LTCC meeting with meeting with Revera

Meeting with Revera
on Wednesday, October 7, 2020

77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 7th day of October, 2020, 1:00 p.m. to 3:00 p.m.

BEFORE:

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

PRESENTERS:

Thomas Wellner, President and Chief Executive Officer, Revera;
Wendy Gilmour, Senior Vice President, Long-Term Care, Revera;
Dr. Rhonda Collins, Chief Medical Officer, Revera.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;
Lisa Di Felice, Administrative Assistant, Long-Term Care Commission Secretariat;
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat;

John Callaghan, Counsel, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;
Lauren MacLeod, Corporate Counsel and Assistant Privacy Officer at Revera;
Tom Friedland, Goodmans LLP;
Melanie Ouanounou, Goodmans LLP;
Michelle Roth, Goodmans LLP;
Jessica Franklin.

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

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

COMMISSIONER FRANK MARROCCO (CHAIR): I think I'm here. Good afternoon.

THOMAS WELLNER: Good afternoon, Commissioner.

COMMISSIONER FRANK MARROCCO (CHAIR): Is everyone here as far as you're concerned? I guess it's Mr. Wellner, is it?

THOMAS WELLNER: Yes. Yes, sir, we are all here.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

THOMAS WELLNER: And thank you, again, for allowing us to be here.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we're all here, so we're ready. Well, let me just sort of tell you a little bit about what we're up to.

And I said this to others. Typically when there's an inquiry, something has happened, and people are looking back to try and figure out what has gone on.

But ours is a little different because the pandemic is ongoing. And so, in effect, we've

been called into existence in the middle of something, and it changes the rules a bit. So we're, at this stage, investigate -- so, you know, in a typical inquiry, there's an investigation, there's public hearings, and then there's a report. And that can take a couple of years.

Now, we don't think that's a prudent way for us to go about this, so we're trying to arrive at an interim report and come out with some recommendations before we get into the question of what happened and why it happened and so on. All very important questions.

But that's not where we're at right now, and so we're doing a series of interviews to try to help ourselves figure that out and, in that sense, would be very appreciative of any recommendations that you have based on your experience. But that's the gist of what we're doing.

There's a reporter, Ms. McDonald, who is here, and there will be a transcript.

And that's kind of what we're about. So with that as an introduction, we're ready when you are.

THOMAS WELLNER: Okay. Thank you very

much, Justice Marrocco and Dr. Kitts and --

COMMISSIONER FRANK MARROCCO (CHAIR): Excuse me, Mr. Wellner. I'm a little bit slow this afternoon. I should have introduced Commissioner Coke and Commissioner Kitts. This is not a one-man show here.

THOMAS WELLNER: Again, thank you very much, Justice Marrocco, Commissioner Coke, as well as Dr. Kitts.

We very much appreciate the opportunity to approach things exactly as you outlined, Justice Marrocco, in your comments. So we'll take that very much to heart.

I am joined by my colleagues Dr. Rhonda Collins who is Revera's Chief Medical Officer, and Rhonda has been with Revera since 2017. She brings a wealth of knowledge and of passion for geriatric care. And we, as an organization, are exceptionally pleased to be the only company in Canada that has a chief medical officer position. And certainly throughout this pandemic, Dr. Collins has been front and centre, and I greatly appreciate her efforts. So Dr. Collins.

As well, I'm joined by Wendy Gilmour who is Revera's Senior Vice President of Long-Term

Care, and Wendy has a deep background in numerous healthcare, both acute as well as community care, settings and has been our senior vice president of long-term care since 2014.

And I'm very pleased. Wendy and her team have really worked tirelessly, and I think, again, our intent today is to very much focus on suggestions and things that we think will help things moving forward.

My background, I have had a number of experiences over my working career. I have had significant experience outside of Canada. I've been back in Canada since 2007, and it's all been in healthcare and regulated environments and large healthcare businesses.

So that's our background, and we're very pleased to be with you today.

COMMISSIONER FRANK MARROCCO (CHAIR): One thing before you start, we have tended in the past to ask questions as we go along rather than waiting until the end.

So if that's all right with you, then as questions occur to us, we'll put them to you and just answer them. We'll try not to throw you off the presentation too much.

THOMAS WELLNER: Understood, and we will do our very best to flow with the dialogue and the discussion.

So I just wanted to give a little bit of background, if I could, now that you know a little bit about who we are as individuals.

Revera, we are a wholly-owned subsidiary of the Public Sector Pension Investment Board who invests on behalf of the federal workers -- so RCMP, CSIS border crossing, and all of the Canadian Armed Forces. So that is our share owning.

Revera, we own, operate, invest, as well as develop across Canada, the US, and the UK. So we basically have over 500 residences, either directly or indirectly, that we are associated with, and we have a passion for seniors' care and accommodation and service.

And we range in everything from seniors apartments in certain jurisdictions all the way through to more complex care through assisted living, memory care, and into long-term care as well here in Canada.

Specifically in Ontario, we own and operate 52 long-term care homes, and we have

approximately 6,000 residents and more than 7,000 employees across the long-term care division. And we also own about 59 retirement residences in the province of Ontario.

So one of the other things that's relevant, I hope, for the way we approach things -- and I'll give you kind of some context for how we approach decision-making at Revera -- is we're not a publicly-traded -- well, we're private. We're not a publicly-traded real co, and we don't focus on making distributions, necessarily, to our shareholders.

And we very much focus on choosing our long-term care partners that have long-term horizons and a desire to better the business. And we make sure that our ideologies are aligned and that we balance a socially responsible approach.

So with that, we want to make sure, always, that we're making sure that our long-term care residences are stable and supported by care-first oriented stakeholders.

The other thing, I think, with Revera and, I know, a number of the operators that you may speak to or participants in the commissions work, we have a scale that, I think, allows us to draw on

some capabilities that will hopefully enhance the delivery of services. Those being we have made significant investments in innovation, and we have a Revera innovation fund where we fund entrepreneurs that focus on seniors. We have innovation ambassadors. We've been able to invest in positions like Dr. Collins' positions. So with that, we try to put our residents and staff first.

So with that, you know, today we've really taken in response to this pandemic -- which has stretched everybody in so many ways. We've really taken a multipronged approach to try to respond.

And so, you know, today I feel we're much better able to deal with some of the challenges that are forthcoming in Waves 2, 3, and 4 as we've learned more, as we've adapted more, and focussed our efforts.

And we really have been focussing all of our efforts, and I'm happy to come back and speak again, if the Commission allows, on more mid-term and longer-term solutions.

But to your point, Justice Marrocco, we're really focussing our energies and efforts on operational enhancements that can immediately

impact our preparation for Wave 2 and also collectively for the betterment of the sector. So we are a company that also wants to make sure that we're doing the right thing for the sector.

And with that, we've focussed on a few areas. So if I could, I'd like -- so much of this is focussed on the front line and on what's happened and the human impact to this pandemic. Because we've all dealt with it but no more so our residents and our care teams at the front lines.

And I wanted to turn it over to Wendy just to walk through a very human expression of that from one of our staff members.

WENDY GILMOUR: Thank you. Thank you, Tom.

We just want to state that the impact that COVID-19 has had on our care homes in Ontario has been tremendously traumatic for our families, our residents, and our staff members as well as our frontline workers and our wider community. Revera will continue to work tirelessly to contain the spread of this virus within its homes and protect our residents.

This is an excerpt from a staff member who reached out to me personally, and she has given

me permission to share this with you:

"COVID at Forest Heights was a bad nightmare, a hell that I hope to never have to go through again, a war where there were no winners. The survivors now walk with deep scars many not even realizing the aftereffects that are coming.

COVID at Forest Heights seems very much the same: Keep working; keep going; comfort the sick and dying; care for the families; care for the staff; bag another body; no time to cry; no time to say goodbye; no time to rest; just no time.

In long-term care, we live with death. All of our residents die with us. We celebrate their death with honour, love, and respect. These people are our friends, and in many instances, we are their family.

Death during COVID took a very dark turn, and how we needed to manage the dead was without dignity and respect, and that broke our

hearts.

I was blessed to be with 49 of the 51 people that died. I was able to bring their families in to say goodbye if they wished. I held phones to the resident's ears so they could hear their family's voices sharing their most intimate feelings. I prayed with each one.

Many times, I confess, I removed my mask so they would see my smile when I saw the fear in their eyes to give them a sense of peace knowing the risk but feeling it's the right thing to do at the time. We are broken. We are sad. I do not feel."

I have to tell you, I have read this many, many times. Each time I'm brought back to the devastation that has hit our homes, our families, our residents, and our staff. One of the things that they want everyone to know is they do not want the loss and suffering to be forgotten. Don't sweep this under the rug. We need to talk about it, and we need to heal.

We also want to express our gratitude for the recent government announcements regarding additional funding for long-term care, particularly the recent announcements of the pay raises for our PSWs.

This additional funding coupled with the relationships of support we have throughout our infrastructure, our capital partners, is vital in preventing further outbreaks.

While there's still more work to be done between governments and operators, we are encouraged by the government's response in long-term care that we have received in the past few months.

Rhonda?

DR. RHONDA COLLINS: Thank you, Wendy. Like you, I have a hard time getting through that letter even hearing it. Thank you, Commissioners.

I will try and turn it to a positive note now that we believe that Revera is well positioned to minimize the impact of the second wave. We'll continue to study and analyze our pandemic response plan as the situation further evolves. As we know, it has evolved over the last seven months, and I'm certain it will continue to.

And our preliminary efforts of outcome over the past months are demonstrating of the efficacy of our efforts.

We have, currently, no residents with COVID who have tested positive and no homes in transmission. Despite the fact that the status of our outbreak changes daily, because we have been doing bimonthly surveillance of all of our staff since June, we've been able to identify those staff members who are positive. That allows us to take quick action, and we can then include positive team members to isolate and prevent further outbreak.

I also think it's very important to underscore -- and I know Dr. Sinha has stated this many times: Solid hospital partnerships are vital for mitigating pandemic risk.

We're very proud that our healthcare sector relationships that existed prior to COVID were strong and mutually beneficial, and we never lose site of the importance of continuing to strengthen these relationships and promoting and sharing our experiences, our learning, and our resources.

And I will turn it over to Tom to talk about the COVID-19 experience.

THOMAS WELLNER: Thanks, Rhonda and Wendy. And again, for me, it humanizes things. And having visited our team at Forest Heights recently to have lunch with them, talking to the team, understanding individuals' impact of this particular disease is exceptionally moving and traumatic. So thank you for getting through that, Wendy. I know it's never easy.

So with respect to our response and trying to move forward and be as prepared as we can possibly be, Revera -- you know, my role as CEO, I oversee our operations in Canada, the US, and the UK.

It was early on in this year that I actually took my last trip in February to the UK, and I came back, and we were fully into our pandemic planning. But we very quickly and in a focussed way repositioned significant resources to respond to this.

And as Wendy said, the government's response, we appreciate very much, and we feel we're doing very much our part. Because we are a highly regulated business -- specifically here in Ontario, it's one of the most highly regulated jurisdictions within which we operate -- we already

have many preexisting policies, protocols, strategies in place that were very -- whether it's IPAC, whether it's emergency pandemic planning, or our normal business continuity planning.

But nonetheless, you know, these policies, as good as they may be, you know, none of us were prepared for this type of event, and we are now doing everything we can to make sure that we continue to learn from the first wave so we can be fully ready and even more prepared for the second wave. We have high alert systems, active screening. We did single-site employment well before, in many instances, we were directed to do so as a business.

And also, again, to get back to our social orientation, we cofounded what's called the CAPEs program which basically is a program that's funded, and we are the largest economic provider to that effort when, early on in the pandemic, we focussed on trying to make sure personal protective equipment was available because certain times -- the stress on the system was there.

So we've invested, you know, more than $7 million already just by additional PPE and making that available to other operators across the

system.

We also made a $2 million investment into what's called the CaRES fund to help frontline staff who have been economically or emotionally impacted by the virus. And that's been rolled out, and we did that on our own accord.

We believe it's just the right thing to do, and we also tried to do this, especially for personal protective equipment, at a time when global supply chains were completely unstable. And we worked with 32 other private providers for long-term care and made about 310 other operators allowing them to have personal protective equipment beyond what they could source themselves.

So we feel very strongly that those are, more along the lines of what you were getting to, what we continue to do moving forward. And we'll get back to that in the future.

So, Wendy, I wanted to turn it over to you just to talk a little bit about staffing.

WENDY GILMOUR: So Revera implemented several monetary- and nonmonetary-embedded strategies to attract and retain staff during the outbreak.

We redirected more than 100 of our

support staff to expedite recruitment of frontline individuals. We screened over 10,000 applicants, and we hired over 25 new hires during Wave 1.

We offered free hotel accommodations, free transportation, meal, snacks, and beverages for staff. Some of our staff lived in hotels for as long as six months. We issued pandemic pay prior to receiving funds or directions from the government.

We also had daily meetings with our leadership team, our clinical, human resources, and operations team to discuss the potential areas of greatest impact -- PPE, IPAC, human resources -- to decipher the directives that came from various sources at various times in the days and weekends. And we were able to synthesize this content and share it out to our homes.

And I think one of the key things that we did is there was daily communications from Dr. Collins to the home. This was done so we had one common voice and the truth that came from one location. So when they received this email from Dr. Collins, they knew they had actions to do and that it was very important.

We also implemented regular business

continuity team meetings. At the onset of outbreaks, an issue was circulated via email, and then a call was organized with team members of the clinical and operations team within hours of the declaration of outbreak. Daily calls ensued after that with the leadership of the homes as well as regional/national leads until the outbreak was declared over.

Dr. Collins also sent out communications to medical directors and attending physicians of policy changes, educational opportunities, outbreak data from provinces, et cetera. This provided, again, the one source of truth for all homes.

Rhonda, do you want to talk about IPAC?

COMMISSIONER ANGELA COKE: Just a --

COMMISSIONER FRANK MARROCCO (CHAIR): Just before you do that, Doctor, you know, one of the things we've heard is that there's this problem of people working part time in different locations for different employers. And do you have a view on why this occurred? What was the driver for this?

WENDY GILMOUR: So we are a 24/7 operation just like hospitals are, and we do require some part time in order to fulfill those

obligations. But what we also find when we went to a single-site employer was that many people took two part-time jobs so they could supplement beyond full-time hours.

THOMAS WELLNER: The other thing --

COMMISSIONER FRANK MARROCCO (CHAIR): So you mean when they were offered a -- when they had a full-time position, they were still taking extra work to try to make some extra money?

WENDY GILMOUR: Or they would take two part-time positions to go beyond the 7.5 or 8 hours a day.

COMMISSIONER FRANK MARROCCO (CHAIR): I see. Okay.

THOMAS WELLNER: And if I could, Justice, the challenge here, I think, initially, was one of balancing risk. And initially, single-site helped with respect to the infection control risks reduction, but it's not a sustainable orientation.

And I think it gets into -- to me, now that we've got active, full, forward screening protocols, as we mentioned before, I think it's also linked directly to active testing, a surveillance testing program, at the sites where

we've been able to monitor and more proactively allow -- and that also links to the ability to have staff.

And, again, this 24/7 operation, we need a blend of full-time and part-time staff based on weekend shifting; based on, you know, the various collective agreements that we have to make sure that those are in balance as well so...

COMMISSIONER FRANK MARROCCO (CHAIR): It was suggested by someone who was here -- I just don't remember off the top of my head who it was -- that it was economically advantageous for a home to have two part-time people rather than one full-time person. Do you think that's correct?

DR. RHONDA COLLINS: If I may, I wonder if that pertains to the fact that part-time positions do not require benefits. However, Revera pays part-time staff benefits.

THOMAS WELLNER: Yeah. I would say that's not an accurate statement, Justice. We do provide, in addition to the part-time hours, a full benefits package to the people.

WENDY GILMOUR: Right. So --

COMMISSIONER FRANK MARROCCO (CHAIR): So from your perspective, there would be no

economic -- if benefits were the incentive, it doesn't exist for Revera. It's the 24/7 --

WENDY GILMOUR: It --

THOMAS WELLNER: The flexibility of staff, I think, is the main message.

WENDY GILMOUR: Yeah. I think the other thing is we have what's called a Case Mix Index for which we are funded under, and that happens every year. It's about a year to two years behind.

And you either receive more funding in your home, or you get reduced funding in your home. So every year, homes are flexing up and flexing down. So we need to have some of that flexibility in the system to allow us to do that.

To me, that creates an immense problem because you don't know from year to year how many staff you're going to have in your home.

COMMISSIONER FRANK MARROCCO (CHAIR): And so this flex mix funding causes a flex mix in the staff in response to whatever the funding arrangement is. But if it's two years out of date, what --

WENDY GILMOUR: That's the other problem.

COMMISSIONER FRANK MARROCCO (CHAIR): You need a crystal ball in addition to the --

WENDY GILMOUR: And basically what you're doing is adjusting for where you were two years ago. It may not be where you are right now. So your Case Mix Index might have gone up, yet you're reducing staff because you don't have the funding.

COMMISSIONER FRANK MARROCCO (CHAIR): I see. Okay. Thank you. A couple more questions.

COMMISSIONER ANGELA COKE: Could I ask a question.

COMMISSIONER FRANK MARROCCO (CHAIR): Certainly.

COMMISSIONER ANGELA COKE: Sure. Wendy, you had mentioned, if I heard right, that you were able to screen 10,000 staff and hire -- was 2,500?

WENDY GILMOUR: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

COMMISSIONER ANGELA COKE: Okay. I'm just wondering if you've been able to retain those new staff.

WENDY GILMOUR: So right now, we have

flexibility. So the government has given us the flexibility -- let me give you an example.

If you are a dietary aide, you must have a certificate under our regulations. If you are a -- if we were never allowed to bring in untrained skilled workers. Now that we have the flexibility, we have brought them in. We are working now on getting them the skills they need so they can stay with us.

We have been able to retain most of those individuals, but if the restrictions are removed -- I mean, or if the restrictions come back, we will lose them because we don't have the classification for them.

COMMISSIONER ANGELA COKE: Okay.

WENDY GILMOUR: So it is critical we remain in that flexibility.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts, you had a question, I think.

