Long-Term Care COVID-19 Commission Meeting

Ontario Hospital Association
on Monday, March 1, 2021

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7 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14 --- Held via Zoom Videoconferencing, with all
15 participants attending remotely, on the 1st day of
16 March, 2021, 10:30 a.m. to 11:50 a.m.
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1 BEFORE:
2 The Honourable Frank N. Marrocco, Commission Chair
3 Angela Coke, Commissioner
4 Dr. Jack Kitts, Commissioner
5
6 PRESENTERS:
7 ONTARIO HOSPITAL ASSOCIATION
8 Anthony Dale, President & CEO, Ontario Hospital
9 Association
10 Elizabeth Carlton, Vice President, Policy & Public
11 Affairs, Ontario Hospital Association
12 Melissa Prokopy, Director of Legal, Policy &
13 Professional Issues, Ontario Hospital Association
14 David Brook, Vice President, Labour Relations and
15 Chief Negotiations Officer, Ontario Hospital
16 Association
17 Sarah Downey, President & CEO, Toronto East Health
18 Network
19 Janice Kaffer, President & CEO, Hôtel-Dieu Grace
20 Healthcare
21 Carmine Stumpo, President & CEO, Orillia Soldiers'
22 Memorial Hospital
23
24 PARTICIPANTS:
25 Alison Drummond, Assistant Deputy Minister,

1 Long-Term Care Commission Secretariat
2 Ida Bianchi, Senior Legal Counsel, Long-Term Care
3 Commission Secretariat
4 Derek Lett, Policy Director, Long-Term Care
5 Commission Secretariat
6 Dawn Palin Rokosh, Director, Operations, Long-Term
7 Care Commission Secretariat
8 Alain Daoust, Team Lead, Long-Term Care Commission
9 Secretariat
10 Adriana Diaz Choconta, Senior Policy Analyst,
11 Long-Term Care Commission Secretariat
12 Angela Walwyn, Senior Policy Analyst, Long-Term
13 Care Commission Secretariat
14 Lynn Mahoney, Counsel, Gowling WLG
15 Michael Finley, Counsel, Gowling WLG
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17
18 ALSO PRESENT:
19 Deana Santedicola, Stenographer/Transcriptionist
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1 -- Upon commencing at 10:30 a.m.
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3 LYNN MAHONEY: So the Commissioners are
4 all here. And are all -- I'm sorry, I don't even
5 know who all the presenters are, so are you all
6 here?
7 ANTHONY DALE: Yes.
8 LYNN MAHONEY: Okay. So,
9 Commissioners, we'll proceed, if you are okay.
10 So we have the Ontario Hospital
11 Association here to speak to you again this
12 morning.
13 You'll recall that the last time they
14 were here I believe was on October 5th, and they
15 made observations and comments regarding sort of
16 wave one of the pandemic specifically as it related
17 to long-term care homes and also with respect to
18 relationships between some of the hospitals and
19 long-term care homes.
20 And I apologize, I haven't seen the
21 deck, but they are here I believe to give comments
22 with respect to wave two of the pandemic, and if
23 they don't, then I will intervene and ask some
24 questions as well as we go along, as I'm sure the
25 Commissioners will also.

1 I'll just hand it over to your team,
2 and perhaps you can just introduce yourselves and
3 then take it from there, and I'll intervene as
4 necessary.
5 Thank you.
6 ANTHONY DALE: Thank you. I'll take
7 the lead this morning to start, and in the
8 interests of time, I'll just introduce everyone.
9 Thank you to the Commissioners and the
10 Commission for having us back today.
11 As you may know, my name is Anthony
12 Dale, and I am President and CEO of the Ontario
13 Hospital Association, and I'm joined by my staff
14 colleagues, Elizabeth Carlton, David Brook, and
15 Melissa Prokopy.
16 We are also very pleased to be joined
17 by several of our members, Janice Kaffer, who is
18 President and CEO of Hôtel-Dieu Grace Healthcare in
19 Windsor, Carmine Stumpo, who is President and CEO
20 of Orillia Soldiers' Memorial Hospital, and Sarah
21 Downey, who is President and CEO of Michael Garron
22 Hospital and Chair of the OHA Board of Directors.
23 You'll recall that the OHA previously
24 presented to you in October, so we have been asked
25 to return to add perspectives and reflections on

1 wave two of the pandemic. Jan, Carmine, and Sarah
2 are best suited to do that given their
3 on-the-ground experience, and so we would like to
4 reserve as much time as possible for them.
5 In our pre-discussions, Commission
6 staff asked us to give an overview of events
7 between the spring and now, and I am going to do so
8 briefly to get us started.
9 As we mentioned in our previous
10 presentation, it was on April 10th that the OHA
11 first submitted urgent recommendations to Premier
12 Ford on actions needed to prevent unnecessary harm
13 and death to residents in long-term care
14 facilities.
15 On June 11th, the OHA wrote to Premier
16 Ford suggesting the need for a comprehensive review
17 of learnings from wave one, and a specific plan for
18 managing future waves.
19 Our letter included a specific request
20 to develop a strategy for health care workers and
21 more preventive efforts to support vulnerable
22 populations.
23 On July 13th, the OHA issued a media
24 statement in response to the government's decision
25 to move to stage three of re-opening, asking for a

1 contingency plan to ensure preparation for wave
2 two, including the creation of regional health
3 service and staffing plans.
4 During a press conference the following
5 day, the Premier said that a plan would be rolling
6 out very shortly over the next little while, and
7 over the course of the summer, the OHA continued to
8 seek information from the government regarding
9 second wave planning.
10 On September 3rd, the OHA was briefed
11 by the Ministry of Health on a draft capacity plan
12 for the fall. Our assessment was that the plan was
13 appropriate and effective in anticipation of acute
14 care sector requirements, but we did also observe
15 that a contingency plan for long-term care was not
16 specifically included.
17 In the short time that followed, we
18 spoke with our partners in long-term care and other
19 colleague associations across the health care
20 system about our collective and growing concern
21 that preparation for wave two in long-term care
22 should be strengthened, and together we encouraged
23 additional action.
24 On September 29th, the government
25 released its long-term care preparedness plan. We

1 received a briefing that same day, and it seemed to
2 us that the fundamentals were sound, but in truth,
3 we were all in a race against time.
4 And as we have unfortunately seen,
5 despite these efforts, the second wave of this
6 pandemic has resulted in a terrible human price
7 being paid by residents of long-term care. As
8 Dr. Steini Brown noted in his modelling last week,
9 the number of deaths in long-term care in wave two
10 has exceeded the number in wave one. There have
11 also been more than twice the number of homes that
12 have come under the management of hospitals through
13 Management Orders.
14 It is important to note many
15 initiatives to support long-term care were reliant
16 on hospitals, particularly when it comes to
17 staffing. However, hospitals also experienced
18 serious capacity challenges in caring for their own
19 patients during wave two, especially since they
20 were determined to cancel elective and scheduled
21 procedures only as a last resort, unlike wave one.
22 This came in addition to
23 responsibilities such as running assessment centres
24 and huge volumes of COVID-19 testing.
25 This juggling act was extremely

1 difficult, and we have heard about agonizing
2 decisions at the hospital, management, and board
3 levels about how to manage competing priorities
4 with limited resources and staff. Hospitals did
5 their very best, but in some instances they were
6 simply not able to respond to every single request
7 for assistance.
8 Despite these challenges, hospitals
9 continues to deepen their support for long-term
10 care during the second wave. Last month we
11 conducted a survey of our members to get a better
12 sense of the scale and nature of the support, which
13 71 hospitals completed. About half the total
14 number of hospital corporations in Ontario filled
15 out the survey.
16 So while this does not reflect the
17 full, true extent of the hospital mobilization, it
18 is certainly illustrative of the depth and breadth
19 of the support that has been provided to long-term
20 care. Of the 71 hospitals that responded, 53
21 hospitals provided support to more than 150 homes.
22 Nearly 60 percent provided supports on an informal
23 basis outside of pre-existing relationships or
24 Management Orders.
25 On average, hospitals provided three

1 types of support concurrently. Infection
2 prevention and control support and staff
3 redeployment were the most common. Many of these
4 supports were also provided over a prolonged
5 period. Half of respondents supported homes for
6 more than two months and 28 percent supported
7 long-term care for four months or longer.
8 LYNN MAHONEY: Can I ask you this about
9 the survey. Was it regarding wave two, or through
10 the entire pandemic, or what was it?
11 ANTHONY DALE: Melissa, do you want to
12 answer that?
13 MELISSA PROKOPY: Yes, it was wave two,
14 since the fall.
15 LYNN MAHONEY: Okay. And the purpose
16 of the survey says "to investigate extent and
17 nature of support"?
18 MELISSA PROKOPY: Correct.
19 LYNN MAHONEY: So it was specifically
20 to see how individual hospitals were supporting
21 long-term care homes?
22 MELISSA PROKOPY: Correct.
23 LYNN MAHONEY: Okay. And is it
24 possible that you would be able to share with us
25 the actual survey results?

1 MELISSA PROKOPY: So we're actually
2 going to --
3 ANTHONY DALE: Absolutely.
4 MELISSA PROKOPY: Yeah, I was going to
5 say we are actually going to be providing a
6 detailed written submission later today which will
7 include, in one of the appendices, the overall
8 survey results so you'll get to see all the
9 questions that we asked and the corresponding
10 responses.
11 LYNN MAHONEY: So the individual
12 responses from the individual hospitals?
13 MELISSA PROKOPY: No, it will be an
14 aggregate of the total number of responses, but it
15 is divided based on -- you can see the types of
16 hospitals that responded, the types of supports
17 that was provided, the duration, as Anthony alluded
18 to. We won't be providing individual hospital
19 survey results.
20 LYNN MAHONEY: Okay.
21 MELISSA PROKOPY: So we won't be naming
22 specific organizations.
23 LYNN MAHONEY: So, for example, we have
24 heard from individual hospitals throughout the
25 course of the Commission, including, for example,

1 Lakeridge Hospital, and Lakeridge Hospital, as we
2 know, went into Orchard Villa in wave one, and it
3 went into Tendercare -- sorry, Sunnycrest in wave
4 two.
5 So to the extent that Lakeridge, for
6 example, provided some sort of response to the
7 survey and sort of details about the interventions
8 or observations it made in a long-term care home,
9 would those sorts of things be included in your
10 surveys?
11 MELISSA PROKOPY: So the survey
12 provided very little opportunity for qualitative
13 observations. It was merely a way for us to
14 quantify how many were providing support, the type
15 of support, and to Anthony's point, the duration of
16 the support. Given the kind of time frame we were
17 under, we thought it was best to assess how much
18 support was being provided, primarily outside of
19 what we know to be the existing kind of Management
20 Order or those voluntary arrangements. Well, as
21 Anthony said, most of us this was done by
22 organizations that were outside the scope of those
23 two dozen or so Management Orders.
24 LYNN MAHONEY: Okay. Thank you.
25 ANTHONY DALE: You are welcome.

1 I'll just conclude my own opening
2 comments before turning it over to our members, but
3 we would say respectfully to the Commissioners that
4 the impression of the OHA staff is that the
5 preparedness plan for long-term care was absolutely
6 well intentioned, and there was clearly a lot of
7 very good work underway at the Ministry of
8 Long-Term Care and elsewhere in the government for
9 wave two.
10 The problem is simply that in the
11 second wave, time was our enemy, and time is an
12 ally of the virus. In the words of Michael Ryan,
13 the WHO's Emergencies Programme Executive Director,
14 "If you need to be right before you move, you will
15 never win. Perfection is the enemy of the good
16 when it comes to emergency management. Speed
17 trumps perfection..."
18 I would like to turn things now over to
19 Jan and Carmine to briefly share the perspectives,
20 then Sarah is going to conclude with a few
21 high-level recommendations that we believe will
22 help ensure a robust and resilient long-term care
23 sector into the future, one that can protect
24 against future pandemics but also give frail
25 seniors the safe, high quality care and quality of

1 life they deserve each and every day.
2 And as Melissa has noted, our written
3 submission will also provide further detail.
4 LYNN MAHONEY: Before we move on to the
5 next presenter, just a follow-up comment to -- just
6 your concluding comments there about speed and
7 perfection.
8 It echos in my head the precautionary
9 principle; is that correct? Is it similar to the
10 precautionary principle that you don't need to have
11 scientific certainty? Best to proceed. You know,
12 you don't need to have all the answers. You just
13 need to proceed with some speed in order to be able
14 to -- quite frankly to save lives?
15 ANTHONY DALE: I think our experience
16 was that speed was the most important factor
17 because ultimately, as we noted, in our view and in
18 consulting with our colleagues in long-term care,
19 the assessment was that the September 29th second
20 wave continues to be planned for long-term care.
21 The fundamentals were there. It is just that by
22 the time it was developed, the second wave was
23 already growing. There was accelerating community
24 spread, leaving a narrow window of time to
25 implement quite a broad range of at times complex

1 initiatives.
2 So that is the basis of our assessment,
3 more on the need for speed and acting swiftly.
4 LYNN MAHONEY: Does that go back to
5 your comment -- in your June letter that you wrote
6 to the Premier with various suggestions for wave
7 two, you talked about the response structure that
8 needed to be put into place and that it needed to
9 be a response structure, and I think the response
10 structure that you talked about was you needed to
11 have a formalized command structure, an appointed
12 incident commander, single point of accountability,
13 and you needed to have -- there needed to be the
14 speed, and I think in your closing remarks to the
15 Commission in October, I think you talked about as
16 well that you needed to have a coordinated,
17 standardized process that allows for very rapid
18 escalation at the earliest opportunity.
19 I think those were some of your
20 concluding remarks in October. And do you believe,
21 is it your observation of what has happened in this
22 pandemic, that the response structure has been an
23 appropriate, speedy response structure ?
24 ANTHONY DALE: Well, I think our
25 experience in both waves suggests that there are

1 many learnings for all of us, including government
2 on the structure and organization of emergency
3 management for the Government of Ontario.
4 What I also think, though, is that our
5 experience is that -- keeping in mind this is a
6 once-in-a-century-event, we hope, that we can
7 improve considerably when it comes to the medium
8 and long-term time horizons for the events in
9 question; that is to say this, this pandemic, which
10 is now unfortunately a year.
11 And if you wind back the clock to the
12 late spring, early summer, when the OHA sent its
13 letter in June, you know, we were very much
14 absorbed as a province on the re-opening and all
15 the ancillary policy work and other documentation
16 that is required to do so in an effective manner.
17 But we also know from experience and
18 science and the advice of experts that we have to
19 anticipate and plan for a second wave, and that has
20 been the guide post for the OHA through the
21 duration of this situation, was certainly
22 supporting the government and supporting the
23 membership of the OHA and our colleagues in
24 long-term care and elsewhere in the moment and
25 solving and trying to fix in the moment, but also

1 trying to anticipate and plan and see problems
2 before they arise.
3 And that is what we were trying to do
4 in June, was really signal we have to -- we know
5 everyone is tired. Everyone is exhausted. We have
6 to work, though, very hard through the summer to
7 prepare for a second wave, and that was really the
8 heart of what we did.
9 LYNN MAHONEY: Okay.
10 COMMISSION CHAIR FRANK MARROCCO: Can I
11 just interrupt for a minute. As I took from what
12 you said, a good plan, too slow in the execution of
13 it. If I have got that right, who was too slow?
14 ANTHONY DALE: Well, I think -- if I
15 had to put my finger on it, I think that our eyes
16 were opened again when we were briefed on the
17 contingency plan that we had asked for in early
18 September, and it was certainly an appropriate plan
19 for acute care and attempting to anticipate the
20 kind of specific needs of our own sector.
21 But the long-term care component was
22 obviously not present, and it took another kind of
23 three or four weeks before that specific plan was
24 released publicly.
25 And so somewhere within the government

