

Long Term Care Covid 19 Commission Mtg.

WRH (David Musyj and Dr Chevalier)
on Thursday, November 19, 2020



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1 MEETING OF THE LONG-TERM CARE
2 COVID-19 COMMISSION

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5 --- Held Virtually via Zoom, with all participants
6 attending remotely, on the 19th day of November, 2020,
7 9:00 a.m. to 10:25 a.m.

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9
10 BEFORE:

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

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16
17 PRESENTING:

18 David Musyj,
19 President and CEO, Windsor Regional Hospital.

20
21 Dr. Marguerite Chevalier,
22 Chief of Family Practice, Windsor Regional Hospital.

23
24 ALSO PRESENT:

25 Judith M. Caputo, Stenographer/Transcriptionist

1 PARTICIPANTS:

2 Jessica Franklin, Policy Lead, Ministry of
3 Long-Term Care

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5 Derek Lett, Policy Director, Long-Term
6 Care Commission Secretariat

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8 Adrian Diaz-Choconta, Long-Term Care
9 Commission Secretariat

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11 Jay Bahal, Long-Term Care Commission
12 Secretariat

13

14 John Callaghan, Lead Counsel, Long-Term
15 Care Commission Secretariat

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17 Lynn Mahoney, Counsel to the Ministry
18 of Health and Long-Term Care

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20 Kate McGrann, Counsel to the Ministry
21 of Health and Long-Term Care

22

23 Ida Bianchi, Counsel to the Ministry of
24 Health and Long-Term Care

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1 -- REPORTER'S NOTE: (Introductions were
2 exchanged before going on the record).

3 MR. MUSYJ: Okay. Thank you.

4 Good morning. What we were asked to
5 put together, and we put together a brief
6 PowerPoint to hopefully guide the discussion, and
7 you interrupt us at any point. So, if you don't
8 mind, we would start going through it.

9 COMMISSIONER MARROCCO: Sure.

10 MS. MAHONEY: May I interrupt for a
11 second?

12 David, I spoke with you yesterday. If
13 you wouldn't mind, please, because I have struggled
14 myself with the pronunciation of your last name, so
15 everybody can properly refer to you, would you
16 introduce yourself and pronounce your last name.

17 MR. MUSYJ: Oh, okay. What, you can't
18 do it by the way it's spelled?

19 MS. MAHONEY: I know. I'm going to
20 fool it up, David. I don't want to do that, so if
21 you don't mind.

22 COMMISSIONER MARROCCO: "Musyj", is
23 that right?

24 MR. MUSYJ: I'm Ukrainian, so you're
25 closer with the pronunciation from a Ukrainian

1 point of view.

2 COMMISSIONER MARROCCO: I've spent my
3 whole life spelling my last name for people, so I
4 have some sympathy for this.

5 MR. MUSYJ: Yes. Yes, you just start
6 with it, David M-U-S-Y-J. So it's "Mooshay"
7 phonetically, M-O-O-S-H-A-Y.

8 COMMISSIONER MARROCCO: Thank you,
9 Mr. Musyj.

10 MR. MUSYJ: I'll share my screen here.

11 COMMISSIONER MARROCCO: We can see it
12 now. At least I can. I think the other two
13 Commissioners can see it. Yes.

14 MR. MUSYJ: Yes? All right, perfect.

15 We'll just start. This is the agenda
16 we plan on following. Again, we're wide open, as
17 you stated, to go wherever you want to go, we'll
18 go. But we tried to provide some of the highlights
19 that just focus on this particular issue with
20 respect to the field hospital, and what we were
21 facing in Windsor-Essex.

22 So to just give you an idea really
23 briefly who we are is we are Windsor Regional
24 Hospital. We're located in Windsor, Ontario. We
25 serve the region of Windsor-Essex, which is

1 approximately 400,000 people.

2 We have two main campuses, our Met and
3 Ouellette campus. Even though they're on two
4 campuses, we have specialized services on each of
5 the campuses, meaning we are not two general
6 hospitals; we're one hospital with two campuses
7 with services on each.

8 In preparations for dealing with COVID,
9 we went back and looked at how March unfolded. We
10 are now part of the West Region, which is on this
11 map, which goes all the way from Windsor to
12 Hamilton and Waterloo.

13 And what happened back in March is we
14 created what was called a Hospital Table Leadership
15 Structure.

16 Here is a diagram of what was created
17 back in March, which started with, at the top you
18 have the current CEO of the West Region, former
19 LHIN, is Mark Walton, and Dr. Tom Stewart is the
20 clinical lead.

21 Then we still use the old LHIN
22 subregions to deal with particular issues and have
23 subregional tables, we call them, that would report
24 into the larger West Region table. So it was
25 similar to an incident management structure or

1 system in the province.

2 What we did here in St. Clair is we had
3 what we called a "hospital table", which had
4 sub-tables underneath it that dealt with things
5 like hospital operations, bioethics,
6 communications, critical care.

7 So on every single one of these
8 sub-tables, we had representation from across Erie,
9 St. Clair LHIN, which goes all the way to London.
10 So it's ourselves, Erie Shores, Bluewater Health,
11 Hotel-Dieu Grace, and Chatham-Kent Hospital, and we
12 all have regular meetings ever since going back to
13 March. At the same time, a little later in
14 March -- I'm sorry.

15 COMMISSIONER MARROCCO: Mr. Musyj, did
16 you create the region yourselves and the tables, or
17 was that imposed?

18 MR. MUSYJ: Yes, so it was -- I
19 wouldn't maybe use the word "imposed". More from,
20 okay, how is this going to work?

21 It started with the discussion of the
22 West Region, the larger region, pulled together,
23 four were CEOs of the larger hospitals from that
24 region. So ourselves, London, St. Mary's and
25 Hamilton. And then we talked amongst ourselves,

1 saying, okay, how can we create this without being
2 too large but being focused.

3 And we said, why don't we go back --
4 because we were in the transition in Ontario Health
5 from the old LHIN regime to the five regional
6 regimes. How can we create focus, and leverage the
7 relationships we had previously, meaning like a
8 year ago? And we landed on creating the
9 subregions, and then it was up to us in the
10 subregion, like myself from a hospital table point
11 of view, to then work with the CEOs in our
12 subregion of Erie-St. Clair, which was the former
13 LHIN, so it was a body, to populate these various
14 teams or tables to make sure there was individuals
15 on them from around the LHIN.