COMMISSIONER JACK KITTS: Yeah. I'm just wondering if someone could give me a very brief primer on the governance and management structure because I'm having a hard time fitting into who's responsible for what as we go along.

You've talk about leadership, staffing,

IPAC controls, PPE-supplied medical directors.

I think, Dr. Collins, the medical director's report to you, but can you just give me a picture of how the governance and management structure came into action and what roles were played in the crisis?

THOMAS WELLNER: Sure. I'll start. So Wendy reports into me as the head of the long-term care division. I have, on my management team, Wendy and her counterpart who oversees our operations of retirement.

And then we have Dr. Collins acting as our chief medical officer. Within that, they each have -- Wendy has a regional team that basically oversees -- they're called regional directors of operations. They oversee roughly 8 to 10 long-term care homes within the provinces that we operate, and those people are responsible -- then there's an executive director that is the responsible individual within the individual long-term care home.

WENDY GILMOUR: As well, we have regional teams that are grouped as educators or clinicians that are also responsible between four and five homes each. And together, both -- the

pair. And they, also, are responsible for all education and clinical directions within the home.

U/T DR. RHONDA COLLINS: And we would be happy to provide an organizational chart, if that would be helpful.

COMMISSIONER JACK KITTS: Yeah. Okay. Because I think I understand, Dr. Collins, that you're sort of the lead, the single source of direction for the medical directors in the homes.

And, Wendy, are you the one that the executive directors report through? I guess the executive --

WENDY GILMOUR: No.

COMMISSIONER JACK KITTS: No.

WENDY GILMOUR: No. We have vice presidents. I have two vice presidents in Ontario, and the regional directors of operations report to them.

COMMISSIONER JACK KITTS: Okay.

WENDY GILMOUR: And the executive directors report to the regional directors of operations.

COMMISSIONER JACK KITTS: Okay. And the nursing directors in the homes report to the executive director in the home?

WENDY GILMOUR: Yes, they do.

COMMISSIONER JACK KITTS: But the medical directors report to Dr. Collins?

WENDY GILMOUR: Yes, they do.

COMMISSIONER JACK KITTS: Okay. Thank you.

THOMAS WELLNER: And then I guess I could add, Dr. Kitts, from a governance perspective, although we're a private business, we have an independent Board of Directors as well as full, internal-audit machinery. We have a Quality Committee that is chaired by Pat Jacobsen, and we have Dr. Cal Stiller who is on that Quality Committee. We have the Governance and Human Resources Committee. We have an Investment Committee, and we operate akin to what most large entities would have from that perspective as well, if that helps.

COMMISSIONER JACK KITTS: Thank you very much. So that's the governing body and then the management?

THOMAS WELLNER: Yeah, yeah. That's correct.

COMMISSIONER JACK KITTS: Thank you. Thank you.

WENDY GILMOUR: We also have a large HR department that is supportive of everybody in the field.

DR. RHONDA COLLINS: I'd also like to add to that that although we are at the corporate level and there are people who report to us from the various departments of clinical and operations and human resources, we are very hands on as a leadership team.

All of us are on phone calls, emails, on sites. I've been to a couple of our sites in outbreak to support families, as has Wendy. So we are very involved from a corporate perspective.

WENDY GILMOUR: I take one day a week to be in the homes.

THOMAS WELLNER: Yeah. And I would say, though, I've spent probably a completely disproportionate amount of my time in the last six months doing very operationally-driven activities. One thing with this pandemic, it very much focusses everybody on the here and now trying to collectively support the effort, so...

COMMISSIONER JACK KITTS: Thank you.

DR. RHONDA COLLINS: So if I may, I was just going to speak very briefly to infection

prevention and control because in several of the themes we see that include staffing and PPE, infection prevention and control is a vital component.

I work together -- Wendy spoke together with this a little -- with our national director of clinical services as well as our vice president of clinical care and our clinical support manager, who is a certified infection prevention and control specialist, and then the operations team to make sure that any critical initiatives we have can be executed on to operations.

And I work closely with these formally. We meet weekly. Informally, it's much more frequent than that but to provide some specialized support and training through the playbook, which you're going to hear about in a few minutes.

Some of the things we have implemented through the playbook include enhanced surveillance testing, more frequent infection prevention and control audits, and more extensive and user-friendly refresher trainings for staff on IPAC policies and procedures that occurs throughout the shift.

Wendy, did you want to talk about

environment?

WENDY GILMOUR: Right. We have ensured and heightened cleaning protocols through secured cleaning resources. We've purchased electrostatic instruments, actually, at the very beginning of this process that clean and kill bacteria and viruss in one minute. These have been deployed to the homes, and they're highly -- result in high cleaning and disinfectants.

We're removing carpets, and we've developed a room divider that we've installed -- that we are installing in our three- and four-person rooms to provide a distance barrier to keep our residents safe. This has been endorsed by our infectious disease specialist, Dr. Krystyna -- I always get this wrong, Rhonda -- Ostrowska.

THOMAS WELLNER: "Ostrowska."

DR. RHONDA COLLINS: "Ostrowska."

WENDY GILMOUR: "Ostrowska." And we are in production to put them in all of our older homes and at the cost of 550,000 -- $550 per partition.

We also built an existing signs and symptoms monitoring tool, and we created a tool for timely tracking and reporting of COVID-19 outbreaks

in our homes. In addition, we've created an internal dashboard to closely monitor our staffing as well as our PPE levels, and we do this on a weekly basis.

THOMAS WELLNER: So with that, I think we'll try to get into some more specific examples and recommendations for the future. One of the things that we decided that was important to do -- and this was in conjunction with our board and our Quality Committee -- was our pandemic response plan -- which we circulated externally in early July or mid July; I think it was the 17th, to be specific -- contained the concept of whilst we have lots of protocols and lots of processes and are used to dealing with various outbreaks -- be they enteric or respiratory or whatever -- this virus is causing us to try to figure out different ways we could lead.

So we are one of the only companies or I think the only company that has enlisted an external advisory panel. The purpose behind this external set of advisors is we feel that it's very important to restore confidence in the congregate living setting as a necessary part of the healthcare continuum, is one reason.

The second reason is, you know, we think it's -- if we have all these activities that we're doing, if we can get external views from experts that we respect to really give us critical views on our approaches and then better what we are doing, that's got to be good.

And the third reason is that we will make this available publically in an effort to play a leadership role to enhance the understanding of both the space, what the experiences have been.

Bit here, basically, you'll see -- I asked -- and Dr. Collins and I together have been really working hand in hand on this one. But I asked Dr. Bob Bell if he would kindly help us, and he is our independent chair. We've got experts across all the constituents. A lot of the names -- I think two or three of the names you've already heard from, and they're certainly not shy about giving us their opinions. And they have basically free rein to look at what we have, what we can do better, and we've contain their suggestions.

So again, for us, it's the right thing to do, and it's basically something that we can talk more deeply about as well.

COMMISSIONER JACK KITTS: Could I just

ask a question?

THOMAS WELLNER: Yeah.

COMMISSIONER JACK KITTS: Did you strike this advisory board to deal with Wave 1 pandemic, or was it created to advise on Wave 2?

THOMAS WELLNER: It was created more to advise on Wave 2, in short. And certainly needing to provide the context of what we experienced in Wave 1 and, as well, we have, as part of our pandemic response, a data and analytics project which basically takes a machine -- we bolstered our own internal capabilities around data analytics and asked Accenture to help us put in some machine where it would basically pull and analyze the data that we have so that we could inform. But no, it specifically is to focus on how we can enhance ourselves for Wave 2.

COMMISSIONER JACK KITTS: Thank you.

THOMAS WELLNER: Okay. So we want to basically talk now -- one of the areas that we think will be helpful and can be helpful -- it has been helpful for us operationally, and we believe it can be helpful for the operators across the sector. And we'd be happy to make it available more broadly, but it's the concept of a pandemic

playbook, and I'll let Wendy walk through some of the details.

But if you think about when everybody goes in to outbreak mode and you're into a pandemic response at the site and you've got multiple directions happening from multiple constituents, we wanted to make it extremely -- as easy as we can to provide checklists and guidance to executive directors on that.

So with that, Wendy -- it's a very pragmatic approach that is very operational in nature.

So, Wendy, over to you.

I think you're muted.

WENDY GILMOUR: There. Not muted now. Thank you, Tom, very much. Appreciate that.

This playbook is actually very frontline friendly and useable. It is a living document as it will change constantly as we get new directions, new best practices, as well as new initiatives.

I will give you an example of a home that just went into a staff-person outbreak. She said that getting the playbook was fabulous. It helped her to focus on what she needed to do.

Because when you go into an outbreak, it does become very chaotic, and this allowed her to keep focus and do what needed to happen and do it in an orderly fashion.

The playbook is actually developed in four phases. One was the prevention and preparedness; the other is outbreaks which is to measure the response of the outbreak when a minimum of one positive case, be it the staff or agency, is identified; the post outbreak recovery which measures the end of an outbreak to transition back to a prevention mode as well as reopening, so the gradual return to normal as the pandemic plays out.

And one of the things that we found as we came out of Wave 1 is returning to normal was not easy. That was -- shutting the whole home down was a lot easier than actually getting them back to normal.

We have rolled this playbook out to all of our homes. It includes quick-reference checklists to highlight key areas. Residents use this checkbook as a quick reference tool and refer to relevant sections in the playbook for more detail.

So we've got a bit of a demonstration.

There we go. So this is the playbook. As you can see, going down, you will see the table of contents, and you can actually just click on the table of contents, and it will take you to that section.

We have -- it is a little long. It is 53 pages, but it's full of actual documents. So you can take us down to the next slide.

This is the overview, again, as I talked about. Where most homes are now taking the time is under prevention and preparedness. But once they go into an outbreak, they've got the one to move in. Can we go to the next slide?

So one of the other areas that we wanted to show you is once you get into the document, we can actually click and find various components that you can identify.

So we were going to go into one in particular, Lauren, that was going to take us to the management outbreak.

So here we are, and here is the checklist that you would see under "Outbreak Roles and Responsibilities" -- so this is the one that she found so amazingly wonderful to keep her focussed. And it goes on and on and on, and you

get to go through it very orderly getting you ready for the outbreak, as you can see. There's 14 pages of this checklist, so it's not small.

One of the other things that's in this playbook is videos. So you can actually go in and pull the videos. Because when we start a shift, we do donning and doffing, every shift. And when we are in full outbreak, we do it twice. Here's an example of one of the videos that's embedded.

(VIDEO PLAYED WITHOUT AUDIO)

And throughout this, there is vocal words telling you what to do, how to do it, what should happen here.

And we are going to be sending you a soft copy of the playbook. You will be able to actually go in and see many of these. However, if they are connected to the Revera site, you won't have access to those, but you will have to the other areas.

So this is the playbook, and as I said, it is very, very helpful. It talks about isolation of symptomatic residents, staff wearing surgical masks at all times. I will state, though, that we did go forward faster than the government did in September with Wave 2. We announced it internally

two weeks prior to the government making the announcement due to what we were seeing happening in our predictive indexing. And we went to not only full masks but also eye protection in all of our homes. We went into high alert in Ontario right across the board.

We also separated many residents as possible into single rooms with a maximum of two residents per room. We set up dining two metres apart, et cetera. So we've done all of these activities getting ready for Wave 2 as well.

Tom, do you want to take us through the pandemic response plan?

THOMAS WELLNER: Sure.

COMMISSIONER JACK KITTS: Just a quick question about the book.

WENDY GILMOUR: Certainly.

COMMISSIONER JACK KITTS: Who contributed to the book?

WENDY GILMOUR: Well, that was very interesting. We actually worked with the Burnie Group, a consulting group, as well as Responsive. They asked if they could work with us when we developed the playbook. So we said absolutely. So we worked together on that. They, then,

implemented their policies/procedures in a different way than we did, of course.

But we are also -- today at the OLTCA webinar for our members, we will be presenting Responsive's playbooks for everybody to use. This is not something that we feel we need to keep to ourselves. We're more than happy to share it.

The embedding of our policies and procedures are just for us, but anybody can take it and do their own.

COMMISSIONER JACK KITTS: Excellent. Thank you.

THOMAS WELLNER: Yeah. There was a lot of operational connectivity with our directors of clinical as well as the executive directors at the sites. We had lots of joint work on that.

WENDY GILMOUR: Yeah, most of the -- we had our IPAC people involved, our IPAC committee, which Rhonda and I co-chair, along with Dr. Krystyna Ostrowska.

And we also had frontline people involved because we needed to make this useable. We didn't want it to be some big administrative thing that nobody would ever pull out of their library when they needed it. So it needed to be

useable. It needed to be highly valued, and what we're hearing is that it is.

THOMAS WELLNER: Okay. That's great. Thank you, Wendy, and thanks for the questions. We think it's a very practical, pragmatic tool that just can help really focus for Wave 2.

Our pandemic response also included focus on five key areas. We'll talk a little bit more about staffing, and we'll talk about some of the clinical orientation things. But before we get there, I just wanted to highlight one area which -- again, it's both a near-term opportunity for Wave 2 but a mid- and long-term as it relates to how can we get the physical infrastructure to complement and make the tasks of infection control and isolation and communications with families and the overall experience for residents in long-term care to be better?

You know, what we've been able to find is, you know, there is very much a link, and I think you've seen that in some of the media reports as well as some of the independently provided analytical support or assessments of ageing infrastructure.

We've found the same thing in our data

exercise where older -- especially C and D homes, where there are still four-bed wards as well as multiple residents having to use bathroom facilities.

In our portfolio, we have a significant number of these types of locations that we've been pushing very hard over the last five or six years. I used to the -- well, I used to be younger, but in the long term, we need to get these older spots redeveloped.

You know, the other things that -- you know, making sure that surfaces -- and part of what our work with the external advisory panel -- two individuals on that panel, aside from Dr. Ostrowska and Dr. McGeer, as well as Mark Loeb, who provided insights into infection control.

We had two individuals, one named Santiago Kunzle who is an architect who has worked with us to design and enhance the designs of our long-term care homes. But also, we had Dr. Diana Anderson who Dr. Collins was -- I credit her with recruiting -- who is a "dochitect," and she's both an infectious disease specialist -- she's Canadian; grew up in Montreal, and she's an infectious disease specialist who also went back and did an

architectural degree. So she has been very helpful to us in these designs.

So that's something that I'd like to come back to in the future and hopefully will be helpful to the committee. But in the short term, you know, there are 38,000 people waiting for long-term care support, and it's certainly the capacity --

This four-bedded ward question, what we have done, I think, is right now, we've been limiting four-bed wards to two residents. That's been very helpful in the short term, but that's not a sustainable long term thing.

If you think about it, that will, just by the nature of it, remove necessary beds from the system. But we feel it's the right thing to do from a infection control standpoint and to deal with the second wave. And we --

WENDY GILMOUR: Tom, if I can, for us alone, it means 800 beds lost.

THOMAS WELLNER: Yeah.

WENDY GILMOUR: And for the system in Ontario, it's 4,500 beds lost.

THOMAS WELLNER: Yeah. And so --

COMMISSIONER JACK KITTS: Could I just

ask -- this is very helpful, and I wonder if you could just give us a very short preview of what happened in Wave 1 to your 52 long-term care homes -- how many in outbreak, you know, that sort of thing. Could you do that?

WENDY GILMOUR: Yes. Out of all of the homes that went into outbreak, only one of them was not a C or D home. The rest were all C or D homes. What happened, I think, is that we were not able to get PPE at that stage until we went into an outbreak.

And once that happened, basically it had spread in the home. And when you're in a four-bed room, everybody in the room became positive.

THOMAS WELLNER: The other thing I think that's an important point here, Dr. Kitts, as well, is if you look at the outbreaks that we experienced in Wave 1, there is a significant difference between the time period prior to April the 8th when universal masking was embedded, and then you can see significant differences there.

So, you know, one of the questions I've asked myself is if I could do something different, I would have wanted us to be able to do universal

masking well in advance of that particular time. Because the difference is in the dynamics between that period and the period after are significant.

COMMISSIONER JACK KITTS: Did you have sufficient PPE to do the universal masking as of April 8th?

THOMAS WELLNER: Not as of April 8th. Unless you went into -- we did as an organization, yes.

WENDY GILMOUR: Yeah, we did, we did.

THOMAS WELLNER: Yeah.

WENDY GILMOUR: And some other --

THOMAS WELLNER: That was another --

WENDY GILMOUR: Some other provinces gave PPE to us, so we were meeting for that province, specifically. But then that allowed us to keep our supplies for those provinces where we did not get supports. And so we were able to go to universal masking, absolutely.

Remember, too, the other thing that we had is we need to keep our occupancy up at 97 percent. Most of our homes were close to 100 percent which meant we had no capacity to move people and cohort.

So we really relied on our hospital

partners to take some of those people and put them into their environment so that we could do the cohorting in our homes that were in outbreak. That helped tremendously.

THOMAS WELLNER: Yeah, I --

WENDY GILMOUR: And --

THOMAS WELLNER: And that goes back to the aging infrastructure question. It's extremely hard to cohort in some of these four-bedded wards and older homes, as you know, Dr. Kitts.

COMMISSIONER JACK KITTS: Yeah. So early on, if you say "what happened," you say "we have older homes with C and D beds," that's a high risk?

THOMAS WELLNER: Yeah.

COMMISSIONER JACK KITTS: "We did not have sufficient PPE before April 8th, and we have high occupancy levels partly due to the hospitals moving patients and making room in the hospitals." Those are three big risk factors that you've just described?

WENDY GILMOUR: Yes. The other, I would say, is staffing. So what happened is when you go into an outbreak, you have staff that don't show up. We had staff who just quit. We had staff

who were terrified who had other issues like elderly members at home or immunosuppressed family members. So in some instances in our home, we went down within one day down to less than 50 percent of our staff.

COMMISSIONER JACK KITTS: What was the impact of working at one site only? I don't recall when that came up, but --

WENDY GILMOUR: That was not at that point. So prior to April the 8th, that was not an issue. We went to one staff shortly after April 8th. I think it was the week after.

Again, that was prior to the directives. That was within our organization. We went to one site ahead of it. It did create additional pressures, but we felt it was the right thing to do.

