:00 p.m. to 3:30 p.m.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

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7 PRESENTERS:

8

9 Alison Blair, Assistant Deputy Minister, Health

10 Services

11 Justine Hartley, Health System Emergency Management

12 Branch, Ministry of Health

13 Robert Francis, Director, Strategic Policy Branch,

14 Ministry of Health

15 Judith Parker, Esq., Crown Law Office, Civil

16 Sunil Mathai, Esq., Crown Law Office, Civil

17 Roopa Mann, Ministry of the Attorney General

18 Kristin Smith, Esq., Ministry of Health and

19 Ministry of Long-Term Care Legal Services

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1 PARTICIPANTS:

2

3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

5 Ida Bianchi, Counsel, Long-Term Care Commission

6 Secretariat

7 Kate McGrann, Counsel, Long-Term Care Commission

8 Secretariat

9 John Callaghan, Counsel, Long-Term Care Commission

10 Secretariat

11 Derek Lett, Policy Director, Long-Term Care

12 Commission Secretariat

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

14 Care Commission Secretariat

15

16 ALSO PRESENT:

17

18 Olivia Arnaud, Stenographer/Transcriptionist

19 Lisa Di Felice, Administrative Assistant, Long-Term

20 Care Commission Secretariat

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1 -- Upon commencing at 2:00 p.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 All right, then. Let's go.

5 ALISON BLAIR: Okay. Great. So great
6 to see the Commissioners, some familiar faces, and,
7 you know, role models throughout my career so far,
8 so it's really an honour to be here today. And I
9 think taking questions as we go is probably a
10 really good idea, and we have the luxury of a
11 couple of hours together.

12 I can tell you that I have done slide
13 decks similar to this, 19 slides in ten minutes
14 before, so if I get too fast, just tell me: We
15 have time, Alison. You can calm down.

16 So we'll go through the slides today.
17 So pleased to be here, and just want to take a
18 teeny tiny bit of time to talk about who I am and
19 perhaps who I'm not.

20 I understand that you have a number of
21 briefings lined up, and I think we're going to talk
22 about what we have done in terms of the COVID
23 response structures and processes.

24 And I think it's important to note that
25 I am obviously not the Chief Medical Officer of

1 Health. You're going to have a chance to talk to
2 Dr. Barbara Yaffe, who will be able to tell you all
3 about public health. I do not have a clinical or a
4 public health background, nor do I have the
5 authorities that the Deputy Minister of Long-Term
6 Care or of the Ministry of Health have.

7 But what I do have over the last little
8 while is experience working since the beginning of
9 March with the structure that was the command table
10 structure and working with many of the people
11 across the Ministry and across government working
12 with COVID.

13 So I have been sometimes the determiner
14 of key areas for advice, based on advice,
15 obviously, from very knowledgeable people in the
16 field about, hey, do we need to know more about the
17 value of testing in communities with low incidence
18 of testing, for example.

19 I've been an action tracker coming out
20 of the command table, making sure that we are
21 documenting the advice that the command table
22 provided, or action items to follow up on.

23 I've also been the adapter of processes
24 and of structures as we've gone forward. So what
25 we'll talk about today is the command table

1 structure that is in place; it has been -- we have
2 been, I would say, agile, but we have adapted our
3 processes as we've gone along throughout the first
4 wave and into the summer and now looking ahead to
5 the fall.

6 So those are the things that I have
7 been involved in, and I'm very much looking forward
8 to giving you a tour of the processes and the
9 structures and also to give you a bit of an
10 overview.

11 I think I've used this with the team
12 that I'm talking about, that this is the -- if you
13 think of a buffet, I can imagine that in the future
14 sometime we will go back to buffet eating, not for
15 a while, but today what I'm doing is I'm giving you
16 a tour of the buffet before you decide what you
17 want to eat more of or what you have questions
18 about. So I'm hoping that I can play that role and
19 be helpful to you.

20 I think what we can do is -- the slide
21 deck, I think, everybody has in front of them; is
22 that right? Okay. That's not something that I
23 need to make sure that I'm -- that we're
24 projecting, and that's great.

25 I will look at the -- if we get to

1 Slide No. 2 is really -- within our purpose today
2 is to provide a high-level overview, including the
3 initial planning, the structure, and the supporting
4 work streams.

5 And I think we're going to -- I'm going
6 to turn it over to the expert on pandemic planning
7 and preparedness, our acting director of the
8 Health System Emergency Management Branch,
9 Justine Hartley, for Slide No. 3.

10 JUSTINE HARTLEY: Great. Thank you,
11 Alison, and good afternoon, everybody.

12 Just a quick question: Are you going
13 to be projecting the slides?

14 KRISTIN SMITH: I don't think that was
15 the plan.

16 JUSTINE HARTLEY: No?

17 KRISTIN SMITH: I can do that if it's
18 helpful to everybody. Just let me know.

19 JUSTINE HARTLEY: You know what, that's
20 okay. Thank you. Thank you for that.

21 KRISTIN SMITH: No problem.

22 JUSTINE HARTLEY: So the Ministry of
23 Health leads the development of the Ontario Health
24 Plan for an influenza pandemic, and that really
25 lays down the foundation of how our provincial

1 health system will prepare in response to an
2 influenza pandemic. It was first released in 2004
3 and has certainly gone through a number of
4 iterations over the year, and these developments
5 have been supported by quite a beefy steering
6 committee set up, which I think includes probably
7 about 80 different stakeholders, but certainly
8 those regulatory bodies, those associations are key
9 organizations, unions, and government
10 organizations.

11 Prior to 2013, our plan looked a little
12 bit different. It was really focused on a moderate
13 influenza pandemic, and it really was focused on
14 preparedness rather than response. So we're really
15 providing those elements to our stakeholders on
16 what they needed to consider to develop a plan for
17 an influenza pandemic.

18 But certainly in 2003, given our
19 experience of H1N1 and what we knew, the new
20 information that, you know, has evolved over the
21 years and certainly best practices, we've reframed
22 that plan to look more of a scaleable response plan
23 and that that really is looking rather than just
24 looking at a moderate pandemic, and certainly one
25 of our key lessons learned from H1N1 was it was a

1 mild pandemic, and many of our chapters within
2 OHPIP weren't necessarily transferrable to that
3 particular response.

4 So for 2013, we wanted to make it
5 scaleable, based on the transmissibility and the
6 clinical severity of a virus. That would allow us
7 to choose different tools and different mechanisms
8 to support a response to a pandemic.

9 We also focused more on some of those
10 system chapters, so those chapters that had
11 applicability across our healthcare system.
12 There's certainly rules and responsibilities that
13 exist in those chapters, but we took more of a
14 broader view to make sure that everybody we were
15 planning as a system rather than a silo. So a lot
16 of the chapters that you will see that are updated
17 in 2013 really have that system perspective.

18 So certainly, surveillance,
19 communication, IPAC -- infection prevention and
20 control -- occupational health and safety, and
21 vaccinations.

22 So that really provided a very good
23 foundation for us to respond to the COVID-19
24 response. Many of those chapters were
25 transferrable and provided us a very quick start to

1 how we should organize our response and certainly
2 informed a lot of the health command table as well
3 as the work streams that fell under that table.

4 Some of the other chapters, while they
5 provided a good foundation for us weren't
6 necessarily as transferrable because this virus is
7 slightly different than an influenza pandemic.
8 There's a different severity to it, and there's a
9 different transmissibility to it. So we had to
10 take those chapters and adapt them for this
11 response.

12 It's certainly a new virus for us. We
13 don't have any immunity. While in an influenza
14 pandemic we may have some slight immunity, we
15 certainly didn't have a population that had any
16 immunity to this virus. And the science was
17 relatively unknown around this virus, so we
18 definitely had to take those virus characteristics
19 and incorporate them into our response, but
20 certainly leveraging what good thinking and good
21 consultation and support we had developed as part
22 of the OHPIP process.

23 Over to you, Alison. Thank you.

24 ALISON BLAIR: Thank you very much,
25 Justine. I love when they -- we first talked about

1 how not immune we are to this. I love the phrase
2 that "we are a naïve population" when it came to
3 coronavirus, and I think the study that will be
4 released -- I think it has been released today by
5 the Feds, looking at Canadian Blood Services, and
6 the percent of samples. I think they looked at
7 about 37,000 samples of blood taken. I think it
8 was from May until June, and it looked like we're
9 still under 1 percent in terms of antibodies, so
10 that's -- we have considerable naïvety when it
11 comes to this virus.

12 So thanks very much, Justine. And
13 Justine will be here for questions, if you have
14 any. If you have any now, then that's fine, and if
15 not, then we can certainly wait until later on.

16 COMMISSIONER JACK KITTS: Can I just
17 ask a question? It's Jack. If the other
18 commissioners are okay, I think I'd be better with
19 you showing the slides on the screen because I'm
20 having a hard time with my iPhone and the size of
21 it.

22 KRISTIN SMITH: So I'll pop those up on
23 the screen, Alison, so you guys don't have to do it
24 while you're presenting.

25 ALISON BLAIR: Thank you. Wonderful.

1 Appreciate it.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Ms. Coke?

4 COMMISSIONER ANGELA COKE: Just a quick
5 question: You mentioned that you updated this plan
6 in 2013. I'm just trying to understand: What is
7 the process by which you review this? Is there a
8 yearly review or a refresh? How often do you go
9 back and make sure it's still up to speed?

10 JUSTINE HARTLEY: Yeah, no, that's a
11 great question. Thank you. And certainly, we have
12 updated it quite a few times since 2004. Some of
13 those significant updates were done in 2008 and
14 then 2009. Really, it's looked at on an annual
15 perspective, but really, the significant updates
16 happen every few years just because it does take a
17 lot of work based on bringing our steering
18 committee together and making sure that we have all
19 of the right people to inform, and then also, if
20 there are significant events, like there was during
21 H1N1, we go through a debrief process prior to the
22 updating of that plan.

23 So that's why there was a little bit of
24 gap between the 2009 iteration and the 2013.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 If I could just ask, Justine, and maybe you're the
2 wrong person for me to ask this, but it says -- you
3 referred to a command table.

4 Does that mean that that table has the
5 authority to direct what happens across the entire
6 response or not?

7 ALISON BLAIR: We have --

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Because it says in the slides it's something about
10 advisory rather than directive.

11 ALISON BLAIR: Yeah. So I promise that
12 we will spend a lot of time talking about that.
13 But the slides are correct that despite its name,
14 the command structure does not provide commands.
15 It provides advice to those organizations that have
16 existing authority, so whether that's the Deputy
17 Minister and the Minister of Health or the Deputy
18 Minister or the Minister of Long-Term Care or
19 Ontario Health, that this was a group that got
20 together to share experience and provide advice to
21 those decision-makers. Okay.

22 COMMISSIONER JACK KITTS: Just a
23 follow-up question: With those you named, would
24 they be at the command table as well or not?

25 ALISON BLAIR: The three co-chairs

1 happen to be three big decision-makers, one who is
2 the Deputy Minister of Health, one who is the
3 president and CEO of Ontario Health, and the third
4 who is the Chief Medical Officer of Health who can
5 provide advice and directives. But the Deputy
6 Minister of Long-Term Care was also at the command
7 table.

8 I think probably so -- so a big
9 decision-maker in government is Cabinet. So
10 Cabinet was not at the table. We had elected
11 officials who came to some of the discussions, but
12 they were not members.

13 COMMISSIONER JACK KITTS: So the
14 command table provided advice to Cabinet?

15 ALISON BLAIR: Provided advice to the
16 Minister of Health, who could then bring that
17 advice to Cabinet in the usual sort of chain of
18 command [indecipherable].

19 COMMISSIONER JACK KITTS: Okay. Thank
20 you.

21 ALISON BLAIR: If I could turn back
22 time and change the word "command," I would in the
23 title. It's been quite a source of confusion for
24 people.

25 Okay. And I know you want to get to

1 that good stuff, so why don't I try and get through
2 the timeline slides just because I think they do
3 provide some context that might be helpful.

4 What you'll see over the next four
5 slides, as we go through them, is a great deal of
6 activity that happened in a very short period of
7 time. I wanted to make sure that everybody here
8 was aware that throughout this process, Cabinet
9 time, availability of ministers, and other
10 decision-makers to deliberate or to hear our advice
11 was always available to us.

12 And Angela, I know you've spent a fair
13 bit of time in government, and you know that that
14 is not always the case, but we were privileged to
15 have people either being open to that or even
16 pulling our advice towards them, which was very
17 helpful in making sure that we had the kind of
18 deliberations that could result in decisions
19 quickly and in an informed way.

20 We know we gave you a chronology
21 document that has more detail than this. So we've
22 got some highlights here that I'll point out, but I
23 think you'll find that the chronology has a lot of
24 detail. And then it also has a bit about what was
25 going on with regards to COVID and the disease in

1 terms of statistics as well.

2 And a thought that I only had this
3 morning was, oh, I wonder if we could draw in where
4 the peak was. There's got to be a way to visually
5 show when the peak was, but as context, the peak --
6 really, the cases began, you can see on the first
7 slide here, January 25th, as when our first case
8 was and that the peak was mid-April.

9 Now, obviously, we didn't know that's
10 what we were working towards at the time. We were
11 working to contain and avoid spread.

12 So that's something that maybe we'll
13 take away and we can show as a visual to see where
14 cases were building and where they were starting to
15 decline and, as we look to the fall, where we're
16 starting to see some re-emergence of cases.

17 So Slide No. 5 here shows from the
18 left-hand side on January 2nd, the World Health
19 Organization was notified about the novel
20 coronavirus, and on the very next day, the Chief
21 Medical Officer of Health e-mailed his local MOHs.
22 As you might have been aware at the time, there was
23 certainly discussion about a strange pneumonia, and
24 we've got a bit more detail about that in the
25 chronology document, but certainly Dr. Williams

1 acted quickly to let the local medical officers of
2 health around the province know about this.

3 Then, you'll see that there was some
4 early communication in early January, but notably
5 on January 22nd when the Minister made her order to
6 make the novel coronavirus a reportable disease to
7 make sure that we were not missing cases because
8 local public health units may or may not have
9 thought it was worthy of reporting. So we made
10 that requirement.

11 And we began with some of the
12 stockholder teleconferences early on -- or in late
13 January. That's also when we had the first
14 confirmed case of COVID-19, which wasn't even
15 called COVID-19 on January 25th, and our first
16 situation report that was released.

17 And Justine can correct me if I'm
18 wrong, but we're now at -- I think it's 221 or
19 something like that in terms of the daily situation
20 reports that have been released to the field, with
21 the latest numbers and guidance documents.

22 On January 27th, we instigated the
23 Emergency Operations Centre, and that has been
24 activated since. That centre is operated out of
25 Justine's branch. And the February 7th and

1 February 18th show what a fair bit of focus for the
2 Ontario Health System was in early days, which was
3 supporting the repatriation of people who were
4 outside of Canada who were coming back and who were
5 being quarantined at CFB Trenton. So that involved
6 the Emergency Medical Assistance Team and other
7 resources, local paramedics and that kind of thing
8 from Ontario.

9 We then did our first test in a
10 licensed way on February 24th rather than having
11 the National Medical Laboratory do all the tests.
12 We did that through Public Health Ontario. And
13 then by the end of February, the first meeting at
14 the Health Command Table was established.

15 Those are the highlights from that
16 slide.

17 COMMISSIONER ANGELA COKE: Can I just
18 ask a question?

19 ALISON BLAIR: Certainly.

20 Do I call you "Commissioner Coke"?

21 COMMISSIONER ANGELA COKE: Sure.

22 ALISON BLAIR: Okay, great. Thank you,
23 Commissioner Coke.

24 COMMISSIONER ANGELA COKE: At the end
25 of January, you mentioned that you had your first

1 stakeholder teleconference.

2 I'm just wondering, did that include
3 the long-term care folks at that point?

4 ALISON BLAIR: I will have to get back
5 to you on that, unless, Justine, do you know
6 exactly who was invited to those?

7 JUSTINE HARTLEY: I would have. It
8 would have included the associations for sure of
9 the long-term care and the retirement homes, and I
10 would have to confirm if it included the Ministry
11 of Long-term Care themselves.

12 COMMISSIONER ANGELA COKE: Okay.
13 Thanks.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 If I can -- oh, sorry.