1 I guess the question remains, you know, why were
2 the two plans created separately? So I can answer
3 your question only with another question back,
4 Commissioner.
5 COMMISSION CHAIR FRANK MARROCCO: Yes,
6 and I understood you to have said that earlier.
7 That is a concern because, of course, the same
8 thing happened when -- and the initial response was
9 being prepared to the pandemic, that it seems to be
10 everybody forgot about long-term care.
11 And I can understand the preoccupation
12 with hospitals because of SARS and everybody
13 figuring the hospitals are going to get hammered.
14 It is just, you know, round two, you forget about
15 long-term care again, and I don't have a really
16 good feel for why that keeps happening.
17 But in any event, that is perhaps a
18 subsidiary question to my first one. But I have
19 got -- if you have got a view on that, Mr. Dale,
20 I'd be happy to hear it.
21 ANTHONY DALE: Well, honestly,
22 Commissioner, I do think there is a lesson here. I
23 can see the merits in creating a stand-alone
24 long-term care Ministry, I honestly can, in a
25 pre-pandemic world, but again - and I think we said

1 this in our original presentation - it has never
2 been a stand-alone portfolio ever.
3 The name was changed in the early 2000s
4 from the Ministry of Health to Ministry of Health
5 and Long-Term Care in order to emphasize that
6 long-term care was a critical component of our
7 health care system.
8 We have read the testimony of Minister
9 Fullerton and Minister Elliott and the Deputy
10 Minister Helen Angus and Dr. Williams, and
11 certainly successive governments have paid
12 different levels of priority and attention to
13 long-term care, but I think looking back and with
14 the benefit of hindsight, carving out that Ministry
15 when the government did, not obviously knowing and
16 seeing truly the pandemic that was looming in the
17 future, I think that dynamic, that reality, has had
18 an impact on the pandemic response.
19 And I say this knowing that all
20 officials, all staff, have been totally committed
21 to working night and day to meet the needs of
22 residents of long-term care. It is not a question
23 of the intention and the effort being there.
24 But I think it is a confounding factor.
25 COMMISSION CHAIR FRANK MARROCCO: So is

1 it that you create what is in essence a junior
2 Ministry dealing with long-term care, can't get its
3 voice heard in a situation where you have a
4 pandemic; is it something like that?
5 ANTHONY DALE: Well, all governments,
6 given the size of, say, the Government of Ontario,
7 the Government of Canada, with portfolios of
8 responsibility with oversight by specific elected
9 officials and public servants, by their nature,
10 they are focussed on serving their portfolios.
11 And in peacetime, integrated thinking
12 is very difficult to do, best efforts always being
13 undertaken, no doubt. But integrated thinking is
14 very hard to do.
15 In an emergency like this, with events
16 moving ever so swiftly in a changing dynamic and
17 such heightened risk, I think it probably was
18 magnified.
19 COMMISSION CHAIR FRANK MARROCCO: Okay.
20 Thank you. Sorry, I took you out of the
21 presentation.
22 LYNN MAHONEY: I have just an
23 additional question related to the response and
24 whether or not you are of the view that -- we
25 understand that the leadership of the pandemic

1 response was led by the Cabinet Secretary and the
2 Premier's Chief of Staff who didn't have public
3 health experience.
4 And do you believe that that was a
5 factor in how the government responded to this
6 pandemic?
7 ANTHONY DALE: I think that our
8 expectation at the beginning of the pandemic in
9 March and early April is that we would have seen a
10 command -- incident command structure of a
11 different type without that kind of centralization
12 of decision-making, which obviously was
13 well-intentioned.
14 But our preference would have been for
15 an independent Chair, perhaps senior official
16 experienced in emergency management, health
17 services delivery, other kind of more specifically
18 relevant competencies to managing the pandemic in a
19 more kind of conventional incident management
20 system.
21 But, you know, we are not part of the
22 government. We are not involved on a day-to-day
23 basis in government decision-making, so you would
24 have to then turn to those officials and ask for
25 their own perspective and let them speak for

1 themselves.
2 LYNN MAHONEY: Thank you.
3 COMMISSION CHAIR FRANK MARROCCO: So go
4 ahead, Mr. Dale.
5 ANTHONY DALE: I think I'll turn it
6 over to our members now for some comments on their
7 experience in wave two.
8 JANICE KAFFER: Thank you so much, and
9 thank you very much to the Commissioners. My name
10 is Jan Kaffer, and I'm the President and CEO of
11 Hôtel-Dieu Grace Healthcare.
12 And I want to thank you for giving me
13 the opportunity to share the story of the amazing
14 team at Hôtel-Dieu Grace and our partners at both
15 the Village at St. Clair in Windsor, Ontario, which
16 is a Schlegel home, as well as a retirement home in
17 Augustine Villas in Kingsville.
18 I won't be able to do these experiences
19 justice in the time I have. However, I am going to
20 try to hit the high points for you.
21 Of note, we have had staff and leaders
22 from our organization engaged in work across our
23 community since the beginning of the pandemic, from
24 agri-food worker testing to supporting leadership
25 in long-term care, to our current deployment, which

1 is staffing and supporting a temporary homeless
2 shelter in the City of Windsor.
3 A little bit about Hôtel-Dieu, which
4 you see on the slide before you. We are a
5 post-acute specialty hospital. We have two main
6 areas of focus, mental health and addictions and
7 restorative and rehab.
8 We offer the only hospital-based
9 palliative care beds, lots of outreach and
10 community-based teams and clinics, and we are the
11 lead agency for child and youth mental health in
12 our region.
13 During the time of deployment to both
14 of the facilities I am going to speak to today, our
15 hospital was dealing with a significant outbreak of
16 COVID-19 within our facility. That was extremely
17 persistent, with several additional units in our
18 hospital added to the outbreak status while we were
19 deployed.
20 Demographically, we have about 1200
21 employees, and a total of 132 of these wonderful
22 souls volunteered to be deployed to long-term care
23 during the course of the pandemic, and of those
24 132, 38 have been deployed to provide care service
25 or support or leadership in the long-term care and

1 retirement homes sector so far, including myself as
2 the CEO. I'm a registered nurse.
3 Some information on -- the first of the
4 outbreaks to talk about is the Villages of
5 St. Clair. So on Tuesday, the 8th of December, the
6 Village was declared in outbreak. Hôtel-Dieu Grace
7 Healthcare had been working with this home, as well
8 as 11 others, since the beginning of wave one.
9 Somewhere in the middle of April, we began having
10 regional meetings as a collective hospital group in
11 Windsor-Essex to talk about how we were going to
12 provide regional and then local support to the
13 long-term care and retirement home facilities.
14 So when the outbreak was declared, we
15 began talks with the Village at St. Clair and
16 deepened our relationship with them. They were
17 fully engaged at that time in trying to respond to
18 what was a catastrophic outbreak in the facility.
19 Cases in the residence and staff were
20 increasing, as was the death toll, and since staff
21 and family members had taken to social media to
22 share their experiences, the community was calling
23 for government to do so something, for government
24 to step in. Labour leaders were calling for
25 action, and families in the community at large were

1 hearing very little from leadership within the
2 facility, and we subsequently learned that local
3 Village at St. Clair leaders, as well as most of
4 the corporate resources deployed from the Schlegel
5 corporation to assist, were actually providing
6 frontline support to resident care, which left the
7 facility with minimal leadership to manage the
8 needs of the families in the general community.
9 There was a clear need for support
10 beyond the ongoing infection prevention and control
11 and high level HHR discussions that we had been
12 having with the home.
13 So in collaboration with the Village
14 and the Windsor-Essex County Health Unit, we
15 identified resources that could assist staff and
16 leadership at the long-term care facility in
17 support of their residents, and we subsequently
18 engaged in discussions with the Ministry of
19 Long-Term Care and Ontario Health, which led to us
20 and the Village entering into a Voluntary
21 Management Agreement effective December the 23rd,
22 and a Recovery Plan was agreed upon and submitted
23 to the Ministry of Long-Term Care at that time.
24 The Recovery Plan included some
25 priority areas: communications, resident and

1 family relations, reporting to the Ministry of
2 Long-Term Care, infection prevention and control
3 and education, physician oversight, and on-site
4 leadership.
5 So beginning on the 23rd, two senior
6 members of the administration of my hospital -
7 myself and one of my senior leaders - were deployed
8 to begin working on-site at the Village at
9 St. Clair. We were there for a little more than
10 three weeks, and in addition to that, we deployed
11 nine frontline clinical staff members to assist
12 with resident care.
13 A team of physicians led by our Chief
14 of Staff, Dr. Andrea Steen, as well as Dr. Marg
15 Chevalier, who is the Chief of Family Practice at
16 Windsor Regional Hospital, came on-site to conduct
17 medical assessments of the COVID-positive
18 residents.
19 We established an incident management
20 response team, and we continued on-site until
21 February the 25th, at which time the outbreak was
22 rescinded.
23 So the home was in outbreak for
24 approximately two months.
25 In summary, of that home, there were

1 318 confirmed COVID-positive cases attributed to
2 the outbreak by the Windsor-Essex County Health
3 Unit, 177 of those were residents, and 63 of those
4 residents passed away.
5 There were 141 Village at St. Clair
6 employee COVID-19 cases, and they have since
7 recovered.
8 Additionally, several employees
9 deployed by Hôtel-Dieu Grace Healthcare also became
10 positive as a result of that deployment.
11 The second deployment that we had was
12 to a retirement home, Augustine Villas, and I know
13 that it is not the same as a long-term care
14 facility, but we utilized the same tool kit that we
15 developed as a hospital to work with the long-term
16 care facility to work with the management of the
17 retirement home.
18 The Villas is a private retirement home
19 owned by the local community, and it is managed by
20 the Mennonite Church by a Senior Director and
21 guided by a community board.
22 The home has 50 licensed rest
23 retirement home beds and 50 subsidized housing
24 accommodation supported through the County of
25 Essex. Occupancy at the time of the outbreak was

1 96. Of note, many of these residents, particularly
2 those in the subsidized housing, are individuals
3 who had significant mental health and behavioural
4 challenges.
5 The Health Unit declared the outbreak
6 on December 26th, Boxing Day. So we were still
7 deployed at the Village at St. Clair when this
8 particular outbreak became a problem. It was
9 rescinded on February the 16th.
10 There were 89 positive cases associated
11 with this outbreak; 66 residents, 23 staff, and 4
12 deaths, a total of 73 percent of the individuals
13 who were associated with the home, residents and
14 staff, were infected overall.
15 So for this one, we entered into an
16 agreement for on-site leadership on January the 8th
17 for what ultimately was a four-week deployment, and
18 our staffing had begun already. We had put in some
19 RNs and RPNs from our hospital who had volunteered
20 to be deployed in advance of the actual agreement
21 beginning.
22 In scope for this Recovery Plan were
23 resident and family relations. Again, a theme was
24 that leadership themselves were unable to manage
25 that because they were trying to respond to the

1 infections and the diseases in the building.
2 Infection prevention and control, clinical
3 oversight to prevent the spread of COVID-19,
4 on-site leadership. Our local EMS provided us a
5 trailer, so our team worked in the trailer in the
6 parking lot during the time that we were deployed.
7 Physician oversight and reporting.
8 So staffing eventually did stabilize by
9 February the 5th, and our work there discontinued
10 when the outbreak was rescinded, although we stay
11 in close contact with both of these facilities as
12 part of our ongoing relationship with them.
13 Some observations from my team they
14 wanted me to share with you folks. It was clear to
15 us that a structured and a focussed response to a
16 major outbreak of the virus -- both of these
17 deployments we had were major outbreaks with
18 considerable infection rate and considerable
19 spread. It was clear that there were very little
20 proactive plans being actioned, and the response
21 that was in place was reactive and in some cases
22 somewhat chaotic.
23 Leadership that was not infected -- and
24 I say that in the case specifically of the
25 retirement home, all of the leadership became

1 infected except for one. But leadership that was
2 not infected and able to still be working was fully
3 engaged as frontline staff in an effort to provide
4 care to the residents and the occupants of the
5 facilities, leaving a very significant leadership
6 void.
7 There is a reliance on agency staff in
8 this sector that surprised us. We knew that there
9 was considerable agency relief utilized to augment
10 staffing, but we had no visibility at the time of
11 the outbreaks the depth and breadth of that.
12 And we don't believe that is conducive
13 to good resident care or even to a comprehensive
14 response during these outbreaks.
15 There are and there were very solid and
16 professional staff that attended from the agencies.
17 However, their commitment to the home and the
18 residents and to best practices at times was less
19 than optimal compared to the full-time staff of the
20 facility.
21 There were at times competing
22 perspectives at what was the right thing to do.
23 From hospital partners, public health partners, and
24 Ministry inspectors, all three groups were telling
25 the home what was right and what to do, and the

1 leadership at the facilities told us that they
2 often had to figure out how to satisfy all of us in
3 order to keep moving forward to be able to respond
4 to the outbreak.
5 And to kind of close my remarks, I will
6 say as well that I personally, having worked in the
7 home for two weeks, approximately two weeks, I
8 witnessed commitment, love, respect, and dedication
9 from the people who work in the long-term care and
10 retirement home sector that is tremendously
11 under-appreciated and undervalued in our health
12 care system.
13 The wage differential between what I
14 can offer staff at my hospital to care for
15 individuals waiting for long-term care and what the
16 facilities can offer staff to do similar or the
17 same work in the facility does, in my mind,
18 contribute to the recruitment challenges our
19 friends face, and we need to address that issue.
20 Our physician leaders, Dr. Andrea Steen
21 and Dr. Chevalier, who are respected physicians in
22 our community, who have had experience and deep
23 expertise with the long-term care and retirement
24 home sector during the outbreaks, have asked me to
25 share some thoughts, and these are their words.

1 Hôtel-Dieu Grace and Windsor Regional
2 Hospital physician leaders, in collaboration with
3 partners at Ontario Health, are working to close
4 some of the gaps that were found in long-term care
5 in our region during the outbreaks. The pandemic
6 created an association of partnership between the
7 hospitals and long-term care and brought all of us
8 in the hospital sector in for a closer glimpse of
9 the clinical issues in the homes.
10 The physicians in long-term care had
11 varying degrees of engagement in the homes. Some
12 made regular visits and others stayed away because
13 of fear or concerns around their personal health
14 and well-being. We could not find a real standard
15 of what was considered appropriate oversight, and
16 when a home went into outbreak, the care burden was
17 completely overwhelming for the physicians and
18 medical team.
19 Physicians have rosters of over 100
20 residents. With an outbreak as their reality, the
21 keeping up with the care was unmanageable,
22 completely unmanageable for them.
23 We found homes and physicians existed
24 in silos, often alone with no real support network
25 or relationships they could call on for help.