16 Does that make sense?

17 COMMISSIONER MARROCCO: It does, to me
18 anyway. I think we're good with that.

19 MR. MUSYJ: Okay. So later on, in the
20 month of March, we created also a "non-hospital
21 table" for the region because, of course, we didn't
22 want this all to be hospital-centric, and there are
23 far more players in healthcare than hospitals, and
24 the only way we were going to pull those off, or
25 anything in healthcare, is as a collective.

1 So we did a similar approach in our
2 region, and you'll see the tables are things like
3 EMS, Home Care, Long-Term Care, Mental Health and
4 Addictions, Primary Care.

5 So all these non-hospital tables met,
6 the hospitals met, over the last couple of months.
7 Now we all meet together. So we're all kind of
8 one. And the chairs of each of these committees
9 report twice a week, probably increased to three
10 times a week shortly. It was three times a week
11 before. Everyone's got access to this website. We
12 minuted all the meetings. It's action items on,
13 okay, what's going on in the region? What can we
14 do to help support each other? So it's very
15 productive.

16 COMMISSIONER MARROCCO: Does it make
17 this -- sorry, Commissioner Kitts.

18 COMMISSIONER KITTS: No, I'm just going
19 to ask another question, so go ahead, Commissioner
20 Marrocco.

21 COMMISSIONER MARROCCO: How do you make
22 decisions at that level? Is it by vote, or how
23 does that work?

24 MR. MUSYJ: Yes. So what we try to do
25 is give a lot of authority to the various tables.

1 So, for instance, on the hospital side, we'd have
2 the operations table. That includes primarily the
3 chief nursing executives, as well as the chiefs of
4 staff on that table. And they will review a
5 particular issue.

6 So, for instance, we had to ramp down
7 surgeries across our region. They work together on
8 their individual plans and on a collective plan
9 and, in effect, signed off on each other's plan.
10 And there's no -- I mean, the goal is, we haven't
11 come across it yet, but it's by, you know,
12 consensus, but we've never had a dispute that
13 needed a resolution by the CEOs.

14 So once the operation table makes their
15 recommendations, say on how they're going to wind
16 down surgeries individually, and then collectively
17 agree, that is then submitted to the CEOs at the
18 hospital table. And it's technically up to the
19 CEOs of the hospital to say "yea" or "nay", we
20 support it or not. And again, since it's our team
21 members --

22 COMMISSIONER MARROCCO: Right.

23 MR. MUSYJ: You know, we haven't had an
24 issue.

25 COMMISSIONER MARROCCO: Okay, thanks.

1 Commissioner Kitts.

2 COMMISSIONER KITTS: David, do you have
3 functioning Ontario Health Teams in your region?
4 And if so, how did they align with your structure
5 and how effective were they in this environment?

6 MR. MUSYJ: So Chatham-Kent Health
7 Alliance, or Chatham-Kent region, was the only
8 Ontario Health Team. Bluewater and Windsor-Essex
9 had not been approved.

10 So what was happening is, they were --
11 and they continued to work, say in Chatham,
12 together, and tried to feed into these tables. So
13 they're trying to make sure that the same
14 individuals who are sitting on their Ontario Health
15 Team are also involved on these tables, and feed it
16 back and forth.

17 COMMISSIONER KITTS: Do you think, in
18 the future and at maturity, Ontario Health Teams
19 will be tables unto themselves?

20 MR. MUSYJ: Yes. As this evolves,
21 we've talked about that, is hopefully the Ontario
22 Health Teams, as they mature, will become the
23 "tables" in effect. It's just right now it's not
24 there yet. And what we're doing is so directly in
25 line with that, that you're exactly right. You're

1 going to where we've talked we're going to end up
2 going.

3 COMMISSIONER KITTS: Yes. Thank you.

4 MR. MUSYJ: So what happens is, on a
5 twice a week -- it was three times a week -- we
6 have this structure where we call it now our G5
7 leadership, which all of these tables report into
8 technically, and then we report up the G5 to what
9 is called the G15, which is for the whole West
10 Region.

11 So on an Erie-St. Clair level, these
12 names, this group of individuals, technically we
13 meet daily. We just met at eight o'clock in the
14 morning and kind of just get a -- you know, talk
15 about what's going on in the region, what needs to
16 be done, and then reconnect with individuals in the
17 region.

18 So when we looked at that org chart, we
19 had the G15, which is the whole region; we have G5,
20 which is this; and underneath it is what I talked
21 about with the various tables: hospital and
22 non-hospital.

23 It's very fluid in the sense of
24 relationships and discussions, but there is some
25 formal process to it, to ensure information not

1 only goes up but comes back down from Ontario
2 Health. So it's worked well.

3 I'll be honest. You know, there's a
4 handful of positive things coming out of COVID, and
5 one of the positive things coming out of COVID is
6 the relationships that have been created. You
7 know, did we have connections with Hamilton
8 previously? Sure. Do we have connections now with
9 Hamilton? Daily.

10 So the great thing about this is it's
11 forced that relationship on a much broader scale to
12 happen a lot quicker. And now we know everyone by
13 first name, which probably would have taken three
14 years to do previously, took us two months to do
15 now. You know, we know each other's offices and
16 kitchens and whether lights need to be replaced,
17 that's how well we know each other now.

18 So, this leads us into the particular
19 issue we're talking about today is, in March, we
20 were asked to focus on hospital bed capacity by
21 Ontario Health and Ontario Health West.

22 We were asked to focus on what's called
23 both "conventional" and "nonconventional" bed
24 capacity, "conventional" meaning your conventional
25 spaces you have in your hospital site.

1 "Nonconventional" would include, also within your
2 hospital site, where you might have had a boardroom
3 that used to be hospital space or a family meeting
4 room that used to be a patient room, you're now
5 reconverting back to a conventional space.

6 And also in those discussions at the
7 time, there was this concept of, if you can't
8 create enough "nonconventional" space within your
9 four walls, you need to start looking outward and
10 using this concept of field hospitals. And that's
11 in the middle of March, I would say, that's when we
12 started actively pursuing the concept of a field
13 hospital.

14 Then I look back and, sure enough,
15 there was the webinar in early April, through the
16 Ministry of Health, that talked about
17 non-conventional "field hospitals" and having to
18 look at that and asking hospitals to look into
19 that.

20 COMMISSIONER COKE: Can I just ask a
21 question?

22 It says here that Ontario Health asked
23 you to look at this issue. Were you the only
24 region that they asked to do this, or were others
25 asked to do the same thing?

