

Long Term Care Covid-19 Commission Mtg.

Second Meeting with LTC Commission and Dr.
Jennie Johnstone
on Thursday, January 28, 2021



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

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1 LONG TERM CARE

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3 COVID-19 COMMISSION

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8 PRESENTATION BY
9 JENNIE JOHNSTONE, MD, PhD, FRCPC

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16 --- This is the transcript of a virtual Zoom
17 meeting, taken by Neesons, a Veritext Company,
18 on the 28th day of January, 2021, commencing at
19 2:00 P.M.

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22
23 [All participants appearing virtually.]

24
25 REPORTED BY: Helen Martineau, CSR

1 C O M M I S S I O N E R S:

2 The Honourable

3 Frank N. Marrocco Lead Commissioner

4 Dr. Jack Kitts Commissioner

5 Angela Coke Commissioner

6

7 P R E S E N T E R S:

8 Jennie Johnstone MD, PhD, FRCPC;

9 Infection Prevention and
10 Control Medical Director,
11 Sinai Health;

12 Infectious Diseases
13 Physician, Sinai Health
14 and University Health
15 Network;

16 Associate Professor,
17 Department of Laboratory
18 Medicine and Pathobiology,
19 University of Toronto;
20 Associate Professor, Dalla
21 Lana School of Public
22 Health, University of
23 Toronto.

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1 P R E S E N T E R S: (continued)
2 Dr. Dylan Kain ID physician,
3 Currently doing a COVID-19
4 pandemic fellowship,
5 (Sinai Health).
6

7 P A R T I C I P A N T S:

8 Alison Drummond Assistant Deputy Minister
9 Long-Term Care Commission
10 Secretariat

11 Jessica Franklin Policy Lead
12 Long-Term Care Commission
13 Secretariat

14 Alain Daoust Team Lead
15 Long-Term Care Commission
16 Secretariat

17 Angeline Hawthorn Senior Policy Analyst
18 Long-Term Care Commission
19 Secretariat

20 Angela Walwyn Senior Policy Analyst
21 Long-Term Care Commission
22 Secretariat

23 John Callaghan Co-Lead Commission Counsel
24 Gowling WLG

25 Patricia Brooks Counsel, Gowling WLG

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

2 JENNIE JOHNSTONE: So again thank you
3 for having me back. I do have just a few slides
4 on testing. I do know that there was a session
5 on testing by Matt Anderson, Vanessa Allen,
6 Frederick Escarf [ph] and Dirk Huyer.

7 I think the perspective I may share is
8 just from an independent individual who was part
9 of the testing strategy, and I'm really here to
10 answer any questions that you may have that are
11 outstanding. But, again, I just put a few
12 slides together to help guide the conversation
13 but truly I'm happy to answer anything that I am
14 able to share, based on my knowledge, I mean.

15 So in terms of the expert testing
16 strategy panel, we were conceived as a result of
17 the backlog, the testing backlog that I'm sure
18 you've heard about in March. As soon as they
19 came out of that backlog and were starting to
20 build additional testing capacity, it became
21 clear that there was need for some guidance as
22 to how you prioritize, as you build your
23 capacity who's next, so to speak.

24 So on April the 5th we formed.
25 Initially, again, we were -- I would say we

1 were -- it was a bit unclear who we reported to
2 at the beginning, but we just put forward
3 recommendations to the Office of the Chief
4 Medical Officer of Health.

5 That did formalize, as you'll see a
6 little bit more -- and I can't remember exactly
7 when, in late May, early June where it became
8 more of a formalized process. But again, we
9 were just sending our recommendations forward
10 and we are one source of input. So again, we
11 were providing expert opinion or
12 evidence-informed opinions, if there was any
13 evidence, forward to the Ministry or to the
14 Office of the Chief Medical Officer of Health
15 who would then overlay whatever policy
16 decisions. So we, of course, did not set policy
17 but we did provide guidance.

18 So --

19 LEAD COMMISSIONER MARROCCO: Did I
20 understand you to say, Doctor, that there were
21 other people providing testing advice or
22 expertise?

23 JENNIE JOHNSTONE: I don't know that
24 there's other people providing expertise. I
25 guess my only point is that expertise is only

1 one input into policy.

2 LEAD COMMISSIONER MARROCCO: I see.

3 JENNIE JOHNSTONE: So there might be
4 additional -- you know, with any policy decision
5 there are the scientific inputs as well as
6 politics, logistics, whatever other --

7 LEAD COMMISSIONER MARROCCO: I
8 understand.

9 JENNIE JOHNSTONE: -- inputs into the
10 policy. So we just provided the science. We
11 tried not to weigh into pragmatics. We just
12 tried to stick to the science.

13 So I think it was late May, early June
14 that we did formalize our structure such that we
15 became a sub-committee of Public Health Ontario,
16 because Public Health Ontario is the official
17 body that provides scientific advice to the
18 government. So we became a sub-committee of
19 PHO.

20 So the way we make our recommendations
21 is we put forward our recommendations to Public
22 Health Ontario who very quickly, usually same
23 day, would then provide those recommendations
24 onward to the Office of the Chief Medical
25 Officer of Health. And we do involve -- we

1 generally do copy both Frederick Escarf, who
2 again I know you heard from, at the Ministry as
3 well as Matt Anderson from Ontario Health
4 because I guess there's multiple players that we
5 find it helpful to make sure that everyone is
6 aware of recommendations coming forward.

7 The membership is, I would say -- I
8 would describe this as a very pragmatic panel.
9 So this is comprised of experts from the field.

10 And so these are people who are on the
11 ground, whether it be geriatricians, myself
12 infectious disease, infection control, so people
13 who are working in microbiology, so the
14 microbiologists. We also have an ethicist on
15 the panel, epidemiologist and analytics.

16 And so our hope was that we could
17 again provide very practical and timely
18 recommendations, recognizing that we are in a
19 world where we didn't necessarily have science.

20 We tried to use science to the extent
21 that we could. But, again, many, many times we
22 had to make decisions in the absence of any
23 guiding science. And we always -- we always
24 revisited our recommendations and updated them
25 as science became clearer. But, again, when we

1 were making decisions, many times there was --
2 there was only our pragmatics to guide us.

3 So the initial mandate, as mentioned,
4 was to provide these recommendations to update
5 the testing guidance mainly around a cascading
6 sort of who is next as to who should get tested.

7 And then as the capacity increased and
8 we were able to test, you know, most people who
9 required testing from symptomatic individuals,
10 then it sort of expanded into what other
11 workplace testing recommendations, travel -- as
12 we had more capacity, we could then shape it.

13 And then now --

14 LEAD COMMISSIONER MARROCCO: Doctor,
15 where did the capacity come from? From the
16 private labs?

17 JENNIE JOHNSTONE: Not necessarily.
18 So this is where -- so I was not involved in
19 building that capacity necessarily. I am aware,
20 but in terms of the network of labs primarily it
21 came from hospitals and so to a lesser degree
22 private labs.

23 So it was -- so currently the network
24 of labs includes Public Health Ontario labs as
25 well as a number of large labs, and I feel I can

1 speak to that because one of the largest labs is
2 at Sinai. And then there are some private labs
3 leveraged as well.

4 This is a slide that -- I think this
5 slide came from the Auditor General's report.
6 And I just wanted to point out that it's not
7 entirely accurate. This was from August, and
8 this puts us as a sub-committee, as a technical
9 advisory table that reports up to the Health
10 command table, but technically it's actually, if
11 you go to the next slide, we are -- the
12 governance is through Public Health Ontario.

13 And again we report our
14 recommendations to Public Health Ontario, and
15 then that goes directly to the Chief Medical
16 Officer of Health. So this reflects the
17 reality. I know that the Auditor General and I
18 think some other slide decks -- and I think
19 John, you even had a slide which again isn't --
20 what you see here is actually more accurate and
21 reflective of our guidance.

22 JOHN CALLAGHAN: Do you actually meet
23 with the Chief Medical Officer of Health or was
24 it all through Public Health Ontario?

25 JENNIE JOHNSTONE: No, we don't meet

1 with him formally in this capacity, but we do
2 have -- we have individuals from his office on
3 our committee.

4 JOHN CALLAGHAN: And I'm going to take
5 you through one of the decisions, but was it
6 ever relayed to you what happened to your
7 advice?

8 JENNIE JOHNSTONE: Oh no. So I would
9 say that -- so from my perspective, our
10 recommendations go forward to the Office of the
11 Chief Medical Officer of Health. And I would
12 say -- I didn't do a line-by-line, but I would
13 say about 95 percent of our recommendations to
14 this office came through in the official testing
15 guidance that's issued. So there's the Chief
16 Medical Officer of Health testing, testing
17 guidance that comes out every once in a while.
18 And I would say those very clearly mirror our
19 recommendations.

20 So that line from our recommendations
21 forward there is very clear. And I would say
22 that, you know, there may be some tweaks here
23 along the way, but as a general statement that
24 was a very clear pathway that I think was quite
25 transparent.

1 And if something was slightly altered,
2 it was very minor and you know not of any
3 consequence.

4 So that pathway was very
5 straightforward.

6 JOHN CALLAGHAN: I'm assuming that
7 wasn't the only pathway.

8 JENNIE JOHNSTONE: Well, we'll get
9 into that.

10 JOHN CALLAGHAN: Okay.

11 JENNIE JOHNSTONE: I think that in
12 terms of testing, testing has been a very
13 political aspect of this pandemic. I think, you
14 know, when I was chairing the panel starting
15 April 5th, it was the number one thing in the
16 media every day, talking about testing, testing,
17 testing. That was at the same time that the WHO
18 was talking about test, test, test, test. And
19 it was building the capacity and trying to keep
20 up with the demand.

21 And then it did become, in my opinion
22 anyway, it appeared to be a very central,
23 important policy statement of the Premier's
24 Office in that anyone who wants a test could get
25 a test, which came about in May.

1 And so those types of decisions, I'm
2 not sure where those decisions were made. And
3 then since then as well, every ministry does
4 issue their own testing. So whether that's the
5 Ministry of Colleges and Universities issues
6 testing, the Ministry of Seniors Issues testing
7 guidance, the Ministry of Long-Term Care issues
8 guidance. There's many ministries, pretty much
9 any ministry you can think of issues testing
10 guidance, which isn't necessarily collated all
11 in one place.

12 And I would say our relationship with
13 other ministries is not linear or clear. So how
14 those decisions are made, I have no idea.

15 But in terms of the Office of the
16 Chief Medical Officer of Health, as a general
17 statement it's -- I think that's -- I do believe
18 that Office accepted most of our
19 recommendations.

20 Next slide. I share this just to make
21 sure that it's clear. So I do know that you
22 spoke with Dr. Vanessa Allen again when she was
23 here at I think the more formal testing
24 testimony, myself as chair, and then again I
25 just share this with mostly to reflect it is

1 reflective of people across the province. It
2 includes public health. And I want to mention
3 specifically Lianne Catton is from the north, so
4 I do feel like we had good geographic
5 representation across the province with
6 representation across all sorts of different
7 aspects of -- that may get impacted by testing.

8 And you can see, so Elizabeth Walker
9 and Daniel Warshafsky are from the Office of the
10 Chief Medical Officer of Health.

11 And I share this not because I want
12 you to read it, the next slide. It was just to
13 share the cadence of our recommendations. In
14 terms of April, so, again, we met for the first
15 time on April 5th at the very top, and by
16 April 7th is when we issued our first
17 recommendations. And then from there it was
18 April 7th -- it was a very, very busy month
19 because as we were building the capacity we were
20 trying to change the recommendations and improve
21 our recommendations as quickly as possible.

22 And then -- and then I think it was
23 from about May 20th -- or May 23rd actually were
24 our most formal -- that was the most
25 comprehensive recommendations. That was kind of

1 the end of that beginning. And then from there
2 we became more responsive to whatever queries
3 and questions came across our way, so
4 essentially we were able to, you know, respond
5 to whatever questions.

6 You know, what do you think of school
7 testing? What do you think of workplace
8 testing? et cetera, et cetera.

9 LEAD COMMISSIONER MARROCCO: Can you
10 help with what problems, if any, were identified
11 in relation to long-term care homes?

12 JENNIE JOHNSTONE: Back in April?

13 LEAD COMMISSIONER MARROCCO: Yeah,
14 well I noticed that on April 7th I think that
15 was -- I mean it was -- I had a quick glance at
16 it and I'm just curious. I'm not so much
17 concerned -- I'm just curious about the issues.

18 JENNIE JOHNSTONE: Yeah, I would
19 share. So absolutely, so I think it was -- I
20 would say the first week or two of our meetings
21 were almost entirely consumed by discussion
22 about long-term care because we recognized that
23 that was one of the most important groups to
24 make sure we were highlighting.

25 So within -- sort of within March I

1 would say that it was very clear that healthcare
2 workers in the hospital had good access to
3 testing, and many of us had assessment centres
4 on site. So those were built right around that
5 time.

6 So in terms of access to testing for
7 those of us in the hospitals, our healthcare
8 workers were getting timely testing.

9 But I do know that before our
10 recommendations, anecdotally anyway, it wasn't
11 clear necessarily that long-term care healthcare
12 workers were getting the same testing.