1 So our plan is to work towards creating
2 a long-term care council for the Windsor-Essex
3 area. The council will consist of Medical
4 Directors and Nurse Practitioners from the homes,
5 with acute and post-acute specialty groups like
6 geriatrics, palliative care, pharmacy, emerg and
7 hospitalists engaged.
8 The goal will be to create dialogue, an
9 education forum, to build relationships, and to
10 support palliation of residents within their homes
11 when appropriate.
12 The disconnection that they have seen
13 in long-term care has left medical staff struggling
14 to feel -- and feeling unable to reach out for help
15 during the crisis. This must be corrected. A hand
16 from the hospital sector has been and will be --
17 continue to be extended into support, connect,
18 engage, and improve accountability in this area of
19 the health care system. It is the opinion of our
20 physicians that this has been forgotten and the
21 pandemic will put a shine on the issues growing
22 quietly within our communities, and we all have a
23 responsibility to see it is not ignored going
24 forward.
25 I shortened up things to make time, and

1 happy to take any questions. Thank you very much
2 for your time and your attention and for all the
3 work that you are doing here. It is important
4 work, so thank you.
5 COMMISSION CHAIR FRANK MARROCCO: If I
6 could just ask, in terms of Hôtel-Dieu's
7 contribution, it is in essence voluntary?
8 JANICE KAFFER: Yes, sir, it was.
9 COMMISSION CHAIR FRANK MARROCCO: I am
10 not sure that is fully understood by people, that
11 the support that the hospitals offered long-term
12 care facilities during wave one and wave two was
13 voluntary as opposed to any other -- for any other
14 reason.
15 JANICE KAFFER: Yes, both of our
16 deployments, very significant deployments, with
17 significant commitments and extremely difficult
18 outbreaks to manage were done voluntarily and with
19 no order in place.
20 We have worked very hard to establish a
21 strong and positive partnership with these
22 facilities and that connection and that work in
23 wave one facilitated a really good opportunity to
24 work together in wave two.
25 COMMISSION CHAIR FRANK MARROCCO: Do

1 you think that that has to -- how does that
2 connection get established? I'm assuming in
3 Windsor the community understood the problems that
4 those two facilities were having because Windsor is
5 not that big a city and people -- the community
6 would get behind doing something.
7 But do you think these orders are a
8 useful starting point or not, the Management Order?
9 JANICE KAFFER: I think that there are
10 likely times - and I am sure that my colleagues
11 could speak to this as well - when an order is an
12 important piece of the tool kit to be able to move
13 forward with resolutions and support.
14 We were very fortunate to have an
15 opportunity to work collaboratively with Jamie
16 Schlegel and his team at the Village at St. Clair,
17 and with the leadership of the Mennonite community
18 in Kingsville, without requiring on an order.
19 I think in some ways, it really -- in
20 our mind, anyway, it was about the relationship
21 that we had established, the way in which we had
22 been working with them. We had the same set of
23 leaders engaged from wave one right through to wave
24 two in supporting the homes.
25 And our willingness to go in and

1 provide support with a very clear articulation that
2 the hospital wasn't there to take over. Our job
3 was to provide support, and in areas where we had
4 some expertise.
5 COMMISSION CHAIR FRANK MARROCCO: Thank
6 you.
7 LYNN MAHONEY: Can I just ask for a
8 clarification. You mentioned -- and I can't recall
9 what you called it, these councils, long-term
10 care --
11 JANICE KAFFER: Yes.
12 LYNN MAHONEY: How does that relate to
13 an Ontario Health team? Are you part of an Ontario
14 Health team? Do Ontario Health Teams exist where
15 you are? I think there is a bit of confusion as to
16 how many there already exists and --
17 JANICE KAFFER: Yes. So our
18 Windsor-Essex Ontario Health Team is still in
19 development. We have a couple of items that the
20 Ministry would like us to finish up with before
21 they actually decree that we are an OHT. For some
22 time I was the lead coordinating CEO for the OHT
23 application.
24 So this long-term care council is not
25 in competition with that. It actually is an idea

1 of the physicians to try and de-silo, for lack of a
2 better word. I don't think that is a word. But
3 de-silo the ways in which the docs are working.
4 So from -- to paraphrase the
5 conversation I had with Dr. Steen, hospital
6 physicians have a lot of supports. There is
7 medical advisory councils, committees. There is
8 medical quality. There are offices. There is
9 quality teams. All of those kinds of things that
10 support really good clinical practice in a hospital
11 setting, but in a long-term care facility, there is
12 very little support provided to the physicians.
13 And what Dr. Steen and her colleagues
14 are hoping to do is to provide a way for the
15 physicians to have better connecting into the
16 hospital, into the hospital expertise and supports,
17 to kind of de-silo - it is the best word I can
18 think of right now - the sector.
19 LYNN MAHONEY: Okay. So now I
20 understand the council idea.
21 And the Ontario Health Team for your
22 area, how is long-term care going to be fully
23 integrated into that?
24 JANICE KAFFER: They actually are part
25 of our leadership council, as well as we have well

1 over 40 partners in the Windsor-Essex area. We may
2 not be a big city, but we have lots of people in
3 terms of partners that wanted to be engaged in the
4 Ontario Health team development, and so long-term
5 care is at the table. They have a sector table,
6 and they are fully engaged in discussions. And
7 that actually was another enabler I think in many
8 ways for our ongoing relationships during wave one
9 into wave two across all three hospitals, that we
10 are all at the Ontario Health team table.
11 LYNN MAHONEY: So there is one table,
12 and there is different people at the table
13 because -- and maybe I misunderstood. I thought
14 you just said there is, like, a separate table for
15 long-term care in these Ontario Health teams?
16 JANICE KAFFER: Well, for ours --
17 because we are not fully developed yet, ours -- we
18 have a steering committee, and then representatives
19 of different sector tables are on the steering
20 committee. But we have our broader partnership
21 council where all signatory members are
22 participating. It is a complicated structure.
23 LYNN MAHONEY: It is a complicated
24 structure.
25 JANICE KAFFER: It is because -- we

1 will be trying to simplify it as we go forward
2 with -- the collaborative decision-making framework
3 and collaborative decision-making structures that
4 are recommended are in discussion in our OHT right
5 now.
6 I think the main point for this
7 Commission is that the long-term care providers are
8 fully engaged and are participants in the work that
9 is happening and have a voice at the table.
10 LYNN MAHONEY: And what about any that
11 might be a little not so enthusiastic about
12 participating in terms of the long-term care home?
13 How do you get them to the table, if there are any?
14 JANICE KAFFER: We haven't really
15 talked a lot about that. At this point, it is all
16 voluntary, and everybody who wanted to be part of
17 the OHT that was funded by the Ministry of Health
18 and Long-Term Care were able to join.
19 And we are still in the early days. We
20 haven't actually been decreed to be an OHT.
21 LYNN MAHONEY: Right.
22 JANICE KAFFER: The group that is more
23 outside right now are the retirement homes. Fewer
24 of those have signed up or are engaged in the work
25 of the OHT at this time. The majority of our

1 long-term care facilities, absolutely our two
2 municipally-owned facilities, as well as many of
3 our others are engaged through an existing
4 structure. It is called a Long-Term Care Council.
5 They have had that pre-existing, the Ontario Health
6 Team developments.
7 LYNN MAHONEY: Okay. So I think you
8 have said the majority but -- so do I assume from
9 that that not all of them are --
10 JANICE KAFFER: No, not all, because we
11 have two municipal homes which are part of the
12 council, and then there is what we call a "fog"
13 group. It is a long-term care administrators'
14 table, and they have been meeting for a very long
15 time, and everyone participates at that table.
16 LYNN MAHONEY: Okay. Thank you.
17 JANICE KAFFER: You are welcome.
18 ANTHONY DALE: Carmine, the challenge
19 is yours to run through as quickly as you can with
20 the attention to detail that this rightly deserves.
21 CARMINE STUMPO: Okay. Thank you very
22 much. Can you hear me okay?
23 LYNN MAHONEY: Yes.
24 COMMISSION CHAIR FRANK MARROCCO: Yes.
25 CARMINE STUMPO: Excellent.

1 So thank you for the opportunity,
2 Anthony, and thank you to the Commission for
3 sharing the Orillia and the OSMH story. I'm
4 Carmine Stumpo, President and CEO. What you see on
5 the slide deck is a quick summary of who we are as
6 an organization. We are -- it is an 180-bed acute
7 hospital serving Orillia and surrounding
8 municipalities. Why that is important? Our
9 community is about 40,000 individuals, and we serve
10 approximately another 40,000 in the more rural
11 areas surrounding Orillia.
12 What is relevant, we have a busy
13 emergency department that drives a lot of our
14 activity. We have some regional services, renal
15 programs, women and children, mental health,
16 surgical programs, and perhaps notable with the
17 previous discussion, we are an active participant
18 in the Couchiching Ontario Health Team. It was
19 approved in the first wave of Ontario Health Teams
20 and is very relevant in our work with the pandemic.
21 So over the past year, we have had a
22 variety of different experiences supporting other
23 institutions and settings, so I would say over 20
24 long-term care retirement home congregate settings
25 throughout the region.

1 So that is four long-term care homes
2 that we would consider local within our catchment
3 area. Similar to what you heard from Janice,
4 before we started in April, we created a Long-Term
5 Care Table in April, meeting every two weeks. The
6 key tasks were organizing the Directors of Care and
7 Medical Directors, facilitating primary care. We
8 have an incredibly organized and integrated primary
9 care model in Orillia, with single a fit Family
10 Health Team, with all the family doctors. There
11 are family doctors, there are hospitalists, there
12 are emergency physicians -- emergency room
13 physicians, and they also support the long-term
14 care facilities as well.
15 So we facilitated the organization of
16 both primary care physicians, pharmacies. We made
17 sure, through the leadership of the family doctor
18 leads, that every home had a direct contact for
19 unattached patients. They had backup systems in
20 place in case someone got sick.
21 We also, through the long-term care
22 homes, facilitated IPAC, infection prevention and
23 control reviews and supports to all the homes, and
24 in the second wave in particular we got very good
25 at deploying rapid testing. As a facility, we do

1 not have access to PCR testing for COVID-19. We
2 send it to Toronto. We needed an alternate
3 strategy, and we used the rapid testing in several
4 outbreak settings, not just for long-term care, for
5 other congregate settings, for other hospitals, in
6 fact to respond to outbreaks.
7 What I am going to speak about isn't
8 necessarily the work we have done within our OHT.
9 It is actually the work we did with Roberta Place
10 in Barrie, and I need to provide a bit of context
11 because it is a slightly different circumstance
12 here.
13 So Roberta Place, it has been highly
14 publicized. It was an absolutely profoundly tragic
15 event that we were involved with. It isn't one of
16 our regular long-term care facilities. It is
17 located in Barrie. So although we are familiar
18 with the operators, the Jarlette Group. They have
19 a home in Orillia. We were not familiar with this
20 home in particular, Roberta Place, nor with the
21 local leadership that was on-site.
22 So that created a new and interesting
23 opportunity for us.
24 So in this -- perhaps the timelines of
25 the outbreak. The outbreak was declared at Roberta

1 Place January 8th. OSMH was engaged on January
2 17th, so well into the outbreak. It was noted
3 early it was well into the exponential phase of the
4 outbreak. And it wasn't a Management Order.
5 Similarly, we saw the commitment of the management
6 team that were present. They were wanting to
7 support this home as best they could. We felt our
8 best role was the leadership agreement, and we
9 framed it as leadership coaching and mentoring.
10 And through that arrangement, we
11 initially -- we negotiated having a single senior
12 leadership as a point person on-site. That is what
13 we could have offered initially, with the
14 understanding that this was mid-January. Case
15 counts were increasing to the thousands in the
16 province per day. We were running our operating
17 rooms at 115, 120 percent. Our emergency
18 department was overflowing. We had opened up 20
19 percent additional capacity -- acute care capacity
20 within our facility.
21 So we were stretched at all levels. We
22 felt compelled that we wanted to do something, and
23 we agreed having that single leadership point
24 person. That quickly escalated as the concerns
25 escalated, and we had multiple leadership

1 individuals, myself included, taking on different
2 roles as defined by our IMS structure that we
3 implemented right away.
4 LYNN MAHONEY: Could I ask you -- could
5 I just interrupt you for a second, because this is
6 very helpful because we really haven't heard a lot
7 about the story of Roberta Place in this
8 Commission, although, as you have said, there has
9 been a lot of media reports.
10 So the outbreak was declared on January
11 8th, you say?
12 CARMINE STUMPO: Yes.
13 LYNN MAHONEY: How did Orillia
14 Soldiers' -- what do you -- OSMH. How did OSMH
15 become involved? Did the province reach out to
16 you? Did the Ministry of Health reach out to you?
17 How did you become involved?
18 CARMINE STUMPO: We became involved
19 through Public Health. So someone from the Public
20 District Health Unit came to us and asked for
21 support. We initially started with rapid testing
22 as a possible support, and then that quickly
23 escalated. Once we got in and we saw -- our team
24 at Soldiers', we have done this at other facilities
25 in terms of going in quickly. Day one, we, within

1 24 hours, did approximately 60 rapid tests on the
2 known negatives, the individuals that were
3 previously tested negative, and within hours, we
4 were getting back positivity rates of 95 percent.
5 LYNN MAHONEY: Wow.
6 CARMINE STUMPO: It was -- everyone we
7 tested came back positive, and we found that out on
8 day one.
9 So that is when the sinking feeling
10 came in, when you realize that you have essentially
11 an entire facility that is concurrently infected
12 with COVID-19. We didn't know it was the variant
13 at the time. And our goals shifted immediately
14 from -- there was no containing this anymore. We
15 had simple goals of managing the acute needs, which
16 some had already started, but we knew that more
17 were coming because we knew a certain percentage of
18 people would become acutely ill. We identified the
19 palliative needs that were already presenting but
20 we knew were going to come. And given the
21 infectivity, a key goal was to keep the staff safe
22 in an environment where anxiety -- we cannot
23 describe the level of anxiety when you see this
24 type of rapid spread. Everyone was concerned and
25 rightfully so.

1 And we soon found out that it was in
2 fact the UK variant B.1.1.7, and that provided a
3 little bit of -- it didn't make anything any
4 easier, but it provided a bit more understanding as
5 to why it was progressing the way it did.
6 LYNN MAHONEY: Do you have any -- did
7 your team make any observations? I understand you
8 went in there on January -- did you say January
9 15th?
10 CARMINE STUMPO: We were on-site on
11 January 18th.
12 LYNN MAHONEY: January 18th. So the
13 outbreak was declared on January 8th. You are
14 on-site January 18th. Do you know who or if
15 anybody was on-site prior to yourselves? What the
16 Public Health Unit was --
17 CARMINE STUMPO: Yes. There were
18 multiple agencies on-site. There was the area
19 hospital RVH, Royal Victoria. They were on-site.
20 Public Health was on-site. We started to see at
21 that point or soon -- around that time, the Red
22 Cross was being -- in the process of being called
23 in, and they had preliminary people coming on-site.
24 So there was a variety. Public Health
25 was on-site as well.