1 MR. MUSYJ: I assume it was others.
2 Like, it was our whole West Region was asked to
3 focus on hospital bed capacity, and the webinar in
4 early April was through the whole Ministry. It was
5 on the Ministry side to talk about this.

6 COMMISSIONER MARROCCO: So the genesis
7 of that, of the idea of nonconventional space, it
8 actually originated with Ontario Health as far as
9 your region was concerned?

10 MR. MUSYJ: Yes. Yeah. We were asked
11 to look at, within our four walls, what we could
12 create, and if we were concerned about capacity
13 within our four walls, it was "look elsewhere".

14 COMMISSIONER MARROCCO: Sorry.

15 MR. MUSYJ: No problem.

16 COMMISSIONER MARROCCO: Was the
17 motivation because there was a concern that the
18 hospital capacity would be exhausted; is that the
19 idea?

20 MR. MUSYJ: Yes, for us in Windsor, so
21 what I didn't outline here -- great question -- is
22 we were designated what -- there was discussions at
23 the time to say: Are we going to create designated
24 COVID hospitals, meaning every single COVID patient
25 would go to that particular hospital?

1 That quickly was eliminated because of
2 the concept of, you don't know you have a COVID
3 patient. If they come into an ED and then they
4 test positive, what do you do? Where do you put
5 them? Do you shift them all? But the hospital
6 already had a COVID-positive, so you can't keep
7 that hospital "clean".

8 As a result though we are the intensive
9 care unit traditionally for our region, all the way
10 to London. So any patients requiring a higher
11 level of intensive care gets transferred to Windsor
12 Regional hospital, pre-COVID days.

13 So that was adopted during COVID,
14 meaning if a patient got critically ill and
15 required a higher level of critical care services
16 and they had COVID, they would be transferred to us
17 as Windsor Regional Hospital. So, as a result, us
18 as a hospital had to sit back and say, okay, what
19 type of capacity are we going to need?

20 Our original thought for the field
21 hospital was: We need a site that if we get that
22 first wave of COVID patients, once they're done
23 their acute phase of COVID, they might not be well
24 enough to go home and/or go somewhere else, but
25 we're going to need a site to create that capacity

1 for them once they're past their acute phase. That
2 was our initial thought of the field hospital.

3 And that's why we started looking at
4 that time -- and you have to remember, we're in
5 Windsor, so sitting, for the "Jeopardy" fans out
6 there, sitting north of us is the City of Detroit.
7 So we sit south of Detroit. And they were going
8 through tragedy at this time.

9 So we're preparing, and we have our
10 staff from Windsor working over there, coming back
11 with stories, and let alone the media stories. So
12 we had to wrap our mind around on we have to create
13 capacity somehow and, hopefully, we never have to
14 use it. But our strategy all along is: Prepare
15 for the worst, pray for the best, be ready for
16 everything in between. And that's worked for us
17 during COVID.

18 COMMISSIONER MARROCCO: Okay.

19 MR. MUSYJ: So I pop up this letter,
20 because it summarizes kind of what we did with
21 respect to the field hospital. I believe you can
22 see it.

23 Basically, what it is, it's a letter
24 from myself to our ADM, Mike Heenan, Assistant
25 Deputy Minister.

1 And what we had to do in order to get
2 the field hospital approved, we had to do what's
3 called a Section 42 application under the Public
4 Hospitals Act, which the Ministry grants authority
5 to create hospital space outside of the existing
6 campuses.

7 I recall at the time there was a memo
8 that went out from Ontario Health saying, "If
9 you're going to be creating these, just give us
10 notification. Here are the terms and conditions of
11 creating these types of spaces, 42. Do exactly
12 what we did here". And attached to this was the
13 actual lease agreement.

14 I'll back up a bit. And the letter
15 explains it. So, middle of March, we're talking
16 about nonconventional spaces, where to create them.
17 And we engaged a retired Lieutenant Colonel, Andy
18 Stewart. He was from the British Army and now he
19 is a major in the Canadian Armed Forces. And we
20 engaged him to help us look for alternative spaces
21 in the community, or field hospitals.

22 You know, we're not used to doing this
23 as a hospital so, you know, the best thing to do is
24 contact those who have done this for a living. And
25 we came across retired Lieutenant Colonel

1 Andy Stewart, who was phenomenal, by the way, and
2 he did this for a living when he worked in
3 Afghanistan, etcetera.

4 So we went around, we connected with a
5 bunch of different organizations, school boards,
6 etcetera. I'll be honest, at the time in our head
7 we were thinking, okay, we just have to pick a
8 school gymnasium, you know, like an elementary
9 school gymnasium should be fine. He's the one who
10 said, "No, no, no, you've got to look bigger. You
11 only want to do this once. You don't want to do
12 this multiple times. You want to pick a location
13 that has the ability to grow and is almost larger
14 than, hopefully, you need because you don't want to
15 have to replicate this multiple times in your
16 region. You don't have the bandwidth to do that.
17 You don't have the infrastructure to do that. You
18 don't have the time to do that".

19 So we connected with a bunch of
20 organizations and connected with St. Clair College.
21 Literally, we pulled out a map. We just went
22 around a map and looked at different large places.
23 And St. Clair said, "Yes". You know, we explained
24 what we were thinking of using it for. And they
25 said, "Sure, come and look at it". The minute

1 Lieutenant Colonel Andy Stewart showed up at St.
2 Clair was the minute he said, "This is your spot".

3 It is what's called a "sportsplex", and
4 in my opinion, I mean, I haven't researched it, but
5 I assume many colleges and universities across the
6 Province of Ontario have similar facilities, indoor
7 facilities. If you picture it, what it is, it's a
8 sports arena that, you know, they play their
9 basketball, volleyball, etcetera, in. It has about
10 three or four courts in it and it has a walking
11 path along the top, but it's an arena.

12 Then, on the outside of the arena is
13 the lobby area to get into the arena. So it's a
14 nice, neat separation between the two. And it has,
15 you know -- I'll go through what it has: It has a
16 back-up generator, etcetera, all sorts of positive
17 things that we needed.

18 So this was, you know, middle of late
19 March. We went back, connected with St. Clair
20 again and we said, "Can we take possession as early
21 as April 1st?" They said, "Yes". We got a lease
22 done like in 24 hours. They charged us \$1; I still
23 haven't paid it.