13 And I had heard that there were even
14 some that were being turned away. So one of the
15 first priorities we wanted to make sure that it
16 was clear that long-term care healthcare workers
17 were in that category of essential, you know,
18 people who required testing. Because remember
19 going back there it was a very, very narrow
20 group of individuals that could access testing.

21 So essentially if you've getting
22 hospitalized or if you are a healthcare worker,
23 but again, I don't know -- and certainly when we
24 went sort of by front-line experience, there
25 were many staff that maybe didn't get tested

1 when they should have. And whether it was
2 because they got turned away or didn't know they
3 were supposed to.

4 So certainly, I can speak at Sinai
5 very early on we said you need to have a low
6 threshold of test to get tested, and we just
7 hammered that home. So every staff person knew
8 that you needed to get tested even if you felt
9 slightly unwell.

10 I would say that that wasn't -- we
11 needed to make sure -- with the testing
12 strategy, we wanted to make sure that same
13 approach was adopted for the workers in
14 long-term care.

15 The other piece of it was about the
16 resident testing. So again, we had many
17 conversations at the table about the fact
18 that -- and we talked about this last time, the
19 culture of testing the residents was not the
20 same as how we approach it in the hospital,
21 meaning that historically in prepandemic time
22 you only sort of get your one, two test even if
23 you had an outbreak and you stop there whereas
24 in the hospital setting we always test people
25 routinely at the onset of symptoms. We didn't

1 stop after a certain point.

2 And again, knowing that, number one,
3 there was also a lack of access to testing --
4 tests and pee swabs in the long-term care homes
5 and those pathways of how you get a swab from a
6 long-term care home to the lab. Now, that was
7 beyond our scope, because we were making
8 recommendations. But we were trying to make --
9 put forward recommendations to make sure that it
10 was clear that every symptomatic resident needed
11 to get tested.

12 And then from there, one of the, I'd
13 say, errors we made, perhaps, is that we wanted
14 to make sure there was a lot of flexibility for
15 how you would then manage on outbreak for the
16 public health physicians who were involved in
17 the outbreaks.

18 So we left it open to say, you know,
19 you can always do a point prevalence of the
20 whole home. You can do a point prevalence of
21 the unit. Whatever you want to do. And when I
22 say point prevalence I mean testing of everyone
23 in that area. We didn't want to paint anyone
24 into a corner. So we left it to say, everything
25 is at the discretion of the public health team

1 beyond testing of symptomatic residents and
2 their roommates.

3 LEAD COMMISSIONER MARROCCO: What
4 about -- go ahead.

5 JENNIE JOHNSTONE: I was just going to
6 say, one of the things I learned and the
7 feedback that we got was that that led to a lot
8 of nonstandardization and lack of clarity within
9 the system as to what to do.

10 So what we heard was that Public
11 Health units wanted to it to be very explicit.
12 So coming from a hospital perspective, as an
13 infection control physician in a hospital, our
14 perspective is we want flexibility to be able to
15 manage an outbreak in the way that we think is
16 best whereas I think what we heard from the
17 Public Health perspective, because there was
18 variability from the Public Health units, is
19 they wanted it to be very clear.

20 So by May 23rd, you'll see there's
21 a -- if you read through the recommendations,
22 they kind of go from more flexible to less
23 flexible and very, very black and white in terms
24 of the recommendations about if you have a case
25 test the whole building.

1 LEAD COMMISSIONER MARROCCO: When
2 you're making recommendations in part about
3 testing long-term care residents and staff,
4 correct?

5 JENNIE JOHNSTONE: That's one of the
6 pieces, yeah.

7 LEAD COMMISSIONER MARROCCO: One of
8 the many pieces you're giving advice about.

9 JENNIE JOHNSTONE: Yes, correct.

10 LEAD COMMISSIONER MARROCCO: And when
11 do you start giving advice about testing
12 long-term care residents and staff?

13 JENNIE JOHNSTONE: When did we first
14 start giving?

15 LEAD COMMISSIONER MARROCCO: Yes.

16 JENNIE JOHNSTONE: I think that was
17 one of our first recommendations.

18 LEAD COMMISSIONER MARROCCO: And
19 between the time that you make the
20 recommendation and a decision, how much time
21 goes by?

22 JENNIE JOHNSTONE: That's variable.
23 So, for example, in the early days -- and I
24 don't have overlaid here when the testing
25 guidance came out -- but I'd say from the very

1 first set of recommendations we put forward,
2 gosh, I would have expected -- it would have
3 been within the week that there was guidance
4 that was issued.

5 And so I would say in the early days,
6 meaning April and May, there were
7 recommendations that came out from the Office
8 fairly regularly.

9 I didn't go back and look, but I don't
10 know the last time the testing guidance was
11 updated and I feel like it was probably
12 September or October now. So I mean, they
13 haven't been updated for a while because the
14 recommendations we're making aren't
15 recommendations that would change that sort of
16 testing guidance. I would say from May 23rd the
17 Chief Medical Officer of Health recommendations
18 haven't changed a whole lot.

19 So that's not the nature of the
20 questions we're being asked at this point. I
21 don't know if I've answered your question.

22 LEAD COMMISSIONER MARROCCO: Not
23 exactly. So your recommendations commence
24 around the end of May -- the end of March?

25 THE WITNESS: No, our panel started

1 April 5th and we put forward our first
2 recommendations April 7th.

3 LEAD COMMISSIONER MARROCCO: So
4 between the declaration of the state of
5 emergency, or the WHO's declaration that there
6 is a pandemic, and April 7th, there's no
7 recommendation from -- concerning testing of
8 long-term care residents and staff? Have I got
9 that right?

10 JENNIE JOHNSTONE: There was no
11 recommendation from our panel.

12 LEAD COMMISSIONER MARROCCO: Correct.

13 JENNIE JOHNSTONE: I would have to go
14 back to find out what the recommendations were.
15 I don't know for sure.

16 They may have relied on the existing
17 respiratory viral testing guidance that exists
18 prepandemic, which is how you approach testing
19 for respiratory viruses. I think actually
20 that's what it was. I think. I couldn't -- I
21 don't want to swear to that, but I believe that
22 is what we were using, which was, we use it for
23 any -- throughout every respiratory viral
24 season. So I think we may have been using --

25 LEAD COMMISSIONER MARROCCO: If that's

1 the case then, did you ever come to understand
2 why there was some confusion about whether
3 long-term care staff should be tested in a
4 manner consistent with hospital staff being
5 tested? Or whether there was -- why there was
6 some confusion about, if there was conclusion,
7 about testing the long-term care residents?

8 JENNIE JOHNSTONE: So that is an
9 excellent question, and I must admit I only
10 moved forward. I didn't look backwards. So I
11 never reflected on what existed before us. We
12 just started it to say, this is where we're at
13 and we're moving forward.

14 Because remembering that part of the
15 recommendations were a bit moot because of the
16 backlog that existed. So whether or not they
17 were getting tested or not was almost irrelevant
18 because the -- there was such a significant
19 backlog that there was no timely testing at all.

20 LEAD COMMISSIONER MARROCCO: So even
21 if they had testing --

22 JENNIE JOHNSTONE: When we were given
23 our mandate --

24 LEAD COMMISSIONER MARROCCO: To repeat
25 the question. The problem is there is testing

1 backlog, so even if you give advice that urges
2 rigorous testing of long-term care staff in
3 residents, it isn't going to be effective
4 because you can't get the results back in a
5 timely fashion.

6 JENNIE JOHNSTONE: That is correct.
7 Which was the state of affairs in March, late
8 March.

9 LEAD COMMISSIONER MARROCCO: In late
10 March.

11 JENNIE JOHNSTONE: That's right. So
12 it didn't occur to me on April 5th to think
13 about what had been happening. I think we all
14 knew, or at least on the panel were quite
15 comfortable knowing what our recommendations
16 should be.

17 I must admit I don't think we thought
18 about what they may have been. We just sort of
19 started from scratch.

20 LEAD COMMISSIONER MARROCCO: Thank
21 you. Go ahead.

22 JENNIE JOHNSTONE: So anyway, I think
23 the point of this slide was mostly just to show,
24 you know, sort of in April it was very, very
25 busy and then it sort of slowed down through the

1 summer, and then through the fall we were -- we
2 stayed busy but it's more, again, more specific,
3 more specific questions that may be relevant for
4 a specific sector. For example, in September we
5 necessarily had a lot of conversations about
6 schools, which you can imagine.

7 More recently we're having a
8 conversation about the role of testing post
9 vaccination, for example. So these are -- just
10 as things become relevant we have -- we put
11 forward recommendations about that.

12 JOHN CALLAGHAN: Let me ask, we've
13 heard several hospitals who went into long-term
14 care, and consistent with Dillon's slide from
15 March, but we heard continual delays in getting
16 results. I mean, I think in December I believe
17 one hospital talked about a five-day delay in a
18 long-term care getting the results and had they
19 had them in a day they could have contained
20 things.

21 Is that continuing, that kind of delay
22 with backlog? or is that something your
23 committee looks at?

24 JENNIE JOHNSTONE: So our committee
25 doesn't look at that so much. What we look at

1 is more what is the -- so we don't -- I mean,
2 we're aware of their testing turnaround times.
3 Our recommendations are to have fast and timely
4 turnaround times, but we don't work on the
5 operational aspect of what those delays may be.

6 We certainly flag that if there are
7 lags that that is a problem. And as it relates
8 to long-term care, perhaps I can just share as
9 on the ground it has proven to be a challenge.

10 I know Public Health Ontario, which
11 historically did all of the testing for
12 long-term care for respiratory viruses
13 prepandemic, they did implement -- so most care
14 homes are still sending their swabs to Public
15 Health Ontario.

16 They did work on implementing what
17 they call "a green sheet process" whereby swabs
18 with this green sheet would be expedited. On
19 the ground though, there was a continued
20 frustration with slow turnaround times.

21 And so I think I spoke to the IPAC
22 hub-and-spoke model that exists and I think
23 quite robustly in the Toronto region, and I
24 think many of us, in the Toronto region anyway,
25 are associated with hospital labs.

1 And so I think all of us, I think,
2 have redirected long-term care home swabs to our
3 own hospital labs because it -- because it's not
4 just the challenge of the turnaround time, it's
5 also the challenge in accessing the results.

6 So they may be done, but if they went
7 to a variety of different labs you're trying to
8 tracking it down from a variety of different
9 places and you don't even know where those swab
10 results went, or maybe you're still trying to
11 tracking down the last two or three or whatever.

12 So from our perspective it was much
13 easier to have them flow through the Sinai lab,
14 and then that way we can get the results
15 directly. And there's no gap in time between
16 when they're processed or very little gap in
17 time from when they're processed to when we are
18 getting the result. And then if we need to
19 track down results, we know exactly where to
20 look and who to talk to, because we have those
21 relationships, or if there's a problem with the
22 result.

23 So I think, again, within -- at least
24 for us anyhow, it became much easier just to
25 relay them through an existing structure that we

1 ourselves were using.

2 And we don't have the same problems
3 with turnaround times since we've gone to that
4 model.

5 JOHN CALLAGHAN: Can I ask probably a
6 simplistic question here.

7 LEAD COMMISSIONER MARROCCO: Just a
8 second, John. I just want to follow up on this.

9 Do most hospital labs have the
10 capability of analyzing a test?

11 JENNIE JOHNSTONE: Most -- so, most?
12 I think that every hospital is affiliated with a
13 microbiology lab. It is not always on site.

14 So, for example, Sinai serves UHN,
15 Women's College, ourselves. And then for Covid
16 testing we also get additional overflow
17 specimens, whether it's from Humber, William
18 Osler, et cetera.

19 But prepandemic we only have Sinai lab
20 that has served UHN, Women's College and
21 ourselves. And then again, now we have
22 additional -- and Baycrest, for example.
23 Baycrest has a contract with us as well.

24 So every hospital would have a known
25 existing lab, and most of those larger labs do

1 have the capability. I wouldn't say everyone,
2 but it sort of has -- there's been a natural
3 organization whereby there are sort of these
4 larger labs that hospitals feed into.

5 LEAD COMMISSIONER MARROCCO: So as a
6 matter of planning, pandemic planning then, as
7 far as long-term care homes are concerned, you
8 would want to tell each long-term care home
9 where to send the samples in a pandemic as
10 opposed to in a time when there's no pandemic,
11 is that right?

12 JENNIE JOHNSTONE: Potentially. So I
13 would say that these -- well this relationship
14 exists just for our own microbiology processing.
15 So it wasn't really -- it wasn't a pandemic
16 plan; it was just our existing plan.

17 And then for the -- I guess the
18 challenge here is that long-term care was
19 sending their specimens pre-pandemic to the
20 Public Health Ontario lab, sort of. Meaning
21 that there wasn't -- it wasn't like they sent
22 10, 15, 20 specimens a day. They were sending
23 two or three a year.

24 So I think it was more the lack of
25 existing pathways and approach, because in a

1 perfect world it should be Public Health Ontario
2 lab. I think that that makes sense.

3 LEAD COMMISSIONER MARROCCO: I guess
4 it does if they can do it. If they can't do it,
5 and it's a pandemic then you have to go to
6 somebody who can do it.