1 So we started to see the converging of
2 a variety of different partners coming together,
3 and when we realized the magnitude of the
4 infections, that was our goal, was to call everyone
5 we could think of.
6 No one had the capacity independently
7 to manage this outbreak. We called other
8 organizations, other Family Health Teams, the local
9 Barrie Family Health Team. We called every
10 professional association, agency, looking for not
11 just the regular basic needs of keeping people fed
12 and hydrated and what we call the core needs, but
13 also identifying the need for registered
14 professionals that can do the assessments.
15 So we worked very closely with the lead
16 physician in coordinating assembling a team of
17 family doctors, nurse practitioners, available
18 nurses, all coming from different directions trying
19 to integrate on the fly and support these
20 individuals.
21 We had Hospice Simcoe come in providing
22 excellent support for palliation. That was clearly
23 very direly required given the tragic 71 deaths
24 that occurred in this group, and the impact -- it
25 is not just the deaths. The impact on the

1 residents that remained, all the families, and the
2 staff, will continue for some time.
3 I think the post traumatic stress will
4 continue for some time from now because it was such
5 an intense -- it was so rapidly escalating, and
6 also rapidly decreasing. And the outbreak -- from
7 our involvement, we had a 30-day leadership
8 agreement and we knew -- by the time we left,
9 transition plans were in place. We were able to
10 leave knowing that the outbreak was soon declared
11 over.
12 So for us, the details of this
13 sequencing of events highlighted a couple of key
14 needs that we have taken back to our teams. Our
15 teams feel very strongly about a few key elements.
16 One, I can't overemphasize the need of
17 pre-existing relationships and integration. Our
18 Ontario Health Team did this work in Orillia, and
19 we see the value of it. Going into a different
20 area, a different region, you see the deficit of
21 not having the relationships, not being able to
22 pick up the phone and accelerate things, because
23 speed is absolutely critical.
24 So that relationship building was very
25 difficult to do in an accelerated manner in the

1 midst of a crisis. It needs to be done ahead of
2 time, and I strongly support the role of Ontario
3 Health Teams for that.
4 There is a role for a staged systematic
5 response so that early -- you have the first case.
6 How do you respond to that? How do you organize
7 the urgency quickly to get on top of outbreaks
8 before they expanded? I'm not sure, quite
9 honestly, Roberta Place could have been avoided.
10 That virus was so incredibly aggressive. By time
11 the first case was identified, quickly we were
12 getting cases 20 and 30 at a time of new positives
13 per wave of testing, which is such an accelerated
14 rate.
15 But that first step is the critical
16 piece because you only get one chance to do that,
17 and having a very clear mechanism of getting in,
18 doing the testing, and trying to contain, is
19 critical. We have seen some success where -- and
20 it is relationship-based. You get a positive test.
21 Somebody picks up the phone. You are there in
22 hours doing the testing. You get the results right
23 away, and you are able to contain outbreaks in
24 geographic areas of the home more effectively.
25 And we saw that with an outbreak we

1 worked on with Trillium Manor in Orillia. The
2 statistic our team takes pride in, we were able to
3 get results back before the outbreak was even
4 declared. We had testing in there on the notice of
5 the first positive, and by end of day, we had test
6 results back. And that is the kind of speed you
7 need to get in, and it needs to be organized
8 because you only get that one chance to respond to
9 early outbreaks.
10 LYNN MAHONEY: Can I ask you -- so we
11 have a heard a lot about the long testing
12 turnaround times and the devastating effect that
13 that had. So what you are saying is you were able
14 to test people and to get the results back, and is
15 it because of the rapid testing? Is that what you
16 are saying was --
17 CARMINE STUMPO: So the data is
18 evolving with rapid testing. So when we go in to
19 do -- at the time of these outbreaks, when we did
20 rapid testing, we had to do two tests, one for
21 rapid, one for PCR.
22 LYNN MAHONEY: Okay.
23 CARMINE STUMPO: And the rapid gave us
24 a very quick window snapshot, which we have now
25 learned to understand it is good enough. It is

1 accurate enough. It gives us a good sense of where
2 the problem lies.
3 And that is -- we have made that
4 recommendation to Ontario Health and the Ministry
5 of Health that the rapid tests -- and it is not any
6 rapid test. It needs to have the validity and the
7 reliability to be able to stand as a stand-alone
8 test. We found it gave us that immediate response
9 within hours, which isn't available in Orillia
10 right now.
11 So that is an important response. And
12 what we saw at Roberta Place is unique in a sense.
13 We needed full emergency support, bigger than any
14 one organization could provide, and when we are
15 busy on all fronts in wave two, every organization,
16 every hospital, has multiple competing priorities.
17 And that is where -- to be able to contain the
18 virus, to not have to transfer people out, to be
19 able to provide the acute care, the palliative
20 care, that requires an entire coordinated effort.
21 And I don't think it is reasonable to
22 expect any facility to have all that capacity on
23 standby. It needs to be a collective effort, and
24 it needs to be organized in a much larger way.
25 So that kind of staged tiered response

1 from a relationship pre-outbreak to immediate
2 response in outbreak to rapid escalation of full
3 emergency support in the throes of a devastating
4 outbreak, those are the staged kind of system
5 responses that we thought would be of benefit.
6 And the last point that our team felt
7 very strongly about is we need to move away --
8 there is a time and place for compliance, and sort
9 of that kind of compliance and punitive approaches
10 to standards setting, and I would encourage more of
11 a quality improvement approach.
12 First and foremost, people need to feel
13 comfortable to ask for help. This was beyond -- I
14 have the world of respect for all the staff at
15 Roberta Place, the leadership that worked
16 tirelessly to work through this tragedy, but we
17 need to create an environment where people don't
18 feel as though they'll be punished for asking for
19 help if they are unable to fulfil all the
20 requirements and move us from a checklist of
21 compliance to how do we continuously improve the
22 quality in the actual delivery, because we know --
23 we know there is so many human factors that affect
24 how these outbreaks continue to propagate, and we
25 need to be able to address those in a proper

1 quality improvement approach that assumes that
2 people are all -- which I think is a safe
3 assumption, that everyone is best intentioned.
4 They come to work to help and support and just need
5 that extra help to improve the quality of care.
6 So I realize we are a little bit short
7 on time, so I'll stop there, if there is any
8 additional questions that people may have?
9 COMMISSION CHAIR FRANK MARROCCO: Well,
10 I think we asked them as we went along.
11 CARMINE STUMPO: Okay. Thank you.
12 COMMISSION CHAIR FRANK MARROCCO: So I
13 don't think we have any questions.
14 Mr. Dale, is there someone else?
15 ANTHONY DALE: Yes, Commissioner, if it
16 is all right. I mean, I know we are at time.
17 If there is --
18 COMMISSION CHAIR FRANK MARROCCO: Well,
19 we are fine. We can go on for a little while
20 longer.
21 ANTHONY DALE: Okay. Well, I would
22 like to invite Sarah Downey, our Board Chair, to
23 make some kind of concluding comments just about
24 thematically the future and its potential. So
25 Sarah.

1 SARAH DOWNEY: Thanks, Anthony.
2 So Janice and Carmine have both
3 explained in exquisite detail the heroic efforts of
4 hospitals in helping out through this most recent
5 wave of the pandemic.
6 And so I think it is pretty clear that
7 we can't return to the place we were pre-pandemic,
8 and if it is not COVID we are dealing with, it is
9 influenza every year and other illnesses that
10 affect long-term care.
11 And that the conversation you are
12 initiating is long overdue, at many levels of our
13 province and our country.
14 And our approach to caring for frail,
15 older adults, we know how much more frail and how
16 much sicker they are in long-term care, really
17 requires a new and fresh approach to deal with the
18 levels of acuity, their cognitive impairments, and
19 their more complex care needs, and I would submit
20 that that doesn't mean, every time something starts
21 to go wrong, you transfer them out of their homes,
22 which is what these are, into a hospital that can
23 often exacerbate some of their conditions.
24 There is a strong correlation between
25 what goes on in long-term care and what goes on in

1 hospitals. Many people who are ALC, alternate
2 level of care, in hospitals are indeed awaiting
3 long-term care beds, and when we transfer people
4 from long-term care into hospitals, some of their
5 conditions change, making it hard to transfer them
6 back.
7 So a lot of the hallway health care
8 issues relate to the relationship between hospitals
9 and long-term care.
10 And we need a whole systems approach to
11 new models that focus on the needs of our frail and
12 aging population.
13 Next slide.
14 And while it is not our place obviously
15 to come up with recommendations, we did think of a
16 few themes that I am sure you are reflecting on in
17 addition to others, where we think there is
18 opportunity to reinforce in an ongoing way the
19 relationship between hospitals and long-term care.
20 The first is imagining some kind of a
21 partnership model that continues beyond what we
22 have seen over the last few waves and is perhaps
23 more consistent across the province.
24 Obviously, accountabilities need to be
25 worked out. It is maybe not easy for a

1 provincial-wide long-term care organization to have
2 partnerships across Ontario's 141 hospital
3 corporations, but this is where the ties and the
4 people are linked. And as Jan has said to me, you
5 know, their staff knew the names of many of the
6 people in the long-term care home they went into,
7 as did my organization, because they have been
8 patients before.
9 And so we do have to work out on a
10 local basis how we link long-term care homes to
11 local hospitals.
12 And we have certainly seen the benefit
13 of IPAC, infection prevention and control training
14 and supports that are offered through hospitals and
15 the long-term care to try to mitigate some of the
16 problems that existed.
17 Carmine mentioned the importance and
18 the value of quality improvement versus compliance
19 checking and punishment. You know, we should be
20 tracking standards together on falls, on infection
21 rates, on pressure ulcers, on antipsychotic use,
22 et cetera, et cetera. There is lots we could be
23 doing together.
24 We need a strategy that allows people
25 to age and be cared for in their homes to a greater

1 degree. Our own experience at Michael Garron has
2 been that different people on different shifts have
3 different tolerance levels for keeping people in
4 long-term care versus calling an ambulance to bring
5 them to the emergency department.
6 And, you know, with some clever tools
7 and people and links between our organizations, we
8 can do a lot in long-term care that provides a
9 better experience for the resident, the patient,
10 and the family, at a time of crisis.
11 Clearly the need for capital in our
12 long-term care homes is vital. Our own problems
13 were certainly in Class C and D homes, created far
14 more trouble than the better homes did, and many,
15 of course, can't wait to get out of long-term care.
16 It is not a profitable business, and may leave
17 cities like Toronto. So there is an issue across
18 our province creating and sustaining that capacity.
19 The need for improved and enhanced
20 medical oversight, perhaps medical advisory
21 committees, perhaps appointments for long-term care
22 people into hospitals, can help provide a linkage,
23 and continuing medical education and shared care
24 models across our systems.
25 And a comprehensive health human

1 resources strategy that allows for our system to be
2 better staffed between hospitals and long-term
3 care. A lot of people from hospitals went in to
4 work in long-term care when we could afford to do
5 that because they trusted the leaders that were
6 on-site to go work there. There is lots of HR and
7 labour issues that would need to be figured out.
8 I will tell you, as hospitals mount
9 mass vaccination efforts, the people we hire are
10 from long-term care and retirement homes. They are
11 tired. They are burned out. As Carmine said, they
12 are suffering from PTSD. They can't wait to get
13 out. And it breaks my heart to think of what we'll
14 do. We all have to expand. We all have expanded
15 capacity. And we still have a long road to get
16 through to the finish line, and my deep worry is
17 that we'll go through other waves because their
18 staff will either quit or go somewhere else to
19 work.
20 So we really do need some quick
21 solutions to make sure that these vital parts of
22 our system can stay as resilient as possible
23 through these final stages hopefully of this
24 pandemic.
25 So with that, those are our few

1 thoughts on themes on that we think would be
2 helpful in terms of recommendations from the
3 Commission.
4 COMMISSION CHAIR FRANK MARROCCO:
5 Commissioner Kitts?
6 COMMISSIONER JACK KITTS: Sarah, thank
7 you for that. It is very helpful.
8 I want to ask a question as to how
9 important are the Emergency Orders and the fact
10 that we worked under emergency conditions where
11 funding was freer than usual. The labour work
12 force was mobilized because of collective
13 bargaining or Collective Agreements were not in
14 place, and even leadership.
15 If we are going to sustain to what we
16 have today and not go back to status quo, how
17 important do you feel the legislation and other
18 orders have been in bringing this massive change
19 about?
20 SARAH DOWNEY: Well, I'll give my two
21 cents' worth, and others may have other views.
22 I think it certainly helped to expedite
23 it, but I will tell you, in my own organization,
24 people felt better going into work in long-term
25 care when they knew that our IPAC people were there

1 beside them and guiding them and many of our best
2 leaders were out there asking them to go and stood
3 beside them as they went.
4 And so I think we did all this because
5 there was a crisis for sure, but in the end, people
6 made choices based on relationships and trust as
7 well.
8 ANTHONY DALE: David, would you mind
9 commenting, David Brook?
10 DAVID BROOK: Certainly. So, I mean,
11 when you are in the midst of the crisis, it was
12 definitely an unprecedented situation that required
13 unprecedented interventions, and I think it is
14 clear the fragility of the workforce, the
15 expertise, and some of the supports that could come
16 from hospitals, was necessary. And this was a way
17 to do it at a point in time when speed really was
18 critical.
19 I think it is unprecedented to --
20 something in terms of collective bargaining
21 relationships, to suspend the nature of that, and
22 it is a difficult thing to think about in the
23 longer term given the sanctity of those
24 arrangements and the instability it creates.
25 I think what this really does

1 demonstrate is how interdependent everything is,
2 and what are some ways in a more go-forward way
3 outside of the confines of a -- you know, the
4 crisis can we recognize the interdependency, the
5 need for agility, the need for integration, but it
6 also, you know, respected there is collective
7 bargain relationships in place. People need to go
8 in understanding what their role is and how can we
9 do something a little bit more proactive go
10 forward.
11 I think it shows all those elements to
12 be very important and really how can you look at it
13 going forward in a way that gets some greater
14 stability and is really more sustainable going
15 forward.
16 COMMISSIONER JACK KITTS: Do you think
17 that going forward that the Ontario Health Teams
18 will be the vehicle upon which legislation and
19 other things are changed to enable the teams to
20 work as well as we have during the emergency?
21 ANTHONY DALE: Well, I think if I could
22 say that -- I think you can hear from the members
23 there is -- and not just Jan and Sarah and Carmine,
24 but members across Ontario at the OHA, that there
25 is a lot of excitement about the potential, the

1 concept of Ontario Health Teams, but they are still
2 such nascent concepts really.
3 And the pandemic has kind of
4 demonstrated to us what happens when you focus
5 directly on the needs of patients and residents and
6 the conditions allow the lifting of barriers, and
7 there are lessons there.
8 And in a post-pandemic world - you
9 know, certainly the OHA is in the midst of
10 extensive consultations with its members thinking
11 about the post-pandemic world - we cannot go back
12 to the siloed approach of the past. We just can't.
13 So working together with our colleagues
14 across the health care continuum, partners in
15 organized labour, we do feel it is time to build on
16 the Ontario Health Team model, Jack, and at the
17 same time significantly accelerate, establish the
18 policy, the incentives and so on, that will rapidly
19 accelerate integration of health services. Not of
20 organizations, but health services. That is the
21 key.
22 COMMISSIONER JACK KITTS: Great. Thank
23 you.
24 COMMISSION CHAIR FRANK MARROCCO: Ms.
25 Downey, if I can just ask, one of your

1 considerations for the future is the enhancement of
2 medical oversight.
3 Do you think there is a role for
4 hospitals in determining whether the -- that the
5 Medical Director has the appropriate skills and
6 background to be the Medical Director in a
7 long-term care facility?
8 You know, in professions, people have
9 different areas of expertise. A person who is
10 trained as a lawyer can close your condominium
11 purchase and appear in a patent action contesting
12 the validity of a patent, but it would be very
13 unwise for a lawyer who does condominium closings
14 to take on a patent case.
15 Is there a role in determining whether
16 the Medical Director has the requisite skills and
17 training to have that position?
18 SARAH DOWNEY: Well, I mean, there are
19 many medical specialties, and in fact, I would say
20 there is many medical specialties required to take
21 care of people who are aging and have cognitive
22 behavioural issues and are fragile, many of whom
23 have been hospital patients as well.
24 The other thing the hospitals do, they
25 appoint a lot of Medical Directors, right, of, you

1 know, neuroscience programs or radiology programs
2 or family medicine, and they often have many large
3 family practice departments that, you know, are
4 often the frontline staff.
5 Ultimately, it is to whom is the
6 Medical Director accountable, and so that is to
7 the -- I guess the leader of the long-term care
8 home and to the corporation maybe that the
9 long-term care home is in.
10 But I do think that some partnership
11 and tie to the hospital to have greater access to
12 some of the medical specialties, be they geriatric
13 or psychiatry or geriatric psychiatry and primary
14 care, might be a helpful model, including
15 partnership maybe on a medical advisory committee
16 of a hospital, so that I'm not sure what kind of
17 professional organization or bounds around Medical
18 Directors in long-term care, but there is a lot in
19 hospitals that may provide a group of peers for
20 somebody to work with and benefit from an
21 organization like a hospital in terms of continuing
22 medical education, access to residents, all the
23 things that hospitals do.
24 COMMISSION CHAIR FRANK MARROCCO: Yes,
25 what occurred to me was, in the area of palliative

1 care, it would seem to me that, you know, as a
2 person who is not a doctor, obviously, that that
3 would be a skill that a person would need if you
4 were going to be the Medical Director of a facility
5 in which, you know, the average life expectancy of
6 the people who are there, the median is like 12 to
7 18 months. That is what prompted the question, and
8 how do you ensure then that those skills are there
9 before the person becomes the Medical Director.
10 In any event, I appreciate the answer.
11 SARAH DOWNEY: Thanks.
12 COMMISSION CHAIR FRANK MARROCCO: So I
13 don't think we have any further questions,
14 Mr. Dale, assuming you are leading the group, which
15 is why I keep directing us back to you.
16 So I think we have asked the questions
17 as we went along.
18 ANTHONY DALE: Excellent. Well, we are
19 grateful for the invitation, Commissioner Marrocco,
20 and grateful for the work of the Commission and you
21 and your colleagues and the staff, and we are at
22 your disposal as you proceed and you complete your
23 final report, and we look forward to reviewing it
24 when it is ready.
25 COMMISSION CHAIR FRANK MARROCCO: Well,

1 you know, I think the thanks should go the other
2 way really. We have been wrestling with how did we
3 do in wave one. How did we do in wave two.
4 Perhaps why didn't we do better.
5 And we have been trying to figure
6 out -- we think the partnerships are important,
7 but, you know, it is important to hear from the
8 hospitals because these partnerships invariably
9 impact the hospitals.
10 And so it is very helpful to hear from
11 the association and get a sense of where you are
12 at. It is very helpful to us.
13 So on behalf of the Commission, we
14 thank all of you for taking the time. I guess,
15 Ms. Downey, you were here before. We aren't going
16 away any time soon.
17 But thank you, all of you, for the
18 assistance.
19 ANTHONY DALE: Best wishes to all of
20 you. Bye for now.
21 COMMISSIONER JACK KITTS: Thanks,
22 everyone.
23 COMMISSIONER ANGELA COKE: Thank you.
24
25 -- Adjourned at 11:50 a.m.