24 And from my point of view, these are
25 provincial assets at the end of the day. They're

1 available in many jurisdictions to be used. And
2 chances are, our theory all along was, when they
3 need it back is when we're no longer going to need
4 it. Meaning, if things are good enough or well
5 enough for them to go back and play basketball and
6 volleyball, that means we're probably not going to
7 need a field hospital if they're back to that. And
8 sure enough, it's followed that path where they've
9 cancelled sports for the spring as well, for the
10 upcoming spring.

11 So I'll back up first to talk about
12 what was happening simultaneous to the field
13 hospital. Then I'll jump in to what the field
14 hospital offered to us. Just to give a snapshot
15 of --

16 COMMISSIONER MARROCCO: Can I just
17 interrupt for a second?

18 How long did it take? You said you
19 signed the lease April 1st, I think it was. How
20 long did it take to build the field hospital or
21 convert the complex to a field hospital?

22 MR. MUSYJ: We took possession
23 April 1st. We had the residents move in
24 April 18th.

25 COMMISSIONER MARROCCO: 17 days?

1 MR. MUSYJ: Yes, and Easter fell in
2 between there.

3 COMMISSIONER MARROCCO: Okay, thanks.

4 MR. MUSYJ: I'll explain kind of what
5 happened. And the teamwork, it's a community, it
6 really is a community that made this happen.

7 Just to give you a snapshot of what was
8 going on at the time. We opened up our assessment
9 centre in the middle of March, to do the swabbing.
10 I think we were one of the first ones in the
11 province to open, so that was similar timing across
12 the province.

13 Early April we started seeing positive
14 staff members -- and I'll focus on two long-term
15 care homes in Windsor-Essex region -- starting
16 coming back positive. In early April there's
17 multiple long-term care homes in Windsor-Essex,
18 it's an outbreak. When I say "multiple", it
19 started at seven and I think it popped up to ten
20 real fast, like, it started taking off, right?

21 April 10th, I've been able to find is
22 when Heron Terrace alerted through our Public
23 Health and then, by then, that non-hospital
24 structure was in place. Through the non-hospital
25 lead, that they were in a staffing crisis. Heron

1 Terrace is a long-term care home, approximately 140
2 residents.

3 Multiple calls and meetings occurred to
4 try to stabilize the staffing and get testing on
5 the residents in a more aggressive manner. And
6 where the multiple calls were is that G5 group I
7 showed you before. That's who had the calls. So,
8 again, we're just feeling our way around this time
9 in the sense of who's doing what and how do we work
10 together.

11 We then immediately have, I recall,
12 calls over April 10th, leading all the way through
13 Easter, calls with Heron Terrace, saying they're in
14 trouble.

15 EMS was engaged by Public Health.
16 EMS is our ambulance service. They have done a ton
17 of work in our region with respect to going out and
18 doing swabbing, be it on agri-food farms or into
19 long-term care retirement homes. And the results
20 started coming back -- they went into Heron
21 Terrace, and the results started coming back the
22 early week of April 13th.

23 Just to back you up a bit. April 1st,
24 we take possession of the field hospital. I
25 remember around April 5th, I went to the field

1 hospital because we were looking at the different
2 types of rooms we were going to build in the
3 facility. They literally had set up in the field
4 hospital three or four different examples of
5 modular units that you could buy prefabricated, or
6 lease. And then there was one that was built by a
7 company we work with, by a construction company
8 that had built one themselves.

9 So we went through all of them. You
10 know, I went through the first one and told, "Okay,
11 this one's going to be a million bucks and delivery
12 in four to six weeks". "This one is going to be an
13 \$800,000 lease, delivery, you know, next week".

14 And then they were -- they were nice,
15 but the walls were shorter and just didn't really
16 fit. And then came the one that was built by the
17 construction company and our team, said, "Okay,
18 this one is going to be \$30,000".

19 And I said, "Oh, 30,000 for each of
20 them?" And we had already plotted out that we
21 could do a hundred rooms in the sportsplex. We
22 already drew it out. And I said, "So 30,000 for
23 each?" And they said, "No, 30,000 to do all 100".
24 And I'm like, "What?" And they said they're only
25 doing it at cost and they'll build them all. And I

1 said, "How long will it take?" And they said,
2 "Maybe a couple of weeks". And at the time I'm
3 like, "Great, that's easy, let's go". So we
4 started immediately.

5 Then I remember, as April 10th started
6 heating up, hearing about Heron Terrace. I went
7 back in. Because they had asked me at the time,
8 our folks said, "Okay, how much time do we got?"
9 And I said, "Well, probably two to three weeks, you
10 know, so near the end of April, we should be fine".

11 And I went back in and said, "Listen,
12 things are heating up. There's a good chance we
13 might be shifting our focus and we might be having
14 to help out some of these long-term care homes. We
15 need this done the week after Easter. We got to
16 get it done".

17 So we targeted the Thursday, I think
18 it's April 16th, after Easter, and I said, you
19 know, "Sorry, we've got to work". And they said,
20 "It's 24 hours". I said, "Let's go".

21 So they pulled it off, and it was a
22 full team effort: our hospital team; this
23 construction company; St. Clair College, their own
24 resources were invaluable because they had their
25 own electricians, etcetera, who knew this building,

1 and plumbers, and they knew how to get, you know,
2 the services around the exterior. We had to bring
3 it in to the interior of the sportsplex. So it was
4 quite impressive.

5 So there was another long-term care
6 home, including Heron Terrace, that was in crisis
7 at that same time, showing a massive majority of
8 their residents positive. They decided to remain
9 in place. And we had around the same time
10 discussions with them about even extracting their
11 negatives into our sub-acute facility, and they
12 decided not to at the time just because they had so
13 many positives. I think the number was 70 to
14 80 percent. They decided to stay in place.

15 It became obvious that Heron Terrace
16 couldn't sustain their operations, even with some
17 staffing support from home and community services,
18 and discussions started rather rapidly about
19 decanting the residents, for safety concerns. I
20 mean, it's been shared with us: For the 140
21 residents, at one point they had three staff taking
22 care of 140 residents.

23 So on April 15th, the Director of Care
24 of Heron Terrace -- all during this, from
25 April 10th to April 15th, it's ongoing discussions

1 between this G5, myself, the Director of Care at
2 Heron Terrace. She attended the field hospital
3 with her team, and by that point we were getting
4 close to -- it was almost close to completion, and
5 she made a decision to decant the residents as
6 early as the 17th, which is the Friday. But we
7 picked the 18th, to make sure -- we didn't want to
8 do it later in the day on the 17th, we wanted her
9 to have a clear day. So we started taking on the
10 18th.