7 JENNIE JOHNSTONE: Exactly. Right now
8 I think it's variable depending on the
9 hospital -- sorry, on the long-term care home
10 where they're sending their specimens, whether
11 it's to Public Health Ontario labs still or
12 whether it's through their hospital partner.

13 JOHN CALLAGHAN: To ask then a
14 simplistic question, I'm assuming when you
15 request a lab result from Sinai it comes to your
16 desktop computer?

17 JENNIE JOHNSTONE: Right, we have our
18 electronic chart that I would just look it up.

19 JOHN CALLAGHAN: And I don't know if
20 you are aware whether you've heard, but we've
21 heard that in some long-term care homes they're
22 getting results by mail; they're getting them by
23 fax. But did that ever come up in your
24 deliberations about the delay because of the
25 mode of delivery of the results?

1 JENNIE JOHNSTONE: I think that
2 there's delays at every step along the way. So
3 whether it's, how do you get them? Is it
4 through taxi -- who is your courier? How are
5 you getting it to the lab? And then there's the
6 necessary turnaround time in the lab. And then
7 there's the data entry in the lab. And then
8 there's the question of how the lab then submits
9 it back to the home.

10 So I think that it's not the in-lab
11 turnaround time necessarily that's the problem;
12 it's all these different pieces along the way.
13 And I think what you've touched upon there, I
14 mean I think fax is like the go-to -- I think
15 that's more the norm, which is shocking in this
16 day and age. I agree.

17 JOHN CALLAGHAN: Okay. Thank you.

18 JENNIE JOHNSTONE: So I think the
19 electronic interface is definitely lacking.

20 But I would say that that isn't -- I
21 mean, just -- we're just sort of talking about
22 things that impactful and important to discuss,
23 but that isn't necessarily something that we
24 discussed other than flagging that turnaround
25 time is a problem and the importance of having

1 timely turnaround time.

2 Beyond that our testing strategy panel
3 was more focused on the populations to test and
4 who to test, but not, again, the operational
5 aspects of that.

6 JOHN CALLAGHAN: Was there a table
7 that was dealing with the operational part of
8 the testing, to your knowledge?

9 JENNIE JOHNSTONE: To my knowledge
10 that would have been the network of labs. The
11 network of labs, they set the goals in terms of
12 the turnaround times that they were aiming for.
13 I think -- I can't think of what it is off the
14 top of my head, but I think it's, what, 60 or
15 70 percent in a 24-hour time period and whatever
16 it is, 80 or 90 percent within a 48-hour time
17 period. Those are the targets. You would have
18 to find the exact targets, but it's something
19 like that. And the proportion of people meeting
20 those timelines.

21 LEAD COMMISSIONER MARROCCO:

22 Commissioner Kitts has a question.

23 COMMISSIONER KITTS: Just, back to
24 your pragmatic panel, in your discussions and
25 recommendations did you consider the capability

1 of the system in terms of setting standards or
2 guidelines? Or did you aim for the ideal and
3 then have to look at it more pragmatically as to
4 what was possible?

5 JENNIE JOHNSTONE: We considered
6 the -- we considered it in terms of numbers. We
7 were very careful in terms of -- so, for
8 example, on April the 5th we didn't say
9 everybody who is symptomatic can get a test
10 because we would have overwhelmed the system.

11 We were very concerned -- we all lived
12 the experience of the backlog and how
13 detrimental that was. So we were very careful
14 to make sure that our recommendations, we were
15 trying to pull the data about, you know, if we
16 add -- if we add, you know, this group of
17 essential workers how many additional people
18 might that be?

19 So we were really trying to make sure
20 that we didn't overload, and possibly we
21 undershot somewhat. I think with the benefit of
22 retrospectoscope, I think every sort of estimate
23 of numbers, we ended up with fewer people than
24 we expected who actually sought testing. But it
25 was an imperfect science, and we wanted to make

1 sure that we controlled the output more so -- we
2 just knew how terrible it would be to go into
3 a -- to overshoot it and go into a backlog.

4 And the other thing is we wanted to
5 make sure that we didn't add a group which we
6 would then have to rescind, because that would
7 be -- that would be very politically unpalatable
8 and also I think that is very confusing and
9 difficult. So we wanted to make sure that we
10 added in a controlled manner.

11 COMMISSIONER KITTS: And the other
12 question is, initially all specimens went to
13 Public Health labs. At some point the hospital
14 labs were incorporated and I think even private
15 labs.

16 Had that happened by April 5th or did
17 that happen after you started?

18 JENNIE JOHNSTONE: So it happened
19 before. Again, I'm not the perfect person to
20 speak to this, but just based on what I know, it
21 was that building of the network of labs which
22 got everyone out of that backlog.

23 So it was started with PHOL, got into
24 the backlog. The network of labs was created
25 towards the end of March and you would have to

1 ask exactly when that happened. And then as
2 these additional labs came on line, that added
3 that capacity.

4 So I would say that we came on board
5 right as that capacity was building. So it had
6 started and was adding to it. So it was sort of
7 all a very dynamic process whereby labs were
8 coming on line and building and getting
9 additional machines and whatnot.

10 COMMISSIONER KITTS: And how long
11 would it take a large hospital lab from the time
12 they said "go, you're going to do this testing
13 for Covid-19" until they got up to full
14 capacity? Is there a ramp-up period?

15 JENNIE JOHNSTONE: Well, for sure. I
16 think it depends on whether you had the machine
17 or not. Some of us had existing machines. But
18 this gets into the challenge in the fall when
19 there was -- so just going backward, all the
20 labs had some machinery because we did influenza
21 and RSV testing on site. So that PCR machinery
22 existed.

23 As you had to purchase additional
24 machines in a pandemic, it depended on whether
25 or not they were available or not and then

1 whether or not there was a backlog in actually
2 getting those in place.

3 So you had to wait for a guarantee
4 that you were going to get reimbursed for those
5 purchases, and then you had to make the
6 purchase. And then you had to get it in house.

7 So it's the delays, those unknowns,
8 those are the dependencies as to when you can
9 actually get started.

10 The other thing at play, in April
11 anyway, were challenges with those NP swabs,
12 securing that. Because as you remember, our
13 main NP swab supplier came from Copan, Italy so
14 when Italy was hit that supply chain went down
15 and that was a huge problem, and also reagents.

16 So to answer your question, it just
17 depends -- so if you have the machines, you can
18 get started -- you know, you have to do some
19 validation and what not. And I think they also
20 have to get an approval license, but that didn't
21 take very long in the order of, I think -- well,
22 you would have to ask the Sinai lab how long it
23 took, but not long, in the order of a few weeks
24 to be able to go from not testing to testing.

25 But if you don't have the machinery,

1 it can take several months. And that was the
2 concern in the fall when we knew we needed the
3 capacity to be built but people hadn't been
4 green lit. And so it's not something you can
5 build overnight because you actually had to
6 purchase the machines, you had to renovate the
7 space, find the space and get it into place and
8 whatnot, and that takes several months.

9 COMMISSIONER KITTS: And then have
10 enough swabs and enough reagent to --

11 JENNIE JOHNSTONE: And so in the
12 second wave that has the been the bigger
13 challenge. Because in Wave 1 in terms of the
14 capacity, most of it could be dealt with by the
15 existing staff, and just -- we stopped doing
16 influenza testing and RSV testing because flu
17 season was ending.

18 But as Wave 2, once we actually built
19 the capacity that was substantially more than
20 anything we had done before, finding the people
21 to man those machines has proven to be a
22 challenge.

23 COMMISSIONER KITTS: So in Wave 2, and
24 this may not be a fair question, are we
25 operating at full capacity or is there still

1 some essential resource that is keeping us from
2 getting to full testing capacity?

3 JENNIE JOHNSTONE: I believe actually
4 as of today, I believe today we have hit 100,000
5 test capacity, which I think is what we're
6 aiming for.

7 COMMISSIONER KITTS: Thank you.

8 LEAD COMMISSIONER MARROCCO: And how
9 long have we been aiming for that? Since March?

10 JENNIE JOHNSTONE: No. I would say
11 that it became clear in the summer that when we
12 were going to look forward to the fall, as we
13 knew that we were going to have a very big wave
14 and as we were a more open society with children
15 in school and the respiratory virus season
16 hitting, I think it was at that point that it
17 looked like we were going to need a testing
18 capacity of about a hundred thousand.

19 We can move to next slide maybe, and
20 I'll just talk -- and I don't want to spend a
21 ton of time on where we landed because probably
22 the structure might be more -- I separated the
23 recommendations into content versus structure.
24 But I did think that there might be some
25 commentary about rapid testing. I think that

1 might be of interest.

2 In terms of where we are at for
3 testing of residents, right now we continue to
4 have guidance where we want to test, have a low
5 threshold of testing. So we have active
6 surveillance of symptoms in the home of all
7 residents, every day twice a day to make sure
8 that everybody remains healthy. And if anybody
9 does develop symptoms, they are to be placed,
10 ideally in a private room, if one is available,
11 on precautions and have their tests done.

12 If, in fact, you find a resident case
13 that is at that point that you would test the
14 whole facility to see whether there are
15 additional cases.

16 And we know from a lot of the
17 asymptomatic testing that occurred in the spring
18 that this is a safe approach, meaning if you
19 don't have cases, if you don't have resident
20 cases, if you don't have staff cases, truly you
21 don't have Covid in the home.

22 We have quite the opposite problem.
23 If you have Covid in the home you don't have
24 asymptomatic people, you actually have more
25 significant mortality associated with this. So

1 generally speaking, we don't need to test
2 residents every day or sporadically or syndrome.
3 We just test around a case, which is the same
4 approach we take in the hospital for our
5 hospital patients.

6 You test them. If you find a case,
7 you test widely around that case.

8 For staff, again, making sure that we
9 have testing of symptomatic staff, making sure
10 they don't work sick. This is not a small
11 point. Making -- I think there's been lots made
12 about people coming to work -- or feeling like
13 they need to work so making sure that people are
14 not working sick.

15 And then broad testing again. If you
16 identify a staff case, make being sure you test
17 broadly around that case. And if there's any
18 residents that they have worked for, it may be a
19 whole floor, et cetera, you make sure you test
20 broadly around that.

21 We have said -- so in terms of our
22 recommendations, we have said in low prevalent
23 state, meaning when you don't have -- when
24 you're in green with our current state of rates,
25 that you don't need to do surveillance testing

1 of staff.

2 Now that is a recommendation that was
3 not taken up. And I understand the reason. I
4 know that there was a lot of concern. But I
5 just want to share, if we're making
6 evidence-informed recommendations, truly when
7 you have no Covid around, the testing is of very
8 low value and in fact the majority of cases you
9 find are actually false positives. So it's very
10 disruptive on the ground.

11 I do understand why that
12 recommendation continued. I know that there was
13 no appetite for -- through the summer for any
14 concern around the residents.

15 But we put forward the recommendation
16 that you don't need to be doing the staff
17 testing in that setting, but that again is not a
18 recommendation that was taken up.

19 JOHN CALLAGHAN: Can I just stop you
20 there? Because we are getting into the
21 symptomatic/asymptomatic testing and can you
22 tell us, because I want to review the decision
23 made by the government in May to test everybody.

24 So what was the advice of your
25 committee about general testing?

1 JENNIE JOHNSTONE: So I think we have
2 had the same recommendation pretty much the
3 whole time, which is that we should be doing PCR
4 testing, diagnostic testing on symptomatic
5 individuals, high-risk contacts, and outbreak
6 setting.

7 And that there is no need to do what
8 we call low-value testing, meaning -- so the
9 decision made in May to do anyone who wants a
10 test gets a test was not based on the
11 recommendation from our panel.

12 JOHN CALLAGHAN: So I just want to
13 show you an email note from Vanessa Allen to
14 Dirk Hire who was on the -- I think he chaired
15 the testing committee, the testing --

16 JENNIE JOHNSTONE: Implementation,
17 Dirk was testing implementation.

18 JOHN CALLAGHAN: This a note of
19 May 3rd, and she reiterates what you say, which
20 is that we shouldn't be testing asymptomatic;
21 but she also points out, it says:

22 "It is important to note that we
23 will not have enough tests to test
24 everyone even with incredible success
25 with building up capacity."

1 And that's May 3rd. So was that --
2 was that the view of the committee at that time?

3 JENNIE JOHNSTONE: For sure. I think
4 there was -- we don't need to do it either. But
5 certainly I mean we will never have enough tests
6 to test everybody every day.

7 JOHN CALLAGHAN: Right. So then
8 there's a memorandum that comes out May 24th.
9 If we can just put that up. And this is the one
10 I think you're referring to?

11 JENNIE JOHNSTONE: Oh, it is.

12 JOHN CALLAGHAN: In other words:

13 "Asymptomatic, risk-based
14 testing. People who are concerned
15 that they have been exposed to
16 Covid-19. This includes people who
17 are contacts of or may have been
18 exposed to a confirmed or suspected
19 case [...]", and it goes on, "[...] no
20 Ontarian who is concerned that they
21 have been exposed to Covid-19 will be
22 declined a test at an assessment
23 centre either through appointment or
24 walk-in for the processes [...]."
25 What was the view of the committee

1 about general ability for everybody who sought a
2 test to get a test? And what was it's --

3 JENNIE JOHNSTONE: I mean, I think we
4 had real concerns. Again, we were tasked with
5 creating a strategy, a testing strategy. And
6 from a testing strategy perspective, the only
7 thing that would make sense from a testing
8 strategy is that anyone who wants a test you
9 would have to get a test every day, which is not
10 a strategy at all.