16 Go Ahead, Commissioner Kitts. You're
17 on mute.

18 COMMISSIONER JACK KITTS: Okay. Just a
19 couple of questions: So I think you answered the
20 first one. So we confirmed the first case in
21 Ontario on January 25th and the first laboratory in
22 Ontario to be licensed was virtually a month later,
23 February 24th.

24 ALISON BLAIR: Yeah.

25 COMMISSIONER JACK KITTS: In between, I

1 think you said the national lab was doing the
2 testing; is that true?

3 ALISON BLAIR: Yeah, the one in
4 Winnipeg.

5 Justine, can you nod to make sure I'm
6 right on that? Yeah. Great.

7 And I think throughout that time, I
8 think, is when we realized that provincial capacity
9 was required, and as we've seen this roll out,
10 obviously a lot of provincial capacity was required
11 for this.

12 COMMISSIONER JACK KITTS: Okay. The
13 other is on January 27th, the Emergency Operations
14 Centre was activated, and on February 28th, a month
15 later, the Health Command Table was established.

16 What are the differences between those?

17 And did EOC shut down when health
18 command started, or are they mutually exclusive or
19 parallel?

20 ALISON BLAIR: They are parallel, and
21 I'll get Justine to jump in in a second, but the
22 Emergency Operations Centre is really the nerve
23 centre of the response from an operational
24 perspective. The Emergency Operations Centre is
25 the area that first found out about the virus, that

1 had been following the media and had been following
2 case trends and are always on the lookout for what
3 new emergency is coming along, and that the
4 Emergency Operations Centre, in fact, is always
5 activated because we have other emergencies like
6 forest fires or that kind of thing.

7 The Health Command Table was
8 established when we felt that coordination across
9 the health sector was going to be required that was
10 in a bigger size than some of the emergencies that
11 the Emergency Operations Centre has to handle.

12 Justine, please feel free to --

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 Just while -- well, Justine, if you wanted to add
15 something, go ahead, then I'll ask my question.

16 JUSTINE HARTLEY: Great, thank you.

17 No, Alison did a wonderful summary
18 there, but yes, we were activated on January 27th,
19 and we remain activated. And as Alison mentioned,
20 we're really the operational arm to the response,
21 and we are also sort of front-facing in terms of
22 our healthcare providers.

23 So the operations centre does receive
24 phone calls and e-mails from our health system
25 partners, and we're often the first entity within

1 the Ministry to receive that.

2 COMMISSIONER FRANK MARROCCO (CHAIR): I
3 just wanted to pick up on something that was said,
4 that the Health Command Table was established
5 because it was perceived that greater coordination
6 was required.

7 How did the Health Command Table
8 communicate with the people it was trying to
9 coordinate?

10 ALISON BLAIR: Great. That's a really
11 good question, and we have a slide where we can
12 talk about the stakeholders coordination.

13 There were a number of ways that the
14 Health Command Table -- well, let's see. There
15 were a few ways that Health Command Table itself
16 communicated and a few ways that, for example, the
17 Emergency Operations Centre had ongoing meetings.

18 But there were summary memos of the
19 Health Command Table proceedings. So they weren't
20 minutes, but they were reports out to health
21 systems stakeholders that were distributed through
22 the daily situation reports that went out through
23 the Emergency Operations Centres.

24 So that's a direct Health Command
25 Table, and it was a memo from the co-chairs, from

1 Deputy Helen Angus, from Mr. Matthew Anderson, and
2 from Dr. David Williams, and then there were also
3 other ways that we communicated with stakeholders,
4 and we will get to that slide in a second. But off
5 the top, they are daily communication calls with
6 stakeholders that the Ministry Emergency Operations
7 Centre had, including weekends for a while and then
8 we managed to give people some weekends back, and
9 now they are once a week; is that right, Justine?

10 JUSTINE HARTLEY: It is, yes.

11 ALISON BLAIR: There was just one this
12 morning.

13 JUSTINE HARTLEY: Yes.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 And then I had a similar question about the
16 Emergency Operations Centre.

17 It says on the slide:

18 "Regular stakeholder
19 communication cycle established."

20 What was the nature of the -- how did
21 you communicate during the communication cycle?

22 ALISON BLAIR: Very good. How about
23 we -- I'm just going to see what slide to flip to,
24 Kristin. We're going to preview ourselves and not
25 go in order, showing our agility.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 I'm quite happy to wait. If it facilitates what
3 you're doing, you just answer it when you get
4 there. That's fine with me.

5 ALISON BLAIR: You know what, if you
6 can flip to Slide 18, Kristin, and then we can
7 revisit it just in case there's something else that
8 comes up.

9 So the MEOC, as we lovingly call it,
10 issues a daily situation report, and those have
11 been provided daily since January 25th. It didn't
12 start off at 1,543 subscribers, but it started off
13 pretty high and then built to that over time.

14 The MEOC also has daily weekday
15 teleconferences where they began on a weekly
16 basis -- or a daily, weekday basis, and those are
17 now weekly as of the end of July.

18 We also had a sub-table of the Health
19 Command Table, which is called the Collaboration
20 Table, which has 31 health systems stakeholder
21 organizations. Many of them are associations,
22 member organizations where we provide an update on
23 command table progress and actions and also
24 government decisions and actions as well, as well
25 as Ontario Health actions.

1 And then the last that we talk about is
2 really -- was a focus, reflection, and
3 planning-ahead focus group that we had after Wave 1
4 and planning for the fall.

5 So we didn't actually include the fact
6 that there were memos diligently written by our
7 team that came out after each of the command
8 tables, and those are available on the website, but
9 we can certainly provide those to you as well.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Thank you.

12 ALISON BLAIR: You're very welcome.

13 Okay. If we go to -- so this slide.
14 So here we are into March, and as you'll recall,
15 the peak was mid-April. So this was climbing the
16 peak where we were trying to flatten the curve.

17 And early in March, we had Ontario's
18 first COVID-19 death; that's on March the 11th.
19 The WHO declared this a pandemic, but if you'll
20 recall, at the time, the labelling of it as a
21 pandemic didn't trigger any particular new actions
22 from our perspective or from the global
23 perspective; this was simply acknowledging that
24 this was broad. It wasn't just happening in one
25 place in the globe.

1 Just before March Break for Ontario
2 schools was the announcement that we will be
3 closing public schools upon return, initially for a
4 two-week period, and the prohibition of gatherings
5 over 250 people was one of the early actions in
6 March.

7 I don't think we necessarily need to go
8 through all of these, but on March 16th, the memo
9 from the Chief Medical Officer of Health to direct
10 long-term care homes to allow essential visitors
11 only was posted, and so that was an early
12 intervention as well.

13 If we go to March 17th, that is when
14 the emergency was declared in Ontario and also the
15 closure of public gathering places and
16 establishments. So this was in advance of -- that
17 was St. Patrick's Day, and we expected that a
18 number of groups of people would be getting
19 together and there was a big potential to spread
20 the virus, and so that's when the closure of public
21 gathering places and establishments happened.

22 Over the course of the remainder of
23 March, the work deployment for health service
24 providers and for long-term care homes, so that was
25 the ability to -- in anticipation of potential

1 staff illness and attendance problems because we
2 expected that people would be sick, we permitted
3 deployment of workers who were not part of
4 collective agreements. So this was an order that
5 happened that Cabinet approved.

6 And then on March the 24th, you can see
7 that those are when the first two deaths were
8 reported in long-term care homes.

9 Shortly after that, the limitation of
10 the public gathering limits went down even farther
11 to five, so this is where we were really shutting
12 down and asking people to stay at home.

13 There was a press conference on April
14 the 3rd on modelling projections, looking at what
15 the potential impact was there, and this was based
16 on the earliest intelligence that we could find and
17 looking at what potentially was in store. We
18 looked at what a South Korea-type model -- or South
19 Korea-type scenario would be versus an Italy-type
20 scenario, and then we were very busy planning and
21 trying to benchmark against how many critical care
22 beds, ventilators would be needed in those
23 scenarios.

24 You can see further closures that
25 happened in late March and early April.

1 And then April the 16th was the --
2 let's see. I think we've got April -- we've got
3 two April 16ths here, and the second one actually
4 happened before the first one, which was the
5 release of the COVID Action Plan for Long-Term Care
6 Homes, and then subsequently, the creation of the
7 Long-Term Care Action Plan/Implementation
8 Intervention Committee as well.

9 On April the 22nd, the Long-Term Care
10 Incident Management System was established, and
11 Ontario requested military support for long-term
12 care homes. So you can see there was a lot of
13 action taken in that time period.

14 And I'm sure that there will be a lot
15 of questions on what was established when and how.
16 I can provide the command table view of that, but
17 that's something that I think Deputy Richard
18 Steele -- I think they're meeting with you
19 tomorrow -- can provide a lot more detail on the
20 development of the IMS structure and how it was
21 formed and what action it took.

22 If we look toward the end of April, the
23 COVID action plan for vulnerable populations was
24 released, and this was outside of long-term care
25 homes. We wanted to make sure that those in group

1 homes or in shelters were also addressed, and that
2 was something that there's a cross-functional team
3 that we'll be able to show you where that fits in
4 the whole government response, but they were the
5 ones who created that action plan and released it,
6 led by the Ministry of Community -- MCCSS. That
7 was Children, Community and Social Services.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Can I just ask, before you go on, I see the action
10 plan there on the 23rd, and you explained before
11 how the command table communicated downward.

12 Was there a way for the stakeholder
13 groups and the people you were communicating with
14 to communicate up?

15 ALISON BLAIR: Yes. There were, off
16 the top, two ways for sure, and then we'll be able
17 to show you in the number of sub-tables that
18 happened, under the command table, there were
19 opportunities there. But two that were on a
20 regular basis was -- one was in the daily
21 stakeholder calls, and the gentleman who was the
22 director of the area -- in Justine's area before,
23 Clint Shingler, on a daily basis stood up and took
24 questions, many of which were comments, from
25 stakeholders on a daily basis.

1 So there was an opportunity for
2 feedback through that venue, through the
3 Collaboration Table meetings where Health meets
4 with health service stakeholders -- and we can tell
5 you a bit more about that table as well -- but also
6 through the sub-tables of the Health Command Table,
7 that was an opportunity for organizations in the
8 health sector to be able to provide their feedback
9 and input.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Thanks. Thank you.

12 ALISON BLAIR: You're welcome.

13 So the pandemic pay is something that
14 was announced also towards the end of April, and if
15 you can believe it, on April 27th, a release for
16 the reopening. I remember thinking, we're just
17 getting through it and being asked to review the
18 reopening. This was obviously -- that's a
19 government, it was a Ministry of Finance lead, but
20 they worked very closely with the Chief Medical
21 Officer of Health and with the Ministry of Health
22 to make sure that we were comfortable with the
23 framework for reopening, and how we might go about
24 reopening the economy.

25 Obviously, economic impact was

1 important as well, although the Ministry of Health
2 in general had our eyes on the public health
3 impact.

4 Next slide. Thank you, Kristin.

5 In May, we also looked at -- with the
6 economy reopening, we also wanted to make sure that
7 scheduled surgeries and procedures could resume.
8 One of the impacts of having stopped emergency
9 surgeries is that we now have a backlog of upwards
10 of 90,000 procedures that need to be done so that
11 people are waiting longer for those.

12 And while they are scheduled surgeries,
13 some people call them elective surgeries, but they
14 still need doing and often have impact on quality
15 of life while they aren't being done. I don't need
16 to explain that to Commissioner Kitts that that's
17 going to be something that's going to be very
18 important to hospitals as they look to ramp up
19 these surgeries.

20 You'll also see on May 8th letters from
21 the Ministry of Long-Term Care requesting recovery
22 plans and a return-to-work plan for a number of
23 site operators on specific homes. So that action
24 was taken.

25 On May 14th -- we'll just talk here. I

1 know that Fredrika Scarth and others are going to
2 be talking to you about testing a little bit later,
3 but looking at testing guidance for Ontarians, at
4 this point, we're understanding that the testing
5 guidelines which were informed by a testing expert
6 panel that made recommendations to the Chief
7 Medical Officer of Health, there was a need to
8 expand the testing guidance to make sure it wasn't
9 as constrained, and so anyone in Ontario with
10 symptoms could have a test.

11 Since then, you've probably seen
12 promotions promoting that if you feel like you may
13 have been exposed but not have symptoms, nobody is
14 being turned away from assessment centres, and so
15 tests are available for anyone who wants one.

16 On May 17th, we began the process of
17 reopening and Stage 1 of the reopening. The
18 recommendation on May 20th about public -- about
19 face coverings where physical distancing is not
20 possible, that certainly remains, the face covering
21 recommendations, and it has been made mandatory in
22 some local [indecipherable] and some public health
23 unit areas.

24 The May 26th, I'll just highlight, the
25 directive No. 2 was amended to gradually reopen

1 health services, and this is permitted where
2 occupancy in the hospital is not so high that it
3 couldn't withstand a surge in cases. We want to
4 make sure that there is capacity to be able to
5 address any surge of COVID cases as well as the
6 availability of personal protective equipment and a
7 number of other criteria that were set out in a
8 document that Ontario Health released.

9 Let's see: Recognizing where we are in
10 time, I'll just highlight that some -- the
11 beginning of entering Stage 2 was on June the 12th
12 with several public health units that entered, and
13 then Toronto and Peel entered on June the 24th.

14 We look at the next slide, please?

15 Thank you.

16 You can see that the continued
17 reopenings, Stage 3, and then everyone except
18 Toronto, Peel, and Windsor, and then eventually on
19 August 12th, all regions had entered Stage 3
20 because there was comfort with the cases and the
21 case rate within all areas of Ontario.

22 You'll see where your Commission is
23 announced on July the 29th, and also in July was
24 the COVID Alert app, which I hope everybody has
25 here, that was available for download.

1 The observations letter from the
2 Canadian Armed Forces came in on August the 4th,
3 and I think that those are the main highlights that
4 we wanted to make sure were covered off in this
5 meeting, but the detailed chronology has much more
6 detail. Okay.

7 So this portion, I wanted to give some
8 context for this structure that existed because
9 we've talked a little bit about Health Command
10 Table, but I wanted to orient you to a number of
11 command tables that existed.

12 Something that I think is important to
13 know is that this structure, as laid out on this
14 slide, not all of it existed before about April.
15 So when the Health Command Table was initiated, it
16 was the only command table that was part of this
17 structure, and as a consequence, I think had --
18 there was a lot of interest in Health Command Table
19 that just didn't go away even though there were
20 other tables to participate at, so we continue to
21 have participation from a number of ministries
22 outside of Health so that they can understand
23 what's going on with the pandemic.

24 On the left-hand side in the purple
25 box, you'll see that Dr. Dirk Huyer, he is

1 recently -- it was a recent government announcement
2 that he is the coordinator for the Provincial
3 Outbreak Response. And so Dirk's role is to work
4 across government and to play a coordination role
5 to make sure that all of the sectors -- certainly
6 where there are vulnerable people but really all
7 sectors -- are ready with a preparedness and an
8 outbreak plan should there be outbreaks in those
9 sectors.

10 You can see where Health fits in under
11 Deputy Health Helen Angus [sic] and the work
12 streams that we have within Health, and you can see
13 that we have everything from testing and
14 surveillance to the science to maintaining a health
15 dashboard scorecard, as we call it, which we'll
16 talk about a little bit later, and the work streams
17 that happened here. You'll also see that long-term
18 care capacity is part of that.

19 But the other command tables that
20 exist, one is about supply chain and domestic
21 production strategy. This, I think, had had
22 several names, but it's basically where we look at
23 clinical supplies and equipment. That was
24 something that initially had been spearheaded
25 through Health and something that Justine and her

1 team have been very much involved in and continue
2 to be involved in on the distribution side from the
3 pandemic stockpile but recognizing that meeting
4 domestic production for some of this clinical
5 supplies and equipment was a priority as something
6 that the government did and has been done through
7 this command table.

8 There's also a critical care or a
9 critical personnel table that looks at workforce
10 and what challenges were there including mental
11 health and vulnerable -- and volunteerisms, rather.
12 The development of these command tables certainly
13 took some of the pressure off the health table to
14 solve problems that were, in fact, solvable by
15 other areas of the Ministry.