11 And construction, basically, was
12 completed by the 16th.

13 COMMISSIONER MARROCCO: This is really
14 off the topic, and I don't want to get too far off,
15 but did Heron Terrace indicate what was the cause
16 of the staffing problem, why the staff were not
17 showing up? I appreciate the nature of the disease
18 and everything, but I'm just curious if they said
19 why they were having the problem.

20 MR. MUSYJ: Yes. And Dr. Chevalier,
21 you can jump in. But this was early on in COVID, a
22 lot of anxiety, a lot of nervousness. No one
23 exactly knew the extent of this.

24 Again, we're in Windsor, right across
25 from Detroit. They're seeing a substantial amount

1 of positives in residents. Staff is testing
2 positive. Then, on top of it, you have staff that
3 are, quite rightfully, very nervous and are saying,
4 "I'm not showing up to work, I'm concerned". I
5 don't know if Dr. Chevalier...

6 DR. CHEVALIER: Yes, I think we have to
7 -- you know, we have the pleasure right now sitting
8 in November and we have eight months of learning
9 behind us. But, you know, back in March and April,
10 people were very, very scared, and there was very
11 little information and we were hearing and watching
12 what was going on in Italy and New York, and
13 Detroit right across the way.

14 You know, most long-term care homes did
15 not have appropriate PPE. They did not know how to
16 use their PPE, the PSWs. They were scared, and
17 they were just not showing up. They thought, "I'm
18 not getting paid enough to do this", quite frankly.
19 And there was very little support for them.

20 You know, the physicians were not
21 making rounds to show anybody any leadership in the
22 long-term care homes. It was a very fearful time
23 for everybody. And some of them were sick as well,
24 and of course, you know, they weren't going because
25 they were sick, but most, I think if you look back,

1 most of it was fear.

2 COMMISSIONER KITTS: Can I just ask.
3 So when it was moved to the hospital tent, I assume
4 that there was sufficient PPE and probably a sense
5 for the staff that they would be safer. And so did
6 you notice many coming back? Or was that
7 noticeable?

8 DR. CHEVALIER: So Dr. Kitts, so I'm a
9 hospitalist in the hospital. I travel between both
10 campuses. I'm well-known amongst the staff. The
11 field hospital was staffed by -- I was the lead
12 physician, the clinical lead. I was there rounding
13 on patients, but I was there every day as the lead
14 physician, and I took that responsibility very
15 seriously.

16 The staff that joined us at the field
17 hospital, some volunteered; many volunteered to go
18 there to work. And some came because they, you
19 know, they were float nurses and that was part of
20 their role, etcetera. But we had lots of PPE. We
21 never had a concern for that.

22 I will tell you that I was a bit of a
23 hound dog with PPE use, from day one. And David is
24 going to laugh at one of my pep talks that I gave
25 in the beginning. And I will tell you that I

1 watched people put their PPE on, and I didn't care
2 who it was, if it was David, if it was our Chief of
3 Staff, if it was the dietary staff or one of my
4 colleagues coming in, nursing staff, if I didn't
5 like how they put it on, I told them. You know,
6 nicely, obviously, and respectfully, but I would
7 take them out and I'd say, "I don't like how you
8 did you that. Can we go back over your PPE use?"
9 And that was donning and doffing.

10 I will say again, you know, the
11 history, it feels kind of funny to go back through
12 all the history, when we came to the field
13 hospital, but I think it's extremely important
14 because I think it was a storm that was happening.
15 You know, in March, when we were seeing all of this
16 unfold, you have to remember the anxiety in the
17 hospital. Just doing rounds, you could feel the
18 palpable anxiety from staff about -- you know, we
19 were not wearing masks in the hospital yet at that
20 time. There was no mandatory masks. I'm going to
21 tell you, I stuck my neck out as a chief and I
22 walked around and I said, "Put your masks on,
23 everybody. Get your masks on".

24 We had some physicians -- one of my
25 colleagues, actually, one of the doctors that

1 worked with me at the field hospital, her husband
2 was making 3D printed shields because we didn't
3 have shields at the time.

4 I was being very aggressive, I guess,
5 and very protective of the staff, whether that's
6 physicians or nurses or whoever it was on the
7 floors. You know, I went every morning, and this
8 is before we went to the field hospital, to kind of
9 give pep talks to calm the staff and say, "Guys,
10 we're going to get through this, but we're going to
11 get through this together".

12 So when we moved to the field hospital,
13 I think that everybody certainly knew that we
14 cared. It was very important for them to know that
15 I recognized their risk of stepping into that
16 arena, if you would, or that gymnasium. You know,
17 we had staff living in hotels. We had staff living
18 in trailers on their front yards so that they
19 wouldn't affect their families. Anxieties were
20 high, and they needed to know that they were safe.
21 And they did know that, I know that they knew that.

22 COMMISSIONER KITTS: Right. So you
23 brought medical leadership and an abundant supply
24 of personal protective equipment.

25 The question is: Did many of the staff

1 who left the long-term care home because of anxiety
2 and fear come back, or were they invited back to
3 the tent?

4 DR. CHEVALIER: So the staff from
5 long-term care never worked at the field hospital.
6 The staff that, if you would, walked away from
7 Heron Terrace, they are employees of Heron Terrace,
8 not of Windsor Regional and not of the field
9 hospital.

10 Remember, again, historically, it was
11 only at the time really when we were launching the
12 field hospital that hospitals were given, you know,
13 the mandate of going into long-term care to help
14 with all of that. Prior to the field hospital,
15 that was not our purview as an organization.

16 MR. MUSYJ: So what we had to do, the
17 concept of decanting was to, of course, extract the
18 positives. Because to this day we think when you
19 -- our theory, you can see it later, is if you have
20 five positives in long-term care, you've
21 technically got ten. You're chasing your tail at a
22 certain point. Especially in a lot of these
23 facilities, there's no way they can cohort safely
24 in place.

25 So the issue was to get them down to a

1 level of residents, that their staffing they had
2 could safely take care of the remaining residents
3 of Heron Terrace safely and from a proper IPAC
4 point of view. So at the same time we came into
5 Heron Terrace with our IPAC teams. And the long
6 story is you get into April, that's when the
7 hospitals and our region and across the province
8 divided up the long-term care retirement homes and
9 really got in with respect to prevention measures,
10 working as partners. And if there's one thing
11 coming out of this, too, is that needs to continue.