11 So I think we were very concerned the
12 sustainability of this approach, the inequity of
13 this approach, because I think what we saw were
14 essentially -- this was used as an excuse to
15 bypass public health measures. And I think I
16 shared that we knew that through the summer this
17 type of thing was being used and being mandated,
18 in fact, by many people before you come to the
19 cottage make sure you get a test.

20 So it wasn't being used in the way in
21 which it was supposed to be designed which is
22 preserving this capacity for those who need it,
23 meaning symptomatic individuals, high-risk
24 contacts, outbreak investigations and
25 specifically -- and again, so we were very

1 worried that people were using -- because again
2 the lay public doesn't understand that a
3 negative test, the negative test is only on the
4 time you actually got it. It doesn't mean -- an
5 hour later you might actually be positive.

6 So, in fact, we thought that this
7 approach may actually lead to increased
8 transmission because people were doing risky
9 behaviour, potentially to bypass the public
10 health measures.

11 And then what we were most
12 particularly worried about is the sustainability
13 going into the fall when we knew we were going
14 to need increased capacity because you're going
15 to have more symptomatic individuals, because we
16 are going to start to see, as we did, more
17 respiratory viruses circulating, rhino virus
18 first and then followed by, you know, RSV and
19 then influenza.

20 So if you have this as a policy and
21 that people expect to be able to get a test
22 whenever they want, to change it becomes very
23 difficult. So -- and I think there was a lot of
24 moral distress at the level of the labs because
25 people were working extremely hard, using up

1 valuable resources for very questionable
2 benefit.

3 And so I think -- I'll speak for
4 myself anyway -- that this approach did not jive
5 with any sort of strategy.

6 LEAD COMMISSIONER MARROCCO:

7 Dr. Kitts, I think.

8 COMMISSIONER KITTTS: And I understand
9 that, Dr. Johnstone, but if there is a sense or
10 any evidence to suggest that asymptomatic spread
11 is of higher risk than I think it is, and maybe
12 you can tell us what it is, then it would make
13 sense. So it all depends on how risky is it
14 that asymptomatic people are spreading it?

15 JENNIE JOHNSTONE: Right. And so what
16 we were able to do -- and that was the counter
17 argument that was made in April. And I think to
18 be fair to the government, there were two groups
19 of individuals -- there was a very loud group of
20 individuals saying that 70 percent of the spread
21 is from these asymptomatic individuals and there
22 was a fear of that.

23 I guess my argument to that was,
24 number one, you have a scientific people which
25 is making recommendations. It might be nice to

1 actually listen to our recommendations as
2 opposed to a media. That's point number one.

3 But point number two is that we were
4 able to collate the data from the information --
5 from the testing that was done. And we were
6 able to show, pretty much in every place you
7 looked, when you did this low-value asymptomatic
8 testing, the percentage was .2 percent,
9 consistently. No matter which group you were
10 doing it in.

11 And if you look now even, the pharmacy
12 testing that is ongoing, which continues to be
13 that low-value asymptomatic group, continues to
14 be .2 percent.

15 So I think that I understand that in
16 April there was reluctance to potentially take
17 the advice. I completely understand that.
18 However, we were able to start sharing the data
19 in May and June which demonstrated that that
20 fear was unfounded.

21 COMMISSIONER KITTS: And with
22 evidence.

23 JENNIE JOHNSTONE: With evidence.

24 COMMISSIONER KITTS: Thank you.

25 JOHN CALLAGHAN: Thank you. Can you

1 just go down the document a little bit? So the
2 approval of this was done by Helen Angus, David
3 Williams and Matthew Anderson. Did any of them
4 provide an explanation as to why the advice
5 wasn't accepted from the panel that you recall?

6 JENNIE JOHNSTONE: No.

7 JOHN CALLAGHAN: And then to just put
8 up the slide deck of your slide deck, because I
9 gather -- if you could go to page 5. This is in
10 July of 2020, you continued to be of the view,
11 number 5, there that, "End testing" -- this is
12 your recommendation:

13 "End testing of asymptomatic
14 general population [...]."

15 That is the point we've been talking
16 about --

17 JENNIE JOHNSTONE: We did. Because a
18 lot of employers were also demanding that
19 workers were coming -- that workers would have
20 to get tested before they started work again.

21 But again, from a strategy perspective
22 that makes no sense. If you're going to demand
23 workers get tested, they need to get tested
24 every day. Doing it the one time before they
25 come back to work makes no sense.

1 JOHN CALLAGHAN: So what happened then
2 in the fall that caused this -- everybody could
3 get a test to change? Because I understood that
4 that position -- the government's position
5 changed this past fall.

6 JENNIE JOHNSTONE: I don't pretend to
7 know how. I mean I think we were very clear and
8 continued to just -- in every forum we were
9 invited to speak we shared our recommendations.
10 I think we continued to share our
11 representations and going up the pathway.

12 And why it changed I could never
13 pretend to know, but I do believe it was out of
14 necessity. Because if you remember back in
15 September, there was the very long lineups in
16 the assessment centres: Children waiting four
17 hours, five hours, out of school, people needing
18 to miss work. And so I think that it was a
19 pragmatic decision. It was just an
20 unsustainable decision.

21 JOHN CALLAGHAN: That is to have
22 everybody tested whenever anybody wanted?

23 JENNIE JOHNSTONE: Correct.

24 JOHN CALLAGHAN: Was unsustainable.

25 JENNIE JOHNSTONE: And I think the

1 other thing we were seeing and pulling it back
2 to long-term care is the turnaround time tests
3 were increasing. And it was September as well
4 that the numbers were starting to climb with
5 Covid and then the outbreaks were starting. And
6 so it became incredibly important that you had
7 that faster turnaround time, so the turnaround
8 times became, you know, unacceptable as well.

9 So it really didn't make sense to have
10 this low-value testing for people who just felt
11 like it in with long-term care residents that
12 were in outbreak trying to -- they were all in
13 the same queue. So that didn't seem right at
14 all. So something had to happen.

15 JOHN CALLAGHAN: Can we go back to the
16 slide deck?

17 JENNIE JOHNSTONE: Now, I do want to
18 touch on rapid testing, and I have read through
19 the recommendations here. And I do want to just
20 share and make sure for the record the concerns
21 associated with rapid testing. Because I know
22 that it has been touted in the -- certainly in
23 the media, and I think in concept it is a good
24 concept. So I wanted to make sure that people
25 understand the reluctance or the concerns

1 associated with rapid testing.

2 So first of all, we know that these
3 rapid antigen -- and we're talking about rapid
4 antigen tests, because there are the other rapid
5 tests. But let's talk rapid antigen testing.

6 So we know that they are not good
7 enough in outbreak setting, and I don't think
8 there is any move from the Ministry to use them
9 in an outbreak setting. So we do need
10 diagnostic, the PCR gold standard in that
11 setting.

12 So when we -- remembering that the
13 testing approach -- the surveillance testing
14 approach is additive. In theory, you shouldn't
15 need this additional approach at all.

16 So in the hospital setting we don't
17 use it. We do not use -- we don't test our
18 staff every day. We don't use this approach,
19 because if you mask appropriately, socially
20 distance, don't work while sick, and all of
21 those good things, you shouldn't have
22 transmission.

23 Now, I understand that that is not the
24 perfect world we're talking about in long-term
25 care. And I understand why we have added this

1 additional layer, especially in high prevalence
2 regions. So again our testing strategy panel
3 has acknowledged that we need this additional
4 layer of protection in high prevalent state,
5 because once it gets high prevalence the room
6 for error is so small.

7 So one of the things that hampered
8 things is the fact that up until now we have had
9 to use antigen testing with NP swabs still. And
10 I don't hear that in the press very often.

11 But remembering we have these staff --
12 and I don't know how often you've had an MP swab
13 but they are very uncomfortable. So as it is,
14 it's been a stretch to get them tested once a
15 week to. To have to do it three times a week
16 was not a reasonable ask.

17 Now with the rollout, they do have
18 permission to actually use the NP swabs as nasal
19 swabs but I want to share that that has not been
20 validated.

21 So we know that the challenge with
22 this rapid, the rapid antigen test is the lower
23 sensitivity on average with an NP swab about 56
24 percent of a PCR test and as you -- if you use
25 nasal swabs, it's going to be less than that.

1 The offset of that is, because you are doing it
2 so frequently, so if you are doing it three
3 times a week, the offset is that you will catch
4 it eventually.

5 But the challenge we are having in the
6 high -- like right now, especially in January,
7 it was like tinder boxes. So we didn't want to
8 roll out rapid tests at a time that we're trying
9 to have staff focus on preventing outbreaks, and
10 vaccines and introducing this thing that there's
11 no data to say that three times a week with a
12 lower sensitivity is any better than once a
13 week. And we were still doing once a week. So
14 we just said, can question we just pause? We're
15 still doing testing. Can we just continue with
16 this?

17 Because the HHR, the human resource
18 associated with this -- this is a massive
19 undertaking. You have to hire two additional
20 people, are the estimates, in order to run these
21 essentially assessment centre clinics in homes
22 three times a week. It is a huge undertaking,
23 and we know staffing is a huge issue.

24 So our challenge with antigen testing
25 isn't in concept; it is just so say, can we just

1 pause? Continue with the testing that we're
2 doing. We're doing testing. Can we just pause
3 until it's the right time?

4 And the other thing is that's at play
5 here is that staff are now vaccinated or many of
6 them are vaccinated, so the other question that
7 is still an unknown, that we are going to
8 address at the testing panel, is whether or not
9 you still need this surveillance testing if
10 you've been vaccinated.

11 So what we didn't want to have is to
12 build this huge infrastructure, infrastructure
13 that quite frankly the homes can't do right now,
14 because there's all these competing priorities
15 and they are challenged with staffing at the
16 best of times, to work toward something that we
17 don't even know if we're going to need in a
18 month, or at least to those who have been
19 vaccinated.

20 So I just wanted to share some of the
21 counter arguments. Like in concept it's great,
22 but in reality it's an incredibly challenging
23 thing.

24 If you just think about your own
25 workplace and if you said, three times a week

1 before you come on site your entire staff has to
2 be tested, it's huge. If someone told me we
3 would have to do this in the hospital, I don't
4 even know how we would do it.

5 So I just want to make sure that it's
6 clear why there is a bit of concern about the
7 approach. It is not to say that it's not about
8 the testing approach; it's just about the
9 modality and the actual reality of doing it
10 properly.

11 So with that I'll just -- I can pause.
12 I'm happy to answer any questions about it. But
13 I just wanted to share the sentiment.

14 Both of at the panel as well as the
15 rapid testing task force as well, so I'm not
16 just sharing my opinion.

17 COMMISSIONER KITTS: Let me just ask,
18 what is accuracy compared to this gold standard?

19 JENNIE JOHNSTONE: So on average if
20 you're using NP it's about -- well they -- on
21 average about 56 percent. It ranges.

22 COMMISSIONER KITTS: Versus what, 90
23 plus percent?

24 JENNIE JOHNSTONE: Well compared to a
25 PCR test. So remembering a PCR test isn't

1 perfect. So it would be -- this is compared to
2 a PCR test knowing that the PCR test itself
3 isn't perfect.

4 COMMISSIONER KITTS: But the PCR is
5 what, 90 percent?

6 JENNIE JOHNSTONE: Yeah, 80 to
7 90 percent.

8 COMMISSIONER KITTS: And this one is
9 50 to 60?

10 JENNIE JOHNSTONE: Of 80 to 90.

11 COMMISSIONER KITTS: Oh, 50 of --

12 JENNIE JOHNSTONE: That's what I'm
13 saying. Because it's compared to the PCR. So
14 the PCR. So the PCR -- so that's using that as
15 the gold standard, which we know is actually not
16 perfect itself.

17 COMMISSIONER KITTS: Okay. Thank you.

18 JENNIE JOHNSTONE: And then, but we
19 know nasal is another drop of about 10 percent.

20 COMMISSIONER KITTS: Correct.

21 JENNIE JOHNSTONE: So I just want to
22 make sure that people understand the antigen
23 test sensitivity is not the same as PCR, which
24 is okay because you are going to do it three
25 times a week so the offset is there.

1 But the one other point I did want to
2 make about the antigen test that we were
3 concerned with in the height of a Wave 2,
4 introducing it, is that sense of security that
5 is not based in reality. So this is the
6 so-called White House approach or the White
7 House concern.

8 Meaning that if you have individuals
9 who truly don't understand the limitation of the
10 test, you now have somebody who is told you're
11 negative. And we don't have data on how that
12 influences behaviour.

13 We know in the White House it
14 influenced behaviour such that it led to an
15 outbreak, because you get this false sense of
16 reassurance. The nice thing about the PCR is
17 you don't find out about it right on the spot so
18 you have to continue to that adherence

19 So I'm not saying that it is a
20 problem, but you can anticipate how that might
21 play into people's actions and that you could
22 see how you may theoretically have increased
23 risk of outbreaks because of it.