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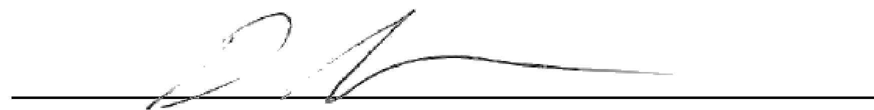
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WORD INDEX

< 1 >
10:30 1:16 4:1
100 32:19
10th 6:10
11 24:8
11:50 1:16 67:25
115 44:17
11th 6:15
12 66:6
120 44:17
1200 23:20
132 23:21, 24
13th 6:23
141 27:5 57:2
150 9:21
15th 47:9
16th 28:9
177 27:3
17th 44:2
18 66:7
180-bed 41:6
18th 47:11, 12, 14
1st 1:15 68:16

< 2 >
20 41:23 44:18 50:12
2000s 19:3
2021 1:16 68:16
23 28:11
23rd 25:21 26:5
24 46:1
25th 26:21
26th 28:6
28 10:6
29th 7:24 14:19

< 3 >
30 50:12
30-day 49:7
318 27:1
38 23:24
3rd 7:10

< 4 >
4 28:11
40 38:1
40,000 41:9, 10

< 5 >
50 27:22, 23
53 9:20
5th 4:14 29:9

< 6 >
60 9:22 46:1
63 27:3
66 28:11

< 7 >
71 9:13, 20 48:23
73 28:12

< 8 >
89 28:10
8th 24:5 28:16 44:1 45:11 47:13

< 9 >
95 46:4
96 28:1

< A >
a.m 1:16 4:1 67:25
Absolutely 11:3 13:5 40:1 43:14 49:23
absorbed 16:14
accelerate 49:22 63:17, 19
accelerated 49:25 50:13
accelerating 14:23
access 43:1 65:11, 22
accommodation 27:24
accountabilities 56:24
accountability 15:12 33:18
accountable 65:6
accurate 52:1
act 8:25
acting 15:3
action 7:23 24:25 64:11
actioned 29:20
actions 6:12
active 41:17
activity 41:14
actual 10:25 28:20 53:22
acuity 55:18
acute 7:13 17:19 33:5 41:6 44:19 46:15 52:19
acutely 46:18
add 5:25
added 23:18
addictions 23:6
addition 8:22 26:10 56:17
additional 7:23 20:23 23:17 44:19 54:8
Additionally 27:8
address 31:19 53:25
Adjourned 67:25
administration 26:6
administrators 40:13
Adriana 3:10
adults 55:15
advance 28:20
advice 16:18
advisory 37:7 58:20 65:15
Affairs 2:11
affect 53:23 55:10
afford 59:4
age 57:25
agencies 30:16 47:18
agency 23:11 30:7, 9 48:10
aggregate 11:14
aggressive 50:10
agility 62:5
aging 56:12 64:21
agonizing 9:1
agreed 25:22 44:23
Agreement 25:21 28:16, 20 44:8 49:8
Agreements 60:13
agri-food 22:24
ahead 22:4 50:1
Alain 3:8
ALC 56:1
Alison 2:25
allow 63:6
allows 15:17 57:24 59:1
alluded 11:17
ally 13:12
alternate 43:2 56:1
amazing 22:13
ambulance 58:4
Analyst 3:10, 12
ancillary 16:15
Andrea 26:14 31:20
Angela 2:3 3:12 67:23
Angus 19:10
answers 14:12
Anthony 2:8 4:7 5:6, 11 10:11 11:3, 17 12:21, 25 14:15 15:24 17:14 18:21 20:5 21:7 22:5 40:18 41:2 54:15, 21 55:1 61:8 62:21 66:18 67:19
Anthony's 12:15
anticipate 16:19 17:1, 19
anticipation 7:13
antipsychotic 57:21
anxiety 46:22, 23
anybody 47:15
anymore 46:14
anyway 35:20
apologize 4:20
appear 64:11
appendices 11:7
application 36:23
appoint 64:25
appointed 15:11
appointments 58:21
appreciate 66:10
approach 53:11 54:1 55:14, 17 56:10 63:12
approaches 53:9
appropriate 7:13 15:23 17:18 32:15 33:11 64:5
approved 41:19
approximately 26:24 31:7 41:10 46:1
April 6:10 21:9 24:9 42:4, 5
area 33:3, 18 37:22 38:1 42:3 47:18 49:20 65:25
areas 23:6 25:25 36:3 41:11 50:24 64:9
arrangement 44:10
arrangements 12:20 61:24
articulation 36:1
asked 5:24 6:6 11:9 17:17 31:24 45:20 54:10 66:16
asking 6:25 53:18 61:2
assembling 48:16
assess 12:17
assessment 7:12 8:23 14:19 15:2
assessments 26:17 48:14
assist 25:5, 15 26:11
assistance 9:7 67:18
Assistant 2:25
associated 28:10, 13
ASSOCIATION 2:7, 9, 11, 13, 16

4:11 5:13 32:6 48:10 67:11
associations 7:19
assume 40:8
assumes 54:1
assuming 35:2 66:14
assumption 54:3
attempting 17:19
attended 30:16
attending 1:15
attention 19:12 34:2 40:20
attributed 27:1
augment 30:9
Augustine 22:17 27:12
available 48:17 52:9
average 9:25 66:5
avoided 50:9
awaiting 56:2

< B >
B.1.1.7 47:2
back 5:10 15:4 16:11 18:3 19:13 46:4, 7 49:14 51:3, 6, 14 56:6 60:16 63:11 66:15
background 64:6
backup 42:19
bargain 62:7
bargaining 60:13 61:20
Barrie 43:10, 17 48:9
barriers 63:6
based 11:15 61:6
basic 48:11
basis 9:23 15:2 21:23 57:10
beds 23:9 27:23 56:3
began 24:9, 15
beginning 21:8 22:23 24:8 26:5 28:21
begun 28:18
behalf 67:13
behavioural 28:3 64:22
believe 4:14, 21 13:21 15:20 21:4 30:12
benefit 19:14 53:5 57:12 65:20
best 6:2 9:5 12:17 14:11 20:12 30:18 37:17 44:7, 8 54:3 61:1 67:19
better 9:11 37:2, 15 58:9, 14 59:2 60:24 67:4
Bianchi 3:2
big 35:5 38:2
bigger 52:13
bit 23:3 36:15 43:10 47:3, 4 54:6 62:9
Board 5:22 9:2 27:21 54:22
bounds 65:17
Boxing 28:6
breadth 9:18 30:11
breaks 59:13
briefed 7:10 17:16
briefing 8:1
briefly 6:8 13:19
bring 58:4
bringing 60:18
broad 14:25
broader 38:20
Brook 2:14 5:14 61:9, 10
brought 32:7
Brown 8:8
build 33:9 63:15
building 29:1 49:24
burden 32:16
burned 59:11
business 58:16
busy 41:12 52:15
Bye 67:20

< C >
Cabinet 21:1
call 32:25 40:12 48:4, 12
called 36:9 40:4 47:22 48:7, 9
calling 24:22, 24 58:4
Canada 20:7
cancel 8:20
capacity 7:11 8:18 44:19 48:6 52:22 58:18 59:15
capital 58:11
CARE 1:7 3:1, 2, 4, 7, 8, 11, 13 4:17, 19 6:13, 20 7:14, 15, 18, 19, 21, 25 8:7, 9, 15 9:10, 20 10:7, 21 12:8 13:5, 8, 22, 25 14:18, 20 16:24 17:19, 21 18:10, 15, 24 19:5, 6, 7, 13, 22 20:2 22:25 23:9, 22, 24, 25 24:13 25:6, 16, 19, 23 26:2, 12 27:13, 16 30:4, 13 31:9, 12, 14, 15, 23 32:4, 7, 10, 16, 21 33:2, 6, 13, 19 34:12 36:10, 24 37:11, 22 38:5, 15 39:7, 12, 18 40:1, 4, 13 41:24 42:1, 5, 6, 7, 9, 14, 16, 21 43:4, 16 44:19 52:19, 20 54:5 55:10, 16, 19, 25 56:2, 3, 4, 7, 9, 19 57:1, 6, 10, 15 58:4, 8, 12, 15, 21, 23 59:3, 4, 10 60:25 63:14 64:7, 21 65:7, 9, 14, 18 66:1
cared 57:25
caring 8:18 55:14
Carlton 2:10 5:14
Carmine 2:21 5:19 6:1 13:19 40:18, 21, 25 41:4 45:12, 18 46:6 47:10, 17 51:17, 23 54:11 55:2 57:17 59:11 62:23
carving 19:14
case 29:24 42:20 44:14 50:5, 11 64:14
Cases 24:19 27:1, 6 28:10 29:21 50:12
catastrophic 24:18
catchment 42:2
centralization 21:11
centres 8:23
cents 60:21
CEO 2:8, 17, 19, 21 5:12, 18, 19, 21 22:10 24:2 36:22 41:4
certain 46:17
certainly 9:18 16:21 17:18 19:11 57:12 58:13 60:22 61:10 63:9
certainty 14:11
CERTIFICATE 68:1
Certified 68:4
certify 68:4
cetera 57:22
Chair 2:2 5:22 17:10 18:5 19:25 20:19 21:15 22:3 34:5, 9, 25 36:5 40:24 54:9, 12, 18, 22 60:4 63:24 65:24
66:12, 25
challenge 40:18
challenges 8:18 9:8 28:4 31:18
chance 50:16 51:8
change 56:5 60:18
changed 19:3 62:19
changing 20:16
chaotic 29:22
checking 57:19
checklist 53:20
Chevalier 26:15 31:21
Chief 2:15 21:2 26:13, 15
child 23:11
children 41:15
Choconta 3:10
choices 61:6
Church 27:20
circumstance 43:11
cities 58:17
City 23:2 35:5 38:2
Clair 22:15 24:5, 15 25:3 26:9 27:5 28:7 35:16
clarification 36:8
Class 58:13
clear 25:9 29:14, 19 36:1 50:17 55:6 61:14
clearly 13:6 48:22 58:11
clever 58:6
clinical 26:11 29:2 32:9 37:10
clinics 23:10
clock 16:11
close 29:11 31:5 32:3 64:10
closely 48:15
closer 32:8
closing 15:14
closings 64:13
coaching 44:9
cognitive 55:18

64:21
Coke 2:3 67:23
collaboration 25:13 32:2
collaborative 39:2, 3
collaboratively 35:15
colleague 7:19
colleagues 5:14 14:18 16:23 35:10 37:13 63:13 66:21
collective 7:20 24:10 52:23 60:12, 13 61:20 62:6
come 8:12 46:20 48:21 54:4 56:15 61:15
comes 8:16 13:16 16:7
comfortable 53:13
coming 46:17 47:23 48:2, 18
command 15:11 21:10
commander 15:12
commencing 4:1
comment 14:5 15:5
commenting 61:9
comments 4:15, 21 13:2 14:6 22:6 54:23
COMMISSION 1:7 2:2 3:1, 3, 5, 7, 8, 11, 13 5:10 6:5 11:25 15:15 17:10 18:5 19:25 20:19 22:3 34:5, 9, 25 36:5 39:7 40:24 41:2 45:8 54:9, 12, 18 60:3, 4 63:24 65:24 66:12, 20, 25 67:13
Commissioner 2:3, 4 18:4, 22 54:15 60:5, 6 62:16 63:22 66:19 67:21, 23
Commissioners 4:3, 9, 25 5:9 13:3 22:9
commitment 30:17 31:8 44:5
commitments 34:17
committed 19:20
committee 38:18, 20 65:15
committees 37:7 58:21
common 10:3
communications 25:25
communities 33:22
community 14:23 22:23 24:22, 25 25:8 27:19, 21 31:22 35:3, 5, 17 41:9
community-based 23:10
COMPANY 68:22
compared 30:19
compelled 44:22
competencies 21:18
competing 9:3 30:21 52:16
competition 36:25
complete 66:22
completed 9:13
completely 32:17, 22
complex 14:25 55:19
compliance 53:8, 9, 21 57:18
complicated 38:22, 23
component 17:21 19:6
comprehensive 6:16 30:13
58:25
concept 63:1
concepts 63:2
concern 7:20 18:7
concerned 46:24
concerns 32:13 44:24
conclude 13:1, 20
concluding 14:6 15:20 54:23
concurrently 10:1 46:11
conditions 55:23 56:5 60:10 63:6
condominium 64:10, 13
conducive 30:12
conduct 26:16
conducted 9:11
conference 7:4
confines 62:3
confirmed 27:1
confounding 19:24
confusion 36:15
congregate 41:24 43:5
connect 33:17
connecting 37:15
connection 34:22 35:2
consider 42:2
considerable 29:18 30:9
considerably 16:7
considerations 64:1
considered 32:15
consist 33:3
consistent 56:23
consultations 63:10
consulting 14:18
contact 29:11 42:18
contain 50:18, 23 52:17
containing 46:14
contesting 64:11
context 43:10
contingency 7:1, 15 17:17
continue 33:17 49:2, 4 53:24
continued 7:7 26:20
continues 9:9 14:20 56:21
continuing 58:23 65:21
continuously 53:21
continuum 63:14
contribute 31:18
contribution 34:7
control 10:2 25:10 26:2 29:2 42:23 57:13
conventional 21:19
converging 48:1
conversation 37:5 55:11
coordinated 15:16 52:20
coordinating 36:22 48:16
core 48:12
corporate 25:4
corporation 25:5 65:8
corporations 9:14 57:3
Correct 10:18, 22 14:9 68:12
corrected 33:15
correlation 55:24
corresponding 11:9
Couchiching 41:18
council 33:2, 3 36:24 37:20, 25 38:21 40:4, 12
councils 36:9 37:7
Counsel 3:2, 14, 15
country 55:13
counts 44:15
County 25:14 27:2, 24
couple 36:19 49:13
course 7:7 11:25 18:7 23:23 58:15
COVID 55:8
COVID-19 1:7 8:24 23:16 27:6 29:3 43:1 46:12
COVID-positive 26:17 27:1
create 20:1 33:8 53:17
created 18:2 32:6 42:4 43:22 58:13
creates 61:24
creating 18:23 33:1 58:18
creation 7:2
crisis 33:15 50:1 58:10 61:5, 11 62:4
critical 19:6 49:23 50:15, 19 61:18
Cross 47:22
CRR 68:3, 23
CSR 68:4, 23
current 22:25