12 Eventually, when COVID goes away, if it
13 goes away, we got to continue those relationships.
14 We cannot lose the relationships that have been
15 formalized between hospitals and retirement homes
16 and long-term care homes regarding prevention
17 partnerships and dialogue. It's been phenomenal.

18 And we've seen recently, when we've had
19 other outbreaks, those relationships allow us to
20 immediately go back in. We go in all the time now
21 anyhow, but to go back in, help stabilize and avoid
22 larger outbreaks and avoid eventual deaths.

23 COMMISSIONER MARROCCO: Right. Does
24 that have an effect on terms of staff then in terms
25 of them staying?

1 MR. MUSYJ: Exactly. So by having
2 those "SWOT" assessments -- and I can tell you
3 personally, I went into the long-term care
4 retirement homes, part of it was selfish because I
5 want to pick my future house, but I went in to be
6 there for support and to show we're all in this
7 together, which we are.

8 We've had subsequent Zoom calls with
9 staff who weren't there at the time, didn't show up
10 to be part of it, to ask questions, to talk to
11 them, to provide that, hopefully, that confidence,
12 and to deal with what Dr. Chevalier stated.

13 Our most nervous time as an
14 organization was before we started getting positive
15 COVID patients. We were walking on eggshells. We
16 were scared to death, our staff was. But we did
17 the training, the education, the tabletops, the
18 ongoing support, that once we started getting COVID
19 patients in the hospital, then all that kicked in.
20 And our team's done an amazing job.

21 To this day, even though we're a pretty
22 large hospital, knock on wood, we've only had 14
23 positive staff members, and all from the community
24 and not one spread within the hospital to another
25 staff member or to patients. And that goes back to

1 what Dr. Chevalier stated. It's continually
2 reiterating that we're there for you.

3 I mean, I went into the field hospital.
4 Dr. Chevalier made sure I had proper PPE on, and
5 when I came out, I took it off properly. Again,
6 it's to show we're all in this together and we can
7 do this together and it's, knock on wood, going to
8 work.

9 COMMISSIONER MARROCCO: Do I understand
10 it that all of the long-term care homes in the
11 region are partnered with a hospital, so now they
12 have access to the expertise that's resident in the
13 hospitals, which the public spends all kinds of
14 money creating in the first place?

15 So now the homes can access that
16 because the partnerships exist?

17 MR. MUSYJ: Yes.

18 DR. CHEVALIER: Commissioner, in our
19 region we have 19 long-term care homes and 25
20 retirement homes, and they're split up regionally.
21 So Windsor Regional is partnered with a group of
22 those for IPAC supplies, practice, any outbreaks,
23 early intervention. Hotel-Dieu Grace Healthcare,
24 who is our sub-acute hospital, they have a
25 proportion, and then Erie Shores, which is our

1 other small community hospital out in Leamington,
2 they have a proportion of those as well. So yes,
3 they --

4 COMMISSIONER MARROCCO: No, go ahead,
5 Doctor. I didn't mean to interrupt. You finish
6 what you were going to say.

7 DR. CHEVALIER: I think that's been a
8 very, very important piece in prevention and
9 education for the staff and confidence for the
10 staff to know, and the families and patients there,
11 that they have appropriate education around what to
12 do to prevent COVID. They can help with cohorting
13 suggestions, they can help with PPE supply, which
14 of course was a huge issue.

15 You know, quite frankly, you had PSWs
16 walking around with the same pair of gloves they
17 had put on for you, they would take off and then
18 they would use for Dr. Kitts in the next room. And
19 they didn't understand. They didn't understand
20 infection control because that's not been a big
21 focus of their training as a PSW, pre-COVID, which
22 of course will change in the future.

23 MR. MUSYJ: So Windsor Regional has
24 responsibility for 21 of those long-term care
25 retirement homes. Physically, our team goes in

1 twice a month physically. We have weekly phone
2 calls with every single one of them, and we're on
3 speed dial.

4 By going through all 21, part of that
5 was not only the education and training, and so we
6 looked at the homes to say, if this home has a
7 positive, there's going to be an issue in this
8 particular home. When we went in, we developed
9 plans with them to say, okay, if you get a
10 positive, where are you going to cohort them. And
11 some of them had places, segregated spots, that
12 they could do it in. A lot of them don't.

13 So they're on our hypersensitivity
14 list, meaning, if positives start, lights go off
15 because we say this could wind out of control
16 really fast in this particular home.

17 COMMISSIONER MARROCCO: Was the
18 partnering or the pairing -- I guess pairing is
19 probably the better word -- was the pairing
20 voluntary, or how did you do that?

21 MR. MUSYJ: Yes, and it took some
22 trust. So what we did is the three hospitals just
23 went through the list and divided them up, as
24 Dr. Chevalier said, proportionately or equitably,
25 based upon the size of the hospital. And

1 geographically we tried to do it that way so
2 they're close to the hospitals.

3 COMMISSIONER MARROCCO: Right.

4 MR. MUSYJ: But it was trust. We had
5 to make it very clear when we were making that
6 first phone call to say we want to come in is we're
7 coming into help, which we were, and we're doing
8 this from a partnership point of view.

9 Again, that's why I felt it important
10 for me to go to try to express that, that we're all
11 in this together, that we cannot do this alone.
12 And this is not meant for us to criticize your
13 operations, we're here to help. If you want to
14 tell us to stop, we'll stop.

15 In general, it was fine, 95 percent had
16 no issues. There was 5 percent it took a little
17 bit of, you know, convincing to get the invite in,
18 but they did eventually. And now it's 100 percent
19 because the relationships have developed, the trust
20 has developed. But you got to earn that trust.

21 So we couldn't come in, you know, guns
22 blazing and saying, "We're here to tell you how to
23 run your place". We're here to help.

24 COMMISSIONER MARROCCO: Was Heron
25 Terrace private, municipal, or provincial?

1 MR. MUSYJ: Private.

2 DR. CHEVALIER: Private.

3 COMMISSIONER MARROCCO: Does it matter,
4 in terms of the model, whether you're dealing with
5 profit, not for profit, in terms of the preparing
6 and that sort of thing?

7 MR. MUSYJ: No, not as concerned the
8 pairing. I know there's studies and things about
9 people have said the differences in the outbreaks,
10 etcetera. We haven't seen that.

11 Clearly, in municipal homes, it's
12 funded differently. We used to run a long-term
13 care facility at Windsor Regional Hospital and we
14 know what the funding is and to operate it, what
15 you're operating at. So the municipal homes are
16 funded and staffed differently than private, or
17 other homes, so...