16 So we were very appreciative, for
17 example, on the volunteerism cross-functional team
18 that Denise Cole and others could -- could make
19 sure that we were utilizing volunteers as much as
20 we could without Health having to organize them.
21 So this was something that we were very
22 appreciative of.

23 And then finally, under public safety,
24 you can see that that command table looked at
25 vulnerable populations. So Janet Menard and

1 Shawn Batise were co-chairs of a Vulnerable
2 Population Table, which ultimately released the
3 Action Plan for Vulnerable Populations.

4 There's also, under that one, emergency
5 planning and the role of the Ministry of the
6 Solicitor General in doing that work through the
7 Provincial Emergency Operations Centre I think
8 features largely and is making sure that the entire
9 Ontario Public Service and the sectors that we
10 represent have readiness for emergency and also
11 facilities and food security.

12 You can see on the right-hand side of
13 the purple box the Central Command Table
14 Secretariat, which reports up to the pink box of
15 the Central Command Table. That is another table
16 where the mandate, which if we go to the next
17 slide, we can just flip to, and this plays a
18 coordination role across government; whereas the
19 Health Command Table plays a coordination role
20 across the health sector, this is looking across
21 government to make sure that the mandates for
22 command tables are clear and defined to be able to
23 support policy decisions made by Cabinet.

24 So you'll see again that this is -- the
25 decision-making is with Cabinet, and I've heard the

1 Secretary of Cabinet talk about Central
2 Coordination Table is about problem solving and
3 avoiding log-jams when it comes to approval
4 processes. So they have been able to make sure
5 that if it's unclear what kind of approval process
6 or who the ultimate deciders are that this table
7 can provide advice on how to do that, and removing
8 barriers, which is a big section of that.

9 And tracking progress, not just from
10 the Health Command Table but from others to make
11 sure there's accountability is also another part of
12 the mandate.

13 COMMISSIONER JACK KITTS: Sorry. So,
14 Alison, I have a question. Can we go back to the
15 previous slide?

16 ALISON BLAIR: Sure.

17 COMMISSIONER JACK KITTS: I'm just
18 wondering. So I see "Health." And I see, I think
19 it's Deputy Helen Angus, right? Is that the --

20 ALISON BLAIR: Yeah.

21 COMMISSIONER JACK KITTS: So where is
22 the Deputy Minister of Long-Term Care, the CO of
23 Ontario Health, and the public health officer?
24 Where are they on that?

25 ALISON BLAIR: They, on that chart, I

1 think the COVID response structure from a
2 government-wide perspective, they would think of
3 Deputy Angus as the lead, but the CO of Ontario
4 Health is one of the three co-chairs for the Health
5 Command Table, and then Deputy Steele is a member
6 of the command.

7 COMMISSIONER JACK KITTS: Okay. And
8 the public health officer, [indecipherable]?

9 ALISON BLAIR: The Chief Medical
10 Officer of Health is a co-chair of the command
11 table as well.

12 COMMISSIONER JACK KITTS: Okay. So
13 they're all co-chairs?

14 ALISON BLAIR: Yeah. Three-way
15 co-chair.

16 COMMISSIONER JACK KITTS: Okay.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 If I can just: How did the various tables -- for
19 example, Health -- how did it communicate with a
20 Central Coordination Table?

21 ALISON BLAIR: So the Central
22 Coordination Table has meetings -- this week, it's
23 only three times. They are not daily. They were
24 daily for a while, and what they would do is
25 through their look at what needed to be happening

1 or at the request of command table, they would have
2 agenda items that they thought were important.

3 So there was reporting up on the work
4 streams through the Central Coordination Table.
5 The Central Coordination Table has a dashboard
6 where it has not just quantitative information but
7 also reporting on key activities of each of the
8 work streams that you can see under the various
9 command tables.

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 And was that [indecipherable] communication, or
12 would it be oral?

13 ALISON BLAIR: There's both.

14 THE REPORTER: Sorry, sir, can you
15 repeat your question?

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Oh. My question was, was it a written
18 communication or oral, and the answer was "both."

19 ALISON BLAIR: Yes, enthusiastically.
20 And so the Central Coordination Table has both
21 updates and communications that would be through
22 presentations but also through regular reporting
23 that we do.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 And when the Central Coordination Table

1 communicated down, was that advice like the other
2 command tables, or was it different?

3 ALISON BLAIR: So I'm going to
4 distinguish between the Central Coordination Table.
5 One of the ways that they communicate down is they
6 say, hey, Health, I'd like an update on -- I'll
7 give a recent example -- what your testing strategy
8 will be going into the fall.

9 So that kind of request, I think, is
10 something that they request, and we do. But in
11 terms of when Central Coordination Table has a
12 discussion, there are recommendations for the
13 decision-makers to take away, and sometimes it's,
14 could you please report back on the progress of
15 implementation, and sometimes it's, we would
16 recommend that go to Cabinet for a decision.

17 And I think it's those kinds of --
18 those kinds of advice and recommendations, but they
19 are not decisions. You are correct.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Okay.

22 ALISON BLAIR: In a very small box, I'm
23 trying to read your facial expression, Commissioner
24 Marrocco.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Well, that may not be terribly productive because
2 I'm sort of used to not giving away what I'm
3 thinking, but you did answer my question, thank
4 you.

5 ALISON BLAIR: There you go. I'll just
6 directly ask next time.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Go right ahead. I may not answer, but you can
9 certainly ask.

10 ALISON BLAIR: Thank you.

11 Okay. So I think hopefully we can go
12 to Slide 11, which is about the Health Command
13 Table.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Ms. Blair, while you're waiting for that slide, I
16 have to attend a meeting, a statutory meeting of
17 the regional senior judges, so I will ring off very
18 shortly. I'll get briefed after about the balance,
19 but please don't take it as a reflection of the
20 presentation because it's not.

21 ALISON BLAIR: Now I will know it
22 wasn't that I personally offended you.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 No, it's nothing like that at all. It's something
25 I have to do with my other tasks.

1 ALISON BLAIR: Great.

2 So Slide 11 looks at the Health Command
3 Table, and I think some of this is review. So it
4 does report to the Minister of Health, and that's
5 where the advice generally goes.

6 It's led by Dr. Williams, Deputy Helen
7 Angus, and Mr. Matthew Anderson. It includes
8 representation from across ministries. I think the
9 most significant participation is from Long-Term
10 Care and from the Ministry of Seniors and
11 Accessibility as well and includes external experts
12 and advisors and stakeholders. There's no
13 remuneration for participating.

14 The discussions at the Health Command
15 Table are informed by the response structure and
16 sub-tables, and we'll get to those, the long list
17 of sub-tables that was providing advice, generally
18 technical advice or other recommendations that may
19 come to command table. And one of those, for
20 example, is the incident management structure for
21 long-term care, and they would do work across many
22 streams and focus on key priorities.

23 So the Health Command Table, when there
24 were recommendations from a table, it would come to
25 the Health Command Table for consideration, and

1 then the Health Command Table would make
2 recommendations or provide advice on that.

3 The work streams, as you can imagine --
4 and Justine gave a great presentation -- or a great
5 description of how some of the foundational work of
6 the pandemic plan from 2013, the influenza pandemic
7 plan informed what work streams were established,
8 certainly in the beginning. They have now evolved,
9 and we'll show you the latest iteration in our fall
10 preparedness plan.

11 That slide is still confidential. We
12 are planning to be releasing the fall preparedness
13 plan in September but wanted to make sure that you
14 knew what kinds of work streams we had, we were
15 working on, and reporting on in the Health Command
16 Table at this time.

17 And the final point --

18 COMMISSIONER JACK KITTS: Alison?

19 ALISON BLAIR: Yeah, go ahead.

20 COMMISSIONER JACK KITTS: Can I just
21 ask a question? So the Health Command Table is
22 established in February. The sub-command or the
23 tables that were created under them, were they
24 created as needed beyond February? Like, they
25 weren't all created at the same time; is that

1 correct?

2 ALISON BLAIR: They weren't. Some of
3 them were in -- the technical word would be
4 "clumps" where we thought, these are the kinds of
5 advice we need, and some where it was identified
6 that, you know, we need an implementation committee
7 for the Long-Term Care Action Plan, for example,
8 and that was established.

9 So you'll see the dates that they were
10 established in the next couple of slides.

11 COMMISSIONER JACK KITTS: Okay.

12 ALISON BLAIR: It's a bit of an eye
13 test in this version, but you'll be able to zoom in
14 on it.

15 COMMISSIONER JACK KITTS: Okay. Thank
16 you.

17 ALISON BLAIR: So if we go to the next
18 slide, it's a fairly very clean version of how
19 things fit. At the top, we have the Central
20 Coordination Table, but I think the important part
21 really above that all is Cabinet in terms of the
22 overall structure, but to understand where the
23 Health Command Table fit in terms of the COVID
24 response structure, it provides reports up to
25 Central Coordination Table.

1 We also wanted to make sure it was
2 clear that ministers and ministers' office, that's
3 where the report from the Health Command Table, the
4 reporting structure goes to the Minister, but
5 there's also reporting up through the Emergency
6 Operations Centre to the Provincial Emergency
7 Operations Centre that has a reporting relationship
8 with a Cabinet Committee on Emergency Management
9 and Cabinet.

10 But if we look at under the Health
11 Command Table, we have a number of tables, and then
12 the next few slides go into more detail on this.
13 But the tables that provided advice in to Health
14 Command Table, which generally had stakeholders and
15 health system providers participating on it, one --
16 and the ones that are circled in red are the most
17 germane to the long-term care area.

18 But maybe I'll quickly cover off the
19 ones that aren't. And you can see Mental Health
20 and Addictions there. Also, the Public Health
21 Measures Table, that was a group that was
22 established to provide advice to Dr. Williams on
23 what kinds of public health measures would need to
24 be tightened or loosened throughout the pandemic.
25 It was helpful to get their advice and their

1 participants on that table who are medical officers
2 of health who are providing advice to Dr. Williams
3 on that.

4 The control table is actually about
5 clinical supplies and equipment and determines
6 the -- recommends the allocations of -- or through
7 the Ministry, I think it provides recommendations
8 to the Minister on what allocations of clinical
9 supplies and equipment should go to which
10 organizations.

11 They obviously have a framework that
12 they've been following on that. It's not a one-off
13 basis. They have a framework that's been informed
14 by one of the technical advice tables in the bottom
15 right corner of the Bioethics Table.

16 There's also Provincial Primary Care
17 Advisory Table and Home Care Table, you can see at
18 the bottom, and then the Rapid Response Table was
19 established -- I think it was in May, but we'll be
20 able to correct me on one of the next slides -- to
21 pull together medical officers of health and others
22 who could help to identify what rapid responses
23 were required if we saw certain cases in
24 higher-population areas.

25 So the medical officers of health for

1 Toronto, Peel, York, Ottawa all participate on that
2 committee because we thought that is where the
3 cases are more likely to be, that's where outbreaks
4 are more likely to be, and we'll be able to work
5 with them to provide the support that could be
6 provided through Ontario Health or through the
7 Ministry of Health to be able to resolve those
8 quickly.

9 You'll also see other tables on -- the
10 Collaboration Table I think we've already talked
11 about with over 30 stakeholder organizations that
12 meet with us regularly where we provide updates on
13 a number of the actions of the Health Command Table
14 and the work streams that we're on, and they're
15 able to ask questions and provide comment on that.

16 The health system response is --
17 oversight is actually an Ontario Health committee
18 where they're looking operationally at who is
19 providing what responses; so that's within Ontario
20 Health and working with their regional tables.

21 And you can see other communication
22 tables. I don't want to spend too much time on
23 this because we can certainly spend hours on it.

24 But the next slide gives you a list and
25 some detail about the mandate of each of those

1 sub-tables.

2 And if we could just flip back? Sorry,
3 Kristin. I didn't cover the red-circled ones. Why
4 don't I do that since that's probably of most
5 interest.

6 These are all the committees that are
7 related to long-term care. So there's a Long-Term
8 Care Sector Table, the Retirement Homes and
9 Long-Term Care Operations Action Table at the
10 bottom, and then there are three committees that I
11 don't think happened -- or, I don't think they
12 happened concurrently.

13 The Long-Term Care Action Plan
14 Implementation and Intervention Committee
15 eventually morphed into an Incident Management
16 System. It supported Incident Management System
17 Committee, and then the Long-Term Care Incident
18 Management System Committee eventually, through a
19 different phase in the pandemic, became the
20 Recovery and Planning Table.

21 And that's something that I think
22 detailed questions on the establishments of those
23 committees and the transition from one to the
24 other, Deputy Steele can certainly provide a lot
25 more detail than I can, but I can provide whatever

1 information I can.

2 So the next slide, why don't we --
3 Kristin, if you just pause on Slide 13 for a few
4 seconds, you can see that we have the dates that
5 they were established and where they were replaced.
6 We've also noted that, so hopefully that's helpful
7 information to you.

8 The next slide has where our Technical
9 Advisory Tables are. We've distinguished -- and I
10 think the line between Strategic Implementation
11 Tables and Technical Advisory Tables, it was just a
12 convenient category to be able to identify those
13 where we were really getting down to the
14 deliberations and nitty-gritty; for example, I
15 believe the testing expert panel is there, or at
16 least the testing strategy panel that reports in to
17 the Lab Testing Table. Sometimes these are quite
18 technical, but we wanted just to make sure that we
19 were being transparent on which ones existed.

20 The most recent additions are the
21 Science Advisory Table, second from the
22 bottom-left, that works with leading researchers
23 and scientists, and they come with a science brief
24 every week, usually on Fridays, and to provide a
25 science brief based on the latest evidence. This

1 has been very useful in understanding promising
2 either surveillance or testing. We've had, for
3 example, presentations on waste water and how
4 testing waste water could be helpful in identifying
5 outbreaks, even in advance of when we're starting
6 to be able to clinically test people for that.

7 And the surveillance strategy working
8 group is looking at enhancing the data and pulling
9 together data so that we can be more aware of where
10 around the province outbreaks are happening based
11 on things like, for example, attendance rates at
12 schools or that kind of thing.

13 If we go to the next slide, another
14 output of the Health Command Table and other
15 structures, so here, if we think about the Chief
16 Medical Officer of Health, Dr. Williams has issued
17 guidance documents, directives, and memos; so has
18 the Health Command Table. And so that's been part
19 of our COVID response. And a full list of those,
20 you can follow that website to see just how many
21 there have been to make sure that -- and it
22 includes the summaries of each of the Health
23 Command Tables -- ah, command table meetings.

24 So that has been one of the key areas.
25 Generally, these have been distributed, obviously

1 on the website, but the notification that there's
2 something new has happened through the situation
3 report that has been released, and often these
4 situation reports were very-much-waited-for e-mails
5 because they were looking for what has the Chief
6 Medical Officer of Health determined is the plan.
7 This was where, for example, visitor memos issued
8 by the Ministry of Long-Term Care or others would
9 have been released.

10 But the compilation of all of the
11 advice is at that link.

12 Next slide. Thank you, Kristin.

13 At each of the Health Command Tables,
14 we've tried to be very data-driven in what we are
15 assessing and recommending and providing advice on,
16 and the scorecard has had different metrics over
17 time. We have certainly tried to -- initially, in
18 the early days, it was about the case count, the
19 geographic dispersion of cases, and as everybody
20 has watched, sort of the epi-curve. That was
21 something that we watched very carefully.

22 And then we built upon it to include
23 not just outcome measures but also health system
24 capacity and response measures. And at this point,
25 we're also including, which wouldn't have been

1 measured at the start, was the percentage of
2 surgeries that are being ramped up, so the surgical
3 volumes in hospitals compared with the previous
4 year. So those are the kinds of indicators that we
5 measure over time.

6 You can see a screenshot of the first
7 slide of the scorecard right now, which is the
8 cumulative confirmed cases, the total deceased, and
9 the number of active cases. And we've also, of
10 course, been monitoring those that are in intensive
11 care unit, those who are vented, and that kind of
12 information that is monitored on a regular basis.

13 Also, outbreaks, that has been
14 something that we have been -- that we've monitored
15 on a very regular basis as well, and it is updated
16 for each Health Command Table meeting.

17 Any questions on that? Okay.

18 That's something where if you were
19 interested in samples of the scorecard or that kind
20 of thing, we could show you either some samples of
21 it, or you could see how it has evolved over time.