< D >
Dale 2:8 4:7 5:6, 12 10:11 11:3 12:25 14:15 15:24 17:14 18:19, 21 20:5 21:7 22:4, 5 40:18 54:14, 15, 21 61:8 62:21 66:14, 18 67:19
Daoust 3:8
data 51:17
Dated 68:16

David 2:14 5:14 61:8, 9, 10
Dawn 3:6
day 1:15 7:5 8:1 14:1 19:21 28:6 44:16 45:25 46:8 51:5 68:16
days 39:19
day-to-day 21:22
deal 55:17
dealing 20:2 23:15 55:8
Deana 3:19 68:3, 23
death 6:13 24:20
deaths 8:9 28:12 48:23, 25
December 24:5 25:21 28:6
decision 6:24
decision-making 21:12, 23 39:2, 3
decisions 9:2
deck 4:21 41:5
declared 24:6, 14 28:5 43:25 45:10 47:13 49:10 51:4
decreasing 49:6
decree 36:21
decreed 39:20
dedication 31:8
deep 31:22 59:16
deepen 9:9
deepened 24:16
deficit 49:20
defined 45:2
definitely 61:12
degree 58:1
degrees 32:11
delivery 21:17 53:22
Demographically 23:20
demonstrate 62:1
demonstrated 63:4
department 41:13 44:18 58:5
departments 65:3
deployed 23:19, 22, 24 25:4 26:7, 10 27:9 28:7, 20 29:6
deploying 42:25
deployment 22:25 23:13 27:10, 11 28:17
deployments 29:17 34:16
depth 9:18 30:11
Deputy 2:25 19:9
Derek 3:4
describe 46:23
deserve 14:1
deserves 40:20
de-silo 37:1, 3, 17
despite 8:5 9:8
detail 14:3 40:20 55:3
detailed 11:6
details 12:7 49:12
determined 8:20
determining 64:4, 15
devastating 51:12 53:3
develop 6:20
developed 14:22 27:15 38:17
development 36:19 38:4
developments 40:6
dialogue 33:8
Diaz 3:10
different 19:12 21:11 38:12, 19 41:22 43:11 45:1 48:2, 18 49:19, 20 58:2, 3 64:9
differential 31:13
difficult 9:1 20:12 34:17 49:25 61:22
direct 42:18
directing 66:15
directions 48:18
directly 63:5
Director 2:12 3:4, 6 13:13 27:20 64:5, 6, 16 65:6 66:4, 9
Directors 5:22 33:4 42:6, 7 64:25 65:18
direly 48:23
disconnection 33:12
discontinued 29:9
discussion 39:4 41:17
discussions 25:11, 18 38:6
diseases 29:1
disposal 66:22
District 45:20
divided 11:15
docs 37:3
doctor 42:17 66:2
doctors 42:10, 11 48:17
documentation 16:15
doing 34:3 35:6 50:18, 22 57:23
doubt 20:13
Downey 2:17 5:21 54:22 55:1 60:20 63:25 64:18 66:11 67:15
dozen 12:23
draft 7:11
drives 41:13
Drummond 2:25
duration 11:17 12:15 16:21
dynamic 19:17 20:16

< E >
earlier 18:6
earliest 15:18
early 16:12 17:17 19:3 21:9 39:19 44:3 50:5 51:9
easier 47:4
East 2:17
easy 56:25
echos 14:8
education 26:3 33:9 58:23 65:22
effect 51:12
effective 7:13 16:16 25:21
effectively 50:24
effort 19:23 30:3 52:20, 23
efforts 6:21 8:5 20:12 55:3 59:9
elected 20:8
elective 8:20
elements 49:15 62:11
Elizabeth 2:10 5:14
Elliott 19:9
emerg 33:6
Emergencies 13:13
emergency 13:16 16:2 20:15 21:16 41:13 42:12 44:17 52:13 53:3 58:5 60:9, 10 62:20
emphasize 19:5
employee 27:6
employees 23:21 27:8
EMS 29:4
enable 62:19
enabler 38:7
encourage 53:10
encouraged 7:22
enemy 13:11, 15
engage 33:18
engaged 22:22 24:17 25:18 30:3 33:7 35:23 38:3, 6 39:8, 24 40:3 44:1
engagement 32:11
enhanced 58:19
enhancement 64:1
ensure 7:1 13:22 66:8
entered 28:15
entering 25:20
enthusiastic 39:11
entire 10:10 46:11 52:20
environment 46:22 53:17
escalated 44:24, 25 45:23
escalating 49:5
escalation 15:18 53:2
especially 8:19
essence 20:1 34:7
essentially 46:10
Essex 27:25
establish 34:20 63:17
established 26:19 35:2, 21
event 18:17 43:15 66:10
events 6:6 16:8 20:15 49:13
eventually 29:8
everybody 18:10, 12 39:16
evolving 51:18
exacerbate 55:23
example 11:23, 25 12:6
exceeded 8:10
Excellent 40:25 48:22 66:18
excitement 62:25
execution 17:12
Executive 13:13
exhausted 17:5
exist 36:14
existed 32:23 57:16

existing 12:19 40:3
exists 36:16
expand 59:14
expanded 50:8 59:14
expect 52:22
expectancy 66:5
expectation 21:8
expedite 60:22
experience 6:3 14:15 15:25 16:5, 17 21:3 22:7 31:22 58:1, 9
experienced 8:17 21:16
experiences 22:18 24:22 41:22
expertise 31:23 36:4 37:16 61:15 64:9
experts 16:18
explained 55:3
exponential 44:3
exquisite 55:3
extended 33:17
extensive 63:10
extent 9:17 10:16 12:5
extra 54:5
extremely 8:25 23:16 34:17
eyes 17:15

< F >
face 31:19
facilitated 34:23 42:15, 22
facilitating 42:7
facilities 6:14 23:14 24:13 29:11 30:5 31:1, 16 34:12, 22 35:4 40:1, 2 42:14 43:16 45:24
facility 23:16 24:18 25:2, 7, 16 27:14, 16 30:20 31:17 37:11 42:25 44:20 46:11 52:22 64:7 66:4
fact 43:6 47:2 60:9 64:19
factor 14:16 19:24 21:5
factors 53:23
fall 7:12 10:14
falls 57:20
familiar 43:17, 19
families 24:25 25:8 49:1
family 24:21 26:1, 15 28:23 42:9, 10, 11, 17 48:8, 9, 17 58:10 65:2, 3
fear 32:13
February 26:21 28:9 29:9
fed 48:11
feel 18:16 33:14 49:15 53:12, 18 60:17 63:15
feeling 33:14 46:9
felt 44:7, 22 53:6 60:24
Fewer 39:23
figure 31:2 67:5
figured 59:7
figuring 18:13
filled 9:14
final 59:23 66:23
find 32:14
fine 54:19
finger 17:15
finish 36:20 59:16
Finley 3:15
fit 42:9
fix 16:25
fly 48:19
focus 23:6 56:11 63:4
focussed 20:10 29:15
fog 40:12
folks 29:14
followed 7:17
following 7:4
follow-up 14:5
force 60:12
Ford 6:12, 16
foregoing 68:5, 11
foremost 53:12
forget 18:14
forgot 18:10
forgotten 33:20
formalized 15:11
forth 68:7
fortunate 35:14
forum 33:9
forward 31:3 33:24 35:13 39:1 62:10, 13, 15, 17 66:23
found 32:4, 23 46:7 47:1 52:8
four-week 28:17
fragile 64:22
fragility 61:14
frail 13:24 55:14, 15 56:11
frame 12:16
framed 44:9
framework 39:2
Frank 2:2 17:10 18:5 19:25 20:19 22:3 34:5, 9, 25 36:5 40:24 54:9, 12, 18 60:4 63:24 65:24 66:12, 25
frankly 14:14
freer 60:11
fresh 55:17
friends 31:19
frontline 25:6 26:11 30:3 65:4
fronts 52:15
fulfil 53:19
full 9:17 52:13 53:2
Fullerton 19:9
full-time 30:19
fully 24:17 30:2 34:10 37:22 38:6, 17 39:8
fundamentals 8:2 14:21
funded 39:17
funding 60:11
future 6:18 13:23, 24 19:17 54:24 64:1

< G >
gaps 32:4
Garron 5:21 58:1
general 25:8
geographic 50:24
geriatric 65:12, 13
geriatrics 33:6
give 4:21 6:6 13:24 60:20
given 6:2 12:16 20:6 46:20 48:23 61:23
gives 52:1
giving 22:12
glimpse 32:8
goal 33:8 46:21 48:4
goals 46:13, 15
go-forward 62:2
good 13:7, 15 17:12 18:16 30:13 34:23 37:10 42:24 51:25 52:1
government 7:8, 24 13:8 16:1, 3, 22 17:25 19:15 20:6, 7 21:5, 22, 23 24:23
governments 19:11 20:5
government's 6:24
Gowling 3:14, 15
Grace 2:19 5:18 22:11, 14 24:6 27:9 32:1
grateful 66:19, 20
Great 63:22
greater 57:25 62:13 65:11
group 24:10 39:22 40:13 43:18 48:24 65:19 66:14
groups 30:24 33:5
growing 7:20 14:23 33:21
guess 18:1 65:7 67:14
guide 16:20
guided 27:21
guiding 61:1

< H >
half 9:13 10:5
hallway 56:7
hammered 18:13
hand 5:1 33:15
happened 15:21 18:8
happening 18:16 39:9
happens 63:4
happy 18:20 34:1
hard 17:6 20:14 34:20 56:5
harm 6:12
head 14:8
Health 2:17 6:20 7:2, 11, 19 19:4, 7 21:3, 16 23:6, 11 25:14, 19 27:2 28:3, 5 30:23 31:11 32:3, 13 33:19 36:13, 14, 18 37:21 38:4, 10, 15 39:17 40:5 41:15, 18, 19 42:10 45:16, 19, 20 47:16, 20, 24 48:8, 9 49:18 50:3 52:4, 5 56:7 58:25 62:17 63:1, 14, 16, 19, 20
Healthcare 2:20 5:18 22:11 24:7 27:9
hear 18:20 40:22 62:22 67:7, 10
heard 9:1 11:24 20:3 42:3 45:6 51:11
hearing 25:1

heart 17:8 59:13
heightened 20:17
Held 1:14
Helen 19:10
help 13:22 32:25 33:14 53:13, 19 54:4, 5 58:22
helped 60:22
helpful 45:6 60:2, 7 65:14 67:10, 12
helping 55:4
heroic 55:3
HHR 25:11
high 13:25 22:20 25:11
high-level 13:21
highlighted 49:13
highly 43:13
hindsight 19:14
hire 59:9
hit 22:20
home 12:8 22:16 24:7, 13 25:12 26:23, 25 27:12, 17, 18, 22, 23 28:13 29:25 30:17, 25 31:7, 10, 24 32:16 39:12 41:24 42:18 43:19, 20 44:7 50:24 57:6 65:8, 9
homeless 23:1
homes 4:17, 19 8:11 9:21 10:5, 21 24:1 32:9, 11, 23 33:4, 10 35:24 39:23 40:11 42:1, 22, 23 55:21 57:10, 25 58:12, 13, 14 59:10
honestly 18:21, 24 50:9
Honourable 2:2
hope 16:6
hopefully 59:23
hoping 37:14
horizons 16:8
Hospice 48:21
HOSPITAL 2:7, 8, 11, 13, 15, 22 4:10 5:13, 20, 22 9:2, 14, 17 11:18 12:1 23:5, 15, 18 24:10 26:6, 16 27:15 28:19 30:23 31:14 32:2, 8 33:16 36:2 37:5, 10, 16 41:7 47:19 52:16 55:22 57:2 64:23 65:11, 16, 21
hospital-based 23:8
hospitalists 33:7 42:11
hospitals 4:18 8:12, 16, 17 9:4, 8, 13, 20, 21, 25 10:20 11:12, 16, 24 18:12, 13 32:7 34:11 38:9 43:5 55:4 56:1, 2, 4, 8, 19 57:11, 14 58:22 59:2, 3, 8 61:16 64:4, 24 65:19, 23 67:8, 9
Hôtel-Dieu 2:19 5:18 22:11, 14 23:3 24:6 27:9 32:1
Hôtel-Dieu's 34:6
hours 46:1, 3 50:22 52:9
housing 27:23 28:2
HR 59:6
huge 8:24
human 8:6 53:23 58:25
hydrated 48:12

< I >
Ida 3:2
idea 36:25 37:20
identified 25:15 46:18 50:11
identifying 48:13
ignored 33:23
ill 46:18
illnesses 55:9
illustrative 9:18
imagining 56:20
immediate 52:8 53:1
immediately 46:13
impact 19:18 48:24, 25 67:9
impairments 55:18
implement 14:25
implemented 45:3
importance 57:17
important 8:14 14:16 34:3 35:12 41:8 52:11 60:9, 17 62:12 67:6, 7
impression 13:4
improve 16:7 33:18 53:21 54:5
improved 58:19
improvement 53:11 54:1 57:18
IMS 45:2
incentives 63:18
incident 15:12 21:10, 19 26:19
include 11:7
included 6:19 7:16 12:9 25:24 45:1
including 7:2 11:25 16:1 24:1 65:14
increasing 24:20 44:15
incredibly 42:8 50:10
independent 21:15
independently 48:6
individual 10:20 11:11, 12, 18, 24
individuals 28:2, 12 31:15 41:9 45:1 46:2 48:20
infected 28:14 29:23 30:1, 2 46:11
Infection 10:1 25:10 26:2 29:2, 18 42:22 57:13, 20
infections 29:1 48:4
infectivity 46:21
influenza 55:9
informal 9:22
information 7:8 24:3
initial 18:8
initially 44:11, 13 45:21
initiating 55:12
initiatives 8:15 15:1
inspectors 30:24
instability 61:24
instances 9:5
institutions 41:23
integrate 48:19
integrated 20:11, 13 37:23 42:8
integration 49:17 62:5 63:19
intense 49:5
intention 19:23
intentioned 13:6 54:3
interdependency 62:4
interdependent 62:1
interesting 43:22
interests 5:8
interrupt 17:11 45:5
intervene 4:23 5:3
interventions 12:7 61:13
introduce 5:2, 8
invariably 67:8
investigate 10:16
invitation 66:19
invite 54:22
involved 21:22 43:15 45:15, 17, 18
involvement 49:7
IPAC 42:22 57:13 60:25
issue 31:19 58:17
issued 6:23
Issues 2:13 32:9 33:21 56:8 59:7 64:22
items 36:19

< J >
Jack 2:4 60:6 62:16 63:16, 22 67:21
Jamie 35:15
Jan 6:1 13:19 22:10 57:4 62:23
Janice 2:19 5:17 22:8 34:8, 15 35:9 36:11, 17 37:24 38:16, 25 39:14, 22 40:10, 17 42:3 55:2
January 28:16 44:1 45:10 47:8, 11, 12, 13, 14
Jarlette 43:18
job 36:2
join 39:18
joined 5:13, 16
juggling 8:25
July 6:23
June 6:15 15:5 16:13 17:4
junior 20:1
justice 22:19

< K >
Kaffer 2:19 5:17 22:8, 10 34:8, 15 35:9 36:11, 17 37:24

38:16, 25 39:14, 22 40:10, 17
keeping 16:5 32:21 48:11 58:3
keeps 18:16
key 42:6 46:21 49:13, 15 63:21
kind 12:16, 19 17:20, 22 21:11, 17, 19 31:5 37:17 51:6 52:25 53:4, 9 54:23 56:20 63:3 65:16
kinds 37:9
Kingsville 22:17 35:18
kit 27:14 35:12
Kitts 2:4 60:5, 6 62:16 63:22 67:21
knew 30:8 46:16, 17, 20 49:8 57:5 60:25
knowing 19:15, 19 49:10
known 46:2