THOMAS WELLNER: Yeah. At that point --

DR. RHONDA COLLINS: I --

THOMAS WELLNER: -- if you think of how much was unknown about the virus as well --

COMMISSIONER JACK KITTS: Yeah.

THOMAS WELLNER: -- I remember having to make some of these decisions that you're

balancing off at that stage decisions, risk decisions, that are really focussed on infection control in the near term.

I think since then and, again, since we've been able to get screening, since we've been able to put in more surveillance testing, that's allowed us to balance off things a little bit.

Because as you progress through the pandemic, one of the challenges we had was relating to communications with families and families missing their loved ones and social isolation of residents. Enabling that balance to happen, especially through the summer period, has been a very important thing just to continue to restore the humanity with residents and make sure the connectivity with their families is there.

But again, changing the balance to having to do that during --

WENDY GILMOUR: I can give you a very interesting example. When we went into a severe outbreak in ReachView, which is in Uxbridge, we reached out to the community, and they offered -- because we had no cook, and so they offered to actually set up a cooking station in their community hall, and they were going to transport

the food to the long-term care facility. We were able to manage to get a cook, and so we didn't need that.

Just also let you know what happened at that home. In Uxbridge, they gave all of our staff Citizens of the Year Awards for what they went through. It was really heart touching.

DR. RHONDA COLLINS: And just to add, I think that this completely enhances the idea that there is a necessity to work with all of our community partners in these situations.

I think that any scenario we've had, the outcome has been based on our ability to work very well with the hospital partners, with the Public Health units.

And I think going forward, I can't underscore enough the importance of continuing to have those collaborative and comprehensive relationships with all the sectors so that everybody understands what one another is doing.

COMMISSIONER JACK KITTS: What --

COMMISSIONER FRANK MARROCCO (CHAIR): What kind of -- oh, sorry, Commissioner. Go ahead. You muted yourself, Jack.

COMMISSIONER JACK KITTS: Sorry. I was

just going to ask what kind of a relationship was it, and is it still ongoing with the hospitals in Public Health?

WENDY GILMOUR: Absolutely. Absolutely, it's ongoing. You know, one of the very successful ones actually was Ottawa. So as you know, we had a very large outbreak at Carlingview, and the Ottawa Hospital -- we already had a very good relationship.

They stepped in immediately and supported us with staff. They supported us with PPE. They took some of our residents -- we didn't actually decant Carlingview. We had daily calls with them. Their IPAC came in. Their physicians came in. It was very, very helpful in supporting us in getting through this. We saw the same thing at Forest Heights with St. Mary's. They were also very supportive. So absolutely.

One of the things that we did find that was very problematic was the inconsistency in some of the things that were going on. So I can give you an example of Garden City when they went into outbreak. It wasn't a severe outbreak. It was a long one but not severe.

And EMS came in and did the training of

our staff on PPE at the announcement of our outbreak. The next day, the Public Health unit came in and contradicted everything that we were told. The next day, the same health unit, different person, contradicted that.

So we were getting a whole bunch of different information that resulted in a lot of confusion, and that resulted in cohorting that should or shouldn't have happened. And we saw that in many instances. And I think we saw that, Rhonda, at Forest Heights which created a great deal of confusion.

Some of our residents at Forest Heights were moved 12 times. These are people with cognitive disabilities.

DR. RHONDA COLLINS: And to your point, Wendy, I think that the ability of us to get on phone calls -- so the situation, for example, at Garden City Manner, the ability of our team to get on a phone call with Public Health and explain to them -- one of the issues that I'm seeing throughout the pandemic is a lack of understanding of what each sector does.

Most physicians in emergency have not stepped into a long-term care home before and are

not necessarily aware of what we can offer.

And I had the privilege of presenting last week to you through Ontario Long-Term Care Clinicians, and one of the recommendations was about additional IPAC training for physicians.

And so one of the things that we did in Ottawa was I talked to all of my attending physicians and medical directors and said at the home with an outbreak "how many of you are comfortable with your current IPAC training?" And they really weren't.

And so I was able to organize, with the hospital, training for our long-term care physicians with the hospital physicians. So that's the type of collaborative approach I'm speaking of with Public Health.

We were with able to say "some of the things that you're recommending are not really well executed in our environment, and here's why." And having Dr. Ostrowska on the phone with me on the meeting with me to help give some additional credibility from an IPAC and PPE standpoint was also very helpful. And it led to more conversations and discussions about what we can do and what we should do and keeping the --

At the bottom of all of this is that this is our resident's home. It's not a hospital. It's not an acute care setting, so we need to respect our residents and their homes.

COMMISSIONER FRANK MARROCCO (CHAIR): Who leads the collaborative effort? Is there a problem with -- or who leads it? How does it happen?

DR. RHONDA COLLINS: It depends on the situation and the scenario.

THOMAS WELLNER: Yeah.

DR. RHONDA COLLINS: In Forest Heights, we were proactive in reaching out to the hospital and the Public Health unit when we went into outbreak. And I think that -- ideally, any time there's an opportunity to reach out to somebody proactively, it shows that we want to work together.

Sometimes it would be the hospital reaching out if they recognized that there was a challenge and had some resources to be able to offer.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you need someone to mandate the collaboration? And I appreciate that, you know, it's a private

business, and I can understand -- but I can foresee situations where they might not be as open.

I don't know for a fact, but I can imagine where some people would figure, no, we have it under control. And you looking at it would say "no, you don't. You don't have it under control." Somebody needs to call the shot, I think.

DR. RHONDA COLLINS: Well --

WENDY GILMOUR: The ones that we were involved in -- and we probably were involved in five serious ones -- we reached out; they reached out; we worked together.

What we found is, you know, the five structures that are still in place as it relates to the LHINs, they seem to take more of a lead role in this. They would reach out to us and say "do you need help? Do you need support? Do you need staff? Do you need PPE?" And then we would get on the calls and start to facilitate it.

We were very lucky. All of the hospitals and groups that we worked with were very, very good. And as I said, we've also had relationships which also helped, particularly in Ottawa area.

Tom?

THOMAS WELLNER: Yeah. If I could just add, as well, I know Dr. Collins has participated in more tables than I know what to do with, but she's very knowledgeable. But if I go back again -- going back to, Dr. Kitts, your point about Wave 1 -- I had, initially, back in February, a significant number of chats with Andy Smith at Sunnybrook really talking about -- at that time, long-term care was supposed to provide surge protection for hospitals.

And as you know, the difference is now, I think, going into Wave 1 is we're going to have elective surgeries that have come back up. Capacity was there in the hospital. We got supports.

So one of my concerns for Wave 2 is now that hospitals are back up to closer to normal capacity, if not at normal capacity, we're going to have to figure out ways to support the alternate level of care patients that may be there. And again, it's that whole dynamic.

But back to your question on the situation in Ottawa, I personally spent a lot of time getting to know Cameron Love quite well. And so, you know, there's a lot of dynamics and working

that can -- as long as it's positive and everybody comes with a collaborative mindset --

Justice Marrocco, to your point about do things need to be mandated, I think that -- one of my big concerns for Wave 2 is the fragility of the staff that we have that have gone through this going into Wave 2.

So anything we can collectively do to allow them to not be distracted, to be supported, and for everyone to work in a positive way, I think, will go a long way to helping.

COMMISSIONER FRANK MARROCCO (CHAIR): I should say, Mr. Wellner, I tend to take a break around 2:15 or so for ten minutes. Let me know when it's a convenient time to break off. I'm not emotionally committed to 2:15. I can be somewhat flexible.

THOMAS WELLNER: Well, you know, we've talked -- I mean, I can just make a couple more comments, I guess, on the physical infrastructure, and then maybe we can come back around just our external advisory panel. Would that be okay with the Commissioners?

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, that's fine.

THOMAS WELLNER: Okay. And, again, I would gladly come back and do a much more specific focus on long-term care redevelopment and suggestions for improvement, which I'm personally very passionate about.

But in the short term, I think the ability -- one of the things we're recommending from a building infrastructure standpoint is around the separation of the four-bed wards. And I think we've got relatively inexpensive plexiglass partitions that we think will help. So that's one of the specific recommendations that we have.

And then I think a lot of the -- we're certainly doing work on our infection control as well as the additional support for HVAC and airflows and things that we can do in the short term that our capital and tech services teams have been implementing across the portfolio.

But I'd really probably stress there in the short term, and then maybe we can take a pause and then come back for our external advisory panel session.

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine. If this is a good time, we'll take ten minutes.

THOMAS WELLNER: Sounds good.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Bye.

-- RECESS AT 2:10 P.M. --

-- RESUMING AT 2:20 P.M. --

COMMISSIONER FRANK MARROCCO (CHAIR): A couple things, Mr. Wellner. Can we get a copy of the playbook?

U/T THOMAS WELLNER: Most certainly, we would be pleased to make that available to the commission.

COMMISSIONER FRANK MARROCCO (CHAIR): Great. Thanks. And our silence about your -- you shouldn't misconstrue our silence about your offer to come back. We will probably take you up on that --

THOMAS WELLNER: Good.

COMMISSIONER FRANK MARROCCO (CHAIR): -- once we are able to turn our minds to a more long-term thinking about this.

THOMAS WELLNER: Yeah. And there's some other additional short-term things, hopefully, that will be helpful as well.

COMMISSIONER FRANK MARROCCO (CHAIR): We're looking forward to hearing it.

So I guess we're ready to go if you're ready to go.

THOMAS WELLNER: Okay. Sure. So again, just to kind of reorient us for the next flow of dialogue, you know, we have our pandemic response plan. We talked -- again, we're focussed on the five areas. We've gone through building and infrastructure. I've got a few more comments to make on that, perhaps, towards the end.

But I wanted to then move into the external advisory committee and just allow Dr. Collins to speak more specifically to that, if it would please the Committee.

COMMISSIONER FRANK MARROCCO (CHAIR): Certainly.

THOMAS WELLNER: So, Dr. Collins, over to you.

To get you unmuted...

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, you're on mute, Doctor.

DR. RHONDA COLLINS: Can you hear me now?

THOMAS WELLNER: We can.

DR. RHONDA COLLINS: Oh, okay. So I dialed in on my phone, so that's why. Okay. Sorry

about that.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, now you're muted again.

Doctor, we can't hear you. We'll have to get her to repeat it.

Ms. McDonald, can you unmute her?

THE REPORTER: It doesn't appear that she is muted, actually.

THOMAS WELLNER: I think she's dialed in on her phone, but she seems to have muted her phone.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, maybe the phone is muted.

We can't hear you, Doctor. We aren't able to hear you. So is your phone muted?

THOMAS WELLNER: If she can't, I can try to speak to her part.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Sure.

Tom FRIEDLAND: Tom, I think she's in the middle of trying to reconnect, so perhaps just give her another second to do that.

THOMAS WELLNER: Yeah. One of the things, if I could, just as it relates to building and infrastructure, one of the areas that I don't

think would cost the system any additional funds -- but certainly if the past is any predictor of the future, I personally have been trying get our older homes redeveloped for more than, probably, the last five years.

One of the points I didn't make early on is just the approvals process and the various steps we have to go through. We -- the linkage between municipalities -- the sort of steps to get -- we've made applications for more than 30 new residences.

Anything that can be done to streamline that process to enable us to batch -- you know, in our case, we could batch four or five sites at once, bid those out, and it's -- again, it's in everybody's interest; it's in the public interest; it's in our interests; and it's in the interest of our construction partners to do that.

I think the other dynamic that I would say would be helpful around building an infrastructure is just more harmonization and even looking at long-term care as a social infrastructure. It doesn't seem to get recognized in municipal plans that way.

We get hit with significant development

charges that would make it not feasible. So whereas people are welcoming public housing into projects, long-term care doesn't get classified like that.

And then the other thing on the sort of approval side of things would be as it relates to being able to do modular construction. Again, a lot of the designs that we've come up with lend themselves to a more efficient and effective -- both infection control.

But if you can do that through a modular component, that would be very helpful to us as we try to redevelop some of the staging infrastructure for the system.

COMMISSIONER FRANK MARRACCO (CHAIR): Is the modular infrastructure not permitted?

THOMAS WELLNER: It is starting to become more recognized, but that's only been a recent push. So the more that we could have it go in that direction, I think, would be helpful to everyone.

COMMISSIONER FRANK MARROCCO (CHAIR): And did I --

THOMAS WELLNER: Both on --

COMMISSIONER FRANK MARROCCO (CHAIR):

Sorry, Mr. Wellner.

THOMAS WELLNER: Sorry. No, you.

COMMISSIONER FRANK MARRACCO (CHAIR): Did I understand that you had some 30 applications in progress somewhere?

THOMAS WELLNER: Yes, yes, we do.

COMMISSIONER FRANK MARRACCO (CHAIR): And so 30 requests to modify or modernize existing structures, existing homes?

THOMAS WELLNER: Yeah, that's correct. And we basically have gone out and purchased lands where we have -- the current program will work when you can access land at less than sort of $300,000 an acre. And that program will not work, obviously, in the city of Toronto and urban sites in that case.

But in rural settings, we've acquired those parcels. We've put in the applications. And this is all just for the redevelopment of the existing beds that we have and, the 32 C- and D-bed homes which would make up about 3,300 across the system.

Within that, we've been granted some top-up beds, but that's just replacing existing infrastructure and not adding new capacity. There

is additional new capacity that we've been granted through some top-up licenses that would enable us to take some of the smaller homes from sort of 60-80 beds up to 128, which is a good natural structure.

COMMISSIONER FRANK MARRACCO (CHAIR): How long would these applications be pending?

THOMAS WELLNER: We've had some that have been -- we resubmitted a bunch recently with the revised program, but we've had applications in for four-plus years.

We've succeeded in getting our first long-term care home in the ground in London, Ontario. It's called Elmwood. We are half constructed. We've been able to keep it on track through COVID. It should be coming out of the ground next year, and we should be then able to transfer more residents into it.

But if we aren't moving a lot faster, the likelihood of getting all of these expiring licenses done before the 2025 plan -- by the time you get through sourcing the land, getting the zoning you need, making sure that we're following the process -- it can be a lot more efficient, I believe.

COMMISSIONER FRANK MARROCCO (CHAIR): Are these municipal approvals or provincial approvals or both?

THOMAS WELLNER: Both.

COMMISSIONER FRANK MARRACCO (CHAIR): Thank you.

THOMAS WELLNER: Dr. Collins, do we have your audio?

DR. RHONDA COLLINS: I'm going to try again. Can you hear me yet?

THOMAS WELLNER: Okay.

WENDY GILMOUR: Yes.

DR. RHONDA COLLINS: Okay.

THOMAS WELLNER: So I mentioned earlier the external advisory committee. And over to you, Dr. Collins.

DR. RHONDA COLLINS: Thank you, Tom, and I apologize for my technical difficulties here.

So we identified several areas that we need to focus on prior to engaging the external advisory committee, and those include infection prevention control.

And we know that, as I spoke to earlier with Public Health, we need to have comprehensive and consistent practices when it comes to infection

prevention and control. And that's not only within our organization, but that's across all the Public Health units -- as mentioned, 34 Public Health units.

With different strategies and different recommendations, it tends to make it a little bit more challenging for us to be able to implement strategies universally. So I think that this, again, needs to be a comprehensive strategy.

With regard to screening, testing, and tracing, we know that one of -- back to Dr. Kitts' earlier question about some of the potential factors that contributed aside from universal masking was the fact that we were unaware of asymptomatic spread at the beginning of this disease, and therefore we were not testing. And Public Health was not testing asymptomatic staff.

And so we know that screening, testing, tracing is paramount for us to maintain our homes free from COVID. As an organization, we are exploring all opportunities to engage in vendors to use technology, alternative testing strategies, point of care antigen testing, antibody testing, effluent waste, and we're looking at effluent testing -- waste-water testing is what I'm trying

to say.

We're looking at all potential strategies that will enhance our ability to rapidly detect COVID before it gets into our homes and therefore mitigate spread.

And then staffing -- I mean, Wendy spoke to this, but there's a major challenge with relation to COVID-19 and the sustainability of staffing, that there needs to be change for more care hours, more care physicians, flexibility in what staff can do.

We need greater training and access to education from a staffing perspective, from an IPAC perspective, from touch screening testing and tracing. So these are all of the areas that we identified as key, and then the external advisory committee then identified any areas that we could improve upon.

And I apologize if I've said this already because I lost audio both ways. Temporary measures such as competing funding to reduce cohorts and capital support for screenings and temporary partitions will need to be relied upon until the ancient infrastructure issues are resolved.

And, Tom, did you want to speak about analytics and data?

THOMAS WELLNER: Sure. I think we chatted a little bit about this. I mean, this is one of the more unique things that we tried to do is focussing on data and analytics because that -- you know, for me, moving things off of facts and getting an understanding --

So we basically looked at about 120 different parameters and tried to get ourselves to benefit from some machine learning as well as support that we had to be able to be in a better situation to be able to predict things.

So we bolstered what we had internally with the help of Accenture who enabled us to do both single variant and multivariant analyses on these 120 different parameters, you know, ranging from, you know, staffing levels -- full time/part time -- you know, community outbreaks versus age of building, et cetera, et cetera.

So it basically, then, has allowed us -- what we want to do is -- like we have with the pandemic playbook, which is a very practical approach -- make sure that our resources are as focussed as possible. Because even as a large

provider, we're always trying to make choices or having to make choices on where do we put and where can we bolster the local support. And so it enables us to potentially take steps in advance and be even more ready to predict things.

So with that, I think those would be my comments around the analytics and insight.

COMMISSIONER FRANK MARROCCO (CHAIR): Were you able to predict or get a prediction as to which locations were more likely to require attention?

THOMAS WELLNER: The short answer is "yes." The biggest predictor seemed to be -- and again, we looked at likelihood of entry, possibility of spread of the virus, and duration of the outbreak.

And certainly in the component of likelihood of entry, a lot of the predictors come down to the variants that are orientated around the local community concentrations. So we actually refreshed this dataset daily with the Public Health information that comes through.

So we're able to basically look at hot spots. So hot spots are a big predictor, obviously, because it's coming in sometimes from

the community.