22 COMMISSIONER JACK KITTS: And just the
23 update of the scorecard would depend on how quickly
24 the data would be available?

25 ALISON BLAIR: Yes. Yeah. And over

1 time -- that's something I don't know if you have a
2 briefing already scheduled on data management and
3 availability, but that's something that has
4 certainly -- on our timeline, we had that Dr. Jane
5 Philpott was appointed to be a key advisor on data
6 and how it is used.

7 I think the availability of data, even
8 over the course of the pandemic, was greatly
9 increased, and sometimes that information was --
10 especially when we're asking public health units
11 and long-term care homes who were in the throes of
12 responding to the pandemic, asking them to then
13 collect the data initially was quite burdensome,
14 but I think they understood why we needed it and,
15 since then, has been integrated into regular
16 processes. So I think the timeliness of the data
17 has also improved over time.

18 COMMISSIONER JACK KITTS: Thank you.

19 ALISON BLAIR: Next slide I think is
20 one that you'll be interested in because I think
21 there's certainly -- and we're happy to answer
22 questions wherever we can on roles and
23 responsibilities.

24 So the Ministry of Health's
25 responsibility we've talked a little bit about and

1 the Ministry of Long-Term Care, but there are also
2 other partners at the command table, and, for
3 example, Ontario Health really looked at the
4 operational responsibilities.

5 The Ministry of Health -- so Ontario
6 Health is a transfer payment of -- organization of
7 the Ministry of Health, and then they, Ontario
8 Health, have relationships, have transfer payment
9 relationships with hospitals, with home care
10 through the LHINs, and with other organizations,
11 including long-term care homes.

12 And so Ontario Health was a way to
13 operationalize many of the directions from the
14 Chief Medical Officer of Health or ways to
15 implement strategies that were agreed by the
16 various -- by the various organizations.

17 If the Ministry of Health wanted -- or
18 had agreed to putting in place surge capacity, it
19 was done through Ontario Health with health system
20 partners. They played a very big role, Ontario
21 Health did, in distribution of supplies, clinical
22 supplies and equipment that had been allocated
23 provincially, but then the distribution happened
24 regionally.

25 The system capacity planning and the

1 establishment of the regional tables through
2 Ontario Health, I think, was very important in our
3 response, that we were looking regionally, not
4 individual organization at a time. And they did a
5 lot of work around health human resources planning
6 among organizations and worked on restarting
7 elective surgeries was well.

8 COMMISSIONER ANGELA COKE: Can I just
9 ask: In terms of these regional tables, who
10 exactly was represented on those?

11 ALISON BLAIR: And that is something
12 that we'll need to get back to you on the
13 specifics, but in general, it was Ontario Health
14 and the health service providers within those
15 regions. So that would include hospitals,
16 long-term care homes, and others, but I think where
17 there might be variability is some -- I would say
18 many of the regions had public health, like, little
19 local public health unit as part of their regional
20 table or the paramedic services, but they were not
21 funded through Ontario Health.

22 So it's not limited to those
23 organizations who had transfer payment
24 relationships with Ontario Health. And I think
25 it -- I think all the health service provider

1 organizations within a region had some kind of
2 representation but not every region had exactly the
3 same structure. So that's why I'm not saying it
4 was a fully consistent approach.

5 COMMISSIONER JACK KITTS: I think there
6 were five regions that each had a CEO of Ontario
7 Health who reported up through Matt Anderson.

8 ALISON BLAIR: That is definitely the
9 case. And the structures that they had underneath
10 each of them, I think, did vary.

11 COMMISSIONER JACK KITTS: Yes. Yeah.
12 I was just going to ask a question about, is it as
13 simple to say -- because I'm still trying to sort
14 out the command table with Ontario. I see Ontario
15 Health and Public Health Ontario's role is very
16 clear here.

17 Just looking at -- and Ministry of
18 Health and Ministry of Long-term Care -- I think
19 Ministry of Long-term Care is fairly specific, and
20 I think we can figure out their responsibility.

21 Would Ministry of Health be kind of
22 like the strategy and funder and Ontario Health the
23 operations arm of it? Is that too simple, or is
24 it --

25 ALISON BLAIR: I'll tell you what might

1 be missing from that. So yes, you're right.
2 Ontario Health was the operational arm for those
3 organizations for which it has funding
4 relationships.

5 So what's outside of that and what the
6 Ministry of Health deals with outside of those
7 relationships are things like physician payment,
8 like drug supply, and then those that are
9 involved with -- that are funded municipally, like
10 paramedic services for local public health.

11 So they couldn't be the operational arm
12 for those, although many of the organizations that
13 I just talked about, whether that's primary care
14 practices or that kind of thing, were involved in
15 the regional tables, but we couldn't say, oh, over
16 to you entirely for implementation, because they
17 didn't have responsibility for some parts of the
18 health system.

19 COMMISSIONER JACK KITTS: Okay. Thank
20 you. And one more question: You suggested that if
21 we don't have a session on data, data integrity,
22 data distribution, actions, we should.

23 Did you give us a name of who we should
24 contact for that type of session?

25 ALISON BLAIR: I didn't, but I will.

1 KRISTIN SMITH: If I can just jump in
2 there, Alison. It's Kristin here. I'm just having
3 some difficulty getting my camera back on;
4 apologies.

5 We do have some people we're setting up
6 a session with. So that is in the works right now,
7 and they are our data experts. So it's Michael
8 Hillmer is the ADM of -- I think it's called
9 Capital Planning and Analytics Division now, and so
10 he'll be able to come and give you a presentation.

11 COMMISSIONER JACK KITTS: Okay. Thank
12 you.

13 ALISON BLAIR: It's capacity planning,
14 and I think also it'd be -- it will be worthwhile.
15 I'm sure Michael will engage Anna Greenberg for
16 Ontario Health.

17 We've found between Public Health
18 Ontario, Ontario Health, and the Ministry of
19 Health's analytics area, there's been good sharing
20 of data, and, for example, Anna Greenberg produces
21 the command table scorecard, but it includes data
22 from both Public Health and Ontario Health, and --
23 sorry, and Ministry of Health, rather, so they're
24 working in collaboration there.

25 COMMISSIONER JACK KITTS: Great. Thank

1 you.

2 ALISON BLAIR: Thank you.

3 So if we just turn to Public Health
4 Ontario for a moment, and Public Health Ontario has
5 representation at the command table. Their acting
6 CEO is there, as well as a number of their vice
7 presidents because they're involved in informing
8 the response. They also sit at many of the --
9 especially the public health-related, the Public
10 Health Measures Table, the Rapid Response Table
11 where we rely on public health advice there.

12 And Public Health Ontario's role here,
13 we've outlined some areas where they are very much
14 involved. One is laboratory testing. Initially,
15 all of the lab tests for COVID went through the
16 Public Health Ontario labs before we connected in
17 the hospital labs and eventually community labs.

18 But certainly Public Health Ontario
19 retains sort of the gold standard of lab systems
20 when it comes to public health. They have been
21 involved through the -- they collect, on the
22 Ministry's behalf, all of the information in the
23 Integrated Public Health Information System, iPHIS.
24 And so they produce the epidemiological report that
25 is posted on a daily basis on the Ministry's

1 website.

2 And they've also been involved in case
3 and contact management. They've supported the
4 public health units by assembling a pool of people
5 who are able to do the kind of contact tracing and
6 case management if a public health unit should need
7 that supplementary help.

8 They've also, because of their
9 scientific arm, have been involved in developing
10 evidence briefs that have informed government
11 policies, especially if we think about the nature
12 of the virus and the protections required around
13 personal protective equipment -- they have been key
14 advisors on that -- as well as scientific and
15 technical advice and guidance to the public health
16 units. Public health units rely heavily on Public
17 Health Ontario when they don't -- outside of the
18 pandemic but also on the pandemic as well.

19 Next slide, please.

20 I think we've covered off most of the
21 stakeholder engagement, but I just wanted to draw
22 your attention to the last two bullets.

23 In July, we pulled together a number of
24 focus groups to have a think about Wave 1, about
25 what went well and what we could do better as we're

1 planning for the fall and had some great feedback
2 on that. It's reflected in the fall plan, which
3 we'll talk about next, but just briefly, some of
4 the most positive feedback that the Ministry or
5 that Ministry of Ontario Health received was that
6 the government was very present with their response
7 and that they felt like the Premier and
8 decision-makers were getting advice from the Health
9 Command Table, mostly because the decision-makers
10 often referred to the Health Command Table and the
11 advice of the Chief Medical Officer of Health as
12 they were announcing decisions. But they certainly
13 felt like the Ministry of Health was involved and
14 listening.

15 Some of the areas where they thought
16 were important for improvement and feedback were
17 the consistency of advice and information,
18 especially where there were different
19 organizations. I'll give an example of Ministry of
20 Health and Ontario Health and Public Health
21 Ontario: Sometimes we thought we were saying
22 exactly the same thing, but if we were using
23 different words, it wasn't clear whether we were
24 all on the same page. So that was going to be
25 really important in having a single source of truth

1 for data, for policy, and directives. They found
2 we had feedback on that. So those are the kinds of
3 things that we're looking to make sure we make
4 improvements as we plan for the fall.

5 If we look at the next and last
6 slide -- so I promise I'll stop talking, and we can
7 have more of a dialogue -- we are planning to
8 release a fall preparedness plan. We expect the
9 government will do that in the month of September,
10 and you can see the streams of work and the
11 readiness objectives that we have outlined here to
12 make sure that we're ready.

13 There are a few things that are
14 different about the fall than was the case in the
15 late winter and early spring, one of them being
16 that we were at the tail-end of flu season in the
17 winter and spring, and now we will be, potentially,
18 beginning in November or December another flu
19 season, so we need to make sure we're factoring in
20 that.

21 We have a surgical and a health service
22 backlog that we didn't have going into the first
23 wave of COVID that we need to make sure we're
24 considering. And we also have long-term care homes
25 with different capacity than they had before, that

1 in homes with rooms that are four-bed rooms, they
2 cannot fill all of those beds right now because of
3 the need to be able to isolate.

4 Similarly in hospitals, you can't have
5 hallway healthcare when you're dealing with a COVID
6 outbreak, and so the capacity within hospitals and
7 with the long-term care is very different this time
8 around. And so we need to make sure that we're
9 building support within community organizations and
10 surge capacity within hospitals to make sure that
11 we can withstand another surge in cases.

12 And the other thing that we're dealing
13 with is a healthcare system and health service
14 providers within that healthcare system who are
15 tired and who have been through a difficult time
16 with COVID. We know that one of the waves that
17 follows COVID is the mental health difficulties
18 that not just healthcare workers but the population
19 will be dealing with, so we want to make sure that
20 we're addressing that as well.

21 So those are the extra challenges on
22 top of dealing with COVID. Also, starting this
23 week and really last week, back-to-school has
24 begun, and you'll have seen some of the media on
25 cases in schools already. So that's the kind of

1 thing that we'll be looking to track.

2 It's also the uptick in cases that
3 we've seen which is largely due to reopenings and
4 people getting tired of dealing with COVID, so
5 whether there are group settings or others where
6 people are really letting down their guard, so this
7 is something that we want to make sure that we're
8 ready for in the fall.

9 And to be able to address those, we've
10 come up with these readiness objectives.

11 The No. 1 on the left is the easiest
12 one because it's just very repetitive from what we
13 did in Wave 1. We want to test, trace, and
14 isolate, and we want to make sure that people are
15 physically distancing, washing their hands, wearing
16 face coverings, and really reinforcing all of these
17 on a regular basis through public education.

18 The readiness objective No. 2 is to
19 make sure that we've got as many people with
20 influenza vaccines in their arms as we can to take
21 the flu out of the equation, and we're hopeful that
22 what we've seen in some other jurisdictions around
23 suppression of the flu will come true here. If
24 everybody is washing their hands and physically
25 distancing and wearing masks, then we're hoping

1 that flu transmission will also be reduced.

2 And No. 3 is really what we need to do
3 in the fall with COVID, is quickly -- to prevent
4 outbreaks wherever we can, but then when they do
5 arise, manage them quickly so that there isn't very
6 much spread within those outbreaks. And that's the
7 case for schools, which will have a lot of
8 headlines.

9 But we also are very much aware of this
10 for long-term care as well and are working in those
11 areas that seem to have higher rates in the local
12 area, in the public health unit, to be brushing up
13 on infection prevention and control within those
14 homes to make sure that those are all up to speed
15 so that they can deal with any cases that come in
16 from the community.

17 And then on the right-hand side of the
18 diagram, which is about health system capacity
19 planning, we want to make sure that we're using the
20 models we can to safely reduce health services
21 backlogs, and that can mean a number of things: It
22 can mean working longer hours within operating
23 rooms, within existing hospitals and facilities.
24 It can be looking at other places where we could be
25 performing basic surgeries and those kind of

1 strategies to make sure that we get those backlogs
2 down, and not just in hospitals for surgeries, but
3 also for immunizations, for screening, and other
4 things that have to happen in person within primary
5 care as well.

6 No. 5 is about making sure that we're
7 prepared for surges. And so as we were trying to
8 avoid being Italy, which we were successful in
9 doing, we built a certain amount of alternate
10 capacity, whether that be field hospitals or being
11 prepared to take over arenas in local areas if we
12 needed it.

13 What we're hoping to do is have more of
14 a focus on how do we make sure we keep people at
15 home as much as possible, so more of a focus on
16 care in the home and primary care support of
17 patients rather than relying on let's build more
18 beds; A, because it's better for patients; and B,
19 it also happens to be less expensive.

20 We also want to make sure that we avoid
21 at all costs the closing down of surgeries again
22 just because we know the impact on quality of life
23 that holding off on surgery can have for people.

24 And then finally, No. 6 is about the
25 people that we need to make sure that we're

1 supporting through this. I think patients are
2 assumed to be the people that we're supporting, but
3 we want to talk here about healthcare workers,
4 families, and caregivers, and making sure for
5 healthcare workers that we're recruiting and
6 retaining them, especially in areas where there
7 have been shortages or in planning for potential
8 attendance issues and supporting through -- whether
9 it's training on PPE, donning and doffing, or
10 whether it's on infection prevention and control
11 techniques. That's what we want to make sure that
12 we're training people on as well as supporting
13 their mental health.

14 And families and caregivers, we also
15 recognize the key role that they play in providing
16 support to patients, so how do we make sure that
17 they are appropriately trained so that we can keep
18 them involved in going forward in a way that we did
19 not in Wave 1.

20 And I think that's the last slide
21 because I think I'm out of saliva anyway. So
22 looking forward to [indecipherable] more time.

23 COMMISSIONER JACK KITTS: Angela, do
24 you have any questions?

25 COMMISSIONER ANGELA COKE: You know

1 what, I do have questions, but I'm thinking they're
2 probably more appropriate for Richard tomorrow
3 because they're digging down a bit more in some of
4 the long-term care areas.

5 COMMISSIONER JACK KITTS: Yeah.

6 COMMISSIONER ANGELA COKE: So I think
7 I'll probably hold off, but this is very helpful in
8 terms of setting a base understanding of what
9 structures and processes you have in place and how
10 they've evolved over time, so I appreciate that.

11 COMMISSIONER JACK KITTS: Yeah, I
12 concur. Alison, that was -- an hour and a half
13 passed quite quickly, actually, and it was very
14 clear and as concise as it could possibly be. I
15 thought it was excellent.

16 I learned a lot, and I appreciate you,
17 obviously, preparing for it because it's a large
18 presentation that you presented. So thank you very
19 much to you and your team for doing it so well.

20 Do you have any questions for us?

21 ALISON BLAIR: Hmm. No, I think what
22 you will -- what I hope we've done here is gave you
23 a tour of the buffet, and I imagine that whether
24 it's through some of the questions that you have
25 for Deputy Steele might lead you back to, oh, you

1 know who you need to talk to about that is, and I
2 know that you've got briefings set up over the
3 course of the next couple of weeks, and I expect it
4 will continue farther through.

5 But certainly in the background, I'm
6 happy to be, again, a tour guide or a point to the
7 right person who can give you answers and happy to
8 come back at any point if you need me.