< L >
Labour 2:14 24:24 59:7 60:11 63:15
lack 37:1
Lakeridge 12:1, 5
large 24:25 65:2
larger 52:24
late 16:12
lawyer 64:10, 13
Lead 3:8 5:7 23:11 36:22 48:15
leader 65:7
leaders 22:21 24:24 25:3 26:7 31:20 32:2 35:23 59:5 61:2
leadership 20:25 22:24 23:25 25:1, 7, 16 26:4 28:16, 24 29:4, 23, 25 30:1, 5 31:1 35:17 37:25 42:17 43:21 44:8, 9, 12, 23, 25 49:7 53:15 60:14
leading 66:14
leads 42:18
learned 25:2 51:25
learnings 6:17 16:1
leave 49:10 58:16
leaving 14:24 30:5
led 21:1 25:19 26:13
left 25:6 33:13 49:8
Legal 2:12 3:2
legislation 60:17 62:18
lesson 18:22
lessons 63:7
Lett 3:4
letter 6:19 15:5 16:13
level 25:11 46:23 56:2
levels 9:3 19:12 44:21 55:12, 18 58:3
licensed 27:22
lies 52:2
life 14:1 66:5
lifting 63:6
limited 9:4
link 57:10
linkage 58:22
linked 57:4
links 58:7
lives 14:14
local 24:12 25:2 27:19 29:4 42:2 43:21 48:8 57:10, 11
located 43:17
long 40:14 51:11 55:12 59:15
longer 10:7 54:20 61:23
LONG-TERM 1:7 3:1, 2, 4, 6, 8, 11, 12 4:17, 19 6:13 7:15, 18, 21, 25 8:7, 9, 15 9:9, 19 10:7, 21 12:8 13:5, 8, 22 14:18, 20 16:8, 24 17:21 18:10, 15, 24 19:5, 6, 13, 22 20:2 22:25 23:22, 25 24:13 25:16, 19, 23 26:2 27:13, 15 31:9, 15, 23 32:4, 7, 10 33:2, 13 34:11 36:9, 24 37:11, 22 38:4, 15 39:7, 12, 18 40:1, 4, 13 41:24 42:1, 4, 13, 21 43:4, 16 55:10, 16, 25 56:3, 4, 9, 19 57:1, 6, 10, 15 58:4, 8, 12, 15, 21 59:2, 4, 10 60:24 64:7 65:7, 9, 18
looking 19:13 48:10
looming 19:16
lot 13:6 29:6 37:6 39:15 41:13 45:6, 9 51:11 56:7 58:8 59:3 62:25 64:25 65:18
lots 23:9 38:2 57:22 59:6
love 31:8
Lynn 3:14 4:3, 8 10:8, 15, 19, 23 11:11, 20, 23 12:24 14:4 15:4 17:9 20:22 22:2 36:7, 12 37:19 38:11, 23 39:10, 21 40:7, 16, 23 45:4, 13 46:5 47:6, 12 51:10, 22

< M >
made 4:15 12:8 32:12 42:16 52:3 61:6 68:8
magnified 20:18
magnitude 48:3
Mahoney 3:14 4:3, 8 10:8, 15, 19, 23 11:11, 20, 23 12:24 14:4 15:4 17:9 20:22 22:2 36:7, 12 37:19 38:11, 23 39:10, 21 40:7, 16, 23 45:4, 13 46:5 47:6, 12 51:10, 22
main 23:5 39:6
major 29:16, 17
majority 39:25 40:8
making 56:5
manage 9:3 25:7 28:24 34:18 48:7
managed 27:19
management 8:12, 13 9:2, 24 12:19, 23 13:16 16:3 21:16, 19 25:21 26:19 27:16 35:8 44:4, 5
managing 6:18 21:18 46:15
manner 16:16 49:25
Manor 51:1
March 1:16 21:9 68:16
Marg 26:14
Marrocco 2:2 17:10 18:5 19:25 20:19 22:3 34:5, 9, 25 36:5 40:24 54:9, 12, 18 60:4 63:24 65:24 66:12, 19, 25
mass 59:9
massive 60:18
mechanism 50:17
media 6:23 24:21 45:9
median 66:6
medical 26:17 32:18 33:3, 13 37:7, 8 42:7 58:20, 23 64:2, 5, 6, 16, 19, 20, 25 65:6, 12, 15, 17, 22 66:4, 9
medicine 65:2
medium 16:7
meet 19:21
MEETING 1:7 40:14 42:5
meetings 24:10
Melissa 2:12 5:15 10:11, 13, 18, 22 11:1, 4, 13, 21 12:11 14:2
members 5:17 9:11 13:2 22:6 24:21 26:6, 11 38:21 62:22, 24 63:10
membership 16:23
Memorial 2:22 5:20
Mennonite 27:20 35:17
mental 23:6, 11 28:3 41:15
mentioned 6:9 36:8 57:17
mentoring 44:9
merely 12:13
merits 18:23
Michael 3:15 5:21 13:12 58:1
middle 24:9
mid-January 44:14
midst 50:1 61:11 63:9
mind 16:5 31:17 35:20 61:8
minimal 25:7

Minister 2:25 19:8, 9, 10
Ministry 7:11 13:7 18:24 19:4, 14 20:2 25:18, 23 26:1 30:24 36:20 39:17 45:16 52:4
minute 17:11
misunderstood 38:13
mitigate 57:15
mobilization 9:17
mobilized 60:12
model 42:9 56:21 63:16 65:14
modelling 8:8
models 56:11 58:24
moment 16:24, 25
month 9:10
months 10:6, 7 26:24 66:7
morning 4:12 5:7
mount 59:8
move 6:25 13:14 14:4 35:12 53:7, 20
moving 20:16 31:3
multiple 44:25 47:18 52:16
municipal 40:11
municipalities 41:8
municipally-owned 40:2

< N >
names 57:5
naming 11:21
narrow 14:24
nascent 63:2
nature 9:12 10:17 20:9 61:21
Nearly 9:22
necessarily 43:8
necessary 5:4 61:16
needed 6:12 15:8, 10, 13, 16 43:2 52:13
needs 17:20 19:21 25:8 46:15, 19 48:11, 12 49:14 50:1 51:7 52:6, 23, 24 55:19 56:11 63:5
NEESONS 68:22
negative 46:3
negatives 46:2
negotiated 44:11
Negotiations 2:15
Network 2:18 32:24
neuroscience 65:1
new 43:22 50:12 55:17 56:11
night 19:21
notable 41:16
note 8:14 22:21 28:1
noted 8:8 14:2, 17 44:2
notes 68:12
notice 51:4
number 8:9, 10, 11 9:14 11:14
nurse 24:2 33:4 48:17
nurses 48:18

< O >
observation 15:21
observations 4:15 12:8, 13 29:13 47:7
observe 7:14
Occupancy 27:25
occupants 30:4
occurred 48:24 65:25
October 4:14 5:24 15:15, 20
offer 23:8 31:14, 16
offered 34:11 44:13 57:14
Officer 2:15
offices 37:8
official 21:15
officials 19:20 20:9 21:24
OHA 5:22, 23 6:10, 15, 23 7:7, 10 13:4 16:12, 20, 23 62:24 63:9
OHT 36:21, 22 39:4, 17, 20, 25 43:8
older 55:15
once-in-a-century-event 16:6
ongoing 25:10 29:12 38:8 56:18
on-site 26:3, 8, 16, 20 28:16 29:4 43:21 44:12 47:10, 14, 15, 18, 19, 20, 23, 25 59:6
ONTARIO 2:7, 8, 11, 13, 15 4:10 5:12 9:14 16:3 20:6 22:15 25:19 32:3 36:13, 14, 18 37:21 38:4, 10, 15 40:5 41:18, 19 49:18 50:2 52:4 62:17, 24 63:1, 16
Ontario's 57:2
on-the-ground 6:3
opened 17:16 44:18
opening 13:1
operating 44:16
Operations 3:6
operators 43:18
opinion 33:19
opportunity 12:12 15:18 22:13 34:23 35:15 41:1 43:23 56:18
opposed 34:13
optimal 30:19
Orchard 12:2
Order 12:20 14:13 19:5 31:3 34:19 35:8, 11, 18 44:4
Orders 8:13 9:24 12:23 35:7 60:9, 18
organization 16:2 22:22 41:6 42:15 52:14, 15 57:1, 7 60:23 65:17, 21
organizations 11:22 12:22 48:8 58:7 63:20
organize 50:6
organized 42:8 51:7 52:24 63:15
organizing 42:6
original 19:1
Orillia 2:21 5:20 41:3, 7, 11 42:9 43:19 45:13 49:18 51:1 52:9
OSMH 41:3 44:1 45:14
outbreak 23:15, 18 24:6, 14, 18 26:21, 23 27:2, 25 28:5, 8, 11 29:10, 16 31:4 32:16, 20 43:4, 25 44:2, 4 45:10 47:13 48:7 49:6, 10 50:25 51:3 53:2, 4
outbreaks 24:4 29:17 30:11, 14 31:24 32:5 34:18 43:6 50:7, 23 51:9, 19 53:24
outreach 23:9
outside 9:23 12:18, 22 39:23 62:3
overall 11:7 28:14
overdue 55:12
overemphasize 49:16
overflowing 44:18
oversight 20:8 26:3 29:3, 7 32:15 58:20 64:2
overview 6:6
overwhelming 32:17
owned 27:19

< P >
paid 8:7 19:11
Palin 3:6
palliation 33:10 48:22
palliative 23:9 33:6 46:19 52:19 65:25
pandemic 4:16, 22 6:1 8:6 10:10 15:22 16:9 18:9 19:16, 18 20:4, 25 21:6, 8, 18 22:23 23:23 32:5 33:21 41:20 55:5 59:24 63:3
pandemics 13:24
paraphrase 37:4
parking 29:6
part 21:21 29:12 36:13 37:24 39:16 40:11
participant 41:17
participants 1:15 2:24 39:8
participates 40:15
participating 38:22 39:12
particular 28:8 42:24 43:20
particularly 8:16 28:1
partners 7:18 22:14 30:23

32:3 38:1, 3 48:2 63:14
partnership 32:6 34:21 38:20 56:21 65:10, 15
partnerships 57:2 67:6, 8
parts 59:21
passed 27:4
patent 64:11, 12, 14
patient 58:9
patients 8:19 42:19 57:8 63:5 64:23
PCR 43:1 51:21
peacetime 20:11
peers 65:19
people 31:9 34:10 35:5 38:2, 12 46:18 47:23 48:11 51:14 52:18 53:12, 17 54:2, 8 56:1, 3 57:4, 6, 24 58:2, 3, 7, 22 59:3, 9 60:24, 25 61:5 62:7 64:8, 21 66:6
percent 9:22 10:6 28:12 44:17, 19 46:4
percentage 46:17
Perfection 13:15, 17 14:7
period 10:5
persistent 23:17
person 44:12, 24 64:9 66:2, 3, 9
personal 32:13
personally 31:6
perspective 21:25
perspectives 5:25 13:19 30:22
pharmacies 42:16
pharmacy 33:6
phase 44:3
phone 49:22 50:21
physician 26:3 29:7 31:20 32:2 48:16
physicians 26:13 31:21 32:10, 17, 19, 23 33:20 37:1, 6, 12, 15 42:12, 13, 16
pick 49:22
picks 50:21
piece 35:12 50:16
place 15:8 29:21 34:19 42:20 43:9, 13, 20 44:1 45:7 49:9 50:9 52:12 53:8, 15 55:7 56:14 60:14 62:7 68:6
plan 6:17 7:1, 5, 11, 12, 15, 25 13:5 16:19 17:1, 12, 17, 18, 23 25:22, 24 28:22 33:1
planned 14:20
planning 7:9
plans 7:3 18:2 29:20 49:9
pleased 5:16
point 12:15 15:12 35:8 39:6, 15 44:12, 23 47:21 53:6 61:17
points 22:20
Policy 2:10, 12 3:4, 10, 12 16:15 63:18
population 56:12
populations 6:22
portfolio 19:2
portfolios 20:7, 10
position 64:17
positive 27:10 28:10 34:21 46:7 50:20 51:5
positives 50:12
positivity 46:4
possible 6:4 10:24 45:22 59:22
post 16:20 49:3
post-acute 23:5 33:5
post-pandemic 63:8, 11
potential 54:24 62:25
Practice 26:15 37:10 65:3
practices 30:18
Practitioners 33:4 48:17
precautionary 14:8, 10
pre-discussions 6:5
pre-existing 9:23 40:5 49:17
preference 21:14
preliminary 47:23
Premier 6:11, 15 7:5 15:6
Premier's 21:2
preoccupation 18:11
pre-outbreak 53:1
pre-pandemic 18:25 55:7
preparation 7:1, 21
prepare 17:7
prepared 18:9
preparedness 7:25 13:5
PRESENT 3:18 17:22 44:6
presentation 6:10 19:1 20:21
presented 5:24
presenter 14:5
PRESENTERS 2:6 4:5
presenting 46:19
President 2:8, 10, 14, 17, 19, 21 5:12, 18, 19, 21 22:10 41:4
press 7:4
pressure 57:21
pretty 55:6
prevent 6:12 29:3
prevention 10:2 25:10 26:2 29:2 42:22 57:13
preventive 6:21
previous 6:9 41:17
previously 5:23 46:3
price 8:6
pride 51:2
primarily 12:18
primary 42:7, 8, 16 65:13
principle 14:9, 10
prior 47:15
priorities 9:3 52:16
priority 19:12 25:25
private 27:18
proactive 29:20 62:9
problem 13:10 28:8 52:2
problems 17:1 35:3 57:16 58:12
procedures 8:21
proceed 4:9 14:11, 13 66:22
proceedings 68:5
process 15:17 47:22
Professional 2:13 30:16 48:10 65:17
professionals 48:14
professions 64:8
profitable 58:16
profoundly 43:14
Programme 13:13
programs 41:15, 16 65:1
progressing 47:5
Prokopy 2:12 5:15 10:13, 18, 22 11:1, 4, 13, 21 12:11
prolonged 10:4
prompted 66:7
propagate 53:24
proper 53:25
protect 13:23
provide 14:3 23:24 24:12 30:3 36:1, 3 37:14 43:10 52:14, 19 58:22 65:19
provided 9:19, 21, 22, 25 10:4 11:17 12:6, 12, 18 29:4 37:12 47:2, 4
providers 39:7
provides 58:8
providing 11:5, 18 12:14 25:5 48:21
province 16:14 44:16 45:15 55:13 56:23 58:18
provincial-wide 57:1
psychiatry 65:13
PTSD 59:12
Public 2:10 20:9 21:2 30:23 45:19 47:16, 20, 24
publicized 43:14
publicly 17:24
punished 53:18
punishment 57:19
punitive 53:9
purchase 64:11
purpose 10:15
put 15:8 17:15 28:18 33:21

< Q >
qualitative 12:12

quality 13:25 37:8, 9 53:11, 22 54:1, 5 57:18
quantify 12:14
question 16:9 18:1, 3, 18 19:22 20:23 60:8 66:7
questions 4:24 11:9 34:1 54:8, 13 66:13, 16
quick 41:5 51:24 59:20
quickly 40:19 44:24 45:22, 25 50:7, 11
quietly 33:22
quit 59:18
quite 14:14, 25 50:8
quo 60:16