The other likely predictor has been, again, back to the ageing of the infrastructure and the size and scale of the building.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

WENDY GILMOUR: One of the other things that we've seen is the tenure of our executive directors also has an impact. So we've started doing advanced training and crisis management for these younger EDs.

COMMISSIONER FRANK MARRACCO (CHAIR): Okay.

WENDY GILMOUR: The other problem we've found in Wave 1 with spread was dementia.

THOMAS WELLNER: Yeah.

WENDY GILMOUR: So if you had a lot of dementia, it was very difficult to control. We ended up putting a lot of one-on-ones to prevent our residents from roaming around. Very, very disconcerting to our residents, but it spreads -- dementia is a very difficult thing to control when you've got this pandemic happening.

DR. RHONDA COLLINS: And, Wendy, if I may add to that, as a consultant for seniors'

mental health one day a week, I see residents outside of Revera in long-term care and in the community who have dementia.

And there has been, certainly, an increase in behaviours, in the requests for consultations for responsive behaviours secondary to residents with dementia being isolated and having one-to-one staff put in place, and increasing requests for medication to mitigate the effects of wandering and not being able to follow isolation and IPAC practices. So it's a challenge that needs to be addressed, certainly.

WENDY GILMOUR: You know, from the data that we've gathered, we've actually implemented action plans in each one of the homes that have been identified. We do things like enhanced surveillance testing, more frequent IPAC audits.

So an example would be our hand hygiene. We do four audits a day. That means we go around and we check to make sure that people are doing the appropriate hand hygiene. We've doubled those in homes that we identified as high risk.

We also do more extensive training and refresher training for staff on all IPAC policies and procedures as well as cleaning and making sure

we have availability of PPE, which also becomes a problem in our older homes because we don't have storage areas.

When we go into an outbreak or we are concerned, we start to have stronger recruiting efforts as well. And again, it's that flexibility, that as long as we're able to maintain that, that will help support that.

THOMAS WELLNER: Okay. Then I would say, just to orient us back, we ended up saying our focus on our pandemic response was in the five areas, and now we'd like to walk through with Dr. Collins a lot of the work that we did on the clinical and operational initiatives.

Still not --

DR. RHONDA COLLINS: There you go.

COMMISSIONER FRANK MARROCCO (CHAIR): She's on again.

DR. RHONDA COLLINS: I give up with telephones and technology. I apologize again.

So --

COMMISSIONER FRANK MARROCCO (CHAIR): You're really going to have to pay your bill, Dr. Collins.

DR. RHONDA COLLINS: Noted, thank you.

So Revera, as I mentioned previously, is working on a comprehensive screening, testing, and tracing program. Since the beginning of the pandemic and even prior to implementation of external directives, we had started active screening at our site with a full-time screener at the entrance to our homes to check temperatures, and we were implementing temperature checks before it was recommended and still being discussed.

Checking temperatures, checking symptoms, asking questions related to travel and other tracing, checking for appropriate PPE, making sure that everybody is trained on infection prevention, and now we're asking questions related to attestation of our visitors. When were they tested? How long ago were they tested? When did they get their results.

And then enhancing the capabilities of one of our existing digital applications called "Health Connect." So this is an application that tracks signs and symptoms and infections at the resident level and by room level. And it has the capability for visualizing infections at the floor level and then creating dashboards for outbreak status and trending.

The same application has a hand hygiene app so that, previously, where nursing staff had to -- or any staff that was doing an audit had a paper-based audit, this allows for an application-based audit that allows the auditor to do up to four hand hygiene audits at one time.

It tracks the time. It tracks the point of care, and it immediately integrates that information into a report that is then on the dashboard so that we can identify our homes that are not at target -- whether it's hand hygiene, whether it's they're not doing it often enough, or they're not doing it long enough -- and then implement additional training strategies at the site.

As mentioned previously, we have contracted Dr. Krystyna Ostrowska. She's a medical microbiologist and infectious disease specialist, and she has been sitting in our IPAC meetings weekly. I also collaborate with her on any initiative such as the partition, whether or not they would meet IPAC standards.

So any initiative that we're thinking of implementing related to infection prevention, I will ask Dr. Ostrowska for her feedback, and then

she will bring that forth to the IPAC meetings so we can discuss it as a team.

We're also establishing a central warehousing program to improve the supply chain control of personal protective equipment and secure availability of PPE inventory. And we're also in the process of negotiations with the current PPE distribution channel to secure additional long-term care inventory capacity so we are always staying ahead.

Wendy, did you want to talk about staffing?

WENDY GILMOUR: Sure. Thank you very much, Dr. Collins.

Revera --

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Gilmour --

WENDY GILMOUR: Yes.

COMMISSIONER FRANK MARRACCO (CHAIR): -- before you do that, in terms of testing results, when do the results come back?

DR. RHONDA COLLINS: From Public Health, or --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I would assume you send the samples to Public

Health to be analyzed, and when do they come back?

DR. RHONDA COLLINS: So currently we send them to Public Health, and that has been one of the challenges is there has been delayed time in recognizing that Public Health has a capacity issue as well with the number of people being tested in the community, in the hospital.

We've asked for prioritization for long-term care obviously because we need to make sure our staff are COVID-negative and that we can isolate as quickly as possible.

Turnaround times have varied from 48 hours up to -- on average, right now, it's about seven days, seven to nine days. Wendy will tell we've seen much longer than that, up to 28 days in one situation.

WENDY GILMOUR: M-hm.

DR. RHONDA COLLINS: And there have been episodes where the results have actually been lost, and we've had to repeat the testing.

So that's part of what we are working on as an organization to establish access to a private laboratory where we can then submit our specimens to them to run with a contracted requirement that we get a minimum 50 percent of

those results within 24 hours.

WENDY GILMOUR: I think, also, we need to move away from NP swabs. Some of our residents and staff have had as many as 10, 12, 15 tests, and it is causing physical damage now to our residents.

THOMAS WELLNER: Okay. So if I could also -- I'm very passionate about this particular subject.

Prior to my time at Revera, I ran the single largest lab in the community setting in the country through -- as co-CEO of LifeLabs.

So as far as testing goes, we need a different solution. If you think of testing from the perspective of the resident and the staff, to Wendy and Rhonda's points, you think about it from the collection of the sample; the sample needs to have integrity; it needs to be put into a courier system; it needs to be taken back to a lab; the lab needs to have the capacity and the capability to be able to run the -- run the test; and then the lab needs to be able to analyze the test and get the data uploaded into the system and then back to the -- either the individual or the professional that has requested the test.

Our current system is chaotic. It

is -- you know, the wait time between when the test has occurred and getting results seven days later or five days later is just unacceptable. Like, it's --

And so we, as a company, are spending millions of dollars now bolstering with our private option, as Rhonda and Wendy have referred to. But again, I think the other dynamic that will be helpful is right now we're doing PCR testing, and we have these nasopharyngeal swabs. More convenient, saliva-based testing.

I'm personally very excited about the possibility of getting antigen testing going because it is an inexpensive solution. It may not be -- you'll read the literature where the sensitivities vary. However, if we can get something that is point of care that at least could give us an indication of whether a staff member or resident has, you know, the antigens, that allows us to either save valuable PCR capacity in the system or have them secondarily tested.

So from a practical -- like, too many times I think the testing process has been looked at in a very technical way, which is fine. But from a practical perspective, I think there are

many -- I'd rather have a point-of-care test that I get the result and be able to do something with it than wait for a system to potentially -- because there's so many other steps in the system that have the potential to not provide a useful result or timely result.

COMMISSIONER FRANK MARROCCO (CHAIR): Is the problem with the antigen testing that you get a false positive?

THOMAS WELLNER: You could get a false positive, but then it's better to then have a confirmatory PCR test. That would be a better outcome than what we currently have today and what we have to deal with.

That would also help us -- the downstream effect of that, it protects our staff, so staffing issues are less. It also reduces the amount of PPE we may have to utilize. There are many, many -- it allows to have families potentially visiting at certain times, so there's so many additional benefits to it. I am very passionate about that. Sorry.

DR. RHONDA COLLINS: And, Tom, if I may add to that, the advantage to our residents -- first of all, to our staff. As Wendy pointed out,

nasopharyngeal testing is unpleasant, and I've done a survey of some of our residents on a scale of 0 to 10, and I get everything from 3 to 12 from our residents. And especially when they've had to go through it multiple times, older residents, frail residents, complex residents with dry nasal mucus membranes, it's unpleasant. If they have dementia, it's even more difficult.

And for our families, I think that there's a really great opportunity for point-of-care testing where we don't rely on families to attest to having been tested.

Some of them are older. We have family members who are the same age as their spouses in long-term care, and so mobility and transportation may be an issue. And us being able to offer them testing at site will allow us instant results from the testing. It will allow our residents back in because -- to Tom's point about being passionate, I'm passionate about allowing our visitors back in to take care of their family members. It was a long haul for them to not being able to see their loved ones, particularly their loved ones who had functional and cognitive decline because of isolation and lack of contact with their family

members in personal contact.

iPads are nice, but it does not make up for personal contact, and so this is an opportunity for us to then be able to offer one more thing to the families that will protect our residents from infection and protect our residents from isolation.

THOMAS WELLNER: Thank you, Dr. Collins.

I'm also passionate about it. My two own parents are -- I'm actually a client as well on the retirement business, and I've gone through the isolation myself having not been able to visit them for more than 10 or 12 weeks. Families are an important voice, and these solutions will help enable a safe connection and a socially balanced connection.

So with that, if we can try and move into -- Wendy's going to talk a little bit about staffing because she's closest to staffing.

WENDY GILMOUR: Thanks, Tom.

So in Revera, we've established a team of talent resource associates with responsibility for sourcing, screening, and pipelining frontline hourly candidates so that the hiring managers only need to fill the vacancy. They get to the final,

and they can do the interviews and the selection stage, and they don't have to do that front part of the work.

As well, a cross-functional committee of leaders from retirement, long-term care, finance, human resources, and talent management have developed a plan to ensure recruitment is a top priority and that sites will have proper staffing throughout the changes in the operating environment. And this is very, very key.

We've heard repeatedly and through our data analysis that staffing is very critical to ensure not only that we stop the spread, but we also help with the duration. So it's critical.

I think now, Tom would want to go on to the recommendations.

THOMAS WELLNER: Yeah. I mean, this is really sort of our preliminary set of -- again, to your point, trying to focus on what we can do more immediately to ready for Wave 2.

Again, we've tried to focus that on it, but, you know, the universal screening, as Dr. Collins said -- and I'd basically like to be able to come back and be more specific with the committee next week. We will do that then.

So, Dr. Collins, do you want to make a few of the comments around the universal screening and tracing and just try to summarize a little bit?

DR. RHONDA COLLINS: Sure. Thanks, Tom. So I think we've spoken to a couple of these items already but just the fact that it remains critical that we have universal screening for everyone who enters our homes -- staff, visitors, families.

Screening with symptoms need to remain in place, but that's not foolproof because not everybody will disclose their symptoms. So routine testing of all staff and residents in our environment should be undertaken on a regular basis depending on the prevalence of the virus in the community. So I think we really need to be focussed on hot spots, for certain. It's going to vary, obviously.

And then contact tracing is also critical. We need to have a documentation of the date and time that everyone comes into the home and limit their movement within the home.

We are using an electronic tool now which has a two-code scan when you check in. So that is very easy for us to identify who has come

and who has gone and where they were in the home and that they've answered the appropriate questions.

All our staff must be educated and regularly reminded about the importance of monitoring their own health. They need to attest that they have no symptoms that suggest of COVID and that they should not work if symptomatic.

Workers who stay home should be provided sick pay so there's no incentive to work while symptomatic. We need to educate them that it is okay not to come into the work when they have any symptoms.

I know some of our staff feel like they might be letting their coworkers down if they don't come in, but we really need to do a great job of letting them know that it's okay not to come in, that we don't want them to come in if they're sick at all, and that's taking into consideration all of the current symptoms that we recognize now -- not just the fever, the cough, the shortness of breath -- but any symptom at all that may suggest COVID.

And we need to ensure that our infection prevention and control standards are

brought to the same level of those in acute care when it comes to things like hand hygiene and appropriate use of personal protective equipment but remember that they need to be adaptive to the fact that this is our resident's home, and it's not a medical institution.

Wendy, did you want to speak about the recommendations on staffing and support?

WENDY GILMOUR: Absolutely. We believe there needs to be a more full-time PSW positions, and we'd also like to see increased flexibility. Single-site employer mandate must continue, but, really, what we would like to see is that within Revera, we would be able to move our resources.

So right now, I can't move resources from one home to another home if they need to be backed up. We would like to see that flexibility that if Home A down the street goes into an outbreak, that we can support that from another home, and then they can go back when needed.

And a prime example of that is we thought we could have used cooks from other homes to help support one of our homes. We actually had no cooks whatsoever, as I indicated earlier.

Cross-sector support would also be

leveraged by maximizing the LHIN's ability to provide home care support and others through the -- providing it to the homes.

One of the examples that we had is when the Board of Education allowed their people to come and work in our homes. That helped immensely during the summer and allowed our people to actually get breaks --

THOMAS WELLNER: Yeah.

WENDY GILMOUR: -- getting ready for Wave 2.

Did somebody have a question?

THOMAS WELLNER: I'm just agreeing with you.

WENDY GILMOUR: Okay. Thank you. We'd like to promote a short-term rehiring of retired healthcare professionals who are able to assist in some emergency situations.

The administrative burdens on care providers decreases the hours of care and attention that we can give our residents. Right now, we must report everything in minute detail including that you had 250 mils to drink at lunch time.

What we would rather see is reporting by exception that you did not finish your meal or

you did not finish your fluids versus reporting to such an extent. It would allow an immense amount of time. And the OLTCA has actually got some documentation on this about how much time can be saved by going to exception reporting.

The PSW certification process should be more akin to a co-op process where students can work in the homes to finish their qualifications, and that would accelerate soon-to-be graduates.

We also need to enhance the recruitment of foreign trained PSWs as well as nurses and amend the integration rules to prioritize recruitment of PSWs from over seas.

One of the rules that exists in Ontario is that if you are attending a private college, a privately funded college, you cannot get immigration status. You have to attend a public college in order to apply for immigration.

We need heightened communication to staff regarding safety to reduce absences based on fear. Employees must feel comfortable to come to work by ensuring that there is efficient and appropriate PPE at all sites.

Regular swabbing -- they want to know that their colleagues are also safe. Even though

we do have constant masking and social distancing, they still want to know that everybody is safe. So rigorous screening before entering the LTC site and rigorous and sufficient visitor screening and rules is very, very important.

Tom, for the infrastructure and environmental?

THOMAS WELLNER: Yeah, no. Just to sum things up a little bit, again, we thoroughly support heightened cleaning protocols, as we mentioned before.

We also support the air ventilation improvements that both our external advisory panel as well as our infection control specialists have highlighted.

We've had the a passionate discussion about the redevelopment of older homes and doing some year-term adjustments to enable the existing infrastructure to be more capable of supporting the operational needs of this pandemic.

And then, again, as I mentioned previously, we can chat more, hopefully, about it around the streamlining of the process.

But we'll happily provide a written version of the recommendations that we have for the

Commission. We thoroughly appreciate the energy, effort, and time that you've put into it and the time that you have given us today.

We're all doing our very best to make sure that residents and our staff are very well supported through the next wave, and hopefully we'll get out the other end and be beyond this as a society. So thank you very much.

COMMISSIONER FRANK MARRACCO (CHAIR): Well, thank you. I think I speak for the three of us that this has been very informative and given us a very interesting perspective on it -- really, a perspective we didn't have before you came -- and so this part of it is extremely helpful. We will take you up on the offer to have a more in-depth conversation.

And you shouldn't feel that if you've forgotten to say something or there's something else that occurs to you that your time is up and you can't do that. I think you know how to reach our counsel or the executive director, and we'd be happy to receive anything that occurs to you after today that you think we ought to know.

So thanks again, and you'll be hearing from us, I suspect.

THOMAS WELLNER: Thank you very much.
COMMISSIONER ANGELA COKE: Thank you.
COMMISSIONER JACK KITTS: Thank you.
DR. RHONDA COLLINS: Thank you.
WENDY GILMOUR: Thank you. Bye-bye.
THOMAS WELLNER: Bye-bye.
-- Adjourned at 3:00 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 7th day of October, 2020.

NEESONS, A VERITEXT COMPANY
PER: MCKAYA MCDONALD, CSR
CHARTERED SHORTHAND REPORTER

C L A R I F I C A T I O N S:

Page 15, line 1: “our preliminary efforts of outcome” should be “efforts and outcomes.”

Page 19, line 3: “25 new hires” should be “25,00 new hires” [See Commissioner Coke’s comment at page 24, line 18 where she understood that Ms. Gilmour said 2,500 (not 25).]

Page 20, line 2: “an issue was circulated” should be “a hot issue was circulated.”

Page 33, line 11: “bit” should be “but.”

Page 67, line 21: “competing funding” should be “continued funding.”

Page 73, line 20: “Health Connect” should be “Health Connex.”

Page 86, line 23: “250 mils” should be “250 ml.”

Page 87, line 12: “integration rules” should be “immigration rules.”