9 COMMISSIONER JACK KITTS: Well, thank
10 you very much, and thank you to your team.

11 So, Angela, I'm not sure what the next
12 step is.

13 Alison, are you on?

14 ALISON BLAIR: The other Alison.

15 COMMISSIONER JACK KITTS: The other --
16 oh, sorry, yes.

17 ALISON BLAIR: The other Alison. So we
18 both spell our names the right way, as we like
19 to --

20 COMMISSIONER JACK KITTS: You do.
21 Saves confusion.

22 Well, I think that we're going to
23 reconvene at 4 o'clock. Is that your
24 understanding, Angela? Okay.

25 COMMISSIONER ANGELA COKE: Yes, yeah.

1 COMMISSIONER JACK KITTS: So why don't
2 we sign-off now, and thank you all again. That was
3 very good.

4 COMMISSIONER ANGELA COKE: Very
5 helpful. Thank you so much.

6 COMMISSIONER JACK KITTS: Thank you.

7 ALISON BLAIR: Thank you. Really
8 appreciate it. Talk to you soon.

9 COMMISSIONER JACK KITTS: Bye.

10 COMMISSIONER ANGELA COKE: Take care.

11

12 -- Adjourned at 3:30 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, OLIVIA ARNAUD, CSR, Certified
4 Shorthand Reporter, certify:

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

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

13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.

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18 Dated this 8th day of September, 2020.

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<p><u>WORD INDEX</u></p> <p>< 1 > 1 11:9 25:3 32:17 61:24 65:11, 13 68:19 1,543 24:12 11 42:12 43:2 11th 25:18 12th 33:11, 19 13 50:3 14th 31:25 16th 26:8 28:1 16ths 28:3 17th 26:13 32:16 18 24:6 18th 18:1 19 4:13</p> <p>< 2 > 2 7:1 32:25 33:11 65:18 2:00 1:16 4:1 2003 8:18 2004 8:2 12:12 2008 12:13 2009 12:14, 24 2013 8:11 9:4, 17 12:6, 24 44:6 2020 1:16 72:18 20th 32:18 221 17:18 22nd 17:5 28:9 23rd 29:10 24th 18:10 19:23 27:6 33:13 250 26:5 25th 16:7 17:15 19:21 24:11 26th 32:24 27th 17:22 20:13 21:18 30:15 28th 20:14 29th 33:23 2nd 16:18</p> <p>< 3 > 3 7:9 33:17, 19 66:2 3:30 1:16 71:12</p>	<p>30 48:11 31 24:20 37,000 11:7 3rd 27:14</p> <p>< 4 > 4 70:23 4th 34:2</p> <p>< 5 > 5 16:17 67:6</p> <p>< 6 > 6 67:24</p> <p>< 7 > 7th 17:25</p> <p>< 8 > 80 8:7 8th 1:15 31:20 72:18</p> <p>< 9 > 90,000 31:10</p> <p>< A > ability 26:25 Accessibility 43:11 accountability 38:11 acknowledging 25:23 acted 17:1 acting 7:7 60:5 action 5:19, 22 28:5, 7, 13, 21, 23 29:5, 9 31:23 37:3 45:7 49:9, 13 actions 24:23, 24, 25 25:21 26:5 48:13 58:22 activated 17:24 20:14 21:5, 18, 19 active 53:9 activities 40:7 activity 15:6 adapt 10:10 adapted 6:2 adapter 5:23 add 21:14</p>	<p>Addictions 46:20 additions 50:20 address 33:5 65:9 addressed 29:1 addressing 64:20 Adjourned 71:12 ADM 59:8 Administrative 3:19 advance 26:16 51:5 advice 5:14, 21 13:15, 20 14:5, 14, 15, 17 15:10, 16 38:7 41:1, 18 43:5, 17, 18 44:2 45:5 46:13, 22, 25 47:2, 14 52:11, 15 60:11 61:15 62:8, 11, 17 advisor 54:5 advisors 43:12 61:14 advisory 13:10 47:17 50:9, 11, 21 after 25:3, 7 27:9 42:18 afternoon 7:11 agenda 40:2 agile 6:2 agility 23:25 agreed 55:15, 18 agreements 27:4 ah 51:23 ahead 6:4 19:16 21:15 42:8 44:19 Alert 33:24 Alison 2:9 3:3 4:5, 15 7:11 10:23, 24 11:23, 25 13:7, 11, 25 14:15, 21 18:19, 22 19:4, 24 20:3, 20 21:17, 19 22:10 23:11, 22 24:5 25:12 29:15 30:12 38:14, 16, 20, 25</p>	<p>39:9, 14, 21 40:13, 19 41:3, 22 42:5, 10, 21 43:1 44:18, 19 45:2, 12, 17 53:25 54:19 56:11 57:8, 25 58:25 59:2, 13 60:2 69:12, 21 70:13, 14, 17 71:7 allocated 55:22 allocations 47:6, 8 allow 9:6 26:10 alternate 67:9 amended 32:25 amount 67:9 Analytics 59:9, 19 Anderson 23:1 43:7 57:7 Angela 2:4 12:4 15:12 18:17, 21, 24 19:12 56:8 68:23, 25 69:6 70:11, 24, 25 71:4, 10 Angus 23:1 35:11 38:19 39:3 43:7 Anna 59:15, 20 announced 30:14 33:23 announcement 26:2 35:1 announcing 62:12 annual 12:14 answered 19:19 answers 70:7 antibodies 11:9 anticipation 26:25 anyway 68:21 apologies 59:4 app 33:24 applicability 9:11 appointed 54:5 Appreciate 12:1 69:10, 16 71:8 appreciative</p>	<p>36:16, 22 approach 57:4 appropriate 69:2 appropriately 68:17 approval 38:3, 5 approved 27:5 April 27:13, 25 28:1, 2, 3, 9, 22 30:14, 15 34:14 area 20:25 29:22 46:17 59:19 66:12 areas 5:14 32:23 33:21 36:15 47:24 51:24 60:13 62:15 66:11 67:11 68:6 69:4 arenas 67:11 arm 21:20 57:23 58:2, 11 61:9 Armed 34:2 arms 65:20 Arnaud 3:18 72:3, 24 asked 30:17 asking 27:12 54:10, 12 assembling 61:4 assessing 52:15 assessment 32:14 Assistance 18:6 Assistant 2:9 3:3, 19 associations 8:8 19:8 24:21 assumed 68:2 attend 42:16 attendance 27:1 51:11 68:8 attending 1:15 attention 61:22 Attorney 2:17 August 33:19 34:2 authorities 5:5 authority 13:5, 16 availability 15:9 33:6 54:3, 7</p>
---	---	--	---	---

<p>available 15:11 25:8 32:15 33:25 53:24 avoid 16:11 67:8, 20 avoiding 38:3 aware 15:8 16:22 51:9 66:9</p> <p>< B ></p> <p>back 6:14 12:9 14:21 18:4 19:4 23:8 38:14 41:14 49:2 56:12 59:3 69:25 70:8 background 5:4 70:5 backlog 31:9 63:22 backlogs 66:21 67:1 back-to-school 64:23 balance 42:18 Barbara 5:2 barriers 38:8 base 69:8 based 5:14 9:5 12:17 27:15 50:25 51:10 basic 66:25 basically 35:22 basis 24:16 29:20, 23, 25 47:13 53:12, 15 60:25 65:17 Batise 37:1 beds 27:22 64:2 67:18 beefy 8:5 began 16:6 17:11 24:15 32:16 beginning 5:8 33:11 44:8 63:18 begun 64:24 behalf 60:22 believe 30:15 50:15 benchmark 27:21 best 8:21</p>	<p>better 11:18 61:25 67:18 Bianchi 3:5 big 14:1, 8 26:19 38:8 55:20 bigger 21:10 Bioethics 47:15 bit 4:18 6:9 8:12 12:23 15:13, 24 16:24 18:1 30:5 32:2 34:9 35:16 45:12 54:25 69:3 Blair 2:9 4:5 10:24 11:25 13:7, 11, 25 14:15, 21 18:19, 22 19:4, 24 20:3, 20 22:10 23:11, 22 24:5 25:12 29:15 30:12 38:16, 20, 25 39:9, 14, 21 40:13, 19 41:3, 22 42:5, 10, 15, 21 43:1 44:19 45:2, 12, 17 53:25 54:19 56:11 57:8, 25 58:25 59:13 60:2 69:21 70:14, 17 71:7 Blood 11:5, 7 bodies 8:8 bottom 47:14, 18 49:10 bottom-left 50:22 box 34:25 37:13, 14 41:22 Branch 2:12, 13 7:8 17:25 Break 26:1 brief 50:23, 25 briefed 42:18 briefing 54:2 briefings 4:21 70:2 briefly 62:3 briefs 61:10 bring 14:16 bringing 12:17</p>	<p>broad 25:24 broader 9:14 brushing 66:12 buffet 6:13, 14, 16 69:23 build 67:17 building 16:14 64:9 built 24:13 52:22 67:9 bullets 61:22 burdensome 54:13 busy 27:20 Bye 71:9</p> <p>< C ></p> <p>Cabinet 14:9, 10, 14, 17 15:8 27:5 37:23, 25 38:1 41:16 45:21 46:8, 9 call 18:20 24:9 31:13 35:15 Callaghan 3:9 called 17:15 24:19 59:8 calls 21:24 23:5 29:21 calm 4:15 camera 59:3 Canada 18:4 Canadian 11:5 34:2 capacity 20:8, 10 33:4 35:18 52:24 55:18, 25 59:13 63:25 64:6, 10 66:18 67:10 Capital 59:9 CARE 1:7 2:19 3:4, 5, 7, 9, 11, 14, 20 5:6 13:18 14:6 19:3, 9, 11 26:10, 24 27:8, 21 28:5, 7, 9, 12, 24 31:21 35:18 36:8 38:22 43:10, 21 45:7 46:17 47:16, 17 49:7, 8, 9, 13, 17 52:8 53:11 54:11 55:1, 9,</p>	<p>11 56:16 57:18, 19 58:13 63:24 64:7 66:10 67:5, 16 69:4 71:10 career 4:7 carefully 52:21 caregivers 68:4, 14 case 15:14 16:7 17:14 19:20 21:2 24:7 33:21 52:18 57:9 61:2, 6 63:14 66:7 cases 16:6, 14, 16 17:7 33:3, 5, 20 47:23 48:3 52:19 53:8, 9 64:11, 25 65:2 66:15 category 50:12 Central 37:13, 15 38:1 39:20, 21 40:4, 5, 20, 25 41:4, 11 45:19, 25 Centre 17:23, 24 20:14, 22, 23, 24 21:4, 11, 23 22:17 23:7, 16 37:7 46:6, 7 Centres 22:23 32:14 CEO 14:3 57:6 60:6 certain 47:23 67:9 certainly 8:3, 7, 18, 21, 24 9:12, 18 10:1, 12, 15, 20 11:15 12:11 16:23, 25 18:19 25:9 32:20 35:5 36:12 42:9 44:8 48:23 49:24 52:17 54:4, 21 60:18 62:12 70:5 CERTIFICATE 72:1 Certified 72:3</p>	<p>certify 72:4 CFB 18:5 chain 14:17 35:20 CHAIR 4:3 12:2, 25 13:8 19:14 21:13 22:2 23:14 24:1 25:10 29:8 30:10 39:17 40:10, 16, 24 41:20, 25 42:7, 14, 23 challenges 36:10 64:21 chance 5:1 change 14:22 chapters 9:1, 10, 13, 16, 24 10:4, 10 characteristics 10:18 chart 38:25 CHARTERED 72:25 Chief 4:25 14:4 16:20 26:9 30:20 32:6 39:9 51:15 52:5 55:14 62:11 Children 29:7 choose 9:7 chronology 15:20, 23 16:25 34:5 circled 46:16 Civil 2:15, 16 clean 45:18 clear 37:22 46:2 57:16 62:23 69:14 climbing 25:15 clinical 5:3 9:6 35:23 36:4 47:5, 8 55:21 clinically 51:6 Clint 29:23 closely 30:20 closing 26:3 67:21 closure 26:15, 20 closures 27:24 clumps 45:4</p>
--	--	--	---	---

<p>co-chair 39:10, 15</p> <p>co-chairs 13:25 22:25 37:1 39:4, 13</p> <p>Coke 2:4 12:3, 4 18:17, 20, 21, 23, 24 19:12 56:8 68:25 69:6 70:25 71:4, 10</p> <p>Cole 36:18</p> <p>Collaboration 24:19 30:3 48:10 59:24</p> <p>collect 54:13 60:21</p> <p>collective 27:4</p> <p>come 43:19, 24 50:23 59:10 65:10, 23 66:15 70:8</p> <p>comes 11:11 24:8 38:3 60:20</p> <p>comfort 33:20</p> <p>comfortable 30:22</p> <p>coming 5:19 18:4 21:3</p> <p>command 5:9, 20, 21, 25 10:2 13:3, 14, 24 14:6, 14, 18, 22 18:14 20:15, 18 21:7 22:4, 7, 14, 15, 19, 24 24:19, 23 25:7 28:16 29:11, 18 30:6 34:9, 11, 15, 16, 18 35:19 36:7, 12, 24 37:13, 15, 19, 22 38:10 39:5, 6, 10 40:1, 9 41:2 42:12 43:2, 14, 19, 23, 25 44:1, 15, 21 45:23 46:3, 11, 14 48:13 51:14, 18, 23 52:13 53:16 55:2 57:14 59:21 60:5 62:9, 10</p> <p>commands 13:14</p>	<p>commencing 4:1</p> <p>comment 48:15</p> <p>comments 29:24</p> <p>COMMISSION 1:7 3:4, 5, 7, 9, 12, 14, 20 33:22</p> <p>Commissioner 2:3, 4, 5 4:3 11:16 12:2, 4, 25 13:8, 22 14:13, 19 18:17, 20, 21, 23, 24 19:12, 14, 16, 18, 25 20:12 21:13 22:2 23:14 24:1 25:10 29:8 30:10 31:16 38:13, 17, 21 39:7, 12, 16, 17 40:10, 16, 24 41:20, 23, 25 42:7, 14, 23 44:18, 20 45:11, 15 53:22 54:18 56:8 57:5, 11 58:19 59:11, 25 68:23, 25 69:5, 6, 11 70:9, 15, 20, 25 71:1, 4, 6, 9, 10</p> <p>Commissioners 4:6 11:18</p> <p>committee 8:6 12:18 28:8 45:6 46:8 48:2, 17 49:14, 17, 18</p> <p>committees 49:6, 10, 23</p> <p>communicate 22:8 23:21 29:14 39:19 41:5</p> <p>communicated 22:16 23:3 29:11 41:1</p> <p>communicating 29:13</p> <p>communication 9:19 17:4 23:5, 19, 21 40:11, 18 48:21</p> <p>communications 40:21</p>	<p>communities 5:17</p> <p>Community 29:6, 7 60:17 64:9 66:16</p> <p>COMPANY 72:23</p> <p>compared 53:3</p> <p>compilation 52:10</p> <p>concise 69:14</p> <p>concur 69:12</p> <p>concurrently 49:12</p> <p>conference 27:13</p> <p>confidential 44:11</p> <p>confirm 19:10</p> <p>confirmed 17:14 19:20 53:8</p> <p>confusion 14:23 70:21</p> <p>connected 60:16</p> <p>consequence 34:17</p> <p>consider 8:16</p> <p>considerable 11:10</p> <p>consideration 43:25</p> <p>considering 63:24</p> <p>consistency 62:17</p> <p>consistent 57:4</p> <p>constrained 32:9</p> <p>consultation 10:21</p> <p>contact 58:24 61:3, 5</p> <p>contain 16:11</p> <p>context 15:3 16:5 34:8</p> <p>continue 34:20 36:1 70:4</p> <p>continued 33:16</p> <p>control 9:20 47:4 66:13 68:10</p> <p>convenient 50:12</p> <p>coordinate 22:9</p>	<p>coordination 21:8 22:5, 12 35:4 37:18, 19 38:2 39:20, 22 40:4, 5, 20, 25 41:4, 11 45:20, 25</p> <p>coordinator 35:2</p> <p>corner 47:15</p> <p>coronavirus 11:3 16:20 17:6</p> <p>correct 13:13 17:17 41:19 45:1 47:20 72:15</p> <p>costs 67:21</p> <p>Counsel 3:5, 7, 9</p> <p>count 52:18</p> <p>couple 4:11 19:19 45:10 70:3</p> <p>course 26:22 53:10 54:8 70:3</p> <p>cover 46:18 49:3</p> <p>covered 34:4 61:20</p> <p>covering 32:20</p> <p>coverings 32:19 65:16</p> <p>COVID 4:22 5:12 15:25 28:5, 23 33:5, 24 39:1 45:23 51:19 60:15 63:23 64:5, 16, 17, 22 65:4 66:3</p> <p>COVID-19 1:7 9:23 17:14, 15 25:18</p> <p>created 29:5 44:23, 24, 25</p> <p>creation 28:6</p> <p>criteria 33:7</p> <p>critical 27:21 36:8, 9</p> <p>cross-functional 29:2 36:17</p> <p>Crown 2:15, 16</p> <p>CSR 72:3, 24</p> <p>cumulative 53:8</p> <p>curve 25:16</p> <p>cycle 23:19, 21</p>	<p>< D ></p> <p>daily 17:19 22:22 23:5 24:10, 11, 14, 16 29:20, 23, 25 39:23, 24 60:25</p> <p>dashboard 35:15 40:5</p> <p>data 51:8, 9 53:24 54:2, 5, 7, 13, 16 58:21, 22 59:7, 20, 21 63:1</p> <p>data-driven 52:14</p> <p>Dated 72:18</p> <p>dates 45:9 50:4</p> <p>David 23:2</p> <p>Dawn 3:13</p> <p>day 1:15 16:20 26:17 72:18</p> <p>days 18:2 52:18</p> <p>deal 15:5 66:15</p> <p>dealing 64:5, 12, 19, 22 65:4</p> <p>deals 58:6</p> <p>death 25:18</p> <p>deaths 27:7</p> <p>debrief 12:21</p> <p>deceased 53:8</p> <p>December 63:18</p> <p>decide 6:16</p> <p>deciders 38:6</p> <p>decision 41:16</p> <p>decision-maker 14:9</p> <p>decision-makers 13:21 14:1 15:10 41:13 62:8, 9</p> <p>decision-making 37:25</p> <p>decisions 15:18 24:24 37:23 41:19 62:12</p> <p>deck 6:21</p> <p>decks 4:13</p> <p>declared 25:19 26:14</p> <p>decline 16:15</p> <p>defined 37:22</p> <p>definitely 10:18 57:8</p> <p>deliberate 15:10</p>
--	--	--	---	--

