

# Ministry of Health's Pandemic Response Structure and Actions Briefing

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



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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

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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

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9 Alison Blair, Assistant Deputy Minister, Health

10 Services

11 Justine Hartley, Health System Emergency Management

12 Branch, Ministry of Health

13 Robert Francis, Director, Strategic Policy Branch,

14 Ministry of Health

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

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

17 Roopa Mann, Ministry of the Attorney General

18 Kristin Smith, Esq., Ministry of Health and

19 Ministry of Long-Term Care Legal Services

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1 PARTICIPANTS:

2

3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

5 Ida Bianchi, Counsel, Long-Term Care Commission

6 Secretariat

7 Kate McGrann, Counsel, Long-Term Care Commission

8 Secretariat

9 John Callaghan, Counsel, Long-Term Care Commission

10 Secretariat

11 Derek Lett, Policy Director, Long-Term Care

12 Commission Secretariat

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

14 Care Commission Secretariat

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16 ALSO PRESENT:

17

18 Olivia Arnaud, Stenographer/Transcriptionist

19 Lisa Di Felice, Administrative Assistant, Long-Term

20 Care Commission Secretariat

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

2

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 All right, then. Let's go.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 JUSTINE HARTLEY: No?

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

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

21 KRISTIN SMITH: No problem.

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



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

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

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

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

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

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

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

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

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

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

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

23           Over to you, Alison. Thank you.

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

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

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

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

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

25 ALISON BLAIR: Thank you. Wonderful.

1 Appreciate it.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Ms. Coke?

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

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

7 ALISON BLAIR: We have --

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

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

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

25 ALISON BLAIR: The three co-chairs

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

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

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

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

19 COMMISSIONER JACK KITTS: Okay. Thank  
20 you.

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

25 Okay. And I know you want to get to

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

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

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

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



1 terms of statistics as well.

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

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

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

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

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

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

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

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

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

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

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

15 Those are the highlights from that  
16 slide.

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

19 ALISON BLAIR: Certainly.  
20 Do I call you "Commissioner Coke"?

21 COMMISSIONER ANGELA COKE: Sure.

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

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

1 stakeholder teleconference.

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

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

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

12 COMMISSIONER ANGELA COKE: Okay.  
13 Thanks.

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

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

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

24 ALISON BLAIR: Yeah.

25 COMMISSIONER JACK KITTS: In between, I

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

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

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

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

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

16 What are the differences between those?

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

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

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

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

12           Justine, please feel free to --

13           COMMISSIONER FRANK MARROCCO (CHAIR):

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

16           JUSTINE HARTLEY: Great, thank you.

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

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

1 the Ministry to receive that.

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

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

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

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

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

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

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

10 JUSTINE HARTLEY: It is, yes.

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

13 JUSTINE HARTLEY: Yes.

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

17 It says on the slide:

18 "Regular stakeholder  
19 communication cycle established."

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

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



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

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

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

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

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

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

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

10           COMMISSIONER FRANK MARROCCO (CHAIR):

11 Thank you.

12           ALISON BLAIR: You're very welcome.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

10                   COMMISSIONER FRANK MARROCCO (CHAIR):

11 Thanks. Thank you.

12                   ALISON BLAIR: You're welcome.

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

25                   Obviously, economic impact was

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

4 Next slide. Thank you, Kristin.

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

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

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

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



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

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

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

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

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

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

14 We look at the next slide, please?

15 Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 ALISON BLAIR: Sure.

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

20 ALISON BLAIR: Yeah.

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

25 ALISON BLAIR: They, on that chart, I

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

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

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

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

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

16 COMMISSIONER JACK KITTS: Okay.

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

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



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

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

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

13 ALISON BLAIR: There's both.

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

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

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

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

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

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

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

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

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Okay.

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

10 ALISON BLAIR: Thank you.

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

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

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

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

1 ALISON BLAIR: Great.

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

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

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

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

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

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

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

17 And the final point --

18 COMMISSIONER JACK KITTS: Alison?

19 ALISON BLAIR: Yeah, go ahead.

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

1 correct?

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

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

11 COMMISSIONER JACK KITTS: Okay.

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

15 COMMISSIONER JACK KITTS: Okay. Thank  
16 you.

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

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

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

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

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

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

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

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

25           So the medical officers of health for



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

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

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

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

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

1 sub-tables.

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

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

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

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

1 information I can.

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

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

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

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

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

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

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

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

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

12 Next slide. Thank you, Kristin.

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

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

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

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

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

17           Any questions on that? Okay.

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

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

25           ALISON BLAIR: Yes. Yeah. And over

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

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

18 COMMISSIONER JACK KITTS: Thank you.

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

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

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

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

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

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

25 The system capacity planning and the



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

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

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

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

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

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

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

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

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

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

25 ALISON BLAIR: I'll tell you what might

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

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

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

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

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

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

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

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

11 COMMISSIONER JACK KITTS: Okay. Thank  
12 you.

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

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

25 COMMISSIONER JACK KITTS: Great. Thank

1 you.

2 ALISON BLAIR: Thank you.

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

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

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

1 website.

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

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

19           Next slide, please.

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

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

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

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

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

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

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

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



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

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

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

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

1 thing that we'll be looking to track.

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

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

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

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

1 that flu transmission will also be reduced.

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

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

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

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

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

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

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

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

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

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

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

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

25 COMMISSIONER ANGELA COKE: You know

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

5 COMMISSIONER JACK KITTS: Yeah.

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

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

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

20 Do you have any questions for us?

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

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

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

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

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

13 Alison, are you on?

14 ALISON BLAIR: The other Alison.

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

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

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

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

25 COMMISSIONER ANGELA COKE: Yes, yeah.

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

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

6                   COMMISSIONER JACK KITTS: Thank you.

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

9                   COMMISSIONER JACK KITTS: Bye.

10                  COMMISSIONER ANGELA COKE: Take care.

11

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

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10 That all remarks made at the time  
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14 That the foregoing is a true and  
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24 PER: OLIVIA ARNAUD, CSR

25 CHARTERED SHORTHAND REPORTER

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