WORD INDEX

< $ >
$2 18:2
$300,000 63:13
$550 31:21
$7 17:24

< 0 >
0 80:2

< 1 >
1 19:3 34:4, 9 36:15 44:3, 19 55:6, 12 70:15 92:3
1:00 1:16 4:1
10 26:16 77:4 80:3 81:13
10,000 19:2 24:17
100 18:25 45:23
11 92:14
12 51:14 77:4 80:3 81:13 92:24
120 68:9, 17
128 64:4
14 38:2
15 77:4 92:3
17th 32:12
18 92:8
19 92:6

< 2 >
2 10:16 11:1 34:5, 7, 17 38:25 39:11 41:6, 12 55:16 56:5, 7 82:20 86:11 92:11
2,500 24:18 92:9
2:10 58:4
2:15 56:14, 16
2:20 58:5
20 92:11, 19
2007 7:13
2014 7:4
2017 6:16
2020 1:15 91:18
2025 64:21
21 92:16
23 92:22
24 77:1 92:8
24/7 20:23 22:4 23:2
25 19:3 92:6, 9
25,00 92:6
250 86:23 92:22
28 76:15

< 3 >
3 10:16 80:3 92:6
3,300 63:21
3:00 1:16 90:7
30 61:10 63:4, 8
310 18:12
32 18:11 63:20
33 92:14
34 66:3
38,000 43:6

< 4 >
4 10:17
4,500 43:23
48 76:13
49 13:2

< 5 >
50 47:4 76:25
500 8:15
51 13:3
52 8:25 44:3
53 37:7
550,000 31:21
59 9:3

< 6 >
6,000 9:1
60-80 64:4
67 92:16

< 7 >
7,000 9:1
7.5 21:11
73 92:19
7th 1:15 91:18

< 8 >
8 21:11 26:16
800 43:20
86 92:22
87 92:24
8th 44:21 45:6, 7 46:17 47:10, 12

< 9 >
97 45:22

< A >
ability 22:2 49:13 51:17, 19 57:7 67:3 86:1
absences 87:20
absolutely 39:24 45:19 50:4, 5, 18 85:9
accelerate 87:9
Accenture 34:13 68:15
access 38:18 63:13 67:12 76:22
accommodation 8:18

accommodations 19:4
accord 18:6
accurate 22:20
acquired 63:17
acre 63:14
acting 26:12
action 15:11 26:5 71:15
actions 19:23
active 17:11 21:22, 24 73:5
activities 29:19 33:2 39:11
actual 37:7
acute 7:2 53:3 85:1
adapted 10:17
adaptive 85:4
add 28:8 29:5 49:8 55:2 70:25 79:24
adding 63:25
addition 22:21 24:2 32:1
additional 14:3, 6 17:24 47:16 52:5, 21 57:15 58:22 61:1 64:1 74:14 75:8 79:21
addressed 71:12
Adjourned 90:7
adjusting 24:4
adjustments 88:18
Administrative 2:22 40:23 86:19
advance 45:1 69:4
advanced 70:10
advantage 79:24
advantageous 22:12
advise 34:5, 7
advisors 32:22
advisory 32:21 34:4 42:13 56:22 57:21 59:11 65:15, 21 67:16 88:13
after 20:5 45:3 47:11, 12 89:22
aftereffects 12:8
afternoon 4:4, 5 6:4
age 68:19 80:14
ageing 41:23 70:3
agency 36:9
aging 46:8
ago 24:5 73:16
agreeing 86:13
agreements 22:7
ahead 47:15 49:23 75:10
aide 25:3
air 88:12
airflows 57:16
akin 28:16 87:7
alert 17:11 39:5
aligned 9:16
Alison 2:18
allow 22:2 23:15 56:9 59:11 80:17, 18 87:2
allowed 25:5 36:2 45:16 48:7 68:21 86:5, 7
allowing 4:15 18:13 80:20
allows 9:25 10:21 15:10 74:4, 5 78:19 79:19
alternate 55:19
alternative 66:22
amazingly 37:24
ambassadors 10:6
amend 87:11
amount 29:18 79:18 87:2
analyses 68:16
analysis 82:12
analytical 41:23
analytics 34:10, 12 68:2, 6 69:7
analyze 14:22 34:14 77:21
analyzed 76:1
ancient 67:24
Anderson 42:21
Andy 55:7
Angela 2:5 20:16 24:11, 15, 22 25:15 90:2
announced 38:25
announcement 39:2 51:1
announcements 14:2, 4
answered 84:2
antibody 66:23
antigen 66:23 78:13 79:8
antigens 78:19
anybody 40:9
apart 39:10
apartments 8:20
apologize 65:18 67:19 72:20
app 74:2
appear 60:7
applicants 19:2
application 73:20 74:1
application-based 74:5
applications 61:10 63:4, 18 64:7, 10 73:19
apply 87:18
appreciate 6:10, 22 16:21 35:16 53:25 89:1

appreciative 5:16
approach 6:11 9:6, 8, 17 10:12 35:11 52:15 68:24
approaches 33:5
appropriate 71:21 73:12 84:2 85:3 87:23
approval 62:6
approvals 61:7 65:2, 3
approximately 9:1
April 44:20 45:6, 7 46:17 47:10, 12
architect 42:18
architectural 43:1
area 41:11 54:24
areas 11:6 19:12 34:20 36:21 37:14 38:19 41:8 59:7 60:25 65:19 67:15, 17 72:3, 12
Armed 8:11
arrangement 23:22
arrive 5:9
aside 42:14 66:13
asked 33:12, 14 34:13 39:23 44:24 76:8
asking 73:11, 14
assessments 41:23
assist 86:17
Assistant 2:18, 22 3:7
assisted 8:21
associated 8:16
associates 81:22
assume 75:25
asymptomatic 66:15, 17
attend 87:17
attending 1:14 20:10 52:7 87:15
attention 69:11 86:20
attest 80:12 84:6
attestation 73:15
attract 18:23
AUDIO 38:10 65:8 67:20
audit 74:3, 4, 5
auditor 74:5
audits 30:21 71:17, 19 74:6
availability 72:1 75:6
available 17:21, 25 33:8 34:24 58:10
average 76:13
Awards 49:6
aware 52:1

< B >
back 4:22 7:13 10:20 13:19 16:16 17:15 18:18 25:13 36:11, 17 42:25 43:4 46:7 55:4, 5, 6, 13, 17, 22 56:21 57:2, 21 58:15 66:11 70:3 72:10 75:21 76:1 77:18, 22 80:18, 20 82:24 85:20
backed 85:17
background 7:1, 10, 16 8:5
bacteria 31:6
bad 12:3
bag 12:13
balance 9:17 22:8 48:7, 12, 17
balanced 81:15
balancing 21:17 48:1
ball 24:2
barrier 31:13
based 5:17 22:5, 6 49:13 87:20
basically 8:15 17:17 24:3 26:14 33:11, 19, 23 34:11, 14, 20 44:12 63:11 68:9, 21 69:23 82:23
basis 32:4 83:14
batch 61:13, 14
bathroom 42:3
beds 43:15, 20, 23 46:13 63:20, 24 64:4
beginning 31:5 66:15 73:3
behalf 8:9
behaviours 71:5, 6
believe 14:20 18:7 34:22 64:25 85:9
Bell 33:14
beneficial 15:19
benefit 68:11
benefits 22:17, 18, 22 23:1 79:21
best 8:2 35:20 89:4
better 9:15 10:15 33:5, 21 41:18 68:12 79:11, 12
betterment 11:2
beverages 19:5
Bianchi 2:24
bid 61:15
big 40:23 46:20 56:5 69:24
biggest 69:13
bill 72:23
bimonthly 15:8
bit 4:18 5:2 6:3 8:4, 6 18:20 33:11 36:25 41:8 48:7 66:6 68:4 81:18 83:3 88:9 92:14
blend 22:5
blessed 13:2
Board 8:9 28:10 32:9 34:4 39:6 86:5
Bob 33:14
body 12:13 28:20
bolster 69:3
bolstered 34:11 68:14
bolstering 78:6
book 39:16, 19
border 8:10
bottom 53:1
break 56:13, 15
breaks 86:8
breath 84:22
brief 25:22
briefly 29:25
bring 13:4 25:5 75:1
brings 6:16
broadly 34:25
broke 12:25
broken 13:16
brought 13:19 25:7 85:1
building 57:8 59:7 60:24 61:20 68:20 70:4
built 31:23
bunch 51:6 64:9
burdens 86:19
Burnie 39:21
business 9:15 16:23 17:4, 14 19:25 28:9 54:1 81:11
businesses 7:15
Bye 58:3
Bye-bye 90:5, 6

< C >
Cal 28:13
call 20:3 51:20 54:7
Callaghan 3:1
called 5:1 17:16 18:3 23:7 26:15 64:14 73:19
calls 20:5 29:10 50:13 51:18 54:19
Cameron 55:24
Canada 6:20 7:12, 13 8:14, 23 16:12
Canadian 8:11 42:23
candidates 81:24
capabilities 10:1 34:12 73:18
capability 73:23 77:19
capable 88:19
capacity 43:8 45:23 55:14, 18 63:25 64:1 75:9 76:5 77:19 78:20
CAPEs 17:17
capital 14:8 57:17 67:22
CARE 1:7 2:13, 19, 21, 23, 24 3:1, 3, 6 6:18 7:1, 2, 4 8:17, 21, 22, 25 9:2, 14, 20 11:10, 17 12:12, 16 14:3, 13 18:12 26:9, 17, 20 30:8 41:17 42:20 43:7 44:3 49:1 51:25 52:3, 13 53:3 55:9, 20 57:3 61:22 62:3 64:13 66:23 67:10 71:2 74:8 75:9 76:9 78:17 80:15, 21 82:5 85:1 86:2, 19, 20
career 7:11
care-first 9:21
CaRES 18:3
Carlingview 50:8, 13
carpets 31:10
Case 23:7 24:6 36:9 61:14 63:16
celebrate 12:18
central 75:3

centre 6:22
CEO 16:11
certain 8:20 14:25 17:21 79:20 83:17
certainly 6:21 24:14 33:18 34:7 39:17 43:7 57:14 58:9 59:15 61:2 69:17 71:4, 12
certificate 25:4 91:1
certification 87:6
certified 30:9 91:3
certify 91:4
cetera 20:13 39:10 68:20
chain 75:4
chains 18:10
CHAIR 4:3, 7, 12, 16 6:2 7:18 20:17 21:6, 13 22:9, 24 23:19 24:1, 9, 13, 20 25:18 33:15 49:22 53:5, 23 56:12, 24 57:23 58:2, 6, 12, 18, 24 59:14, 19 60:2, 12, 18 62:15, 22, 25 63:3, 7 64:6 65:1, 5 69:8 70:5, 12 72:17, 22 75:16, 19, 24 79:7 89:9
chaired 28:12
challenge 21:16 53:21 67:7 71:11
challenges 10:16 48:9 76:4
challenging 66:7
change 35:19 67:9
changes 5:2 15:7 20:11 82:9
changing 48:17
channel 75:8
chaotic 36:2 77:25
charges 62:1
chart 27:4
CHARTERED 91:25
chat 88:22
chats 55:7
chatted 68:4
check 71:20 73:7 83:24
checkbook 36:22
Checking 73:10, 12
checklist 37:22 38:3
checklists 35:8 36:21
checks 73:8
Chief 2:10, 14 6:15, 20 26:13
choices 69:1, 2
choosing 9:13
circulated 20:2 32:11 92:11, 12
Citizens 49:6
City 50:22 51:19 63:15
classification 25:14
classified 62:3
clean 31:6
cleaning 31:3, 4, 9 71:25 88:10
click 37:3, 16
client 81:10
clinical 19:11 20:4 27:2 29:7 30:7, 8 40:15 41:10 72:14
clinicians 26:24 52:4
close 45:22
closely 30:13 32:2
closer 55:17
closest 81:19
co-CEO 77:11
co-chair 40:19
cofounded 17:16
cognitive 51:15 80:24
cohort 45:24 46:9
cohorting 46:3 51:8
cohorts 67:22
Coke 2:5 6:5, 8 20:16 24:11, 15, 22 25:15 90:2 92:7
collaborate 74:20
collaboration 53:24
collaborative 49:18 52:15 53:6 56:2
colleagues 6:14 87:25
collection 77:16
collective 22:7
collectively 11:2 29:22 56:8
college 87:15, 16, 18
Collins 2:14 6:15, 21, 23 10:7 14:16 19:20, 23 20:9 22:15 26:2, 12 27:3, 7 28:3 29:4, 24 31:18 33:12 42:21 47:20 49:8 51:16 53:9, 12 54:8 55:2 59:12, 16, 21, 24 65:7, 9, 13, 16, 17 70:24 72:13, 16, 19, 24, 25 75:14, 22 76:2, 18 79:23 81:8 82:23 83:1, 4 90:4
come 5:9 10:20 25:12 43:4 55:13 56:21 57:2, 21 58:15 62:8 69:18 75:21 76:1 82:24 83:25 84:12, 16, 17, 18 86:5 87:21
comes 56:2 65:25 69:22 83:21 85:2
comfort 12:11
comfortable 52:10 87:21
coming 12:8 64:16 69:25
commencing 4:1
comment 92:7
comments 6:12 56:20 59:8 69:7 83:2
COMMISSION 1:7 2:19, 21, 23, 24 3:1, 4 10:21 58:11 89:1
Commissioner 2:4, 5, 6 4:3, 6, 7, 12, 16 6:2, 4, 5, 8 7:18 20:16, 17 21:6, 13 22:9, 24 23:19 24:1, 9, 11, 13, 15, 20, 22 25:15, 18, 19, 20 27:6, 14, 19, 23 28:2, 5, 19, 24 29:23 33:25 34:3, 18 39:15, 18 40:11 43:25 45:4 46:11, 16 47:6, 23 49:21, 22, 23, 25 53:5, 23 56:12, 24 57:23 58:2, 6, 12, 18, 24 59:14, 19 60:2, 12, 18 62:15, 22, 25 63:3, 7 64:6 65:1, 5 69:8 70:5, 12 72:17, 22 75:16, 19, 24 79:7 89:9 90:2, 3 92:7
Commissioners 14:18 56:23
commissions 9:24
committed 56:16
Committee 28:12, 14, 15, 16 32:10 40:18 43:5 59:11, 13 65:15, 21 67:17 82:4, 25
common 19:21
communication 87:19
communications 19:19 20:10 41:16 48:10
community 7:2 11:20 48:22, 25 49:11 68:19 69:20 70:1 71:3 76:7 77:10 83:16
companies 32:19
company 6:19 11:3 32:20 78:5 91:23
competing 67:21 92:16
complement 41:14
completely 18:10 29:17 49:9
complex 8:21 80:6
component 30:4 62:12 69:17
components 37:17
comprehensive 49:18 65:24 66:9 73:2
concentrations 69:20
concept 32:13 34:25
concerned 4:8 72:5
concerns 55:16 56:5
confess 13:10
confidence 32:23
confirmatory 79:12
confusion 51:8, 12
congregate 32:23
conjunction 32:9
Connect 73:20 92:19
connected 38:17

connection 81:15, 16
connectivity 40:14 48:16
Connex 92:20
consideration 84:19
consistent 65:25
constant 88:1
constantly 35:19
constituents 33:16 35:6
constructed 64:15
construction 61:18 62:7
consultant 70:25
consultations 71:6
consulting 39:22
contact 80:25 81:1, 3 83:19
contain 11:21 33:21
contained 32:13
content 19:16
contents 37:3, 4
context 9:7 34:8
continue 11:21 14:22, 25 17:9 18:17 48:14 85:12
continued 92:17
continuing 15:20 49:17
continuity 17:4 20:1
continuum 32:25
contracted 74:17 76:24
contradicted 51:3, 5
contributed 39:19 66:13
control 21:19 30:1, 3, 9, 21 41:15 42:16 43:17 48:3 54:5, 6 57:14 62:10 65:22 66:1 70:18, 22 75:5 84:25 88:14
controls 26:1
convenient 56:15 78:11
conversation 89:16
conversations 52:24
cook 48:23 49:2
cooking 48:24
cooks 85:22, 24
co-op 87:7
copy 38:15 58:7
Corporate 3:7 29:5, 13
correct 22:14 28:23 63:10 91:15
cost 31:21 61:1
cough 84:21
Counsel 2:24 3:1, 5, 7 89:21
counterpart 26:10
country 77:11
couple 5:6 24:10 29:11 56:19 58:7 83:5
coupled 14:6
courier 77:17
course 40:2
COVID 12:2, 9, 22 15:5, 18 64:16 66:20 67:4 84:7, 23
COVID-19 1:7 11:17 15:25 31:25 67:8
COVID-negative 76:10
coworkers 84:15
create 47:15
created 31:24 32:1 34:5, 6 51:11
creates 23:16
creating 73:24
credibility 52:22
credit 42:21
crisis 26:6 70:10
critical 25:16 30:11 33:4 82:12, 14 83:7, 20
cross-functional 82:4
crossing 8:10
Cross-sector 85:25
cry 12:14
crystal 24:2
CSIS 8:10
CSR 91:3, 24
current 52:10 63:12 75:7 77:25 84:20
currently 15:4 76:2 79:13

< D >
daily 15:7 19:10, 19 20:5 50:13 69:21
damage 77:5
dark 12:23
dashboard 32:2 74:10
dashboards 73:24
data 20:12 34:10, 12, 14 41:25 68:2, 6 71:13 77:22 82:12
dataset 69:21
date 23:22 83:21
Dated 91:18
Dawn 2:20
day 1:15 21:12 29:14 47:4 51:2, 4 71:1, 19 91:18
days 19:15 76:14, 15 78:2, 3
D-bed 63:20
dead 12:24
deal 10:15 34:4 43:17 51:12 79:14
dealing 32:15
dealt 11:9
death 12:17, 18, 22
decant 50:13
decided 32:8
decipher 19:14
decision-making 9:8
decisions 47:25 48:1, 2
declaration 20:5
declared 20:8
decline 80:24
decreases 86:20
deep 7:1 12:6
deeply 33:24
degree 43:1
delayed 76:4
delivery 10:2
dementia 70:15, 18, 22 71:3, 7 80:7
demonstrating 15:2
demonstration 36:25
department 29:2
departments 29:7
depending 83:15
depends 53:9
deployed 31:7
Deputy 2:18
Derek 3:3
described 46:21
design 42:19
designs 42:19 43:2 62:8
desire 9:15
Despite 15:6
detail 36:24 86:22
details 35:2
detect 67:4
devastation 13:20
develop 8:14
developed 31:11 36:5 39:24 82:7
development 61:25
Di 2:22
dialed 59:25 60:9
dialogue 8:2 59:5
Diana 42:20
die 12:17
died 13:3
dietary 25:3
difference 44:20 45:2 55:11
differences 44:22
different 4:24 20:20, 21 32:17 40:2 44:24 51:5, 7 66:5 68:10, 17 77:13
difficult 70:18, 22 80:8
difficulties 65:18
digital 73:19
dignity 12:24
dining 39:9
directed 17:13
direction 27:9 62:20
directions 19:8 27:2 35:6, 20
directives 19:14 47:14 73:5
directly 8:16 21:24
Director 2:20 3:3 26:19 27:25 30:6 89:21
directors 20:10 26:1, 15 27:9, 11, 17, 21, 24 28:3, 10 35:9 40:14, 15 52:8 70:9
director's 26:3
disabilities 51:15
disclose 83:12
disconcerting 70:21
discuss 19:12 75:2
discussed 73:9
discussion 8:3 88:16
discussions 52:24

disease 16:6 31:15 42:23, 25 66:16 74:18
disinfectants 31:9
disproportionate 29:18
distance 31:13
distancing 88:1
distracted 56:9
distribution 75:8
distributions 9:11
divider 31:11
division 9:2 26:9
dochitect 42:22
Doctor 20:18 59:20 60:4, 14
document 35:19 37:16
documentation 83:20 87:4
documents 37:7
doffing 38:7
doing 5:14, 19 11:4 15:8 16:22 17:8 24:4 29:19 33:3, 6 49:20 57:14 70:10 71:21 74:3, 12, 13 78:9 88:17 89:4
dollars 78:6
donning 38:7
doubled 71:21
downstream 79:16
draw 9:25
drink 86:23
driver 20:22
Drummond 2:18
dry 80:6
due 39:2 46:18
duration 69:15 82:14
dying 12:12
dynamic 55:21 61:19 78:8
dynamics 45:2 55:25