<p>deliberations 15:18 50:14 Denise 36:18 depend 53:23 deployment 26:23 27:3 Deputy 2:9 3:3 5:5 13:16, 17 14:2, 5 23:1 28:17 35:11 38:19, 22 39:3, 5 43:6 49:24 69:25 Derek 3:11 description 44:5 despite 13:13 detail 15:21, 24 16:24 28:19 34:6 46:12 48:25 49:25 detailed 34:5 49:22 determined 52:6 determiner 5:13 determines 47:5 develop 8:16 developed 10:21 developing 61:9 development 7:23 28:20 36:12 developments 8:4 Di 3:19 diagram 66:18 dialogue 63:7 differences 20:16 different 8:7, 12 9:7 10:7, 8, 9 41:2 49:19 52:16 62:18, 23 63:14, 25 64:7 difficult 64:15 difficulties 64:17 difficulty 59:3 digging 69:3 diligently 25:6 direct 13:5 22:24 26:9 directions 55:13 directive 13:10 32:25 directives 14:5</p>	<p>51:17 63:1 directly 42:6 Director 2:13 3:11, 13 7:7 29:22 Dirk 34:25 Dirk's 35:3 discussion 16:23 41:12 discussions 14:11 43:14 disease 15:25 17:6 dispersion 52:19 distancing 32:19 65:15, 25 distinguish 41:4 distinguished 50:9 distributed 22:21 51:25 distribution 36:2 55:21, 23 58:22 Division 59:9 document 15:21 16:25 33:8 documenting 5:21 documents 17:21 51:17 doffing 68:9 doing 6:15 20:1 24:3 31:14 37:6 67:9 69:19 domestic 35:20 36:4 donning 68:9 download 33:25 downward 29:11 draw 16:3 61:21 drug 58:8 Drummond 3:3 due 65:3 < E > earliest 27:16 early 17:4, 12 18:2 25:17 26:5, 11 27:25</p>	<p>52:18 63:15 easiest 65:11 eat 6:17 eating 6:14 economic 30:25 economy 30:24 31:6 education 65:17 elected 14:10 elective 31:13 56:7 elements 8:15 e-mailed 16:21 e-mails 21:24 52:4 emergencies 21:5, 10 Emergency 2:11 7:8 17:23 18:6 20:13, 22, 24 21:3, 4, 11 22:17, 23 23:6, 16 26:14 31:8 37:4, 7, 10 46:5, 6, 8 engage 59:15 engagement 61:21 enhancing 51:8 entered 33:12, 13, 19 entering 33:11 enthusiastically 40:19 entire 13:5 37:8 entirely 58:16 entity 21:25 EOC 20:17 epi-curve 52:20 epidemiological 60:24 equation 65:21 equipment 33:6 35:23 36:5 47:5, 9 55:22 61:13 especially 54:10 60:9 61:11 62:18 68:6 Esq 2:15, 16, 18 essential 26:10 established 18:14 20:15 21:8 22:4</p>	<p>23:19 28:10, 15 44:7, 22 45:8, 10 46:22 47:19 50:5 establishment 56:1 establishments 26:16, 21 49:22 events 12:20 eventually 33:18 49:15, 18 60:17 everybody 6:21 7:11, 18 9:14 15:7 33:24 52:19 65:24 evidence 50:25 61:10 evolved 8:20 44:8 53:21 69:10 exactly 19:6 56:10 57:2 62:22 example 5:18 22:16 36:17 39:19 41:7 43:20 45:7 50:14 51:3, 11 52:7 55:3 59:20 62:19 excellent 69:15 exclusive 20:18 exist 9:13 35:20 existed 34:8, 11, 14 50:19 existing 13:16 66:23 expand 32:8 expect 63:8 70:3 expected 26:17 27:2 expensive 67:19 experience 5:8 8:19 13:20 expert 7:6 32:5 50:15 experts 43:11 59:7 explain 31:16 explained 29:10 exposed 32:13</p>	<p>expression 41:23 external 43:11 extra 64:21 eye 45:12 eyes 31:2 < F > face 32:19, 20 65:16 faces 4:6 facial 41:23 facilitates 24:2 facilities 37:11 66:23 fact 21:4 25:5 36:14 factoring 63:19 fair 15:12 18:1 fairly 45:18 57:19 fall 6:5 16:15 25:4 41:8 44:9, 12 62:1, 2 63:4, 8, 14 65:8 66:3 familiar 4:6 families 68:4, 14 farther 27:10 70:4 fast 4:14 features 37:8 February 17:25 18:1, 10, 13 19:23 20:14 44:22, 24 Feds 11:5 feedback 30:2, 8 62:1, 4, 16 63:2 feel 21:12 32:12 Felice 3:19 fell 10:3 felt 21:8 62:7, 13 field 5:16 17:20 67:10 figure 57:20 fill 64:2 final 44:17 finally 36:23 67:24 Finance 30:19 find 15:23</p>
---	---	---	---	--

<p>27:16 fine 11:14 24:4 fires 21:6 fit 45:19, 23 fits 29:3 35:10 flatten 25:16 flip 23:23 24:6 37:17 49:2 flu 63:16, 18 65:21, 23 66:1 focus 18:1 25:2, 3 43:22 61:24 67:14, 15 focused 8:12, 13 9:9 folks 19:3 follow 5:22 51:20 following 21:1 47:12 follows 64:17 follow-up 13:23 food 37:11 Forces 34:2 foregoing 72:6, 14 forest 21:6 formed 28:21 forth 72:8 forward 5:24 6:7 68:18, 22 found 20:25 59:17 63:1 foundation 7:25 9:23 10:5 foundational 44:5 four-bed 64:1 framework 30:23 47:11, 13 Francis 2:13 Frank 2:3 4:3 12:2, 25 13:8 19:14 21:13 22:2 23:14 24:1 25:10 29:8 30:10 39:17 40:10, 16, 24 41:20, 25 42:7, 14, 23 Fredrika 32:1 free 21:12 Fridays 50:24 front 6:21</p>	<p>front-facing 21:21 full 51:19 fully 57:4 funded 56:21 58:9 funder 57:22 funding 58:3 future 6:13</p> <p>< G > gap 12:24 gathering 26:15, 21 27:10 gatherings 26:4 General 2:17 31:2 37:6 56:13 generally 43:5, 17 46:14 51:25 gentleman 29:21 geographic 52:19 germane 46:17 give 6:9 23:8 34:7 41:7 58:23 59:10 62:19 70:7 given 8:18 gives 48:24 giving 6:8, 15 42:2 global 25:22 globe 25:25 gold 60:19 good 4:10 7:11 9:22 10:5, 20 15:1 22:11 23:22 59:19 71:3 government 5:11 8:9 14:9 15:13 24:24 29:4 30:19 35:1, 4 36:6 37:18, 21 61:10 62:6 63:9 government- wide 39:2 gradually 32:25 Great 4:5 6:24 7:10 12:11 15:5 18:22 20:6 21:16 22:10 43:1</p>	<p>44:4 59:25 62:1 greater 22:5 greatly 54:8 Greenberg 59:15, 20 group 13:19 25:3 28:25 46:21 51:8 65:5 groups 26:18 29:13 61:24 guard 65:6 guidance 17:21 32:3, 8 51:17 61:15 guide 70:6 guidelines 32:5 guys 11:23</p> <p>< H > H1N1 8:19, 25 12:21 half 69:12 hallway 64:5 handle 21:11 hands 65:15, 24 happen 12:16 14:1 67:4 happened 15:6 26:21 27:5, 25 28:4 29:18 35:17 49:11, 12 52:2 55:23 happening 25:24 39:25 51:10 happens 13:5 67:19 happy 24:2 54:21 70:6, 7 hard 11:20 Hartley 2:11 7:9, 10, 16, 19, 22 12:10 19:7 21:16 23:10, 13 headlines 66:8 Health 2:9, 11, 12, 14, 18 5:1, 3, 4, 6 7:8, 23 8:1 9:20 10:2 13:17, 19 14:2, 3, 4, 16 16:18, 21 17:2, 8 18:2, 12, 14 20:15, 17 21:7, 9, 24 22:4, 7, 14, 15, 19, 20,</p>	<p>24 24:18, 20, 25 26:9, 23 30:3, 4, 6, 8, 21 31:1, 2 32:7, 22 33:1, 8, 12 34:9, 15, 18, 22 35:10, 11, 12, 14, 25 36:11, 13, 20 37:19, 20 38:10, 18, 23 39:4, 8, 10, 19 41:6 42:12 43:2, 4, 14, 23, 25 44:1, 15, 21 45:23 46:3, 10, 13, 15, 19, 20, 23 47:2, 21, 25 48:6, 7, 13, 16, 17, 20 51:14, 16, 18, 22 52:6, 13, 23 53:16 54:10 55:3, 5, 6, 7, 8, 12, 14, 17, 19, 21 56:2, 5, 13, 14, 18, 19, 21, 24, 25 57:7, 15, 18, 21, 22 58:2, 6, 10, 18 59:16, 17, 18, 22, 23 60:3, 4, 10, 11, 12, 16, 18, 20, 23 61:4, 6, 15, 16, 17 62:5, 8, 10, 11, 13, 20 63:21 64:13, 17 66:12, 18, 20 68:13 healthcare 9:11 21:22 64:5, 13, 14, 18 68:3, 5 health-related 60:9 Health's 54:24 59:19 hear 15:10 heard 37:25 heavily 61:16 Held 1:14 Helen 23:1 35:11 38:19 43:6 he'll 59:10 help 47:22 61:7 helpful 6:19 7:18 15:3, 17 46:25 50:6</p>	<p>51:4 69:7 71:5 hey 5:16 41:6 high 24:13 33:2 higher 66:11 higher- population 47:24 high-level 7:2 highlight 32:24 33:10 highlights 15:22 18:15 34:3 Hillmer 59:8 Hmm 69:21 hold 69:7 holding 67:23 home 27:12 47:17 55:9 67:15, 16 homes 19:9 26:10, 24 27:8 28:6, 12, 25 29:1 31:23 49:8 54:11 55:11 56:16 63:24 64:1 66:14 honour 4:8 Honourable 2:3 hope 33:24 69:22 hopeful 65:21 hopefully 42:11 50:6 hoping 6:18 65:25 67:13 hospital 33:2 60:17 hospitals 31:18 53:3 55:9 56:15 64:4, 6, 10 66:23 67:2, 10 hour 69:12 hours 4:11 48:23 66:22 human 56:5 Huyer 34:25</p> <p>< I > Ida 3:5 idea 4:10 identified 45:5</p>
---	---	---	--	--

<p>identify 47:22 50:12</p> <p>identifying 51:4</p> <p>illness 27:1</p> <p>imagine 6:13 44:3 69:23</p> <p>immune 11:1</p> <p>immunity 10:13, 14, 16</p> <p>immunizations 67:3</p> <p>impact 27:15 30:25 31:3, 14 67:22</p> <p>impacts 31:8</p> <p>implement 55:15</p> <p>implementation 41:15 45:6 49:14 50:10 58:16</p> <p>important 4:24 31:1, 18 34:12 40:2 45:20 56:2 62:16, 25</p> <p>improved 54:17</p> <p>improvement 62:16</p> <p>improvements 63:4</p> <p>IMS 28:20</p> <p>incidence 5:17</p> <p>Incident 28:10 43:20 49:15, 16, 17</p> <p>include 19:2 25:5 52:22 56:15</p> <p>included 19:8, 10</p> <p>includes 8:6 43:7, 11 51:22 59:21</p> <p>including 7:2 23:7 36:10 52:25 55:11</p> <p>incorporate 10:19</p> <p>increased 54:9</p> <p>indecipherable 14:18 32:22 39:8 40:11 68:22</p> <p>indicators 53:4</p> <p>individual 56:4</p>	<p>infection 9:19 66:13 68:10</p> <p>influenza 7:24 8:2, 13, 17 10:7, 13 44:6 65:20</p> <p>inform 12:19</p> <p>information 8:20 40:6 50:1, 7 53:12 54:9 60:22, 23 62:17</p> <p>informed 10:2 15:19 32:5 43:15 44:7 47:13 61:10</p> <p>informing 60:7</p> <p>initial 7:3</p> <p>initially 26:3 35:24 52:17 54:13 60:14</p> <p>initiated 34:15</p> <p>input 30:9</p> <p>instigated 17:22</p> <p>integrated 54:15 60:23</p> <p>integrity 58:21</p> <p>intelligence 27:16</p> <p>intensive 53:10</p> <p>interest 34:18 49:5</p> <p>interested 53:19 54:20</p> <p>intervention 26:12 28:8 49:14</p> <p>invited 19:6</p> <p>involved 6:7 18:5 36:1, 2 58:9, 14 60:7, 14, 21 61:2, 9 62:13 68:18</p> <p>IPAC 9:19</p> <p>iPHIS 60:23</p> <p>iPhone 11:20</p> <p>isolate 64:3 65:14</p> <p>issued 51:16 52:7</p> <p>issues 24:10 68:8</p> <p>Italy 67:8</p> <p>Italy-type 27:19</p> <p>it'd 59:14</p> <p>items 5:22 40:2</p>	<p>iteration 12:24 44:9</p> <p>iterations 8:4</p> <p>< J ></p> <p>Jack 2:5 11:16, 17 13:22 14:13, 19 19:18, 25 20:12 38:13, 17, 21 39:7, 12, 16 44:18, 20 45:11, 15 53:22 54:18 57:5, 11 58:19 59:11, 25 68:23 69:5, 11 70:9, 15, 20 71:1, 6, 9</p> <p>Jane 54:4</p> <p>Janet 36:25</p> <p>January 16:7, 18 17:4, 5, 13, 15, 22 18:25 19:21 20:13 21:18 24:11</p> <p>John 3:9</p> <p>judges 42:17</p> <p>Judith 2:15</p> <p>July 24:17 33:23 61:23</p> <p>jump 20:21 59:1</p> <p>June 11:8 33:11, 13</p> <p>jurisdictions 65:22</p> <p>Justine 2:11 7:9, 10, 16, 19, 22 10:25 11:12, 13 12:10 13:1 17:17 19:5, 7 20:5, 21 21:12, 14, 16 23:9, 10, 13 35:25 44:4</p> <p>Justine's 17:25 29:22</p> <p>< K ></p> <p>Kate 3:7</p> <p>key 5:14 8:8, 25 40:7 43:22 51:24 54:5 61:13 68:15</p> <p>kind 15:17 18:7 21:6 38:5 41:9 51:12 53:11, 19 57:1,</p>	<p>21 58:14 61:5 64:25 66:25</p> <p>kinds 41:17, 18 44:14 45:4 46:23 53:4 63:2</p> <p>Kitts 2:5 11:16 13:22 14:13, 19 19:16, 18, 25 20:12 31:16 38:13, 17, 21 39:7, 12, 16 44:18, 20 45:11, 15 53:22 54:18 57:5, 11 58:19 59:11, 25 68:23 69:5, 11 70:9, 15, 20 71:1, 6, 9</p> <p>knew 8:19 44:14</p> <p>knowledgeable 5:15</p> <p>Korea-type 27:18, 19</p> <p>Kristin 2:18 7:14, 17, 21 11:22 23:24 24:6 31:4 49:3 50:3 52:12 59:1, 2</p> <p>< L ></p> <p>lab 20:1 50:17 60:15, 19</p> <p>labelling 25:20</p> <p>Laboratory 18:11 19:21 60:14</p> <p>labs 60:16, 17</p> <p>laid 34:13</p> <p>large 69:17</p> <p>largely 37:8 65:3</p> <p>late 17:12 27:25 63:15</p> <p>latest 17:21 44:9 50:25</p> <p>Law 2:15, 16</p> <p>lays 7:25</p> <p>Lead 2:3 30:19 39:3 69:25</p> <p>leading 50:22</p> <p>leads 7:23</p> <p>learned 8:25 69:16</p>	<p>led 29:6 43:6</p> <p>left 65:11</p> <p>left-hand 16:18 34:24</p> <p>Legal 2:19</p> <p>lessons 8:25</p> <p>Lett 3:11</p> <p>letter 34:1</p> <p>letters 31:20</p> <p>letting 65:6</p> <p>leveraging 10:20</p> <p>LHINs 55:10</p> <p>licensed 18:10 19:22</p> <p>life 31:15 67:22</p> <p>limitation 27:9</p> <p>limited 56:22</p> <p>limits 27:10</p> <p>lined 4:21</p> <p>link 52:11</p> <p>Lisa 3:19</p> <p>listening 62:14</p> <p>local 16:21 17:1, 8 18:7 32:22 56:19 58:10 66:11 67:11</p> <p>log-jams 38:3</p> <p>long 43:16</p> <p>longer 31:11 66:22</p> <p>LONG-TERM 1:7 2:19 3:4, 5, 7, 9, 11, 13, 19 5:5 13:18 14:6 19:3, 9, 11 26:10, 24 27:8 28:5, 7, 9, 11, 24 31:21 35:17 38:22 43:9, 21 45:7 46:17 49:7, 9, 13, 17 52:8 54:11 55:1, 11 56:16 57:18, 19 63:24 64:7 66:10 69:4</p> <p>looked 8:11 11:6, 8 12:14 27:18 31:5 36:24 55:3</p> <p>looking 6:4, 7 8:23, 24 11:5 27:14, 17 32:3 37:20 48:18 51:8 52:5 56:3</p>
--	--	---	--	--