< R >
race 8:3
radiology 65:1
range 14:25
rapid 15:17 42:25 43:3 45:21 46:1, 24 51:15, 18, 20, 21, 23 52:5, 6 53:2
rapidly 49:5, 6 63:18
rate 29:18 50:14
rates 46:4 57:21
reach 33:14 45:15, 16
reactive 29:21
read 19:8
ready 66:24
real 32:14, 24
reality 19:17 32:20
realize 46:10 54:6
realized 48:3
really 17:4, 7 18:15 34:23 35:19 37:10 39:14 45:6 55:16 59:20 61:17, 25 62:12, 14 63:2 67:2
reason 34:14
reasonable 52:21
recall 4:13 5:23 36:8
received 8:1
recognize 62:4
recommendation 52:4
recommendations 6:11 13:21 56:15 60:2
recommended 39:4
recorded 68:9
recovered 27:7
Recovery 25:22, 24 28:22
recruitment 31:18
Red 47:21
redeployment 10:3
reflect 9:16
reflecting 56:16
reflections 5:25
regarding 4:15 7:8 10:9
region 23:12 32:5 41:25 49:20
regional 7:2 24:10, 12 26:16 32:1 41:14
registered 24:2 48:13
regular 32:12 43:16 48:11
rehab 23:7
reinforce 56:18
relate 36:12 56:8
related 4:16 20:23
Relations 2:14 26:1 28:23
relationship 24:16 29:12 35:20 49:24 53:1 56:8, 19
relationship-based 50:20
relationships 4:18 9:23 32:25 33:9 38:8 49:17, 21 61:6, 21 62:7
released 7:25 17:24
relevant 21:18 41:12, 20
reliability 52:7
reliance 30:7
reliant 8:15
relief 30:9
remained 49:1
remains 18:1
remarks 15:14, 20 31:5 68:8
remotely 1:15
renal 41:14
re-opening 6:25 16:14
report 66:23
Reporter 68:4
REPORTER'S 68:1
reporting 26:1 29:7
reports 45:9
representatives 38:18
request 6:19 9:6
required 16:16 48:23 61:12 64:20
requirements 7:14 53:20
requires 52:20 55:17
requiring 35:18
requisite 64:16
rescinded 26:22 28:9 29:10
reserve 6:4
residence 24:19
resident 25:6, 25 26:12 28:23 30:13 58:9
residents 6:13 8:7 19:22 25:17 26:18 27:3, 4 28:1, 11, 13 30:4, 18 32:20 33:10 49:1 63:5 65:22
resilient 13:22 59:22
resolutions 35:13
resort 8:21
resources 9:4 25:4, 15 59:1
respect 4:17, 22 31:8 53:14
respected 31:21 62:6
respectfully 13:3
respond 9:6 24:17 28:25 31:3 43:6 50:6 51:8
responded 9:20 11:16 21:5
respondents 10:5
response 6:24 12:6 15:7, 9, 22, 23 18:8 19:18 20:23 21:1 26:20 29:15, 20 30:14 50:5 52:8, 11, 25 53:2
responses 11:10, 12, 14 53:5
responsibilities 8:23
responsibility 20:8 33:23
rest 27:22
restorative 23:7
result 27:10
resulted 8:6
results 10:25 11:8, 19 50:22 51:3, 6, 14
retirement 22:16 24:1, 13 27:12, 17, 18, 23 29:25 31:10, 23 39:23 41:24 59:10
return 5:25 55:7
review 6:16
reviewing 66:23
reviews 42:23
rightfully 46:25
rightly 40:20
risk 20:17
RNs 28:19
road 59:15
Roberta 43:9, 13, 20, 25 45:7 50:9 52:12 53:15
robust 13:22
Rokosh 3:6
role 44:8 50:2, 4 62:8 64:3, 15
roles 45:2
rolling 7:5
room 42:12
rooms 44:17
rosters 32:19
round 18:14
Royal 47:19
RPNs 28:19
RPR 68:3, 23
run 40:19
running 8:23 44:16
rural 41:10
RVH 47:19
Ryan 13:12

< S >
safe 13:25 46:21 54:2
sanctity 61:23
Santedicola 3:19 68:3, 23
Sarah 2:17 5:20 6:1 13:20 54:22, 25 55:1 60:6, 20 62:23 64:18 66:11
SARS 18:12
satisfy 31:2
save 14:14
scale 9:12
scheduled 8:20
Schlegel 22:16 25:4 35:16
science 16:18
scientific 14:11
scope 12:22 28:22
Secretariat 3:1, 3, 5, 7, 9, 11, 13
Secretary 21:1
sector 7:14 13:23 17:20 24:1 30:8 31:10, 24 32:8

33:16 37:18
38:5, 19
seek 7:8
send 43:2
Senior 3:2, 10, 12 21:15 26:5, 7 27:20 44:11
seniors 13:25
sense 9:12 52:1, 12 67:11
separate 38:14
separately 18:2
September 7:10, 24 14:19 17:18
sequencing 49:13
serious 8:18
servants 20:9
serve 41:9
service 7:3 23:24
services 21:17 41:14 63:19, 20
serving 20:10 41:7
set 35:22 68:6
setting 37:11 53:10
settings 41:23, 24 43:4, 5
share 10:24 13:19 22:13 24:22 29:14 31:25
shared 58:23
sharing 41:3
shelter 23:2
shifted 46:13
shifts 58:2
shine 33:21
short 7:17 54:6
shortened 33:25
Shorthand 68:4, 12
shortly 7:6
shows 62:11
sick 42:20
sicker 55:16
signal 17:4
signatory 38:21
signed 39:24
significant 23:15 28:3 30:5 34:16, 17
significantly 63:17
siloed 63:12
silos 32:24
Simcoe 48:21
similar 14:9 31:16 42:3
Similarly 44:5
simple 46:15
simplify 39:1
simply 9:6 13:10
single 9:6 15:12 42:9 44:11, 23
sinking 46:9
sir 34:8
situation 16:21 20:3 61:12
size 20:6
skill 66:3
skills 64:5, 16 66:8
slide 23:4 41:5 56:13
slightly 43:11
slow 17:12, 13
snapshot 51:24
social 24:21
Soldiers 2:21 5:20 45:14, 24
solid 30:15
solutions 59:21
solving 16:25
Somebody 50:21 65:20
somewhat 29:22
soon 47:1, 21 49:10 67:16
sorry 4:4 12:3 20:20
sort 4:15 12:6, 7 53:8
sorts 12:9
souls 23:22
sound 8:2
speak 4:11 21:25 23:14 35:11 43:7
specialties 64:19, 20 65:12
specialty 23:5 33:5
specific 6:17, 19 11:22 17:20, 23 20:8
specifically 4:16 7:16 10:19 21:17 29:24
Speed 13:16 14:6, 13, 16 15:3, 14 49:23 51:6 61:17
speedy 15:23
spoke 7:18
spread 14:24 29:3, 19 46:24
spring 6:7 16:12
St 22:15 24:5, 15 25:3 26:9 27:5 28:7 35:16
stability 62:14
stabilize 29:8
staff 5:13 6:6 9:4 10:2 13:4 19:20 21:2 22:21 24:19, 20 25:15 26:11, 14 28:11, 14 30:3, 7, 16, 19 31:14, 16 33:13 46:21 49:2 53:14 57:5 59:18 65:4 66:21
staffed 59:2
staffing 7:3 8:17 23:1 28:18 29:8 30:10
stage 6:25
staged 50:4 52:25 53:4
stages 59:23
stand 52:7
stand-alone 18:23 19:2 52:7
standard 32:14
standardized 15:17
standards 53:10 57:20
standby 52:23
start 5:7
started 6:8 42:4 45:21
46:16 47:20 48:1
starting 35:8
starts 55:20
statement 6:24
statistic 51:2
status 23:18 60:16
stay 29:10 59:22
stayed 32:12
Steen 26:14 31:20 37:5, 13
steering 38:18, 19
Steini 8:8
Stenographer/Tra nscriptionist 3:19
stenographically 68:9
step 24:24 50:15
stood 61:2
stop 54:7
story 22:13 41:3 45:7
strategy 6:20 43:3 57:24 59:1
strengthened 7:22
stress 49:3
stretched 44:21
strong 34:21 55:24
strongly 49:15 50:2 53:7
structure 15:7, 9, 10, 11, 22, 23 16:2 21:10 38:22, 24 40:4 45:2
structured 29:15
structures 39:3
struggling 33:13
Stumpo 2:21 5:19 40:21, 25 41:4 45:12, 18 46:6 47:10, 17 51:17, 23 54:11
submission 11:6 14:3
submit 55:19
submitted 6:11 25:22
subsequently 25:2, 17
subsidiary 18:18
subsidized 27:23 28:2
success 50:19
successive 19:11
suffering 59:12
suggesting 6:16
suggestions 15:6
suggests 15:25
suited 6:2
summary 26:25 41:5
summer 7:7 16:12 17:6
Sunnycrest 12:3
support 6:21 8:15 9:9, 12, 19, 21 10:1, 2, 17 12:14, 15, 16, 18 23:25 24:12 25:6, 9, 17 32:24 33:10, 17 34:11 35:13 36:1, 3 37:10, 12 42:13 44:7 45:21, 22 48:19, 22 50:2 52:13 53:3 54:4
supported 10:5, 6 27:24
supporting 10:20 16:22 22:24 23:1 35:24 41:22
supports 9:22 10:4 11:16 37:6, 16 42:23 57:14 61:15
surgical 41:16
surprised 30:8
surrounding 41:7, 11
survey 9:11, 15 10:9, 16, 25 11:8, 19 12:7, 11
surveys 12:10
suspend 61:21
sustain 60:15
sustainable 62:14
sustaining 58:18

swiftly 15:3 20:16
system 7:20 19:7 21:20 31:12 33:19 53:4 59:1, 22
systematic 50:4
systems 42:19 56:10 58:24

< T >
table 38:5, 10, 11, 12, 14 39:9, 13 40:14, 15 42:5
tables 38:19
takes 51:2
talk 24:4, 11
talked 15:7, 10, 15 39:15
talks 24:15
tasks 42:6
Team 3:8 5:1 22:14 26:13, 20 29:5, 13 32:18 35:16 36:13, 14, 18 37:21 38:4, 10 40:6 41:18 42:10 44:6 45:23 47:7 48:9, 16 49:18 51:2 53:6 63:16
teams 23:10 36:14 37:9 38:15 41:19 48:8 49:14, 15 50:3 62:17, 19 63:1
temporary 23:1
Tendercare 12:3
term 61:23
terms 34:6 38:3 39:12 45:25 60:2 61:20 65:21
terrible 8:6
test 50:20 51:5, 14 52:6, 8
tested 46:3, 7
testimony 19:8
testing 8:24 22:24 42:25 43:1, 3 45:21 50:13, 18, 22
51:4, 11, 15, 18, 20
tests 46:1 51:20 52:5
Thanks 55:1 66:11 67:1, 21
thematically 54:24
theme 28:23
themes 56:16 60:1
thing 18:8 30:22 61:22 64:24
things 12:9 13:18 33:25 37:9 49:22 62:19 65:23
thinking 20:11, 13 63:10
thought 12:17 38:13 53:5
thoughts 31:25 60:1
thousands 44:15
throes 53:3
tie 65:11
tiered 52:25
ties 57:3
time 4:13 5:8 6:4 7:17 8:3 12:16 13:11 14:22, 24 16:8 22:19 23:13 24:17 25:23 26:21 27:25 29:6 30:10 33:25 34:2 36:22 39:25 40:15 46:13 47:21 49:2, 4, 8 50:2, 10, 12 51:19 53:8 54:7, 16 55:20 58:10 61:17 63:15, 17 67:14, 16 68:6, 8
timelines 43:24
times 14:25 30:18, 21 35:10 51:12
tired 17:5 59:11
tirelessly 53:16
today 5:10 11:6 23:14 60:16
told 31:1
tolerance 58:3
toll 24:20
tool 27:14 35:12
tools 58:6
top 50:7
Toronto 2:17 43:2 58:17
total 9:13 11:14 23:21 28:12
totally 19:20
tracking 57:20
tragedy 53:16
tragic 43:14 48:23
trailer 29:5
trained 64:10
training 57:13 64:17
transcribed 68:10
transcript 68:12
transfer 52:18 55:21 56:3, 5
transition 49:9
traumatic 49:3
tremendously 31:10
Trillium 51:1
trouble 58:14
true 9:17 68:11
truly 19:16
trumps 13:17
trust 61:6
trusted 59:5
truth 8:2
trying 16:25 17:1, 3 24:17 28:25 39:1 48:18 50:18 67:5
Tuesday 24:5
turn 13:18 21:24 22:5
turnaround 51:12
turning 13:2
type 12:14 21:11 46:24
types 10:1 11:15, 16

< U >
UK 47:2
ulcers 57:21
ultimately 14:17 28:17 65:5
unable 28:24 33:14 53:19
unattached 42:19
under-appreciated 31:11
understand 18:11 20:25 37:20 47:7 51:25
understanding 44:14 47:4 62:8
understood 18:6 34:10 35:3
undertaken 20:13
undervalued 31:11
underway 13:7
unfortunately 8:4 16:10
unique 52:12
Unit 25:14 27:3 28:5 45:20 47:16
units 23:17
unmanageable 32:21, 22
unnecessary 6:12
unprecedented 61:12, 13, 19
unwise 64:13
urgency 50:7
urgent 6:11
useful 35:8
usual 60:11
utilized 27:14 30:9

< V >
vaccination 59:9
validity 52:6 64:12
value 49:19 57:18
variant 46:12 47:2
variety 41:22 47:24 48:2
various 15:6
varying 32:11
vehicle 62:18
VERITEXT 68:22
versus 57:18 58:4
Vice 2:10, 14
Victoria 47:19
Videoconferencing 1:14
view 14:17 18:19 20:24
views 60:21
Villa 12:2
Village 22:15 24:6, 15 25:3, 13, 20 26:8 27:5 28:7 35:16
Villages 24:4
Villas 22:17 27:12, 18
virus 13:12 29:16 50:10 52:18
visibility 30:10
visits 32:12
vital 58:12 59:21
voice 20:3 39:9
void 30:6
volumes 8:24
voluntarily 34:18
voluntary 12:20 25:20 34:7, 13 39:16
volunteered 23:22 28:19
vulnerable 6:21

< W >
wage 31:13
wait 58:15 59:12
waiting 31:15
Walwyn 3:12
wanted 29:14 38:3 39:16 44:22
wanting 44:6

wave 4:16, 22 6:1, 17 7:1, 9, 21 8:5, 9, 10, 19, 21 9:10 10:9, 13 12:2, 3 13:9, 11 14:20, 22 15:6 16:19 17:7 22:7 24:8 34:12, 23, 24 35:23 38:8, 9 41:19 42:24 50:13 52:15 55:5 67:3
waves 6:18 15:25 56:22 59:17
ways 35:19 37:3 38:8 62:2
week 8:8
weeks 17:23 26:10 31:7 42:5
well-being 32:14
well-intentioned 21:13
Williams 19:10
willingness 35:25
win 13:15
wind 16:11
window 14:24 51:24
Windsor 5:19 22:15 23:2 26:16 32:1 35:3, 4
Windsor-Essex 24:11 25:14 27:2 33:2 36:18 38:1
wishes 67:19
witnessed 31:8
WLG 3:14, 15
women 41:15
wonderful 23:21
won't 11:18, 21 22:18
word 37:2, 17
words 13:12 31:25
work 13:7 16:15 17:6 22:22 27:15, 16 29:9 31:9, 17 33:1 34:3, 4, 22, 24 35:15 39:8, 24 41:20 43:8, 9 49:18 53:16 54:4 57:9 59:4, 6, 19 60:11, 24 62:20 65:20 66:20
worked 29:5 31:6 34:20 48:15 51:1 53:15 56:25 60:10
worker 22:24
workers 6:20
workforce 61:14
working 19:21 24:7 26:8 30:2 32:3 35:22 37:3 63:13
world 18:25 53:14 63:8, 11
worry 59:16
worth 60:21
Wow 46:5
wrestling 67:2
written 11:6 14:2
wrong 55:21
wrote 6:15 15:5

< Y >
Yeah 11:4
year 16:10 41:21 55:9
youth 23:11

< Z >
Zoom 1:14