24 So our issue was, there are all these
25 unknowns. Can we just not do it at the height

1 of Wave 2? Let's just wait until things calm
2 down a little bit.

3 COMMISSIONER KITTS: I think some of
4 the confusion may be that Health Canada
5 approval, I think to the general public is go,
6 fire away, it's a good thing.

7 JENNIE JOHNSTONE: Yeah. And we know
8 that if -- as I know you know, but if you talk
9 to Health Canada, they are just doing approval,
10 that's it. They're not -- they are not weighing
11 in on whether it is or isn't a good thing.
12 They're just saying based on our criteria it
13 meets it.

14 COMMISSIONER KITTS: Okay, thank you.

15 JENNIE JOHNSTONE: Next slide.

16 So then I just wanted to end on
17 structural issues, which are several. So I do
18 think that -- I want to reiterate, our testing
19 panel to the Office of the CMOH was fairly
20 straightforward, but other Ministry testing
21 decisions, I really do not know who approves
22 those or how those move forward.

23 And the other thing that I have
24 concern about is who has a sort of bird's eye
25 view of all the different decisions being made?

1 And that doesn't appear, again to me,
2 on the ground, that there is co-ordination at
3 that level. There may be, but I don't know -- I
4 don't know who is doing it or how that's
5 happening. It just seems like each individual
6 body is making decisions, and no one is sort of
7 overseeing those decisions.

8 The other challenge is the lack of
9 centralization of guidance. So with two hats
10 on, I have had to collate the data -- or collate
11 the different guidance documents.

12 So for the Toronto region, I helped
13 the hospital operations table collate everything
14 for the assessment centre. Because of course
15 when the guidance changed in September, only
16 specific people met criteria, but understanding
17 who that was came from numerous documents, memos
18 to the field, guide -- it was everywhere and you
19 have to pull it all together in one place.

20 And it changed almost weekly. And you
21 almost had to know that something existed to be
22 able to tracking it down and find out, because
23 you are not necessarily on the all the
24 distributions. Because, again, if you're just
25 getting stuff from -- you know, I'm not

1 receiving Ministry of Long-term Care memos, so I
2 would have to know that Ministry of Long-term
3 Care memo exists to track it down to know what
4 it says in order to incorporate it into the
5 Guidance Assessment Centre document. And that
6 was a recurrent theme. It was very confusing.

7 And then also for the long-term care
8 providers, understanding who needs to get
9 tested -- or retirement homes, it took us three
10 months to find out what is the cadence of
11 testing for retirement home staff? And who
12 needs to get tested and who doesn't?

13 So it's not straightforward to the --
14 because, again, it's in different memos. And
15 you have to collate all of it, and it's very
16 challenging.

17 So having a co-ordinated table or
18 co-ordinated document that shared all of the
19 different testing that existed would have been
20 very helpful.

21 And then with respect long-term care,
22 this was very challenging for me as an infection
23 control person. There was an overreliance on
24 testing.

25 So at the beginning access to testing

1 was a problem, no question. We had to fix that,
2 for sure. So in terms of the recommendations
3 for residents getting tested and those
4 symptomatic and making sure we had all of that
5 testing guidance clear was very important.

6 But all of the other pieces of
7 adding -- you know, testing every single
8 resident in long-term care in the province,
9 testing of the staff, especially in the low
10 prevalence time, became what I felt like was a
11 crutch. Because that was an easy thing to say
12 or relatively easy thing to say.

13 Fixing the fundamentals is much
14 harder. And I think that in Ontario we do more
15 testing, I think, of this population than
16 anywhere else in the province -- than any other
17 provinces yet we have one of the worst track
18 records.

19 And so it felt like, to me, that any
20 time we got into trouble, we tried to throw more
21 testing at it instead of actually saying, what
22 is the problem here? And the problem isn't
23 testing. Yes, there was some problems in test
24 turnaround testing, whatever.

25 But at its core, there were all the

1 other things that you guys are looking into,
2 which were staffing, infection control,
3 infrastructure and all of these other pieces,
4 which are far harder to fix.

5 So I felt like many times adding this
6 additional testing created -- becomes a
7 distraction in the sense that now you're taking
8 staffing, especially -- so like today there is
9 the Ministry of Long-term Care memo that says
10 there is the mandatory shift to rapid antigen
11 testing. And they say that you can reach out to
12 pharmacies, and some people have already reached
13 out to pharmacies and they said, sorry, we're
14 not going to be able to do that for you. So
15 this is going to have to come as an opportunity
16 cost of staffing.

17 If they are staffing this within the
18 home, and they are saying you are going to have
19 to do it for essential care partners so you're
20 going to have to have seven days a week staffing
21 for this, that means those people -- you're
22 robbing Peter to pay Paul. The staff are only
23 going to come from the staffing of the
24 residents.

25 So I don't have a -- like it's more

1 about thinking through how this testing is going
2 to add and making sure that you're doing it in a
3 way that is implemented such that it's going to
4 achieve your goal. Otherwise, again it just
5 becomes a distraction. So it's not about being
6 anti-testing -- certainly I'm for it -- but you
7 have to do it properly. Otherwise it's actually
8 going to do a disservice.

9 So with that I think that's everything
10 I wanted to say. I think I have a conclusion
11 slide but I think it's essentially -- oh, this
12 included the conclusions from the original
13 presentation.

14 JOHN CALLAGHAN: Thank you,
15 Dr. Johnstone, that's been very helpful and
16 thank you very much for agreeing to come back.

17 I hate to say it but I think we're on
18 tap to see you one more time but you probably
19 don't know that yet.

20 JENNIE JOHNSTONE: I don't know that
21 but I'll always happy to -- I can't say how
22 happy I am that you guys are doing this very
23 good work and any way that I can support, or any
24 of our colleagues, I know that we're all happy
25 to help.

1 LEAD COMMISSIONER MARROCCO: Well,
2 thank you very much for that. It gives us some
3 reassurance that we're not being unduly
4 bothersome. But as you can appreciate, we need
5 to get inside these things in order to avoid
6 saying something that turns out to be incorrect.
7 So thanks very much for the insight.

8 COMMISSIONER KITTS: Thank you.

9 JENNIE JOHNSTONE: Thank you.

10 --- Meeting adjourned at 3:09 p.m.

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REPORTER'S CERTIFICATE

I, HELEN MARTINEAU, CSR, Certified
Shorthand Reporter, certify;

That the foregoing meeting was taken
before me at the time and date 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
accurate transcript of my shorthand notes so
taken. Dated this 28th day of January, 2021.



PER: HELEN MARTINEAU
CERTIFIED SHORTHAND REPORTER

WORD INDEX

< 1 >

1 36:13
10 28:22 55:19
100,000 37:4
15 28:22

< 2 >

2 36:18, 23
46:8, 14 56:3
57:1
2:00 1:19 4:1
20 28:22
2020 47:10
2021 1:18 64:13
20th 13:23
23rd 13:23
18:20 20:16
24-hour 31:15
24th 42:8
28th 1:18 64:13

< 3 >

3:09 63:10
3rd 41:19 42:1

< 4 >

48-hour 31:16

< 5 >

5 47:9, 11
50 55:9, 11
56 51:23 54:21
5th 4:24 11:15
13:15 21:1
23:12 32:8
33:16

< 6 >

60 31:14 55:9

< 7 >

70 31:15 45:20
7th 13:16, 18
14:14 21:2, 6

< 8 >

80 31:16 55:6,
10

< 9 >

90 31:16 54:22
55:5, 7, 10

95 10:13

< A >

ability 43:1
absence 7:22
absolutely 14:19
accepted 12:18
47:5
access 15:2, 6,
20 17:3 59:25
accessing 26:5
accuracy 54:18
accurate 9:7, 20
64:12
achieve 62:4
acknowledged
51:3
actions 56:21
active 38:5
actual 54:9
add 32:16 33:5
62:2
added 33:10
34:2 50:25
adding 34:6
60:7 61:5
additional 4:20
6:4 27:16, 22
32:17 34:2, 9,
23 38:15 50:15
51:1, 3 52:19
61:6
additive 50:14
address 53:8
adherence 56:18
adjourned 63:10
admit 22:9
23:17
adopted 16:13
advice 5:21
6:17 10:7 19:8,
11 23:1 40:24
46:17 47:4
advisory 9:9
affairs 23:7
affiliated 27:12
after 17:1 33:17
age 30:16
agree 30:16
agreeing 62:16
ahead 18:4
23:21
aim 32:2
aiming 31:12

37:6, 9
Alain 3:14
Alison 3:8
Allen 4:5 12:22
41:13
altered 11:1
Analyst 3:17, 20
analytics 7:15
analyzing 27:10
Anderson 4:5
7:3 47:3
anecdotally
15:10
Angela 2:5 3:20
Angeline 3:17
Angus 47:2
answered 20:21
anticipate 56:20
antigen 50:3, 4,
5 51:9, 22
52:24 55:22
56:2 61:10
anti-testing 62:6
anybody 38:8
48:22
anyway 11:22
15:10 23:22
25:24 35:11
45:4
appear 58:1
appeared 11:22
appearing 1:23
appetite 40:13
appointment
42:23
appreciate 63:4
approach 16:13,
20 21:18 28:25
38:18 39:4
43:12, 13 44:7
45:4 50:13, 14,
15, 18 54:7, 8
56:6
appropriately
50:19
approval 35:20
47:2 57:5, 9
approves 57:21
April 4:24
11:15 13:14, 15,
16, 18 14:12, 14
20:6 21:1, 2, 6
23:12, 24 32:8
33:16 35:10

45:17 46:16
area 17:23
argument 45:17,
23
arguments
53:21
asked 20:20
aspect 11:13
25:5
aspects 13:7
31:5
assessment
15:3 42:22
48:16 52:21
58:14 59:5
Assistant 3:8
Associate 2:16,
20
associated
25:25 38:25
49:21 50:1
52:18
assuming 11:6
29:14
asymptomatic
38:17, 24 41:20
42:13 45:10, 14,
21 46:7, 13
47:13
Auditor 9:5, 17
August 9:7
available 34:25
38:10
average 51:23
54:19, 21
avoid 63:5
aware 7:6 8:19
25:2 29:20

< B >

back 4:3 14:12
15:19 20:9
21:14 23:4
30:9 31:23
47:25 48:14
49:1, 15 62:16
backlog 4:17,
19 22:16, 19
23:1 24:22
32:12 33:3, 22,
24 35:1
backward 34:19
backwards
22:10

based 4:14
33:20 41:10
56:5 57:12
Baycrest 27:22,
23
beginning 5:2
14:1 59:25
behaviour 44:9
56:12, 14
believe 12:17
21:21 24:16
37:3, 4 48:13
benefit 32:21
45:2
best 18:16
53:16
better 52:12
big 37:13
bigger 36:12
bird's 57:24
bit 5:1, 6 22:15
47:1 54:6 57:2
black 18:23
board 34:4
body 6:17 58:6
bothersome
63:4
boxes 52:7
broad 39:15
broadly 39:17,
20
Brooks 3:25
build 4:20, 22
36:5 53:12
building 8:19
11:19 13:19
18:25 33:21
34:5, 8 41:25
built 15:4 36:3,
18
busy 13:18
23:25 24:2
bypass 43:15
44:9

< C >
cadence 13:13
59:10
call 25:17 41:8
Callaghan 3:23
9:22 10:4 11:6,
10 24:12 27:5
29:13, 19 30:17
31:6 40:19
41:12, 18 42:7,