<p>57:17 63:3 65:1 66:24 68:22 lookout 21:2 looks 36:9 43:2 loosened 46:24 lot 9:15 10:2 12:17 13:12 15:23 20:10 28:12, 14, 19 34:18 49:24 56:5 66:7 69:16 love 10:25 11:1 lovingly 24:9 low 5:17 luxury 4:10</p> <p>< M > made 17:5, 9 32:6, 21 37:23 72:10 main 34:3 maintaining 35:14 making 5:20 12:18 15:17 37:8 67:6 68:4 manage 66:5 managed 23:8 Management 2:11 7:8 28:10 43:20 46:8 49:15, 16, 18 54:2 61:3, 6 mandate 37:16 38:12 48:25 mandates 37:21 mandatory 32:21 Mann 2:17 March 5:9 25:14, 17, 18 26:1, 6, 8, 13, 23 27:6, 25 Marrocco 2:3 4:3 12:2, 25 13:8 19:14 21:13 22:2 23:14 24:1 25:10 29:8 30:10 39:17 40:10, 16, 24 41:20, 24, 25 42:7, 14, 23</p>	<p>masks 65:25 Mathai 2:16 Matt 57:7 Matthew 23:1 43:7 MCCSS 29:6 McGrann 3:7 measure 53:5 measured 53:1 Measures 46:21, 23 52:23, 24 60:10 mechanisms 9:7 media 21:1 64:24 Medical 4:25 14:4 16:21 17:1 18:6, 11 26:9 30:20 32:7 39:9 47:1, 21, 25 51:16 52:6 55:14 62:11 meet 48:12 MEETING 1:7 18:13 28:18 34:5 36:3 42:16 53:16 meetings 22:17 30:3 39:22 51:23 meets 30:3 member 24:22 39:5 members 14:12 memo 22:25 26:8 memos 22:18 25:6 51:17 52:7 Menard 36:25 mental 36:10 46:19 64:17 68:13 mentioned 12:5 18:25 21:19 MEOC 24:9, 14 metrics 52:16 Michael 59:7, 15 mid-April 16:8 25:15 mild 9:1 military 28:11 Minister 2:9 3:3 5:5 13:17, 18 14:2, 6, 16</p>	<p>17:5 38:22 43:4 46:4 47:8 ministers 15:9 46:2 ministries 34:21 43:8 Ministry 2:12, 14, 17, 18, 19 5:6, 11 7:22 19:10 22:1 23:6 29:6 30:19, 21 31:1, 21 36:15 37:5 43:10 47:7 48:7 52:8 54:24 55:1, 5, 7, 17 57:17, 18, 19, 21 58:6 59:18, 23 62:4, 5, 13, 19 Ministry's 60:22, 25 minutes 4:13 22:20 missing 17:7 58:1 model 27:18 modelling 27:14 models 4:7 66:20 moderate 8:12, 24 MOHs 16:21 moment 60:4 monitored 53:12, 14 monitoring 53:10 month 19:22 20:14 63:9 morning 16:3 23:12 morphed 49:15 municipally 58:9 mute 19:17 mutually 20:18</p> <p>< N > naïve 11:2 naïvety 11:10 named 13:23 names 35:22 70:18 National 18:11 20:1</p>	<p>nature 23:20 61:11 necessarily 9:2 10:6 26:7 needed 8:16 27:22 39:25 44:24 54:14 67:12 NEESONS 72:23 nerve 20:22 new 8:19 10:12 21:3 25:21 52:2 nitty-gritty 50:14 nod 20:5 notably 17:4 note 4:24 noted 50:6 notes 72:15 notification 52:1 notified 16:19 novel 16:19 17:6 November 63:18 number 4:20 8:3 22:13 26:18 29:17 31:22 33:7 34:10, 21 46:11 48:13 53:9 60:6 61:23 66:21 numbers 17:21</p> <p>< O > objective 65:18 objectives 63:11 65:10 observations 34:1 occupancy 33:2 occupational 9:20 o'clock 70:23 offended 42:22 Office 2:15, 16 46:2 Officer 4:25 14:4 16:21 26:9 30:21 32:7 38:23 39:8, 10 51:16 52:6 55:14 62:11 officers 17:1</p>	<p>47:1, 21, 25 officials 14:11 OHPIP 9:2 10:22 Olivia 3:18 72:3, 24 one-off 47:12 ones 29:5 46:16, 19 49:3 50:19 ongoing 22:17 Ontarians 32:3 Ontario 7:23 13:19 14:3 18:2, 8, 12 19:21, 22 24:25 26:1, 14 28:11 32:9 33:8, 21 37:9 38:23 39:3 48:6, 17, 19 55:3, 5, 7, 12, 19, 20 56:2, 13, 21, 24 57:6, 14, 22 58:2 59:16, 18, 22 60:4, 16, 18 61:17 62:5, 20, 21 Ontario's 25:17 57:15 60:12 open 15:15 operated 17:24 operating 66:22 operational 20:23 21:20 55:4 58:2, 11 operationalize 55:13 operationally 48:18 Operations 3:13 17:23 20:13, 22, 24 21:4, 11, 23 22:17, 23 23:6, 16 37:7 46:6, 7 49:9 57:23 operators 31:23 opportunities 29:19 opportunity 30:1, 7 oral 40:12, 18 order 17:5 23:25 27:4 Organization 16:19 55:6 56:4</p>
---	--	--	---	---

<p>organizations 8:9, 10 13:15 24:21, 22 30:7 47:10 48:11 55:10, 16 56:6, 23 57:1 58:3, 12 62:19 64:9 organize 10:1 36:20 orient 34:10 Ottawa 48:1 Outbreak 35:3, 8 64:6 outbreaks 35:8 48:3 51:5, 10 53:13 66:4, 6 outcome 52:23 outlined 60:13 63:11 output 51:14 outside 18:4 28:24 34:22 58:5, 6 61:17 overall 45:22 oversight 48:17 overview 6:10 7:2</p> <p>< P > p.m 1:16 4:1 71:12 Palin 3:13 pandemic 7:6, 24 8:2, 13, 17, 24 9:1, 8 10:7, 14 25:19, 21 30:13 34:23 36:3 44:6 46:24 49:19 54:8, 12 61:18 panel 32:6 50:15, 16 parallel 20:19, 20 paramedic 56:20 58:10 paramedics 18:7 Parker 2:15 part 10:21 27:3 34:16 35:18 38:11 45:20 51:18 56:19 participants 1:14 3:1 47:1</p>	<p>participate 34:20 48:1 participating 43:13 46:15 participation 34:21 43:9 particular 9:3 25:21 partners 21:25 55:2, 20 parts 58:17 passed 69:13 patients 67:17, 18 68:1, 16 Patrick's 26:17 pause 50:3 pay 30:13 payment 55:6, 8 56:23 58:7 peak 16:4, 5, 8 25:15, 16 Peel 33:13, 18 48:1 people 5:10, 15 12:19 14:24 15:15 18:3 22:8 23:8 26:5, 18 27:2, 12 29:13 31:11, 13 35:6 51:6 59:5 61:4 65:4, 6, 14, 19 67:14, 23, 25 68:2, 12 perceived 22:5 percent 11:6, 9 percentage 53:1 performing 66:25 period 15:6 26:4 28:13 permitted 27:2 33:1 person 13:2 67:4 70:7 personal 33:6 61:13 personally 42:22 personnel 36:9 perspective 9:17 12:15 20:24 25:22, 23 39:2 phase 49:19 Philpott 54:5</p>	<p>phone 21:24 phrase 11:1 physical 32:19 physically 65:15, 24 physician 58:7 pick 22:3 pink 37:14 place 6:1 25:25 55:18 69:9 72:7 places 26:15, 21 66:24 plan 7:15, 24 8:11, 16, 22 12:5, 22 28:5, 23 29:5, 10 31:22 35:8 37:3 44:6, 7, 10, 13 45:7 49:13 52:6 62:2 63:4, 8 Plan/Implementat ion 28:7 planning 7:3, 6 9:15 25:4 27:20 37:5 44:12 49:20 55:25 56:5 59:9, 13 62:1 63:7 66:19 68:7 planning-ahead 25:3 plans 31:22 play 6:18 35:4 68:15 played 55:20 plays 37:17, 19 pleased 4:17 pneumonia 16:23 point 15:22 19:3 32:4 44:17 52:24 70:6, 8 policies 61:11 Policy 2:13 3:11 37:23 63:1 pool 61:4 pop 11:22 population 10:15 11:2 37:2 64:18</p>	<p>populations 28:23 36:25 37:3 portion 34:7 positive 62:4 possible 32:20 67:15 possibly 69:14 posted 26:11 60:25 potential 26:19, 25 27:15 68:7 potentially 27:17 63:17 PPE 68:9 practices 8:21 58:14 Premier 62:7 prepare 8:1 prepared 67:7, 11 preparedness 7:7 8:14 35:7 44:10, 12 63:8 preparing 69:17 PRESENT 3:16 62:6 presentation 42:20 44:4 59:10 69:18 presentations 40:22 51:3 presented 69:18 PRESENTERS 2:7 presenting 11:24 president 14:3 presidents 60:7 press 27:13 pressure 36:13 pretty 24:13 prevent 66:3 prevention 9:19 66:13 68:10 preview 23:24 previous 38:15 53:3 Primary 47:16 58:13 67:4, 16 Prior 8:11 12:21 priorities 43:22 priority 36:5 privileged 15:14</p>	<p>problem 7:21 38:2 problems 27:1 36:14 procedures 31:7, 10 proceedings 22:19 72:6 process 10:22 12:7, 21 15:8 32:16 38:5 processes 4:23 5:23 6:3, 8 38:4 54:16 69:9 produce 60:24 produces 59:20 production 35:21 36:4 productive 42:1 progress 24:23 38:9 41:14 prohibition 26:4 projecting 6:24 7:13 projections 27:14 promise 13:11 63:6 promising 51:1 promoting 32:12 promotions 32:12 protections 61:12 protective 33:6 61:13 provide 7:2 13:14, 20 14:5 15:3 24:22 25:9 28:16, 19 30:8 38:7 44:2 46:22 48:5, 12, 15 49:24, 25 50:24 provided 5:22 9:22, 25 10:5 14:14, 15 24:11 46:13 48:6 provider 56:25 providers 21:22 26:24 46:15 56:14 64:14 provides 13:15 45:24 47:7</p>
---	---	--	---	---

<p>providing 8:15 43:17 47:2 48:19 52:15 68:15 province 17:2 51:10 provincial 7:25 20:8, 10 35:2 37:7 46:6 47:16 provincially 55:23 public 5:3, 4 17:8 18:12 26:3, 15, 20 27:10 31:2 32:18, 22 33:12 36:23 37:9 38:23 39:8 46:20, 23 54:10 56:18, 19 57:15 58:10 59:17, 22 60:3, 4, 9, 11, 12, 16, 18, 20, 23 61:4, 6, 15, 16 62:20 65:17 66:12 pull 47:21 pulled 61:23 pulling 15:16 51:8 purple 34:24 37:13 purpose 7:1 putting 55:18</p> <p>< Q > quality 31:14 67:22 quantitative 40:6 quarantined 18:5 question 7:12 11:17 12:5, 11 13:23 18:18 21:15 22:11 23:15 38:14 40:15, 17 42:3 44:21 57:12 58:20 questions 4:9 6:17 11:13 19:19 28:15 29:24 48:15 49:22 53:17</p>	<p>54:22 68:24 69:1, 20, 24 quick 7:12 9:25 12:4 quickly 15:19 17:1 46:18 48:8 53:23 66:3, 5 69:13 quite 8:5 12:12 14:23 24:2 50:17 54:13 69:13</p> <p>< R > ramp 31:18 ramped 53:2 Rapid 47:18, 22 60:10 rate 33:21 rates 51:11 66:11 read 41:23 readiness 37:10 63:11 65:10, 18 ready 35:7 63:12 65:8 realized 20:8 really 4:8, 10 7:1, 24 8:12, 13, 14, 23 9:17, 22 12:14, 15 16:6 20:22 21:20 22:10 25:2 27:11 35:6 45:21 50:13 55:3 62:25 64:23 65:6, 16 66:2 71:7 recall 25:14, 20 receive 21:23 22:1 received 62:5 recognize 68:15 Recognizing 33:9 36:3 recommend 41:16 recommendation 32:18 recommendation s 32:6, 21 41:12, 18 43:18, 24 44:2 47:7 recommending 52:15</p>	<p>recommends 47:6 reconvene 70:23 recorded 72:11 recovery 31:21 49:20 recruiting 68:5 red 46:16 red-circled 49:3 reduce 66:20 reduced 66:1 re-emergence 16:16 referred 13:3 62:10 reflected 62:2 reflection 25:2 42:19 reframed 8:21 refresh 12:8 regards 15:25 region 57:1, 2 regional 42:17 48:20 56:1, 9, 19 58:15 regionally 55:24 56:3 regions 33:19 56:15, 18 57:6 Regular 23:18 29:20 40:22 53:12, 15 54:15 65:17 regularly 48:12 regulatory 8:8 reinforcing 65:16 related 49:7 relationship 46:7 relationships 55:8, 9 56:24 58:4, 7 relatively 10:17 release 28:5 30:15 63:8 released 8:2 11:4 17:16, 20 28:24 29:5 33:8 37:2 52:3, 9 releasing 44:12 rely 60:11 61:16</p>	<p>relying 67:17 remain 21:19 remainder 26:22 remains 32:20 remarks 72:10 remember 30:16 remotely 1:15 removing 38:7 remuneration 43:13 reopen 32:25 reopening 30:16, 18, 23, 24 31:6 32:17 reopenings 33:17 65:3 repatriation 18:3 repeat 40:15 repetitive 65:12 replaced 50:5 report 17:16 24:10 41:14 43:4 46:3 52:3 60:24 reportable 17:6 reported 27:8 57:7 REPORTER 40:14 72:4, 25 REPORTER'S 72:1 reporting 17:9 40:3, 7, 22 44:15 46:4, 5, 7 reports 17:20 22:20, 22 37:14 45:24 50:16 52:4 represent 37:10 representation 43:8 57:2 60:5 represented 56:10 request 40:1 41:9, 10 requested 28:11 requesting 31:21 required 20:9, 10 21:9 22:6 47:23 61:12 requirement 17:10 researchers</p>	<p>50:22 resolve 48:7 resources 18:7 56:5 respond 9:23 responding 54:12 response 4:23 8:1, 14, 22 9:3, 8, 24 10:1, 11, 19 13:6 20:23 21:20 29:4 35:3 39:1 43:15 45:24 47:18 48:16 51:19 52:24 56:3 60:8, 10 62:6 responses 47:22 48:19 responsibilities 9:12 54:23 55:4 responsibility 54:25 57:20 58:17 restarting 56:6 result 15:18 resume 31:7 retaining 68:6 retains 60:19 retirement 19:9 49:8 return 26:3 return-to-work 31:22 review 12:7, 8 30:17 43:3 revisit 24:7 Richard 28:17 69:2 right-hand 37:12 66:17 ring 42:17 Robert 2:13 Rokosh 3:13 role 4:7 6:18 35:3, 4 37:5, 18, 19 55:20 57:15 60:12 68:15 roles 54:22 roll 20:9 rooms 64:1 66:23 Roopa 2:17</p>
---	---	--	--	---