18 COMMISSIONER KITTS: Can I ask a
19 question about the cohorting? So I understand that
20 the tent was created to help cohort COVID-positive
21 patients from long-term care.

22 MR. MUSYJ: Well, it wasn't created,
23 and just Dr. Kitts will just -- we've heard that
24 before. It's not a tent, it's a building, the
25 field hospital. Just so it's on the record, people

1 don't think it's a tent in the middle of a field.

2 But it was originally created, in our
3 mind, to create additional space for patients past
4 their acute phase in the hospital that had nowhere
5 to go but still needed care.

6 In early April, it shifted. When this
7 started happening, we said -- we got together as a
8 team and said, "Okay, we're starting to see this
9 long-term care thing break loose. Why don't we
10 shift gears and use it for this?" And immediately
11 everyone said, "Yes, let's go. It's the right
12 thing to do".

13 COMMISSIONER KITTS: We now know that
14 cohorting is an important IPAC measure. A lot of
15 the homes don't have the ability to cohort. So my
16 question is, when you're in those homes and now
17 that everybody has seen how good it was for the
18 Heron Terrace, is there pressure to move patients
19 from long-term care homes who have outbreaks and
20 cohort them at the hospital facility? And if so,
21 who makes the decision as to whether they cohort in
22 place or cohort at the hospital facility?

23 MR. MUSYJ: So the way it's worked is,
24 right now the process would be Public Health
25 Medical Officer or Health would work with the

1 medical director of the particular home, along with
2 the director of care at the particular home. And
3 they would collectively make the decision. They
4 might, you know, ask us for advice or suggestions,
5 but we'd leave it up to them to agree on the
6 transfer to the field hospital.

7 The retirement homes, which a lot of
8 them don't have -- you know, each person has their
9 own individual physician. There might be a
10 physician over the top of it for the corporation.
11 They've indicated the same thing, if they start
12 getting outbreaks, they got us on speed dial. And
13 we're, right now, hours away from ready to go, if
14 needed.

15 COMMISSIONER KITTS: And does the field
16 hospital have significant capacity, or is that
17 filling up as well?

18 MR. MUSYJ: The field hospital has
19 capacity for 100.

20 COMMISSIONER KITTS: Okay. So you're
21 not using it right now?

22 DR. CHEVALIER: No.

23 MR. MUSYJ: As of right now, we are
24 not, but by the time we hang up this call, we
25 could. We have one home in our (overspeaking) --

1 DR. CHEVALIER: So Dr. Kitts, after we
2 cleared Heron Terrace and returned their patients,
3 we have not had to go back to the field hospital
4 for any of the local outbreaks. They have been
5 managed because of that relationship and our
6 ability of healthcare organizations to go in with
7 their IPAC suggestions and practice and cohorting.

8 We have had a number of outbreaks in
9 our community since we actually, if you would, turn
10 the lights out at the field hospital. It's still
11 all there, ready to go at a moment's notice. But
12 we've done all these other things in the meantime
13 with all those other outbreaks and have managed
14 quite well, to be honest with you.

15 COMMISSIONER KITTS: Yes.

16 DR. CHEVALIER: So it's a combination,
17 and I think that's what's really important for us
18 all to remember, it's a combination of things to
19 help our communities in long-term care and
20 retirement home care.

21 The IPAC, the prevention, is so very
22 important. And then, you know, you go down your
23 list of prevents and tests. And, of course, now we
24 can get testing on turn-around much quicker than we
25 could back in the springtime.

1 So you can effectively cohort if you
2 have the capacity in the long-term care home. And
3 most of them have scaled back their patient
4 numbers, so they have left themselves, if you
5 would, some wiggle room to cohort, which has been
6 helpful. Of course, maybe if you're not trying to
7 get into long-term care because there's not as much
8 capacity, but... And then the field hospital or
9 extrication of the patients, when you've got an
10 outbreak that's too big, is really of paramount
11 importance, I think.

12 COMMISSIONER KITTS: Thank you very
13 much. That's very, very clear. Thank you.

14 COMMISSIONER MARROCCO: Commissioner
15 Coke.

16 COMMISSIONER COKE: May I just ask the
17 question.

18 In terms of when that decision is made
19 that we're going to transfer somebody out to the
20 field hospital, does that require the resident or
21 the family's approval or permission to do that?

22 MR. MUSYJ: Yes.

23 COMMISSIONER COKE: Okay.

24 MR. MUSYJ: Yes, that takes place -- so
25 with Heron Terrace, it took place, and some of them

1 initially said "No". And then once they heard
2 about what was happening at the field hospital,
3 they would say "Yes". And some of them stayed in
4 place. So I don't know.

5 Dr. Chevalier?

6 DR. CHEVALIER: I was going to say, the
7 other issue, they need consent, of course, to move
8 there. There were some patients that I felt --
9 because all those calls would go through me so that
10 I would know who was coming.

11 You know, in long-term care, it's not
12 all just seniors, you know, that have complex --
13 some of them are younger people with Down Syndrome,
14 etcetera. If they were clinically very unwell,
15 needing high oxygen already, and their family
16 wanted them to be a full resuscitation, it is not
17 appropriate, in my medical opinion, to have them go
18 to field hospitals. So we would divert those as
19 they came up to the acute care facility, where the
20 care needs would be better met if someone was
21 needing ICU, for example.

22 So the family has to consent, but you
23 do have to know the clinical scenario and the goals
24 of care and expectation for resuscitation and
25 whatnot of the patient prior to moving to a field

1 hospital.

2 COMMISSIONER MARROCCO: So part of it
3 is whether the person's condition can be --

4 DR. CHEVALIER: Managed.

5 COMMISSIONER MARROCCO: -- if
6 necessary, managed at the field hospital, it's part
7 of the -- so you make that decision?

8 DR. CHEVALIER: Yes. I made those
9 decisions when we were having the intake of the
10 patients, yes. I mean, we did have to move some
11 out to acute care. That's why you have to have
12 someone who's seasoned and willing to make those
13 decisions.

14 When people with COVID start to do
15 poorly, they crash fairly quickly, so you don't
16 necessarily have time to move them. So everybody
17 needs to know at the outset what the goal is with
18 that patient's care. And, of course, coming from
19 long-term care, many patients are not full
20 resuscitation. They are, you know, aggressive
21 medical management but not to go to ICU.