< E >

earlier 65:14, 23 66:12 85:24
early 16:14 17:19 32:11 46:12 61:6
ears 13:6
easier 36:17
easy 16:8 35:7 36:16 83:25
economic 17:18 23:1
economically 18:4 22:12
EDs 70:11
educate 84:11
educated 84:4
education 27:2 67:13 86:5
educational 20:11
educators 26:23
effect 4:25 79:16
effective 62:9
effects 71:10
efficacy 15:2
efficient 62:9 64:24 87:22
effluent 66:24
effort 17:19 29:22 33:8 53:6 89:2
efforts 6:23 10:18, 20, 24 15:1, 3 72:6 92:3, 4
elderly 47:2
elective 55:13
electronic 83:23
electrostatic 31:4
Elmwood 64:14
email 19:22 20:2
emails 29:10
embedded 38:9 44:21
embedding 40:8
emergency 17:3 51:24 86:18
emotionally 18:4 56:16
employees 9:2 87:21
employer 21:2 85:12
employers 20:21
employment 17:12
EMS 50:25
enable 61:13 64:2 81:15 88:18
enabled 68:15
enables 69:4
Enabling 48:12
encouraged 14:12
ended 70:19 72:10
endorsed 31:14
energies 10:24
energy 89:1
engage 66:21
engaging 65:20
enhance 10:1 33:9 34:16 42:19 67:3 87:10
enhanced 30:19 71:16
enhancements 10:25
enhances 49:9
enhancing 73:18
enlisted 32:20
ensued 20:5
ensure 82:7, 13 84:24
ensured 31:2
ensuring 87:22
enteric 32:16
entering 88:3
enters 83:8
entities 28:17
entrance 73:7
entrepreneurs 10:5
entry 69:14, 18
environment 31:1 46:2 52:19 82:10 83:14
environmental 88:7
environments 7:14
episodes 76:19
equipment 17:21 18:9, 13 75:5 85:3
especially 18:8 42:1 48:13 80:4
establish 76:22
established 81:21
establishing 75:3
event 17:7
everybody 10:11 29:2, 21 35:3 40:5 44:14 49:20 56:1 73:13 83:12 88:2
everybody's 61:16
evolved 14:24
evolves 14:24
exactly 6:11
example 25:2 35:22 38:9 48:20 50:22 51:18 71:18 85:21
examples 32:6 86:4
Excellent 40:11
exception 86:25 87:5
exceptionally 6:19 16:6
excerpt 11:24
excited 78:12
Excuse 6:3
executed 30:12 52:19
Executive 2:10 26:19 27:11, 12, 20, 25 35:8 40:15 70:8 89:21
exercise 42:1
exist 23:2
existed 15:18
existence 5:1
existing 31:23 63:8, 9, 20, 24 73:19 88:18
exists 87:14
expedite 19:1
experience 5:18 7:12 15:25 41:17
experienced 34:8 44:19
experiences 7:11 15:22 33:10
experts 33:4, 15
expiring 64:20
explain 51:20
exploring 66:21
express 14:1
expression 11:12
extensive 30:21 71:23
extent 87:2
external 32:21, 22 33:3 42:13 56:22 57:21 59:11 65:15, 20 67:16 73:5 88:13
externally 32:11
extra 21:9
extremely 35:7 46:8 89:14
eye 39:4
eyes 13:12

< F >
fabulous 35:24
facilitate 54:19
facilities 42:4
facility 49:1
fact 15:6 22:16 54:3 66:14 83:6 85:5
factors 46:20 66:13
facts 68:7
false 79:9, 10
families 11:18 12:12 13:4, 21 29:12 41:16 48:10, 16 79:19 80:9, 12 81:5, 13 83:9
family 12:21 47:2 80:13, 21, 25
family's 13:7
fashion 36:4

faster 38:24 64:19
fear 13:12 87:21
feasible 62:1
February 16:15 55:6
federal 8:9
feedback 74:25
feel 10:14 13:17 16:21 18:15 32:22 40:6 43:16 84:14 87:21 89:17
feeling 13:14
feelings 13:9
Felice 2:22
felt 47:16
fever 84:21
field 29:3
figure 4:22 5:15 32:17 54:4 55:19
fill 81:25
final 81:25
finance 82:6
find 21:1 37:16 41:19 50:19
fine 56:25 57:24 78:24
finish 86:25 87:1, 8
fitting 25:23
flex 23:20
flexibility 23:4, 14 25:1, 2, 7, 17 67:10 72:6 85:11, 17
flexible 56:17
flexing 23:13
floor 73:23
flow 8:2 59:5
fluids 87:1
focus 7:7 9:10, 13 10:5 34:16 35:25 36:3 41:6, 8 57:3 65:20 72:11 82:19, 21
focussed 10:18 11:5, 7 16:18 17:20 37:25 48:2 59:6 68:25 83:17
focusses 29:20
focussing 10:19, 24 68:6
follow 71:10
following 64:23
food 49:1
foolproof 83:11
Forces 8:11
foregoing 91:6, 14
foreign 87:11
foresee 54:1
Forest 12:2, 9 16:3 50:17 51:11, 13 53:12
forgotten 13:23 89:18
formally 30:13
forth 75:1 91:8
forthcoming 10:16
forward 7:9 16:10 18:17 21:22 38:24 49:16 58:25
found 36:14 37:24 41:25 54:13 70:15
four-bed 42:2 43:11 44:14 57:9
four-bedded 43:9 46:9
four-person 31:13
four-plus 64:11
fragility 56:5
frail 80:5
Frank 2:3 4:3, 7, 12, 16 6:2 7:18 20:17 21:6, 13 22:9, 24 23:19 24:1, 9, 13, 20 25:18 49:22 53:5, 23 56:12, 24 57:23 58:2, 6, 12, 18, 24 59:14, 19 60:2, 12, 18 62:15, 22, 25 63:3, 7 64:6 65:1, 5 69:8 70:5, 12 72:17, 22 75:16, 19, 24 79:7 89:9
Franklin 3:12
free 19:4, 5 33:20 66:20
frequent 30:15, 20 71:17
Friedland 3:9 60:20
friendly 35:18
friends 12:20
front 6:22 11:7, 10 82:2
frontline 11:20 18:3 19:1 35:18 40:21 81:23
fulfill 20:25
full 21:22 22:21 28:11 37:7 38:8 39:4 68:18
full-time 21:4, 8 22:5, 13 73:6 85:10
fully 16:16 17:10
functional 80:24
fund 10:4 18:3
funded 17:18 23:8 87:16
funding 14:3, 6 23:11, 12, 20, 21 24:8 67:21 92:16, 17
funds 19:8 61:1
future 18:18 32:7 43:4 61:3

< G >
Garden 50:22 51:19
gathered 71:14
geriatric 6:17
Gilmour 2:12 6:24 11:14 18:21 20:23 21:10 22:23 23:3, 6, 24 24:3, 19, 25 25:16 26:22 27:13, 15, 20 28:1, 4 29:1, 14 31:2, 19 35:15 39:17, 20 40:17 43:19, 22 44:6 45:10, 12, 14 46:6, 22 47:9 48:19 50:4 54:9 65:12 70:7, 14, 17 71:13 75:13, 17, 18 76:17 77:2 81:20 85:9 86:10, 15 90:5 92:8
gist 5:18
give 8:4 9:7 13:13 25:2, 21 26:3 33:4 35:22 44:2 48:19 50:21 52:21 60:22 72:19 78:18 86:21
given 11:25 25:1 89:3, 11
giving 33:19
gladly 57:2
global 18:10
Good 4:4, 5 17:6 33:6 50:9 54:22 57:24 58:1, 17 64:4
goodbye 12:14 13:5
Goodmans 3:9, 10, 11
governance 25:22 26:4 28:8, 14
governing 28:20
government 14:2 19:9 25:1 38:24 39:1
governments 14:11
government's 14:12 16:20
gradual 36:13
graduates 87:9
granted 63:23 64:1
gratitude 14:1
great 41:3 51:11 58:13 80:10 84:16
greater 67:12
greatest 19:13
greatly 6:22
grew 42:24
ground 64:13, 17
Group 39:22
grouped 26:23
groups 54:21
guess 4:9 27:11 28:7 56:20 59:1
guidance 35:8

< H >
half 64:14
hall 48:25
hand 33:13 71:18, 21 74:1, 6, 11 85:2
hands 29:8
happen 36:3 38:13 48:12 53:8
happened 4:21 5:11 11:8 44:3, 9, 12 46:12, 23 49:4 51:9
happening 35:6 39:2 70:23
happens 23:9
happily 88:24
happy 10:20 27:4 34:24 40:7 89:22
hard 14:17 25:23 42:7 46:9
harmonization 61:21
haul 80:22
head 22:11 26:8
heal 13:25
Health 3:5 49:15 50:3 51:2, 4, 20 52:16 53:14 65:24 66:3, 17 69:21 71:1 73:20 75:23 76:1, 3, 5 84:6 92:19, 20
healthcare 7:2, 14, 15 15:17 32:25 86:17
hear 13:7 30:17 59:21 60:4, 14, 15 65:10

heard 20:19 24:16 33:18 82:11
hearing 14:18 41:2 58:25 89:24
hearings 5:5
heart 6:13 49:7
hearts 13:1
heightened 31:3 87:19 88:10
Heights 12:2, 9 16:3 50:17 51:11, 13 53:12
Held 1:14 13:5
hell 12:3
help 5:15 7:8 18:3 33:14 34:13 41:6 52:21 54:17 57:11 68:15 72:8 79:15 81:14 82:14 85:23
helped 21:18 35:25 46:4 54:23 86:6
helpful 27:5 34:21, 22, 23 38:21 43:1, 5, 12 44:1 50:15 52:23 58:23 61:20 62:12, 20 78:9 89:14
helping 56:11
helps 28:18
high 17:11 31:8 39:5 46:13, 18 71:22
highlight 36:21 41:11
highlighted 88:15
highly 16:23, 24 31:8 41:1
hire 24:17
hired 19:3
hires 19:3 92:6, 7
hiring 81:24
hit 13:20 61:25
home 19:20 22:12 23:12, 18 26:21 27:2, 25 35:22 36:16 44:8, 13 47:2, 3 49:5 51:25 52:9 53:2 64:13 83:21, 22 84:1, 9 85:5, 16, 18, 20 86:2
homes 8:25 11:17, 22 13:20 15:5 19:17 20:6, 14 23:13 26:17, 25 27:9, 24 29:15 31:8, 21 32:1 36:20 37:10 39:5 42:1, 20 44:4, 7, 8 45:22 46:3, 10, 13 53:4 61:4 63:9, 21 64:3 66:19 67:4 71:15, 22 72:2 73:7 74:10 83:8 85:22, 23 86:3, 6 87:8 88:17
honour 12:19
Honourable 2:3
hope 9:6 12:3
hopefully 10:1 43:4 58:22 88:22 89:6
horizons 9:15
hospital 15:15 45:25 49:14 50:8 52:13, 14 53:2, 13, 19 55:14 76:7
hospitals 20:24 46:18, 19 50:2 54:21 55:10, 17
hot 69:23, 24 83:17 92:12
hotel 19:4
hotels 19:6
hourly 81:24
hours 20:4 21:4, 11 22:21 67:10 76:13 77:1 86:20
housing 62:2
HR 29:1
human 11:8, 12 19:11, 13 28:14 29:8 82:6
humanity 48:15
humanizes 16:2
HVAC 57:15
hygiene 71:19, 21 74:1, 6, 11 85:2

< I >
Ida 2:24
idea 49:9
ideally 53:15
identified 36:10 65:19 67:16, 17 71:16, 22
identify 15:9 37:17 74:10 83:25
ideologies 9:16
imagine 54:4
immediately 10:25 50:10 74:8 82:20
immense 23:16 87:2
immensely 86:6
immigration 87:17, 18 92:25
immunosuppressed 47:2
impact 11:1, 8, 16 14:21 16:5 19:13 47:7 70:9
impacted 18:5
implement 66:7 74:14
implementation 73:4
implemented 18:21 19:25 30:18 40:1 71:14
implementing 57:18 73:8 74:24
importance 15:20 49:17 84:5
important 5:12 15:13 19:24 32:8, 23 44:17 48:14 81:14 88:5
improve 67:18 75:4
improvement 57:4
improvements 88:13
incentive 23:1 84:10
include 15:11 30:2, 19 65:21
included 41:7
includes 36:20
including 86:22
inconsistency 50:20
increase 71:5
increased 85:11
increasing 71:9
independent 28:10 33:15
independently 41:22
in-depth 89:15
Index 23:8 24:6
indexing 39:3
indicated 85:24
indication 78:18
indirectly 8:16
individual 26:20 77:23
individuals 8:6 16:5 19:2 25:11 42:14, 17
inexpensive 57:10 78:14
infection 21:18 29:25 30:3, 9, 20 41:15 42:16 43:17 48:2 57:14 62:10 65:21, 25 73:13 74:24 81:6 84:25 88:14
infections 73:21, 23
infectious 31:15 42:23, 24 74:18
inform 34:15
Informally 30:14
information 51:7 69:22 74:9
informative 89:11
infrastructure 14:8 41:14, 24 46:8 56:20 57:8 59:8 60:25 61:21, 23 62:14, 16 63:25 67:24 70:3 88:6, 19
initially 21:16, 17 55:6
initiative 74:21, 23
initiatives 30:11 35:21 72:14
innovation 10:3, 4, 6
inquiry 4:21 5:4
insight 69:7
insights 42:16
installed 31:11
installing 31:12
instances 12:21 17:13 47:3 51:10
instant 80:17
institution 85:6
instruments 31:5
integrates 74:8
integration 87:12 92:24
integrity 77:17
intent 7:7
interest 61:16, 17
interesting 39:21 48:20 89:12
interests 61:17
interim 5:9
internal 32:2 34:12
internal-audit 28:11
internally 38:25 68:14
interviews 5:14 82:1
intimate 13:8
introduced 6:4
introduction 5:23
inventory 75:6, 9
invest 8:13 10:6
invested 17:23
investigate 5:3

investigation 5:4
Investment 8:8 18:2 28:15
investments 10:3
invests 8:9
involved 29:13 40:18, 22 54:10
IPAC 17:3 19:13 20:15 26:1 30:22 40:18 50:14 52:5, 10, 22 67:13 71:11, 17, 24 74:19, 22 75:1
iPads 81:2
isolate 15:12 76:11
isolated 71:7
isolation 38:21 41:16 48:11 71:11 80:25 81:6, 12
issue 20:2 47:11 76:5 80:16 92:11, 12
issued 19:7
issues 47:1 51:21 67:24 79:17
items 83:6

< J >
Jack 2:6 25:20 27:6, 14, 19, 23 28:2, 5, 19, 24 29:23 33:25 34:3, 18 39:15, 18 40:11 43:25 45:4 46:11, 16 47:6, 23 49:21, 24, 25 90:3
Jacobsen 28:12
Jessica 3:12
job 84:16
jobs 21:3
John 3:1
joined 6:14, 24
joint 40:16
July 32:12
June 15:9
jurisdictions 8:20 16:25
Justice 6:1, 8, 11 10:23 21:16 22:20 56:3

< K >
keeping 52:25
key 19:18 36:21 41:8 67:16 82:10
kill 31:6
kind 5:22 9:7 49:23 50:1 59:4
kindly 33:14
Kitts 2:6 6:1, 5, 9 25:19, 20 27:6, 14, 19, 23 28:2, 5, 8, 19, 24 29:23 33:25 34:3, 18 39:15, 18 40:11 43:25 44:17 45:4 46:10, 11, 16 47:6, 23 49:21, 25 55:5 66:11 90:3
knew 19:23
knowing 13:13
knowledge 6:17
knowledgeable 55:4
Krystyna 31:15 40:20 74:17
Kunzle 42:18