<p>rules 9:12</p> <p>< S ></p> <p>safely 66:20</p> <p>safety 9:20 36:23</p> <p>saliva 68:21</p> <p>samples 11:6, 7 53:19, 20</p> <p>Saves 70:21</p> <p>scaleable 8:22 9:5</p> <p>Scarth 32:1</p> <p>scenario 27:19, 20</p> <p>scenarios 27:23</p> <p>scheduled 31:7, 12 54:2</p> <p>schools 26:2, 3 51:12 64:25 66:7</p> <p>science 10:16 35:14 50:21, 23, 25</p> <p>scientific 61:9, 14</p> <p>scientists 50:23</p> <p>scorecard 35:15 52:16 53:7, 19, 23 59:21</p> <p>screen 11:19, 23</p> <p>screening 67:3</p> <p>screenshot 53:6</p> <p>season 63:16, 19</p> <p>seconds 50:4</p> <p>Secretariat 3:4, 6, 8, 10, 12, 14, 20 37:14</p> <p>Secretary 38:1</p> <p>section 38:8</p> <p>sector 21:9 30:8 37:20 49:8</p> <p>sectors 35:5, 7, 9 37:9</p> <p>security 37:11</p> <p>senior 42:17</p> <p>Seniors 43:10</p> <p>September 1:15 44:13 63:9 72:18</p> <p>service 26:23 30:4 37:9</p>	<p>56:14, 25 63:21 64:13</p> <p>Services 2:10, 19 11:5 29:7 33:1 56:20 58:10 66:20</p> <p>session 58:21, 24 59:6</p> <p>set 8:6 33:7 70:2 72:7</p> <p>setting 59:5 69:8</p> <p>settings 65:5</p> <p>severity 9:6 10:8</p> <p>share 13:20</p> <p>sharing 59:19</p> <p>Shawn 37:1</p> <p>shelters 29:1</p> <p>Shingler 29:23</p> <p>short 15:6</p> <p>shortages 68:7</p> <p>Shorthand 72:4, 15, 25</p> <p>Shortly 27:9 42:18</p> <p>show 16:5, 13 18:1 29:3, 17 44:9 53:20</p> <p>showing 11:19 23:25</p> <p>shows 16:17</p> <p>shut 20:17</p> <p>shutting 27:11</p> <p>sic 35:11</p> <p>sick 27:2</p> <p>side 16:18 34:24 36:2 37:12 66:17</p> <p>significant 12:13, 15, 20 43:9</p> <p>sign-off 71:2</p> <p>silos 9:15</p> <p>similar 4:13 23:15</p> <p>Similarly 64:4</p> <p>simple 57:13, 23</p> <p>simply 25:23</p> <p>single 62:25</p> <p>sir 40:14</p> <p>sit 60:8</p> <p>site 31:23</p>	<p>situation 17:16, 19 22:22 24:10 52:2, 4</p> <p>size 11:20 21:10</p> <p>slide 4:12 6:20 7:1, 9 16:7, 17 18:16 22:11 23:4, 17, 23 24:6 25:13 31:4 33:14 34:14 37:17 38:15 42:12, 15 43:2 44:11 45:18 48:24 50:2, 3, 8 51:13 52:12 53:7 54:19 61:19 63:6 68:20</p> <p>slides 4:13, 16 7:13 11:19 13:9, 13 15:2, 5 45:10 46:12 47:20</p> <p>slight 10:14</p> <p>slightly 10:7</p> <p>small 41:22</p> <p>Smith 2:18 7:14, 17, 21 11:22 59:1</p> <p>Social 29:7</p> <p>Solicitor 37:6</p> <p>solvable 36:14</p> <p>solve 36:14</p> <p>solving 38:2</p> <p>soon 71:8</p> <p>sorry 19:15 38:13 40:14 49:2 59:23 70:16</p> <p>sort 14:17 21:21 42:2 52:20 57:13 60:19</p> <p>source 14:23 62:25</p> <p>South 27:18</p> <p>spearheaded 35:24</p> <p>specific 31:23 57:19</p> <p>specifics 56:13</p> <p>speed 12:9 66:14</p> <p>spell 70:18</p>	<p>spend 13:12 48:22, 23</p> <p>spent 15:12</p> <p>spread 16:11 26:19 66:6</p> <p>spring 63:15, 17</p> <p>St 26:17</p> <p>staff 27:1</p> <p>Stage 32:17 33:11, 17, 19</p> <p>stakeholder 19:1 23:18 24:20 29:12, 21 48:11 61:21</p> <p>stakeholders 8:7, 15 22:12, 21 23:3, 6 29:25 30:4 43:12 46:14</p> <p>standard 60:19</p> <p>start 9:25 24:12 53:1</p> <p>started 20:18 24:12</p> <p>starting 16:14, 16 51:5 64:22</p> <p>statistics 16:1</p> <p>statutory 42:16</p> <p>stay 27:12</p> <p>Steele 28:18 39:5 49:24 69:25</p> <p>steering 8:5 12:17</p> <p>Stenographer/Tra nscriptionist 3:18</p> <p>stenographically 72:11</p> <p>step 70:12</p> <p>stockholder 17:12</p> <p>stockpile 36:3</p> <p>stood 29:23</p> <p>stop 63:6</p> <p>stopped 31:8</p> <p>store 27:17</p> <p>strange 16:23</p> <p>Strategic 2:13 50:10</p> <p>strategies 55:15 67:1</p> <p>strategy 35:21 41:7 50:16 51:7 57:22</p>	<p>streams 7:4 10:3 35:12, 16 40:4, 8 43:22 44:3, 7, 14 48:14 63:10</p> <p>structure 5:9, 10 6:1 7:3 13:14 28:20 34:8, 13, 17 39:1 43:15, 20 45:22, 24 46:4 57:3</p> <p>structures 4:23 5:24 6:9 51:15 57:9 69:9</p> <p>study 11:3</p> <p>stuff 15:1</p> <p>sub-command 44:22</p> <p>subscribers 24:12</p> <p>subsequently 28:6</p> <p>sub-table 24:18</p> <p>sub-tables 29:17 30:6 43:16, 17 49:1</p> <p>successful 67:8</p> <p>suggested 58:20</p> <p>summaries 51:22</p> <p>summary 21:17 22:18</p> <p>summer 6:4</p> <p>Sunil 2:16</p> <p>supplementary 61:7</p> <p>supplies 35:23 36:5 47:5, 9 55:21, 22</p> <p>supply 35:20 58:8</p> <p>support 9:8 10:21 28:11 37:23 48:5 64:9 67:16 68:16</p> <p>supported 8:5 49:16 61:3</p> <p>supporting 7:3 18:3 68:1, 2, 8, 12</p> <p>suppression 65:23</p>
---	---	--	--	---

surge 33:3, 5
55:18 64:10, 11
surgeries 31:7,
9, 12, 13, 19
53:2 56:7
66:25 67:2, 21
surgery 67:23
surges 67:7
surgical 53:2
63:21
surveillance
9:18 35:14
51:2, 7
symptoms
32:10, 13
System 2:11
7:8 8:1 9:10,
11, 15, 17 18:2
21:24 28:10
46:15 48:16
49:16, 18 52:23
55:19, 25 58:18
60:23 64:13, 14
66:18
systems 22:21
24:20 60:19

< T >

table 5:9, 20, 21,
25 10:2, 3 13:3,
4, 24 14:7, 10,
14 18:14 20:15
21:7 22:4, 7, 14,
15, 19, 25 24:19,
20, 23 28:16
29:11, 18 30:3,
5, 6 34:10, 15,
16, 18 36:7, 9,
13, 24 37:2, 13,
15, 19 38:2, 6,
10 39:5, 11, 20,
22 40:1, 4, 5, 20,
25 41:4, 11
42:13 43:3, 15,
19, 23, 24, 25
44:1, 16, 21
45:20, 23, 25
46:3, 11, 14, 21
47:1, 4, 15, 17,
18 48:10, 13
49:8, 9, 20
50:17, 21 51:14,
18, 23 53:16
55:2 56:20

57:14 59:21
60:5, 10 62:9, 10
tables 25:8
34:11, 20 35:19
36:12 37:22
39:18 40:9
41:2 44:23
46:11, 13 47:14
48:9, 20, 22
50:9, 11 51:23
52:13 56:1, 9
58:15
tail-end 63:16
talk 4:18, 21
5:1, 25 22:12
25:1 31:25
35:16 38:1
62:3 68:3 70:1
71:8
talked 10:25
34:9 48:10
54:25 58:13
talking 6:12
13:12 32:2 63:6
tasks 42:25
team 6:11 18:6
25:7 29:2 36:1,
17 69:19 70:10
technical 43:18
45:3 47:14
50:8, 11, 18
61:15
techniques
68:11
teeny 4:18
teleconference
19:1
teleconferences
17:12 24:15
terms 4:22
11:9 16:1
17:19 21:21
41:11 45:21, 23
56:9 69:8
terribly 42:1
test 18:9 32:10
45:13 51:6
65:13
testing 5:17, 18
20:2 32:2, 3, 4,
5, 8 35:13 41:7
50:15, 16, 17
51:2, 4 60:14
tests 18:11
32:15 60:15

thanks 11:12
19:13 30:11
thing 18:7 21:6
51:12 53:20
58:14 62:22
64:12 65:1
things 6:6
45:19 51:11
58:7 63:3, 13
66:21 67:4
thinking 10:20
30:16 42:3 69:1
third 14:3
thought 16:2
17:9 40:2 45:4
48:2 62:15, 21
69:15
Three-way 39:14
throes 54:11
tightened 46:24
time 4:15, 18
11:20 13:12
14:22 15:7, 9,
13 16:10, 22
20:7 24:13
25:20 28:13
33:10 42:6
44:16, 25 48:22
52:17 53:5, 21
54:1, 17 56:4
64:7, 15 68:22
69:10 72:7, 10
timeline 15:2
54:4
timeliness 54:16
times 12:12
39:23
tiny 4:18
tired 64:15 65:4
title 14:23
today 4:8, 16
5:25 6:15 7:1
11:4
tomorrow 28:19
69:2
tools 9:7
top 23:5 29:16
45:19 64:22
Toronto 33:13,
18 48:1
total 53:8
tour 6:8, 16
69:23 70:6
trace 65:13

tracing 61:5
track 65:1
tracker 5:19
tracking 38:9
trained 68:17
training 68:9, 12
transcribed
72:12
transcript 72:15
transfer 55:6, 8
56:23
transferrable
9:2, 25 10:6
transition 49:23
transmissibility
9:5 10:9
transmission
66:1
transparent
50:19
trends 21:2
Trenton 18:5
trigger 25:21
true 20:2 65:23
72:14
truth 62:25
trying 12:6
22:8 25:16
27:21 41:23
57:13 67:7
turn 7:6 14:21
60:3
turned 32:14
two-week 26:4
type 58:24

< U >

ultimate 38:6
ultimately 37:2
unclear 38:5
underneath 57:9
understand
4:20 12:6
34:22 45:22
understanding
32:4 51:1 69:8
70:24
understood
54:14
unions 8:9
unit 32:23
53:11 56:19
61:6 66:12

units 17:8
33:12 54:10
61:4, 16
unknown 10:17
update 24:22
41:6 53:23
updated 9:16
12:5, 12 53:15
updates 12:13,
15 40:21 48:12
updating 12:22
uptick 65:2
upwards 31:9
useful 51:1
usual 14:17
utilizing 36:19

< V >

vaccinations
9:21
vaccines 65:20
value 5:17
variability 56:17
various 39:18
40:8 55:16
vary 57:10
vented 53:11
ventilators
27:22
venue 30:2
VERITEXT 72:23
version 45:13,
18
versus 27:19
**very-much-
waited-for** 52:4
vice 60:6
view 9:14 28:16
Virtually 1:14
19:22
virus 9:6 10:6,
12, 16, 17, 18
11:11 20:25
26:20 61:12
visitor 52:7
visitors 26:10
visual 16:13
visually 16:4
volumes 53:3
volunteerism
36:17
volunteerisms
36:11
volunteers
36:19

<p>vulnerable 28:23 35:6 36:11, 25 37:1, 3</p> <p>< W > wait 11:15 24:2 waiting 31:11 42:15 wanted 9:4 15:7 21:14 22:3 28:25 31:6 34:4, 7, 10 44:13 46:1 50:18 55:17 61:21 wants 32:15 washing 65:15, 24 waste 51:3, 4 watched 52:20, 21 water 51:3, 4 wave 6:4 25:3 61:24 63:23 65:13 68:19 waves 64:16 ways 22:13, 15, 16 23:3 29:16 41:5 55:14 wearing 65:15, 25 website 25:8 51:20 52:1 61:1 week 23:9 39:22 50:24 64:23 weekday 24:14, 16 weekends 23:7, 8 weekly 24:15, 17 weeks 70:3 Williams 16:25 23:2 43:6 46:22 47:2 51:16 Windsor 33:18 Winnipeg 20:4 winter 63:15, 17 withstand 33:3 64:11 wonder 16:3 Wonderful 11:25 21:17</p>	<p>wondering 19:2 38:18 word 14:22 45:3 words 62:23 work 7:4 10:3 12:17 26:23 35:3, 11, 16 37:6 40:3, 8 43:21 44:3, 5, 7, 14 48:4, 14 56:5 63:10 worked 30:20 56:6 workers 27:3 64:18 68:3, 5 workforce 36:9 working 5:8, 10, 11 16:10, 11 44:15 48:20 51:7 59:24 66:10, 22 works 50:22 59:6 World 16:18 worthwhile 59:14 worthy 17:9 written 25:6 40:17 wrong 13:2 17:18</p> <p>< Y > Yaffe 5:2 Yeah 12:10 13:11 19:24 20:3, 6 38:20 39:14 44:19 53:25 57:11 69:5, 11 70:25 year 8:4 53:4 yearly 12:8 years 8:21 12:16 York 48:1</p> <p>< Z > Zoom 1:14 45:13</p>			
--	---	--	--	--