<p>12 46:25 47:7 48:1, 21, 24 49:15 62:14 calm 57:1 Canada 57:4, 9 capability 27:10 28:1 31:25 capacity 4:20, 23 8:7, 12, 15, 19 10:1 11:19 13:19 34:3, 5, 14 36:3, 14, 19, 25 37:2, 5, 18 41:25 43:22 44:14 CARE 1:1 3:9, 12, 15, 18, 21 12:7 14:11, 22 15:11, 16 16:14 17:4, 6 19:3, 12 21:8 22:3, 7 23:2 24:14, 18 25:8, 12, 13 26:2 28:7, 8, 18 29:9, 21 49:2, 11 50:25 59:1, 3, 7, 21 60:8 61:9, 19 careful 32:7, 13 cascading 8:5 case 18:24 22:1 38:12 39:3, 6, 7, 16, 17 42:19 cases 38:15, 19, 20 40:8 catch 52:3 category 15:17 Catton 13:3 caused 48:2 central 11:22 centralization 58:9 centre 42:23 52:21 58:14 59:5 centres 15:3 48:16 certain 17:1 certainly 15:23 16:4 25:6 42:5 49:22 62:6 CERTIFICATE 64:1</p>	<p>Certified 64:3, 18 certify 64:4 cetera 14:8 27:18 39:19 chain 35:14 chair 12:24 chaired 41:14 chairing 11:14 challenge 25:9 26:4, 5 28:18 34:18 36:13, 22 51:21 52:5, 24 58:8 challenged 53:15 challenges 35:11 challenging 53:22 59:16, 22 change 13:20 20:15 44:22 48:3 changed 20:18 48:5, 12 58:15, 20 chart 29:18 Chief 5:3, 14 6:24 9:15, 23 10:11, 15 12:16 13:10 20:17 children 37:14 48:16 circulating 44:17 clarity 18:8 clear 4:21 10:21, 24 12:13, 21 15:1, 11, 16 17:10 18:19 37:11 48:7 54:6 60:5 clearer 7:25 clearly 10:18 climb 49:4 clinics 52:21 CMOH 57:19 Coke 2:5 Co-Lead 3:23 collate 46:4 58:10, 13 59:15 collated 12:10 colleagues 62:24</p>	<p>College 27:15, 20 Colleges 12:5 come 8:15 22:1 29:23 43:18 47:25 54:1 61:15, 23 62:16 comes 10:17 29:15 42:8 comfortable 23:15 coming 7:6 18:12 34:8 39:12 47:19 command 9:10 commence 20:23 commencing 1:18 4:1 commentary 37:25 COMMISSION 1:3 3:9, 12, 15, 18, 21, 23 Commissioner 2:3, 4, 5 5:19 6:2, 7 8:14 14:9, 13 18:3 19:1, 7, 10, 15, 18 20:22 21:3, 12, 25 22:20, 24 23:9, 20 27:7 28:5 29:3 31:21, 22, 23 33:11 34:10 36:9, 23 37:7, 8 45:6, 8 46:21, 24 54:17, 22 55:4, 8, 11, 17, 20 57:3, 14 63:1, 8 committee 10:3 24:23, 24 40:25 41:15 42:2, 25 Company 1:17 compared 54:18, 24 55:1, 13 competing 53:14 completely 46:17 comprehensive</p>	<p>13:25 comprised 7:9 computer 29:16 conceived 4:16 concept 49:23, 24 52:25 53:21 concern 36:2 40:4, 14 54:6 56:7 57:24 concerned 14:17 28:7 32:11 42:14, 20 43:11 56:3 concerning 21:7 concerns 43:4 49:20, 25 conclusion 22:6 62:10 conclusions 62:12 confirmed 42:18 confusing 33:8 59:6 confusion 22:2, 6 57:4 consequence 11:3 consider 31:25 considered 32:5, 6 consistent 22:4 24:14 consistently 46:9 consumed 14:21 contacts 41:5 42:17 43:24 contained 24:19 content 37:23 continual 24:15 continue 38:3 52:15 53:1 56:18 continued 3:1 25:19 40:12 47:10 48:8, 10 continues 46:12, 13 continuing 24:21 contract 27:23 Control 2:10 7:12 18:13 59:23 61:2</p>	<p>controlled 33:1, 10 conversation 4:12 24:8 conversations 16:17 24:5 co-ordinated 59:17, 18 co-ordination 58:2 Copan 35:13 copy 7:1 core 60:25 corner 17:24 correct 19:4, 9 21:12 23:6 48:23 55:20 cost 61:16 cottage 43:19 Counsel 3:23, 25 counter 45:16 53:21 courier 30:4 course 5:16 58:14 Covid 27:15 38:21, 23 40:7 49:5 COVID-19 1:3 3:3 34:13 42:16, 21 created 33:24 61:6 creating 43:5 criteria 57:12 58:16 crutch 60:11 CSR 1:25 64:3 culture 16:19 curious 14:16, 17 current 39:24 Currently 3:3 8:23 < D > Dalla 2:20 Daniel 13:9 Daoust 3:14 data 30:7 32:15 46:4, 18 52:11 56:11 58:10</p>
--	---	--	---	--

<p>date 64:6 Dated 64:13 David 47:2 day 1:18 6:23 11:16 24:19 28:22 30:16 38:7 39:2 42:6 43:9 47:24 50:18 64:13 days 19:23 20:5 61:20 dealing 31:7 dealt 36:14 December 24:16 decision 6:4 19:20 40:22 41:9 48:19, 20 decisions 5:16 7:22 8:1 10:5 12:1, 2, 14 57:21, 25 58:6, 7 deck 47:8 49:16 decks 9:18 declaration 21:4, 5 declined 42:22 definitely 30:19 degree 8:21 delay 24:17, 21 29:24 delays 24:15 25:5 30:2 35:7 deliberations 29:24 delivery 29:25 demand 11:20 47:22 demanding 47:18 demonstrated 46:19 Department 2:17 depended 34:24 dependencies 35:8 depending 29:8 depends 34:16 35:17 45:13 Deputy 3:8 describe 7:8 designed 43:21 desktop 29:16 detrimental</p>	<p>32:13 develop 38:9 diagnostic 41:4 50:10 different 13:6 26:7, 8 30:12 57:25 58:11 59:14, 19 difficult 33:9 44:23 Dillon's 24:14 directly 9:15 26:15 Director 2:10 Dirk 4:6 41:14, 17 discretion 17:25 discuss 30:22 discussed 30:24 discussion 14:21 discussions 31:24 disease 7:12 Diseases 2:12 disruptive 40:10 disservice 62:8 distance 50:20 distraction 61:7 62:5 distress 44:24 distributions 58:24 Doctor 5:20 8:14 document 47:1 59:5, 18 documents 58:11, 17 doing 3:3 36:15 40:16 41:3 44:8 46:10 47:24 52:1, 2, 13, 15 53:2 54:9 57:9 58:4 62:2, 22 drop 55:19 Drummond 3:8 Dylan 3:2 dynamic 34:7 < E > early 5:7 6:13 16:5 19:23 20:5</p>	<p>easier 26:13, 24 easy 60:11, 12 effective 23:3 electronic 29:18 30:19 Elizabeth 13:8 email 41:13 emergency 21:5 employers 47:18 ended 32:23 entire 54:1 entirely 9:7 14:21 entry 30:7 epidemiologist 7:15 error 51:6 errors 17:13 Escarf 4:6 7:1 especially 51:1 52:6 60:9 61:8 essential 15:17 32:17 37:1 61:19 essentially 14:4 15:21 43:14 52:21 62:11 estimate 32:22 estimates 52:20 ethicist 7:14 eventually 52:4 everybody 32:9 38:8 40:23 42:6 43:1 48:2, 22 evidence 5:13 45:10 46:22, 23 evidence- informed 5:12 40:6 exact 31:18 exactly 5:6 20:23 26:19 29:7 34:1 example 19:23 24:4, 9 27:14, 22 32:8 excellent 22:9 excuse 43:14 existed 22:11, 16 34:22 58:21 59:19 existing 21:16 26:25 27:25</p>	<p>28:16, 25 34:17 36:15 exists 21:17 25:22 28:14 59:3 expanded 8:10 expect 44:21 expected 20:2 32:24 expedited 25:18 experience 15:24 32:12 expert 4:15 5:11 expertise 5:22, 24, 25 experts 7:9 explanation 47:4 explicit 18:11 exposed 42:15, 18, 21 extent 7:20 extremely 44:25 eye 57:24 < F > facility 38:14 fact 16:17 38:12 40:8 43:18 44:6 51:8 fair 36:24 45:18 fairly 20:8 57:19 fall 24:1 34:18 36:2 37:12 44:13 48:2, 5 false 40:9 56:15 fashion 23:5 fast 25:3 faster 49:7 fax 29:23 30:14 fear 45:22 46:20 feed 28:4 feedback 18:7 feel 8:25 13:4 20:11 feeling 39:12 fellowship 3:4 felt 16:8 49:10 60:10, 19 61:5 fewer 32:23 field 7:9 58:18</p>	<p>find 7:5 21:14 31:18 36:7 38:12 39:6 40:9 56:17 58:22 59:10 finding 36:20 fire 57:6 five-day 24:17 fix 60:1 61:4 Fixing 60:13 flag 25:6 flagging 30:24 flexibility 17:14 18:14 flexible 18:22, 23 floor 39:19 flow 26:13 flu 36:16 focus 52:9 focused 31:3 follow 27:8 followed 44:18 force 54:15 foregoing 64:5, 11 formal 12:23 13:24 formalize 5:5 6:14 formalized 5:8 formally 10:1 formed 4:24 forth 64:7 forum 48:8 forward 5:2, 9, 13 6:21 7:6 10:10, 21 17:9 20:1 21:1 22:10, 13 24:11 37:12 40:15 57:22 Frank 2:3 Franklin 3:11 frankly 53:13 FRCP 1:9 2:8 Frederick 4:6 7:1 frequently 52:2 front-line 15:24 frustration 25:20 full 34:13 36:25 37:2 fundamentals</p>
--	---	---	--	---

60:13	guidance 4:21 5:17 8:5 9:21 10:15, 17 12:7, 8, 10 19:25 20:3, 10, 16 21:17 38:4 58:9, 11, 15 59:5 60:5 guide 4:12 8:2 58:18 guidelines 32:2 guiding 7:23 guys 61:1 62:22	24:13, 15 29:20, 21 height 56:3, 25 Helen 1:25 47:2 64:3, 17 help 4:12 14:10 62:25 helped 58:12 helpful 7:5 59:20 62:15 HHR 52:17 high 51:1, 4, 5 52:6 higher 45:11 highlighting 14:24 high-risk 41:5 43:23 Hire 41:14 52:19 historically 16:21 25:11 hit 35:14 37:4 hitting 37:16 home 16:7 17:6, 20 26:2 28:8 29:9 30:9 38:6, 21, 23 59:11 61:18 homes 14:11 17:4 25:14 28:7 29:21 52:21 53:13 59:9 Honourable 2:2 hope 7:16 hospital 15:2 16:20, 24 18:12, 13 22:4 24:17 25:25 26:3 27:9, 12, 24 29:9, 12 33:13 34:11 39:4, 5 50:16 54:3 58:13 hospitalized 15:22 hospitals 8:21 15:7 24:13 28:4 hour 44:5 hours 48:17 house 35:6 56:6, 7, 13 hub-and-spoke 25:22	huge 35:15 52:22, 23 53:12 54:2 human 52:17 Humber 27:17 hundred 37:18 Huyer 4:6	Infection 2:9 7:12 18:13 59:22 61:2 Infectious 2:12 7:12 influenced 56:14 influences 56:12 influenza 34:20 36:16 44:19 information 46:4 infrastructure 53:12 61:3 initial 8:3 Initially 4:25 33:12 in-lab 30:10 input 5:10 6:1 inputs 6:5, 9 inside 63:5 insight 63:7 interest 38:1 interface 30:19 introducing 52:10 56:4 investigations 43:24 invited 48:9 involve 6:25 involved 8:18 17:16 IPAC 25:21 irrelevant 22:17 issue 12:4 52:23 56:24 issued 10:15 13:16 20:4 issues 12:5, 6, 7, 9 14:17 57:17 Italy 35:13, 14
< G > gap 26:15, 16 gather 47:9 General 9:17 10:23 12:16 40:25 43:1 47:14 57:5 generally 7:1 39:1 General's 9:5 geographic 13:4 geriatricians 7:11 give 23:1 given 22:22 gives 63:2 giving 19:8, 11, 14 glance 14:15 goal 62:4 goals 31:11 gold 50:10 54:18 55:15 good 13:4 15:2 49:23 50:6, 21 57:6, 11 62:23 gosh 20:2 go-to 30:14 governance 9:12 government 6:18 40:23 45:18 government's 48:4 Gowling 3:24, 25 great 53:21 green 25:17, 18 36:4 39:24 ground 7:11 25:9, 19 40:10 58:2 group 15:20 32:16 33:5 45:19 46:9, 13 groups 14:23 45:18 guarantee 35:3 guess 5:25 7:4 28:17 29:3 45:23	< H > hammered 16:7 hampered 51:7 happen 33:17 49:14 happened 10:6 33:16, 18 34:1 48:1 happening 23:13 58:5 happy 4:13 54:12 62:21, 22, 24 hard 44:25 harder 60:14 61:4 hate 62:17 hats 58:9 Hawthorn 3:17 head 31:14 Health 2:11, 13, 14, 22 3:5 5:4, 14 6:15, 16, 22, 25 7:3 8:24 9:9, 12, 14, 16, 23, 24 10:11, 16 12:16 13:2, 10 17:16, 25 18:11, 17, 18 20:17 25:10, 15 28:20 29:1, 11 33:13 43:15 44:10 57:4, 9 healthcare 15:1, 7, 11, 16, 22 healthy 38:8 hear 51:10 heard 4:18 7:2 15:13 18:10, 16	< I > ID 3:2 idea 12:14 ideal 32:2 ideally 38:10 identified 14:10 identify 39:16 imagine 24:6 impacted 13:7 impactful 30:22 imperfect 32:25 implement 25:13 Implementation 41:16, 17 implemented 62:3 implementing 25:16 importance 30:25 important 11:23 14:23 30:22 41:22 49:6 60:5 improve 13:20 included 62:12 includes 8:24 13:2 42:16 incorporate 59:4 incorporated 33:14 incorrect 63:6 increased 8:7 44:7, 14 56:22 increasing 49:3 incredible 41:24 incredibly 49:6 53:22 independent 4:8 individual 4:8 58:5 individuals 8:9 10:2 15:20 41:5 43:23 44:15 45:19, 20, 21 56:8 inequity 43:12		