< L >
lab 77:10, 18, 20
laboratory 76:23
lack 51:22 80:25
land 63:13 64:22
lands 63:11
large 7:14 28:16 29:1 50:7 68:25
largest 17:18 77:10
Lauren 3:7 37:19
Lead 2:3 27:8 32:18 54:15
leaders 82:5
leadership 19:11 20:6 25:25 29:9 33:9
leads 20:7 53:6, 7
learn 17:9
learned 10:17
learning 15:22 68:11
led 52:23
lend 62:8
Lett 3:3
letter 14:18
letting 84:15, 17
level 29:6 55:20 73:22, 24 85:1
levels 32:3 46:18 68:18
leveraged 86:1
LHINs 54:15
LHIN's 86:1
library 40:25
licenses 64:2, 21
LifeLabs 77:11
likelihood 64:20 69:14, 18
limit 83:22
limiting 43:11
lines 11:10 18:16
link 41:20
linkage 61:8
linked 21:24
links 22:2
Lisa 2:22
literature 78:15
live 12:16
lived 19:6
living 8:22 32:24 35:18
LLP 3:9, 10, 11
local 69:3, 20
location 19:22
locations 20:20 42:6 69:10
Loeb 42:15
London 64:13
long 19:7 37:6 42:9 43:13 50:24 56:1, 11 64:7 72:7 73:16 74:13 80:22
longer 76:15
longer-term 10:22
LONG-TERM 1:7 2:12, 19, 20, 22, 24 3:1, 3, 6 6:25 7:4 8:22, 25 9:2, 14, 19 12:16 14:3, 13 18:12 26:8, 16, 20 41:13, 17 42:20 43:7 44:3 49:1 51:25 52:3, 13 55:9 57:3 58:20 61:22 62:3 64:13 71:2 75:8 76:9 80:15 82:5
looked 68:9 69:14 78:23
looking 4:22 54:5 58:25 61:22 66:24 67:2
lose 15:20 25:13
loss 13:23
lost 43:20, 23 67:20 76:20
lot 33:16 36:17 40:13 51:7 55:23, 25 57:13 62:8 64:19, 24 69:18 70:17, 19 72:13
lots 32:14 40:16
love 12:19 55:24
loved 48:11 80:23
LTC 88:3
lucky 54:20
lunch 16:4 86:23
Lynn 3:5

< M >
machine 34:11, 13 68:11
machinery 28:11
MacLeod 3:7
made 10:2 18:2, 12 61:10 91:10
Mahoney 3:5
main 23:5
maintain 66:19 72:7
major 67:7
making 9:11, 19 17:25 39:1 42:12 46:19 64:23 71:25 73:12
manage 12:24 49:2
management 25:22 26:4, 9 28:21 37:20 70:10 82:6
manager 30:8
managers 81:24
mandate 53:24 85:12
mandated 56:4
Manner 51:19
Mark 42:15
MARRACCO 62:15 63:3, 7 64:6 65:5 70:12 75:19 89:9
Marrocco 2:3 4:3, 7, 12, 16 6:1, 2, 8, 12 7:18 10:23 20:17 21:6, 13 22:9, 24 23:19 24:1, 9, 13, 20 25:18 49:22 53:5, 23 56:3, 12, 24 57:23 58:2, 6, 12, 18, 24 59:14, 19 60:2, 12, 18 62:22, 25 65:1 69:8 70:5 72:17, 22 75:16, 24 79:7
Mary's 50:17
mask 13:11
masking 44:21 45:1, 5, 19 66:14 88:1
masks 38:23 39:4
maximizing 86:1
maximum 39:8
McDonald 3:16 5:20 60:6 91:3,

24
McGeer 42:15
McKaya 3:16 91:3, 24
meal 19:5 86:25
means 43:20 71:19
meant 45:23
measure 36:8
measures 36:11 67:21
media 41:21
Medical 2:14 6:15, 20 20:10 26:1, 2, 13 27:9 28:3 52:8 74:17 85:6
medication 71:9
meet 30:14 74:22
MEETING 1:7 45:15 52:21
meetings 19:10 20:1 74:19 75:1
Melanie 3:10
member 11:24 78:18
members 11:13, 19 15:10, 12 20:3 40:4 47:2, 3 80:14, 21 81:1
membranes 80:7
memory 8:22
mental 71:1
mentioned 21:23 24:16 65:14 66:3 73:1 74:16 88:11, 21
message 23:5
metres 39:9
M-hm 76:17
Michelle 3:11
microbiologist 74:18
mid 32:12 41:13
middle 5:1 60:21
mid-term 10:22
million 17:24 18:2
millions 78:6
mils 86:23 92:22
minds 58:19
mindset 56:2
minimize 14:21
minimum 36:8 76:25
Minister 2:18
Ministry 3:5
minute 31:7 86:22
minutes 30:17 56:14 57:25
misconstrue 58:14
missing 48:11
mitigate 67:5 71:9
mitigating 15:16
Mix 23:7, 20 24:6
ml 92:22
mobility 80:15
mode 35:4 36:12
modernize 63:8
modify 63:8
modular 62:7, 12, 16
monetary 18:22
money 21:9
monitor 22:1 32:2
monitoring 31:24 84:6
months 14:14, 25 15:2 19:7 29:19
Montreal 42:24
move 16:10 37:13 45:23 59:10 77:3 81:17 85:14, 15
moved 51:14
movement 83:22
moving 7:9 16:6 18:17 46:19 64:19 68:7
mucus 80:6
multiple 35:5, 6 42:3 80:5
multipronged 10:12
multivariant 68:16
municipal 61:24 65:2
municipalities 61:9
mute 59:20
muted 35:14, 15 49:24 60:3, 8, 10, 13, 15
mutually 15:19

< N >
named 42:17
names 33:16, 17
nasal 80:6
nasopharyngeal 78:10 80:1
national 30:6
natural 64:4
nature 35:12 43:15
near 48:3
near-term 41:12
necessarily 9:11 52:1
necessary 32:24 43:15
necessity 49:10
needed 12:23 35:25 36:3 40:22, 25 41:1 85:20
needing 34:7
needs 54:7 66:9 67:9 71:12 77:16, 17, 18, 19, 21 85:10 88:20
NEESONS 91:23
negotiations 75:7
new 19:3 24:24 35:19, 20 61:10 63:25 64:1 92:6, 7
nice 81:2
nightmare 12:3
nonmonetary-embedded 18:22
normal 17:4 36:13, 15, 18 55:17, 18
note 14:20
Noted 72:25
notes 91:15
NP 77:3
number 7:10 9:23 42:6 55:7 76:6
numerous 7:1
nurses 87:11
nursing 27:24 74:2

< O >
obligations 21:1
occupancy 45:21 46:18
occur 7:23
occurred 20:22 78:2
occurs 30:23 89:19, 22
October 1:15 91:18
offer 52:1 53:22 58:14 80:16 81:4 89:15
offered 19:4 21:7 48:22, 23
Officer 2:11, 14 3:8 6:15, 20 26:13
older 31:20 42:1, 9 46:10, 13 61:3 72:2 80:5, 13 88:17
OLTCA 40:3 87:3
one-man 6:5
one-on-ones 70:19
ones 48:11 50:6 54:9, 11 80:23
one-to-one 71:8
ongoing 4:25 50:2, 5
onset 20:1
Ontario 8:24 9:4 11:17 16:24 27:16 39:5 43:23 52:3 64:14 87:14
open 54:2
operate 8:13, 25 16:25 26:17 28:16
operating 82:9
operation 20:24 22:4
operational 10:25 35:11 40:14 72:14 88:20
operationally 34:22
operationally-driven 29:19
Operations 2:20 16:12 19:12 20:4 26:11, 16 27:17, 22 29:7 30:10, 12
operators 9:23 14:11 17:25 18:12 34:23
opinions 33:19
opportunities 20:12 66:21
opportunity 6:10 41:12 53:16 80:10 81:3
option 78:7
order 20:25 87:18
orderly 36:4 38:1
organization 6:18 45:8 47:14 66:2, 20 76:22
organizational 27:4
organize 52:12
organized 20:3
orient 72:10
orientated 69:19
orientation 17:16 21:20 41:10
oriented 9:21
Ostrowska 31:16, 17, 18, 19 40:20 42:14 52:20 74:17, 25
Ottawa 50:6, 8 52:7 54:24 55:23

Ouanounou 3:10
ought 89:23
outbreak 15:7, 12 18:24 20:5, 7, 12 29:12 35:4, 23 36:1, 8, 10, 11 37:12, 20, 22 38:2, 8 44:4, 7, 11 46:3, 24 48:21 50:7, 23 51:2 52:9 53:15 69:16 72:4 73:24 85:19
outbreaks 14:9 20:2 31:25 32:15 36:7 44:18 68:19
outcome 15:1 49:13 79:13 92:4
outcomes 92:4
outlined 6:11
outside 7:12 71:2
overall 41:17
oversee 16:12 26:16
oversees 26:10, 15
overview 37:9
owning 8:12

< P >
p.m 1:16 4:1 58:4, 5 90:7
package 22:22
pages 37:7 38:2
pair 27:1
Palin 2:20
pandemic 4:25 6:21 10:10 11:8 14:23 15:16 16:17 17:3, 19 19:7 29:20 32:10 34:5, 10, 25 35:4 36:13 39:13 41:7 48:9 51:22 59:5 68:23 70:23 72:11 73:4 88:20
panel 32:21 42:13, 14 56:22 57:21 88:13
paper-based 74:4
parameters 68:10, 17
paramount 66:19
parcels 63:18
parents 81:10
part 16:22 20:20, 25 32:24 34:9 42:12 60:17 76:21 82:2 89:14
participants 1:14 2:16 9:24
participated 55:2
particular 16:6 37:19 45:1 77:7
particularly 14:3 54:23 80:23
partition 31:22 74:21
partitions 57:11 67:23
partly 46:18
partners 9:14 14:8 46:1 49:11, 14 61:18
partnerships 15:15
part-time 21:3, 11 22:5, 13, 16, 18, 21
passion 6:17 8:17
passionate 57:5 77:7 79:22 80:19, 20 81:9 88:16
Pat 28:12
patients 46:19 55:20
pause 57:20
pay 14:4 19:7 72:23 84:10
pays 22:18
PCR 78:9, 20 79:12
peace 13:13
pending 64:7
Pension 8:8
people 4:22 12:20 13:3 20:20 21:2 22:13, 22 26:18 29:6 40:18, 21 43:6 45:24 46:1 51:14 54:4 62:2 71:20 76:6 86:5, 7
percent 45:22, 23 47:4 76:25
period 44:20 45:3 48:13
permission 12:1
permitted 62:16
person 22:14 51:5
personal 17:20 18:9, 13 75:5 81:1, 3 85:3
personally 11:25 55:23 57:4 61:3 78:12
perspective 22:25 28:9, 17 29:13 67:13, 14 77:14 78:25 89:12, 13
pertains 22:16
phases 36:6
phone 29:10 51:18, 20 52:20 59:25 60:10, 11, 13, 15
phones 13:6
physical 41:14 56:20 77:5
physicians 20:11 50:14 51:24 52:5, 8, 14 67:10
picture 26:4
pipelining 81:23
place 17:2 54:14 71:8 83:11 91:7
plan 14:23 32:11 39:13 59:6 64:21 82:7
planning 16:17 17:3, 4
plans 61:24 71:15
play 33:8
playbook 30:16, 19 35:1, 17, 24 36:5, 19, 23 37:1 38:5, 15, 20 39:24 58:8 68:23
playbooks 40:5
played 26:6 38:10
plays 36:13
pleased 6:19 7:5, 17 58:10
plexiglass 57:10
point 10:23 44:17 47:10, 19 51:16 55:5 56:3 66:23 74:8 78:17 80:19 82:19
pointed 79:25
point-of-care 79:1 80:11
points 61:6 77:15
policies 17:1, 6 30:23 40:8 71:24
policies/procedures 40:1
Policy 3:3 20:11
portfolio 42:5 57:18
position 6:20 21:8
positioned 14:21
positions 10:7 21:11 22:17 85:10
positive 14:19 15:5, 10, 11 36:9 44:15 56:1, 10 79:9, 11
possibility 69:15 78:13
possible 39:8 68:25 76:11
possibly 16:11
post 36:10
potential 19:12 66:12 67:2 79:5
potentially 69:4 79:3, 20
PPE 17:24 19:13 30:2 32:3 44:10 45:5, 15 46:17 50:12 51:1 52:22 54:18 72:1 73:12 75:6, 7 79:18 87:23
PPE-supplied 26:1
practical 41:5 68:23 78:22, 25
practices 35:20 65:25 71:11
pragmatic 35:11 41:5
prayed 13:9
predict 68:13 69:5, 9
prediction 69:9
predictive 39:3
predictor 61:2 69:13, 24 70:2
predictors 69:18
preexisting 17:1
preliminary 15:1 82:18 92:3
preparation 11:1
prepared 16:10 17:7, 10
preparedness 36:7 37:11
PRESENT 3:14
presentation 7:25
PRESENTERS 2:8
presenting 40:4 52:2
President 2:10, 12 6:25 7:3 30:7
presidents 27:16
pressures 47:16
prevalence 83:15
prevent 15:12 70:19
preventing 14:9
prevention 30:1, 3, 9, 20 36:6, 12

37:11 65:22 66:1 73:14 74:24 84:25
preview 44:2
previously 73:1 74:2, 16 88:22
prime 85:21
primer 25:22
prior 15:18 19:8 39:1 44:20 47:10, 13 65:20 73:4 77:9
prioritization 76:8
prioritize 87:12
priority 82:8
Privacy 3:8
private 9:9 18:11 28:9 53:25 76:23 78:6 87:15
privately 87:16
privilege 52:2
proactive 53:13
proactively 22:1 53:17
problem 20:19 23:16, 25 53:7 70:14 72:2 79:8
problematic 50:20
procedures 30:23 40:9 71:25
proceedings 91:6
process 31:6 61:7, 13 64:24 75:7 78:23 87:6, 7 88:23
processes 32:14
production 31:20
professional 77:23
professionals 86:17
program 17:17 21:25 63:12, 14 64:10 73:3 75:4
progress 48:8 63:5
project 34:10
projects 62:3
promote 86:16
promoting 15:21
proper 82:8
protect 11:22 81:5, 6
protection 39:4 55:10
protective 17:20 18:9, 13 75:5 85:3
protects 79:16
protocols 17:1 21:23 31:3 32:14 88:10
proud 15:17
provide 22:21 27:4 30:15 31:13 34:8 35:8 55:9 79:5 86:2 88:24
provided 20:13 41:22 42:15 84:10
provider 17:18 69:1
providers 18:11 86:20
providing 86:3
province 9:4 45:16
provinces 20:12 26:17 45:14, 17
provincial 65:2
prudent 5:7
PSW 85:10 87:6
PSWs 14:5 87:11, 13
public 5:5 8:8 49:15 50:3 51:2, 20 52:16 53:14 61:16 62:2 65:24 66:2, 3, 17 69:21 75:22, 25 76:3, 5 87:17
publically 33:8
publicly-traded 9:9, 10
pull 34:14 38:6 40:24
purchased 31:4 63:11
purpose 32:21
push 62:19
pushing 42:7
put 7:23 10:8 31:20 34:13 46:1 48:6 63:18 69:2 71:8 77:17 89:2
putting 70:19

< Q >
qualifications 87:8
Quality 28:11, 13 32:10
question 5:10 24:12 25:19 34:1 39:16 43:9 46:8 55:22 66:12 86:12
questions 5:12 7:20, 23 24:10 41:4 44:23 73:11, 14 84:3
quick 15:11 36:22 39:15
quickly 16:17 76:11
quick-reference 36:20
quit 46:25
quite 55:24

< R >
raises 14:4
ran 77:9
range 8:19
ranging 68:17
rapidly 67:3
RCMP 8:10
reach 53:16 54:16 89:20
reached 11:25 48:22 54:11
reaching 53:13, 20
ReachView 48:21
read 13:18 78:15
ready 4:17 5:23 17:10 38:1 39:11 59:1, 2 69:5 82:20 86:10
real 9:10
realizing 12:7
really 7:6 10:10, 12, 19, 24 33:4, 13 41:6 45:25 48:2 49:7 52:11, 18 55:8 57:19 72:23 80:10 82:18 83:16 84:16 85:13 89:12
reason 32:25 33:1, 7
recall 47:7
receive 23:11 89:22
received 14:13 19:22
receiving 19:8
RECESS 58:4
recognize 84:20
recognized 53:20 61:23 62:18
recognizing 76:5
recommendations 5:10, 17 32:7 52:4 57:12 66:6 82:16 85:8 88:25
recommended 73:9
recommending 52:18 57:7
reconnect 60:21
recorded 91:11
recovery 36:10
recruiting 42:22 72:5
recruitment 19:1 82:7 87:10, 12
redevelop 62:13
redeveloped 42:10 61:4
redevelopment 57:3 63:19 88:17
redirected 18:25
reduce 67:21 87:20
reduced 23:12
reduces 79:17
reducing 24:7
reduction 21:19
refer 36:22
reference 36:22
referred 78:7
refreshed 69:21
refresher 30:22 71:24
regard 66:10
regarding 14:2 87:20
regional 26:14, 15, 23 27:17, 21
regional/national 20:7
regular 19:25 83:14 87:24
regularly 84:5
regulated 7:14 16:23, 24
regulations 25:4
rehiring 86:16
rein 33:20
related 73:11, 14 74:24
relates 41:13 54:14 60:24 62:6
relating 48:9
relation 67:8
relationship 50:1, 9
relationships 14:7 15:18, 21 49:19 54:23
relatively 57:10
relevant 9:6 36:23
relied 45:25 67:23
rely 80:11
remain 25:17 83:10
remains 83:6
remarks 91:10
remember 22:11 45:20 47:24 85:4
reminded 84:5
remotely 1:15
remove 43:15
removed 13:10

