Ministry of Health's Pandemic Response Structure and Actions Briefing

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

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

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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

BEFORE:

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

PRESENTERS:

Alison Blair, Assistant Deputy Minister, Health Services
Justine Hartley, Health System Emergency Management Branch, Ministry of Health
Robert Francis, Director, Strategic Policy Branch, Ministry of Health
Judith Parker, Esq., Crown Law Office, Civil
Sunil Mathai, Esq., Crown Law Office, Civil
Roopa Mann, Ministry of the Attorney General
Kristin Smith, Esq., Ministry of Health and Ministry of Long-Term Care Legal Services

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist
Lisa Di Felice, Administrative Assistant, Long-Term Care Commission Secretariat

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

COMMISSIONER FRANK MARROCCO (CHAIR): All right, then. Let's go.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I will look at the -- if we get to

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

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

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

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

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

JUSTINE HARTLEY: No?

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

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

KRISTIN SMITH: No problem.

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

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

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

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

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

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

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

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

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

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

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

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

Over to you, Alison. Thank you.

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

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

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

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

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

ALISON BLAIR: Thank you. Wonderful.

Appreciate it.

COMMISSIONER FRANK MARROCCO (CHAIR): Ms. Coke?

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

ALISON BLAIR: We have --

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

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

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

ALISON BLAIR: The three co-chairs

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

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

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

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

COMMISSIONER JACK KITTS: Okay. Thank you.

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

Okay. And I know you want to get to

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

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

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

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

terms of statistics as well.

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

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

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

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

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

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

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

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

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

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

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

Those are the highlights from that slide.

COMMISSIONER ANGELA COKE: Can I just ask a question?

ALISON BLAIR: Certainly.

Do I call you "Commissioner Coke"?

COMMISSIONER ANGELA COKE: Sure.

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

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

stakeholder teleconference.

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

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

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

COMMISSIONER ANGELA COKE: Okay. Thanks.

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

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

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

ALISON BLAIR: Yeah.

COMMISSIONER JACK KITTS: In between, I

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

ALISON BLAIR: Yeah, the one in Winnipeg.

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

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

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

What are the differences between those?

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

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

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

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

Justine, please feel free to --

COMMISSIONER FRANK MARROCCO (CHAIR): Just while -- well, Justine, if you wanted to add something, go ahead, then I'll ask my question.

JUSTINE HARTLEY: Great, thank you.

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

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

the Ministry to receive that.

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

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

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

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

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

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

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

JUSTINE HARTLEY: It is, yes.

ALISON BLAIR: There was just one this morning.

JUSTINE HARTLEY: Yes.

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

It says on the slide:

"Regular stakeholder communication cycle established."

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

ALISON BLAIR: You're very welcome.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just ask, before you go on, I see the action plan there on the 23rd, and you explained before how the command table communicated downward.

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thanks. Thank you.

ALISON BLAIR: You're welcome.

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

Obviously, economic impact was

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

Next slide. Thank you, Kristin.

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

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

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

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

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

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

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

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

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

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

We look at the next slide, please?

Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ALISON BLAIR: Sure.

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

ALISON BLAIR: Yeah.

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

ALISON BLAIR: They, on that chart, I

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

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

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

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

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

COMMISSIONER JACK KITTS: Okay.

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

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

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

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

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

ALISON BLAIR: There's both.

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

ALISON BLAIR: Thank you.

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

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

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

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

ALISON BLAIR: Great.

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

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

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

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

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

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

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

And the final point --

COMMISSIONER JACK KITTS: Alison?

ALISON BLAIR: Yeah, go ahead.

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

correct?

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

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

COMMISSIONER JACK KITTS: Okay.

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

COMMISSIONER JACK KITTS: Okay. Thank you.

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

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

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

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

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

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

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

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

So the medical officers of health for

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

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

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

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

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

sub-tables.

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

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

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

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

information I can.

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

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

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

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

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

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

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

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

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

Next slide. Thank you, Kristin.

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

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

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

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

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

Any questions on that? Okay.

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

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

ALISON BLAIR: Yes. Yeah. And over

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

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

COMMISSIONER JACK KITTS: Thank you.

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

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

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

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

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

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

The system capacity planning and the

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

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

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

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

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

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

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

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

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

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

ALISON BLAIR: I'll tell you what might

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

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

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Okay. Thank you.

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

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

COMMISSIONER JACK KITTS: Great. Thank

you.

ALISON BLAIR: Thank you.

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

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

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

website.

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

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

Next slide, please.

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

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

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

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

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

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

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

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

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

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

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

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

thing that we'll be looking to track.

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

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

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

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

that flu transmission will also be reduced.

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER ANGELA COKE: You know

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

COMMISSIONER JACK KITTS: Yeah.

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

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

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

Do you have any questions for us?

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

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

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

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

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

Alison, are you on?

ALISON BLAIR: The other Alison.

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

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

COMMISSIONER JACK KITTS: You do. Saves confusion.

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

COMMISSIONER ANGELA COKE: Yes, yeah.

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

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

COMMISSIONER JACK KITTS: Thank you.

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

COMMISSIONER JACK KITTS: Bye.

COMMISSIONER ANGELA COKE: Take care.

-- Adjourned at 3:30 p.m.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 8th day of September, 2020.

_____

NEESONS, A VERITEXT COMPANY
PER: OLIVIA ARNAUD, CSR
CHARTERED SHORTHAND REPORTER

WORD INDEX