32:5 33:18 34:15 36:11 37:3, 10 41:1, 16 42:3, 11 43:3 45:15 46:23 47:6, 17 48:6, 23, 25 49:17 54:19, 24 55:6, 10, 12, 18, 21 57:7, 15 62:20 63:9 Jessica 3:11 jive 45:4 John 3:23 9:19, 22 10:4 11:6, 10 24:12 27:5, 8 29:13, 19 30:17 31:6 40:19 41:12, 18 42:7, 12 46:25 47:7 48:1, 21, 24 49:15 62:14 JOHNSTONE 1:9 2:8 4:2 5:23 6:3, 9 8:17 9:25 10:8 11:8, 11 14:12, 18 18:5 19:5, 9, 13, 16, 22 21:10, 13 22:8, 22 23:6, 11, 22 24:24 27:11 28:12 29:7, 17 30:1, 18 31:9 32:5 33:18 34:15 36:11 37:3, 10 41:1, 16 42:3, 11 43:3 45:9, 15 46:23 47:6, 17 48:6, 23, 25 49:17 54:19, 24 55:6, 10, 12, 18, 21 57:7, 15 62:15, 20 63:9 July 47:10 June 5:7 6:13 46:19 < K > Kain 3:2 keeping 37:1 kind 13:25 18:22 24:21	Kitts 2:4 31:22, 23 33:11 34:10 36:9, 23 37:7 45:7, 8 46:21, 24 54:17, 22 55:4, 8, 11, 17, 20 57:3, 14 63:8 knew 16:7 23:14 33:2 36:2 37:13 43:16 44:13 knowing 17:2 23:15 55:2 knowledge 4:14 31:8, 9 known 27:24 < L > lab 17:6 26:13 27:13, 19, 25 28:20 29:2, 15 30:5, 6, 7, 8 34:11 35:22 Laboratory 2:17 labs 8:16, 20, 22, 24, 25 9:1, 2 25:25 26:3, 7 27:9, 25 28:4 29:11 31:10, 11 33:13, 14, 15, 21, 24 34:2, 7, 20 44:24 lack 17:3 18:8 28:24 58:8 lacking 30:19 lags 25:7 Lana 2:21 landed 37:21 large 8:25 34:11 larger 27:25 28:4 largest 9:1 late 5:7 6:13 23:7, 9 lay 44:2 layer 51:1, 4 Lead 2:3 3:11, 14 5:19 6:2, 7 8:14 14:9, 13 18:3 19:1, 7, 10, 15, 18 20:22 21:3, 12, 25 22:20, 24 23:9, 20 27:7 28:5 lots 39:11 loud 45:19 low 16:5 38:4 39:22 40:8 60:9 lower 51:22 52:12 low-value 41:8 46:7, 13 49:10 < M > machine 34:16	29:3 31:21 37:8 44:7 45:6 63:1 learned 18:6 led 18:7 56:14 left 17:18, 24 lesser 8:21 level 44:24 58:3 leveraged 9:3 Lianne 13:3 license 35:20 limitation 56:9 linear 12:13 line-by-line 10:12 lineups 48:15 listen 46:1 lit 36:4 lived 32:11 logistics 6:6 LONG 1:1 34:10 35:21, 22, 23 37:9 48:15 Long-Term 3:9, 12, 15, 18, 21 12:7 14:11, 22 15:11, 16 16:14 17:4, 6 19:3, 12 21:8 22:3, 7 23:2 24:13, 18 25:8, 12 26:2 28:7, 8, 18 29:9, 21 49:2, 11 50:24 59:1, 2, 7, 21 60:8 61:9 looked 37:17 46:7 looking 61:1 looks 24:23 lot 17:14 18:7 20:18 24:5 38:16 40:4 44:23 47:18 lots 39:11 loud 45:19 low 16:5 38:4 39:22 40:8 60:9 lower 51:22 52:12 low-value 41:8 46:7, 13 49:10 < M > machinery 34:20, 21 35:25 machines 34:9, 17, 24 35:17 36:6, 21 made 12:2, 14 17:13 39:11 40:23 41:9 45:17 57:25 64:8 mail 29:22 main 35:13 majority 40:8 making 8:1 17:7 19:2 20:14 39:8, 9, 11, 13 40:5 45:25 58:6 60:4 62:2 man 36:21 manage 17:15 18:15 mandate 8:3 22:23 mandated 43:17 mandatory 61:10 manner 22:4 33:10 March 4:18 14:25 20:24 23:7, 8, 10 24:15 33:25 37:9 Marrocco 2:3 5:19 6:2, 7 8:14 14:9, 13 18:3 19:1, 7, 10, 15, 18 20:22 21:3, 12, 25 22:20, 24 23:9, 20 27:7 28:5 29:3 31:21 37:8 45:6 63:1 Martineau 1:25 64:3, 17 mask 50:19 massive 52:18 Matt 4:5 7:3 matter 28:6 46:9 Matthew 47:3 MD 1:9 2:8 meaning 16:21 20:6 28:20	38:18 39:23 41:8 43:23 56:8 means 61:21 measures 43:15 44:10 media 11:16 46:2 49:23 Medical 2:10 5:4, 14 6:24 9:15, 23 10:11, 16 12:16 13:10 20:17 Medicine 2:18 meet 9:22, 25 meeting 1:17 31:19 63:10 64:5 meetings 14:20 meets 57:13 membership 7:7 memo 59:3 61:9 memorandum 42:8 memos 58:17 59:1, 14 mention 13:2 mentioned 8:3 met 13:14 58:16 microbiologists 7:14 microbiology 7:13 27:13 28:14 Minister 3:8 ministries 12:8, 13 Ministry 5:13 7:2 12:3, 5, 6, 7, 9 50:8 57:20 59:1, 2 61:9 minor 11:2 mirror 10:18 modality 54:9 mode 29:25 model 25:22 27:4 month 13:18 53:18 months 36:1, 8 59:10 moot 22:15 moral 44:24 mortality 38:25
---	--	--	---

move 37:19
50:8 57:22
moved 22:10
moving 22:13
MP 51:12
multiple 7:4

< N >
narrow 15:19
nasal 51:18, 25
55:19
natural 28:2
nature 20:19
necessarily
7:19 8:17, 19
12:10 15:11
24:5 30:11, 23
58:23
necessary 30:6
necessity 48:14
needed 16:8, 11
17:10 36:2
needing 48:17
needs 59:8, 12
Neesons 1:17
negative 44:3
56:11
Network 2:15
8:20, 23 31:10,
11 33:21, 24
nice 45:25
56:16
**nonstandardizati
on** 18:8
norm 30:15
north 13:3
note 41:13, 18,
22
notes 64:12
noticed 14:14
NP 35:11, 13
51:9, 18, 23
54:20
number 8:25
11:15 17:2
45:24 46:2, 3
47:11
numbers 32:6,
23 49:4
numerous 58:17

< O >
occur 23:12
occurred 38:17
October 20:12

Office 5:3, 14
6:24 10:2, 10,
14 11:24 12:15,
18 13:9 20:7
57:19
Officer 5:4, 14
6:25 9:16, 23
10:11, 16 12:16
13:10 20:17
official 6:16
10:14
offset 52:1, 3
55:25
ongoing 46:12
onset 16:25
Ontarian 42:20
Ontario 6:15, 16,
22 7:3 8:24
9:12, 14, 24
25:10, 15 28:20
29:1, 11 60:14
onward 6:24
open 17:18
37:14
operating 36:25
operational
25:5 31:4, 7
operations
58:13
opinion 5:11
11:21 54:16
opinions 5:12
opportunity
61:15
opposed 28:10
46:2
opposite 38:22
order 35:21, 23
52:20 59:4 63:5
organization
28:3
original 62:12
Osler 27:18
outbreak 16:23
17:15 18:15
41:5 43:24
49:12 50:7, 9
56:15
outbreaks
17:17 49:5
52:9 56:23
output 33:1
outstanding
4:11

overflow 27:16
overlaid 19:24
overlay 5:15
overload 32:20
overnight 36:5
overreliance
59:23
overseeing 58:7
overshoot 33:3
overwhelmed
32:10

< P >
P.M 1:19 4:1
63:10
paint 17:23
pandemic 3:4
11:13 21:6
28:6, 9, 10, 15
29:5 34:24
panel 4:16 7:8,
15 11:14 20:25
21:11 23:14
31:2, 24 41:11
47:5 51:2 53:8
54:14 57:19
part 4:8 19:2
22:14 31:7
participants
1:23
particularly
44:12
partner 29:12
partners 61:19
Pathobiology
2:18
pathway 10:24
11:4, 7 48:11
pathways 17:5
28:25
patients 39:5
Patricia 3:25
Paul 61:22
pause 52:14
53:1, 2 54:11
pay 61:22
PCR 34:21
41:3 50:10
51:24 54:25
55:2, 4, 13, 14,
23 56:16
pee 17:4
people 5:21, 24
7:10, 12 8:8
13:1 15:18

16:24 31:19
32:17, 23 36:3,
20 38:24 39:12,
13 42:14, 16
43:18 44:1, 8,
21, 25 45:14, 24
48:17 49:10, 24
52:20 55:22
58:16 61:12, 21
people's 56:21
percent 10:13
31:15, 16 45:20
46:8, 14 51:24
54:21, 23 55:5,
7, 19
percentage 46:8
perfect 29:1
33:19 50:24
55:1, 3, 16
period 31:15, 17
34:14
permission
51:18
person 16:7
33:19 59:23
perspective 4:7
10:9 18:12, 14,
17 26:12 43:6
47:21
Peter 61:22
ph 4:6
pharmacies
61:12, 13
pharmacy 46:11
PhD 1:9 2:8
PHO 6:19
PHOL 33:23
Physician 2:13
3:2 18:13
physicians
17:16
piece 16:15
pieces 19:6, 8
30:12 60:6 61:3
place 12:11
35:2 36:7 46:6
58:19
placed 38:9
places 26:9
plan 28:16
planning 28:6
play 35:10
53:4 56:21
players 7:4
plus 54:23

point 5:25 9:6
17:1, 19, 20, 22
20:20 23:23
33:13 37:16
38:13 39:11
46:2, 3 47:15
56:1
points 41:21
Policy 3:11, 17,
20 5:15, 16 6:1,
4, 10 11:23
44:20
political 11:13
politically 33:7
politics 6:6
population
47:14 60:15
populations
31:3
position 48:4
positive 44:5
positives 40:9
possible 13:21
32:4
possibly 32:20
post 24:8
Potentially
28:12 44:9
46:16
practical 7:17
pragmatic 7:8
31:24 48:19
pragmatically
32:3
pragmatics
6:11 8:2
precautions
38:11
Premier's 11:23
prepandemic
16:21 21:18
25:13 27:19
28:19
PRESENTATION
1:8 62:13
preserving
43:22
press 51:10
pretend 48:6, 13
pretty 12:8
41:2 46:6
prevalence
17:19, 20, 22
51:1, 5 60:10