25:12
removing 31:10
reopening 36:12
reorient 59:4
repeat 60:5 76:20
repeatedly 82:11
replacing 63:24
report 5:5, 9 26:3 27:11, 17, 21, 24 28:3 29:6 74:9 86:22
reporter 5:20 60:7 91:4, 25
REPORTER'S 91:1
reporting 31:25 86:24 87:1, 5
reports 26:8 41:21
repositioned 16:18
requested 77:24
requests 63:8 71:5, 9
require 20:25 22:17 69:10
requirement 76:25
residences 8:15 9:3, 20 61:11
resident 73:22 77:14 78:19
residents 9:1 10:8 11:10, 19, 23 12:17 13:21 15:4 31:14 36:21 38:22 39:7, 9 41:17 42:3 43:11 48:12, 15 50:12 51:13 53:4 64:18 70:20, 21 71:1, 7 77:3, 5 79:24 80:2, 4, 5, 6, 18 81:5, 6 83:13 86:21 89:5
resident's 13:6 53:2 85:5
resolved 67:25
resource 81:22
resources 15:23 16:18 19:11, 13 28:15 29:8 31:4 53:21 68:24 82:6 85:14, 15
respect 12:19, 25 16:9 21:18 33:4 53:4
respiratory 32:16
respond 10:13 16:19
response 10:10 14:12, 23 16:9, 21 23:21 32:10 34:10 35:5 36:8 39:13 41:7 59:6 72:11
Responsibilities 37:23
responsibility 81:22
responsible 9:17 25:24 26:18, 19, 24 27:1
Responsive 39:22 71:6
Responsive's 40:5
rest 12:15 44:8
restore 32:23 48:14
restrictions 25:11, 12
resubmitted 64:9
result 31:8 79:2, 5, 6
resulted 51:7, 8
results 73:17 75:21 76:19 77:1 78:2 80:17
RESUMING 58:5
retain 18:23 24:23 25:10
retired 86:16
retirement 9:3 26:11 81:11 82:5
return 36:13
returning 36:15
Revera 2:11, 13, 14 3:8 6:16 8:7, 13 9:8, 22 10:4 11:20 14:20 16:11 18:21 22:17 23:2 38:17 71:2 73:1 75:15 77:9 81:21 85:14
Revera's 6:15, 25
revised 64:10
Rhonda 2:14 6:14, 16 14:15, 16 16:1 20:15 22:15 27:3 29:4, 24 31:16, 18 40:19 47:20 49:8 51:11, 16 53:9, 12 54:8 59:21, 24 65:9, 13, 17 70:24 72:16, 19, 25 75:22 76:2, 18 78:7 79:23 83:4 90:4
Rhonda's 77:15
rigorous 88:3, 4
risk 13:14 15:16 21:17 46:14, 20 48:1 71:22
risks 21:19
roaming 70:20
Rokosh 2:20
role 16:11 33:9 54:15
roles 26:5 37:22
rolled 18:5 36:19
room 31:11 39:9 44:14 46:19 73:22
rooms 31:13 39:8
Roth 3:11
roughly 26:16
routine 83:12
rug 13:24
rules 5:2 87:12, 14 88:4 92:24, 25
run 76:24 77:20
rural 63:17

< S >
sad 13:16
safe 31:14 81:15 87:25 88:2
safety 87:20
saliva-based 78:11
sample 77:16
samples 75:25
Santiago 42:18
save 78:20
saved 87:5
scale 9:25 70:4 80:2
scan 83:24
scars 12:7
scenario 49:12 53:10
screen 24:17
screened 19:2
screener 73:6
screening 17:12 21:22 48:5 66:10, 18 67:14 73:2, 6 81:23 82:22 83:2, 7, 10 88:3, 4
screenings 67:22
seas 87:13
secondarily 78:21
secondary 71:6
Secretariat 2:19, 21, 23, 25 3:2, 4
section 37:5
sections 36:23
Sector 8:8 11:2, 4 15:18 34:24 51:23
sectors 49:19
secure 75:5, 8
secured 31:3
selection 82:1
send 75:25 76:3
sending 38:14
Senior 2:12 6:25 7:3
seniors 8:17, 19 10:5 70:25
sense 5:16 13:13
sensitivities 78:16
separated 39:7
separation 57:9
September 38:25
series 5:14
serious 54:11
service 8:18
services 10:2 30:7 57:17
session 57:22
set 32:22 39:9 48:24 82:18 91:7
setting 32:24 53:3 77:10
settings 7:3 63:17
severe 48:20 50:23, 24
share 8:11 12:1 19:17 40:7
shareholders 9:12
sharing 13:8 15:22
shift 30:24 38:6, 7
shifting 22:6
short 34:7 43:5, 12 44:2 57:6, 16, 20 69:12
Shorthand 91:4, 15, 25
shortly 47:11
shortness 84:21
short-term 58:22 86:16
shot 54:7
show 6:6 37:15 46:25
shows 53:17
shutting 36:16
shy 33:18
sick 12:11 84:10, 18
side 62:6
significant 7:12 10:3 16:18 42:5 44:19, 22 45:3 55:7 61:25
signs 31:23 73:21
silence 58:13, 14

single 27:8 39:8 68:16 77:10
single-site 17:12 21:2, 18 85:12
Sinha 15:14
sir 4:10
site 15:20 35:5 38:17 47:7, 15 73:6 74:15 80:17 88:3
sites 21:25 29:11 40:16 61:14 63:15 82:8 87:23
sitting 74:19
situation 14:23 51:18 53:10 55:23 68:13 76:16
situations 49:11 54:2 86:18
size 70:4
skilled 25:6
skills 25:8
slide 37:8, 13
slow 6:3
small 38:3
smaller 64:3
smile 13:11
Smith 55:7
snacks 19:5
social 17:16 48:11 61:22 88:1
socially 9:17 81:15
society 89:8
soft 38:15
Solid 15:15
solution 77:13 78:14
solutions 10:22 81:14
somebody 53:16 54:7 86:12
somewhat 56:16
soon-to-be 87:9
sorry 49:23, 25 59:25 63:1, 2 79:22
sort 4:18 27:8 44:4 61:9 62:5 63:13 64:3 82:18
Sounds 58:1
source 18:14 20:13 27:8
sources 19:15
sourcing 64:22 81:23
space 33:10
speak 9:24 10:21 29:25 59:12 60:17 68:1 85:7 89:10
speaking 52:15
specialist 30:10 31:15 42:23, 25 74:18
specialists 88:14
specialized 30:15
specific 32:6, 13 57:2, 12 82:24
Specifically 8:24 16:23 34:16 45:16 59:12
specimens 76:24
spending 78:5
spent 29:17 55:23
spoke 30:5 65:23 67:7
spoken 83:5
spots 42:9 69:24 83:17
spouses 80:14
spread 11:22 44:13 66:15 67:5 69:15 70:15 82:13
spreads 70:21
St 50:17
stable 9:20
staff 10:8 11:13, 19, 24 12:13 13:21 15:8, 9 18:4, 23 19:1, 6 22:3, 5, 18 23:5, 18, 21 24:7, 17, 24 30:22 36:9 38:22 46:24, 25 47:5, 11 49:5 50:11 51:1 54:18 56:6 66:17 67:11 71:8, 24 74:2, 3 76:10 77:4, 14 78:18 79:16, 25 83:8, 13 84:4, 14 87:20 89:5
staffing 18:20 25:25 30:2 32:2 41:9 46:23 67:6, 9, 13 68:18 75:12 79:17 81:19 82:9, 12 85:8
staff-person 35:23
stage 5:3 44:10 48:1 82:2
staging 62:13
stakeholders 9:21
standards 74:22 84:25
standpoint 43:17 52:22 57:8
start 7:19 26:7 38:6 54:19 72:5
started 70:9 73:5
starting 62:17
state 11:16 38:23
stated 15:14
statement 22:20
station 48:24
status 15:6 73:25 87:17
stay 25:9 84:9
staying 75:9
Stenographer/Transcriptionist 3:16
stenographically 91:11
stepped 50:10 51:25
steps 61:8, 9 69:4 79:4
Stiller 28:13
stop 82:13
storage 72:3
strategies 17:2 18:23 66:5, 8, 22 67:3 74:14
strategy 66:9
streamline 61:12
streamlining 88:23
street 85:18
strengthen 15:21
stress 17:22 57:19
stretched 10:11
strike 34:4
strong 15:19
stronger 72:5
strongly 18:15
structure 25:23 26:5 64:5
structures 54:14 63:9
students 87:7
study 14:22
subject 77:8
submit 76:23
subsidiary 8:8
succeeded 64:12
successful 50:6
suffering 13:23
sufficient 45:5 46:17 88:4
suggest 84:7, 22
suggested 22:10
suggestions 7:8 33:21 57:4
sum 88:8
summarize 83:3
summer 48:13 86:7
Sunnybrook 55:8
supplement 21:3
supplies 45:17
supply 18:10 75:4
support 14:7 19:1 29:12, 22 30:8, 16 41:23 43:7 54:17 55:19 57:15 67:22 68:12 69:3 72:8 85:8, 19, 23, 25 86:2 88:10, 12
supported 9:20 50:11 56:9 89:6
supporting 50:15 88:19
supportive 29:2 50:18
supports 45:18 55:15
supposed 55:9
surfaces 42:12
surge 55:9
surgeries 55:13
surgical 38:22
surveillance 15:8 21:25 30:19 48:6 71:17
survey 80:2
survivors 12:6
suspect 89:25
sustainability 67:8
sustainable 21:19 43:13
swabbing 87:24
swabs 77:3 78:10
sweep 13:24
symptom 84:22
symptomatic 38:22 84:8, 11
symptoms 31:24 73:11, 21 83:10, 12 84:7, 13, 20
synthesize 19:16
system 17:22 18:1 23:15 43:16, 22 61:1 62:14 63:22 77:18, 22, 25 78:21 79:3, 4
systems 17:11

< T >
table 37:2, 4
tables 55:3
takes 34:11
talent 81:22 82:6
talk 13:24 15:24 18:20

20:15 25:25 30:25 33:24 34:20 41:8, 9 75:11 81:18
talked 37:10 52:7 56:19 59:6
talking 16:4 55:8
talks 38:21
target 74:11
tasks 41:15
team 7:6 15:11 16:3, 5 19:11, 12 20:1, 3, 4 26:9, 14 29:9 30:10 51:19 75:2 81:21
teams 11:10 26:23 57:17
tech 57:17
technical 65:18 78:24
technology 66:22 72:20
telephones 72:20
temperature 73:8
temperatures 73:7, 10
Temporary 67:20, 23
tend 56:13
tended 7:19
tends 66:6
tenure 70:8
term 42:9 43:5, 12, 13 48:3 57:6, 17, 20
terms 75:20
terrified 47:1
test 77:20, 21, 24 78:1 79:1, 12
tested 15:5 73:16 76:6 78:21 80:12
testing 21:24, 25 30:20 48:6 66:10, 16, 17, 18, 22, 23, 25 67:14 71:17 73:2 75:20 76:20 77:12, 13 78:9, 11, 13, 23 79:8 80:1, 11, 17, 18 83:13
tests 77:4
Thanks 16:1 41:4 58:13 81:20 83:4 89:24
themes 30:2
thing 7:19 9:22 11:4 13:15 18:7 21:5 23:7 29:20 33:22 40:24 41:25 43:13, 16 44:5, 16 45:20 47:17 48:14 50:16 62:5 70:22 81:4
things 6:11 7:8, 9 9:5, 6 13:22 16:2 19:18 20:19 30:18 32:8 36:14 38:4 41:10 42:11 48:7 50:19, 21 52:6, 18 56:4 57:7, 16 58:7, 22 60:24 62:6 68:5, 7, 13 69:5 70:7 71:16 85:2 88:9
thinking 58:20 74:23
third 33:7
Thomas 2:10 4:5, 10, 14 5:25 6:7 8:1 16:1 21:5, 15 22:19 23:4 26:7 28:7, 22 29:16 31:17 32:5 34:2, 6, 19 39:14 40:13 41:3 43:21, 24 44:16 45:7, 11, 13 46:5, 7, 15 47:18, 21, 24 53:11 55:1 56:18 57:1 58:1, 9, 17, 21 59:3, 16, 23 60:9, 16, 23 62:17, 24 63:2, 6, 10 64:8 65:4, 7, 11, 14 68:3 69:12 70:16 72:9 77:6 79:10 81:7 82:17 86:9, 13 88:8 90:1, 6
thoroughly 88:9 89:1
thought 85:22
throw 7:24
time 12:14, 15 13:15, 19 14:17 18:9 20:20, 25 25:23 29:18 37:11 44:20 45:1 53:15 55:8, 24 56:15 57:24 64:21 68:19 74:6, 7 76:4 77:9 78:1 83:21 86:23 87:3, 4 89:2, 3, 19 91:7, 10
time/part 68:18
timely 31:25 79:6
times 13:10, 19 15:15 17:21 19:15 38:23 51:14 76:12 78:23 79:20 80:5
tirelessly 7:6 11:21
today 7:7, 17 10:9, 14 40:3 79:13 89:3, 23
told 51:4
Tom 3:9 11:15 15:24 35:16 39:12 43:19 54:25 60:20 65:17 68:1 79:23 81:20 82:15 83:5 88:6
Tom's 80:19
tool 31:24 36:22 41:5 83:23
top 22:11 82:8
top-up 63:24 64:2
Toronto 63:15
touch 67:14
touching 49:7
tracing 66:11, 19 67:15 73:3, 12 83:3, 19
track 64:15
tracking 31:25
tracks 73:21 74:7
trained 73:13 87:11
training 30:16 50:25 52:5, 10, 13 67:12 70:10 71:23, 24 74:14
trainings 30:22
transcribed 91:12
transcript 5:21 91:15
transfer 64:18
transition 36:11
transmission 15:6
transport 48:25
transportation 19:5 80:15
traumatic 11:18 16:7
travel 73:11
tremendously 11:18 46:4
trending 73:25
trip 16:15
true 91:14
truth 19:21 20:14
trying 5:8 16:10 17:20 29:21 60:21 61:3 66:25 69:1 82:19
turn 11:11 12:23 14:19 15:24 18:19 58:19
Turnaround 76:12
two-code 83:24
type 17:7 52:15
types 42:6
typical 5:4
Typically 4:20

< U >
U/T 27:3 58:9
UK 8:14 16:13, 15
unacceptable 78:3
unaware 66:14
underscore 15:14 49:17
understand 27:7 54:1 63:4
understanding 16:5 33:9 51:22 68:8
understands 49:20
Understood 8:1 92:8
undertaken 83:14
unique 68:5
unit 51:2, 4 53:14
units 49:15 66:3, 4
universal 44:21, 25 45:5, 19 66:13 82:22 83:2, 7
universally 66:8
unknown 47:22
unmute 60:6
unmuted 59:18
unpleasant 80:1, 7
unstable 18:10
untrained 25:6
uploaded 77:22
urban 63:15
useable 35:18 40:22 41:1
useful 79:5
user-friendly 30:22
utilize 79:18
Uxbridge 48:21 49:5

< V >
vacancy 81:25
valuable 78:20
valued 41:1
variant 68:16
variants 69:19
varied 76:12
various 19:14, 15 22:7 29:7

32:15 37:16 61:7
vary 78:16 83:18
vendors 66:21
ventilation 88:12
VERITEXT 91:23
version 88:25
versus 68:19 87:1
Vice 2:12 6:25 7:3 27:15, 16 30:7
VIDEO 38:10
videos 38:5, 6, 9
view 20:21
views 33:3, 5
virus 11:22 18:5 32:16 47:22 69:15 83:15
viruss 31:7
visit 81:12
visited 16:3
visiting 79:20
visitor 88:4
visitors 73:15 80:20 83:8
visualizing 73:23
vital 14:8 15:15 30:3
vocal 38:11
voice 19:21 81:14
voices 13:8

< W >
wait 78:1 79:3
waiting 7:21 43:6
walk 11:12 12:6 35:1 72:12
wandering 71:10
wanted 8:4 11:11 18:19 35:7 37:15 41:11 44:25 59:10
wants 11:3
war 12:5
ward 43:9
wards 42:2 43:11 46:9 57:9
warehousing 75:4
waste 66:24
waste-water 66:25
Wave 11:1 14:22 17:9, 11 19:3 34:4, 5, 7, 9, 17 36:15 38:25 39:11 41:6, 12 43:18 44:3, 19 55:6, 12, 16 56:5, 7 70:15 82:20 86:11 89:6
Waves 10:16
ways 10:11 32:17 55:19 67:20
wealth 6:17
wearing 38:22
webinar 40:4
week 29:14 47:12 52:3 71:1 82:25
weekend 22:6
weekends 19:15
weekly 30:14 32:4 74:20
weeks 39:1 81:13
welcoming 62:2
Wellner 2:10 4:5, 9, 10, 14 5:25 6:3, 7 8:1 16:1 21:5, 15 22:19 23:4 26:7 28:7, 22 29:16 31:17 32:5 34:2, 6, 19 39:14 40:13 41:3 43:21, 24 44:16 45:7, 11, 13 46:5, 7, 15 47:18, 21, 24 53:11 55:1 56:13, 18 57:1 58:1, 7, 9, 17, 21 59:3, 16, 23 60:9, 16, 23 62:17, 24 63:1, 2, 6, 10 64:8 65:4, 7, 11, 14 68:3 69:12 70:16 72:9 77:6 79:10 81:7 82:17 86:9, 13 88:8 90:1, 6
Wendy 2:12 6:24 7:1, 5 11:11, 14 14:16 16:2, 8, 20 18:19, 21 20:23 21:10 22:23 23:3, 6, 24 24:3, 16, 19, 25 25:16 26:8, 10, 14, 22 27:10, 13, 15, 20 28:1, 4 29:1, 12, 14 30:5, 25 31:2, 19 35:1, 10, 13, 15 39:17, 20 40:17 41:4 43:19, 22 44:6 45:10, 12, 14 46:6, 22 47:9 48:19 50:4 51:17 54:9 65:12 67:6 70:7, 14, 17, 24 71:13 75:11, 13, 18 76:14, 17 77:2, 15 78:7 79:25 81:20 85:7, 9 86:10, 15 90:5
Wendy's 81:18
whatsoever 85:24
whilst 32:13
wholly-owned 8:7
wider 11:20
winners 12:5
wished 13:5
wonder 22:15 44:1
wonderful 37:24
wondering 24:23 25:21
won't 38:17
words 38:12
work 9:24 11:21 14:10 21:9 30:5, 13 39:23 40:16 42:13 49:10, 13 53:17 56:10 57:14 63:12, 14 72:13 82:3 84:8, 10, 12 86:6 87:8, 22
worked 7:6 18:11 39:21, 25 42:18 54:12, 21
workers 8:10 11:20 25:6 84:9
working 7:11 12:10 20:20 25:8 33:13 47:7 55:25 73:2 76:21
written 88:24
wrong 31:16

< Y >
Yeah 22:19 23:6 25:20 27:6 28:22 29:16 34:2 40:13, 17 43:21, 24 45:10, 11 46:5, 11, 15 47:18, 23 53:11 55:1 56:25 58:21 60:23 63:10 70:16 82:17 86:9 88:8
year 16:14 23:9, 13, 17 49:6 64:17
years 5:6 23:9, 22 24:5 42:7 61:5 64:11
year-term 88:18
younger 42:8 70:11

< Z >
zoning 64:23
Zoom 1:14