<p>prevalent 39:22 51:4 preventing 52:9 Prevention 2:9 primarily 8:20 priorities 15:15 53:14 prioritize 4:22 private 8:16, 22 9:2 33:14 38:10 problem 22:25 25:7 26:21 30:11, 25 35:15 38:22 56:20 60:1, 22 problems 14:10 27:2 60:23 process 5:8 25:17 34:7 processed 26:16, 17 processes 42:24 processing 28:14 Professor 2:16, 20 properly 54:10 62:7 proportion 31:19 protection 51:4 proven 25:9 36:21 provide 5:17 6:23 7:17 8:4 47:4 provided 6:10 providers 59:8 provides 6:17 providing 5:11, 21, 24 province 13:1, 5 60:8, 16 provinces 60:17 Public 2:21 6:15, 16, 21 8:24 9:12, 14, 24 13:2 17:16, 25 18:10, 17, 18 25:10, 14 28:20 29:1, 11 33:13 43:15 44:2, 9 57:5 pull 32:15</p>	<p>58:19 pulling 49:1 purchase 34:23 35:6 36:6 purchases 35:5 put 4:11 5:2 6:21 17:9 20:1 21:1 24:10 40:15 42:9 47:7 puts 9:8 < Q > queries 14:2 question 20:21 22:9, 25 27:6 29:14 30:8 31:22 33:12 35:16 36:24 52:14 53:6 60:1 questionable 45:1 questions 4:10 14:3, 5 20:20 24:3 54:12 queue 49:13 quick 14:15 quickly 6:22 13:21 quite 10:24 23:14 25:23 38:22 53:13 < R > ramp-up 34:14 ranges 54:21 rapid 37:25 49:18, 21 50:1, 3, 4, 5 51:22 52:8 54:15 61:10 rates 39:24 reach 61:11 reached 61:12 read 13:12 18:21 49:18 reagent 36:10 reagents 35:15 real 43:4 reality 9:17 53:22 54:9 56:5 really 4:9 28:15 32:19 49:9 57:21 reason 40:3</p>	<p>reasonable 51:16 reassurance 56:16 63:3 recall 47:5 receiving 59:1 recognized 14:22 recognizing 7:18 recommendation 19:20 21:7, 11 40:2, 12, 15, 18 41:2, 11 47:12 recommendation s 5:3, 9 6:20, 21, 23 7:6, 18, 24 8:4, 11 9:14 10:10, 13, 19, 20 12:19 13:13, 17, 20, 21, 25 15:10 17:8, 9 18:21, 24 19:2, 17 20:1, 7, 14, 15, 17, 23 21:2, 14 22:15 23:15 24:11 25:3 31:25 32:14 37:23 39:22 40:6 45:25 46:1 48:9 49:19 60:2 record 49:20 recorded 64:9 records 60:18 recurrent 59:6 redirected 26:2 referring 42:10 reflect 12:25 reflected 22:11 reflective 9:21 13:1 reflects 9:16 region 25:23, 24 58:12 regions 51:2 regularly 20:8 reimbursed 35:4 reiterate 57:18 reiterates 41:19 relates 25:7 relation 14:11 relationship 12:12 28:13</p>	<p>relationships 26:21 relatively 60:12 relay 26:25 relayed 10:6 relevant 24:3, 10 relied 21:16 reluctance 46:16 49:25 remains 38:8 remarks 64:8 remember 5:6 15:18 35:12 48:14 remembering 22:14 50:12 51:11 54:25 renovate 36:6 repeat 22:24 report 9:5, 13 REPORTED 1:25 5:1 Reporter 64:4, 18 REPORTER'S 64:1 reports 9:9 representation 13:5, 6 representations 48:11 request 29:15 required 8:9 15:18 rescind 33:6 resident 16:16 17:10 38:12, 19 60:8 residents 16:19 18:1 19:3, 12 21:8 22:7 23:3 38:3, 7 39:2, 18 40:14 49:11 60:3 61:24 resource 37:1 52:17 resources 45:1 respect 59:21 respiratory 21:17, 19, 23 25:12 37:15 44:17 respond 14:4 responsive 14:2</p>	<p>result 4:16 26:18, 22 29:15 results 23:4 24:16, 18 26:5, 10, 14, 19 29:22, 25 retirement 59:9, 11 retrospectoscop e 32:22 review 40:22 revisited 7:24 rhino 44:17 rigorous 23:2 risk 45:11 56:23 risk-based 42:13 risky 44:8 45:13 robbing 61:22 robustly 25:23 role 24:8 roll 52:8 rollout 51:17 room 38:10 51:5 roommates 18:2 routinely 16:25 RSV 34:21 36:16 44:18 run 52:20 < S > safe 38:18 samples 28:9 School 2:21 14:6 37:15 48:17 schools 24:6 science 6:10, 12 7:19, 20, 23, 25 32:25 scientific 6:5, 17 45:24 scope 17:7 scratch 23:19 season 21:24 36:17 37:15 Secretariat 3:10, 13, 16, 19, 22 sector 24:4 securing 35:12 security 56:4 send 28:9</p>
---	--	--	--	---

<p>sending 5:9 25:14 28:19, 22 29:10 Senior 3:17, 20 Seniors 12:6 sense 29:2 43:7 45:9, 13 47:22, 25 49:9 56:4, 15 61:7 sensitivity 51:23 52:12 55:23 sentiment 54:13 separated 37:22 September 20:12 24:4 48:15 49:3 58:15 served 27:20 serves 27:14 session 4:4 set 5:16 20:1 31:11 64:6 setting 16:24 32:1 40:17 41:6 50:7, 9, 11, 16 shape 8:12 share 4:7, 14 12:20, 25 13:11, 13 14:19 25:8 40:5 48:10 49:20 51:19 53:20 54:13 shared 43:16 48:9 59:18 sharing 46:18 54:16 sheet 25:17, 18 shift 61:10 shocking 30:15 Shorthand 64:4, 12, 18 show 23:23 41:13 46:6 sick 39:10, 14 50:20 significant 22:18 38:25 simplistic 27:6 29:14 Sinai 2:11, 13 3:5 9:2 16:4 26:13 27:14, 19</p>	<p>29:15 35:22 single 60:7 site 15:4 27:13 34:21 54:1 slide 9:4, 5, 11, 18, 19 12:20 13:12 23:23 24:14 37:19 47:8 49:16 57:15 62:11 slides 4:3, 12 slightly 11:1 16:9 slow 25:20 slowed 23:25 small 39:10 51:6 so-called 56:6 socially 50:19 society 37:14 somebody 29:6 56:10 somewhat 32:21 soon 4:18 sorry 29:9 61:13 sort 8:6, 10 14:25 15:24 16:22 20:15 23:18, 24, 25 28:2, 3, 20 30:21 32:22 34:6 45:5 57:24 58:6 sorts 13:6 sought 32:24 43:1 source 5:10 space 36:7 speak 4:23 9:1 16:4 33:20 45:3 48:9 speaking 39:1 specific 24:2, 3, 4 58:16 specifically 13:3 43:25 specimens 27:17 28:19, 22 29:10 33:12 spend 37:20 spoke 12:22 25:21 sporadically</p>	<p>39:2 spot 56:17 spread 45:10, 20 spreading 45:14 spring 38:17 staff 15:25 16:7 19:3, 12 21:8 22:3, 4 23:2 36:15 38:20 39:8, 9, 16 40:1, 16 50:18 51:11 52:9 53:5 54:1 59:11 60:9 61:22 staffing 52:23 53:15 61:2, 8, 16, 17, 20, 23 standard 50:10 54:18 55:15 standards 32:1 start 19:11, 14 44:16 46:18 started 20:25 22:12 23:19 33:17, 23 34:6 35:9, 18 47:20 starting 4:19 11:14 49:4, 5 state 21:4 23:7 39:23, 24 51:4 statement 10:23 11:23 12:17 stayed 24:2 stenographically 64:9 step 30:2 stick 6:12 stop 16:23 17:1 40:19 stopped 36:15 straightforward 11:5 57:20 59:13 strategy 4:9, 16 16:12 31:2 43:5, 6, 8, 10 45:5 47:21 51:2 stretch 51:14 structural 57:17 structure 6:14 26:25 37:22, 23 stuff 58:25 sub-committee</p>	<p>6:15, 18 9:8 submits 30:8 substantially 36:19 success 41:24 suggest 45:10 summer 24:1 37:11 40:13 43:16 supplier 35:13 supply 35:14 support 62:23 supposed 16:3 43:21 surveillance 38:6 39:25 50:13 53:9 suspected 42:18 sustainability 43:12 44:12 swab 17:5 26:9 35:13 51:12, 23 swabs 17:4 25:14, 17 26:2 35:11 36:10 51:9, 18, 19, 25 swear 21:21 symptomatic 8:9 17:10 18:1 32:9 39:9 41:4 43:23 44:15 60:4 symptomatic/asy mptomatic 40:21 symptoms 16:25 38:6, 9 syndrome 39:2 system 18:9 32:1, 10 < T > table 9:9, 10 16:17 31:6 58:13 59:17 takes 36:8 talk 26:20 37:20 50:5 57:8 talked 16:18 24:17 talking 11:16, 18 30:21 47:15 50:3, 24 tap 62:18</p>	<p>targets 31:17, 18 task 54:15 tasked 43:4 taxi 30:4 Team 3:14 17:25 technical 9:8 technically 9:10 TERM 1:1 terms 4:15 8:20 11:12 12:15 13:14 15:6 18:23 31:11 32:1, 6, 7 36:13 38:2 39:21 60:2 terrible 33:2 test 8:8 11:18, 24, 25 16:6, 22, 24 18:25 27:10 31:3, 4 32:9 37:5 38:4, 13 39:1, 3, 6, 7, 16, 19 40:23 41:10, 23 42:6, 22 43:2, 8, 9, 19 44:3, 21 48:3 50:17 51:22, 24 54:25 55:2, 23 56:2, 10 60:23 tested 8:6 15:25 16:6, 8 17:11 22:3, 5, 17 47:20, 23 48:22 51:14 54:2 59:9, 12 60:3 testimony 12:24 testing 4:4, 5, 9, 15, 17, 20 5:21 8:5, 9, 11 10:14, 16 11:12, 16, 17 12:4, 6, 9, 23 13:7 14:7, 8 15:3, 6, 8, 12, 18, 20 16:11, 16, 19 17:3, 22 18:1 19:3, 11, 24 20:10, 16 21:7, 17, 18 22:7, 19, 21, 25 23:2 24:8 25:2, 11 27:16 31:2, 8 32:24 34:12, 21 35:24 36:16</p>
--	---	--	---	---

<p>37:2, 17, 25 38:3, 5, 17 39:9, 15, 25 40:7, 17, 21, 25 41:4, 8, 15, 17, 20 42:14 43:5, 6, 7 46:5, 8, 12 47:11, 13 49:10, 18, 21 50:1, 5, 13 51:2, 9 52:15, 24 53:1, 2, 8, 9 54:8, 15 57:18, 20 59:11, 19, 24, 25 60:5, 7, 9, 15, 21, 23, 24 61:6, 11 62:1 tests 17:4 38:11 41:23 42:5 49:2 50:4, 5 52:8 thanks 63:7 theme 59:6 theoretically 56:22 theory 50:14 thing 11:15 33:4 35:10 43:7, 17 49:1 52:10 53:4, 23 56:16 57:6, 11, 23 60:11, 12 things 18:6 24:10, 20 30:22 50:21 51:7, 8 57:1 61:1 63:5 thinking 62:1 thought 23:17 44:6 thousand 37:18 threshold 16:6 38:5 throw 60:20 time 11:17 13:15 15:5 16:18, 21 19:19, 20 20:10 26:4, 15, 17 28:10 30:6, 11, 25 31:1, 15, 16 34:11 37:21 41:3 42:2 44:4 47:24 49:2, 7 52:8 53:3 60:10, 20 62:18</p>	<p>64:6, 8 timelines 31:20 timely 7:17 15:8 22:19 23:5 25:3 31:1 times 7:21 8:1 25:2, 4, 20 27:3 31:12 49:8 51:15 52:3, 11, 22 53:16, 25 55:25 61:5 tinder 52:7 today 37:4 61:8 told 54:2 56:10 ton 37:21 top 13:15 31:14 Toronto 2:19, 23 25:23, 24 58:12 touch 49:18 touched 30:13 touted 49:22 track 26:19 59:3 60:17 tracking 26:8, 11 58:22 transcribed 64:10 transcript 1:16 64:12 transmission 44:8 50:22 transparent 10:25 travel 8:11 trouble 60:20 true 64:11 truly 4:13 38:20 40:6 56:9 trying 11:19 13:20 17:8 26:7, 10 32:15, 19 49:12 52:8 turnaround 25:2, 4, 20 26:4 27:3 30:6, 11, 24 31:1, 12 49:2, 7 60:24 turned 15:14 16:2 turns 63:6 tweaks 10:22 type 43:17 types 12:1</p>	<p>< U > UHN 27:14, 20 unacceptable 49:8 unclear 5:1 uncomfortable 51:13 undershot 32:21 understand 5:20 6:8 22:1 40:3, 11 44:2 45:8 46:15, 17 49:25 50:23, 25 55:22 56:9 understanding 58:16 59:8 understood 48:3 undertaking 52:19, 22 unduly 63:3 unfounded 46:20 unit 17:21 units 18:11, 18 Universities 12:5 University 2:14, 19, 22 unknown 53:7 unknowns 35:7 56:25 unpalatable 33:7 unsustainable 48:20, 24 unwell 16:9 update 8:4 updated 7:24 20:11, 13 urges 23:1</p> <p>< V > vaccinated 53:5, 6, 10, 19 vaccination 24:9 vaccines 52:10 validated 51:20 validation 35:19 valuable 45:1 value 40:8 Vanessa 4:5 12:22 41:13 variability 18:18 variable 19:22</p>	<p>29:8 variety 26:7, 8 Veritext 1:17 versus 37:23 54:22 view 42:2, 25 47:10 57:25 viral 21:17, 23 virtual 1:16 virtually 1:23 virus 37:15 44:17 viruses 21:19 25:12 44:17</p> <p>< W > wait 35:3 57:1 waiting 48:16 Walker 13:8 walk-in 42:24 Walwyn 3:20 wanted 9:6 15:15 16:12 17:13 18:11, 19 32:25 33:4, 9 48:22 49:24 53:20 54:13 57:16 62:10 wants 11:24 41:9 43:8 Warshafsky 13:9 wave 36:12, 13, 18, 23 37:13 56:3 57:1 week 14:20 20:3 51:15 52:3, 11, 13, 22 53:25 55:25 61:20 weekly 58:20 weeks 35:23 weigh 6:11 weighing 57:10 whatnot 34:9 36:8 white 18:23 56:6, 13 widely 39:7 William 27:17 Williams 47:3 WITNESS 20:25 WLG 3:24, 25 Women's 27:15,</p>	<p>20 words 42:12 work 25:4, 16 39:10, 12, 13 47:20, 25 48:18 50:20 53:16 62:23 worked 39:18 worker 15:22 workers 15:2, 8, 12, 16 16:13 32:17 47:19, 23 working 7:13 39:14 44:25 workplace 8:11 14:7 53:25 world 7:19 29:1 50:24 worried 44:1, 12 worst 60:17</p> <p>< Y > Yeah 14:13, 18 19:6 55:6 57:7 year 28:23</p> <p>< Z > Zoom 1:16</p>
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