22 We do know, of course, that patients
23 with COVID that were -- of course, back in March
24 time or April, remembering, you know, we didn't
25 have much experience with intubating COVID-positive

1 patients, but at this stage in your life, if you're
2 requiring intubation, you are not going to survive,
3 quite frankly.

4 MR. MUSYJ: So we have to remember
5 again at this time a lot of the families hadn't
6 seen their loved one or talked to their loved one,
7 there wasn't enough time for like four to
8 six weeks. So those were the stories we were
9 getting once they moved to the field hospital.

10 So I just outlined some of the things
11 on this slide. It gives you a photo of what it
12 looked like, all the benefits of being in this
13 facility, aside from the price. It had overhead
14 sound for music; it had a back-up generator; a
15 separate area for hot and cold, meaning hot zone
16 being where COVID's at, cold zone being outside in
17 the lobby area. Making sure we have proper donning
18 and doffing areas; easy access in and out for food
19 supplies, residents, to come in and out, through
20 ambulance. We had our own lab and pharmacy in
21 there. It was basically a satellite hospital
22 facility.

23 If you look at this, what we did is we
24 brought electricity and water into the middle, so
25 there's sinks with running water. There's Pyxis

1 machines for drugs, the hospital computer system.
2 If someone called the hospital main switchboard,
3 you could ask for the field hospital and you would
4 get directly dropped over here.

5 We created it as if it was just an
6 individual hospital site.

7 It has WiFi. Why that's important --
8 and we enhanced it -- is we could run a hundred
9 iPads, and we bought iPads for every single
10 resident so they could communicate. It was on a
11 stand and our staff would help; they could
12 communicate 24 hours a day, if they wanted to, with
13 their family. From a resident point of view, we
14 had some circumstances where residents were passing
15 away and the family just wanted to watch and be
16 with them remotely. We set that up.

17 At the same time as things evolved,
18 some of these residents really liked their TV and
19 they were into Netflix and TV. We had it going.
20 And they thoroughly enjoyed that as the time
21 evolved. And they had that, stuff they were not
22 able to have at their long-term care home.

23 For those, and we talk about that, I
24 know because at the time we were hearing about it,
25 is you shouldn't move the residents to these

1 facilities, they should stay in place as best you
2 can. Yes, that's great, but they were staying in
3 place, and I'll be blunt: They're going to die in
4 place. The goal here is to survive.

5 The team did it in an amazing fashion,
6 not only survive but survive within a very warm and
7 caring environment. And if they did pass away,
8 they passed away in that same warm and caring
9 environment. That's no disrespect to the long-term
10 care home at the time, but they just couldn't do
11 it. And some just can't do it. It just starts
12 unwinding so quickly, they can't do it.

13 I don't know, Dr. Chevalier, if I heard
14 that properly.

15 DR. CHEVALIER: You know, there was a
16 lot of heavy-handed comments. One in particular
17 that was very, I thought was hurtful, actually,
18 from a geriatrician in Toronto, about moving this
19 population into the field hospital.

20 But I'll be honest with you,
21 Commissioners, those patients -- you know, we had
22 53 patients of that 150-bed facility, and had we
23 not moved them, that whole facility would have been
24 infected. Truly, those patients die of neglect,
25 and that is just horrific, in my opinion.

1 While we moved them to a gymnasium,
2 yes, we had wonderful staff, the patients were
3 cared for. And I think, in Canada, I think our
4 citizens deserve that. If they died, they died
5 with dignity and their family being able to at
6 least know what was going on, and we were with them
7 that whole time. You know, we had nurses sit with
8 patients. And I promised every family member -- I
9 mean, I spoke to them every single day and I -- no
10 one will die alone if they were going to pass with
11 COVID at the field hospital.

12 I think at the time it was the best
13 thing that we could have done for our community. I
14 really feel strongly that I think that, for
15 \$50,000, you guys, with the healthcare expenses
16 that we waste, I think that if this health
17 community survive a COVID outbreak in long-term
18 care, that is -- I think it is well worth and I
19 would do it again, and that's why we only have the
20 lights off, and I'll go there tomorrow if we need
21 to. I --

22 COMMISSIONER MARROCCO: Go ahead,
23 Doctor.

24 DR. CHEVALIER: No, that's all right.
25 You go ahead, Commissioner.

1 COMMISSIONER MARROCCO: I have some
2 difficulty with the idea that for the patient's own
3 good, and this notion that for the patient's own
4 good, don't move them.

5 That just seems to me to be a very, if
6 you'll pardon the gender-specific term, a
7 paternalistic approach. Each one of these
8 families, or the individuals, if they were
9 competent, were asked to consent, and they
10 consented. And I don't understand, quite frankly,
11 why their consent doesn't -- it seems to me, in
12 terms of what you were doing, their consent counts
13 for something. If they agree to go there, why
14 would somebody come along and say it's not good for
15 them? I just think that that disregards their
16 control over their own affairs.

17 I think it's an excuse, quite frankly.
18 It may very well be an excuse for not doing
19 something that needs to be done.

20 DR. CHEVALIER: I would totally agree
21 with you. I think the other thing is, I think it
22 really is almost ignorance of what the fear was at
23 the time and of the inability to stop this thing.
24 Once it gets into a home, it's like wildfire,
25 without the proper help. And at the time we

1 definitely did not have the proper help to get
2 them, other than this. And this worked
3 wonderfully. Honestly, it did. And the
4 relationships that were built.

5 The patients were very, very, well
6 cared for. Had my mother been sick, I would have
7 been happy for her to have been there, really. I
8 can honestly say that. Yes.

9 COMMISSIONER MARROCCO: On the staffing
10 side, one of the things we've heard is that the
11 hospitals were able to staff because of the
12 anticipated wave of people that didn't show up, or
13 I'll put it differently. The hospitals are gearing
14 down in certain areas, created a kind of surplus
15 that could be employed in the field hospital. Is
16 that kind of a necessary component to this?

17 MR. MUSYJ: Yes. Yes, at the time we
18 were ramping down surgeries. So, as a result, we
19 had staff "available", a lot easier back then.

20 However, even through today, we've
21 continually planned ahead. And one of the issues
22 that we came across was this concept of tuition fee
23 set-aside. It's for colleges and universities. I
24 guess, when you sign up to be in a college or
25 university, the college or university holds back a

1 certain amount of the tuition and then reinvests it
2 in work-study programs, etcetera, for the students.

3 So what we worked very closely with is
4 St. Clair College, in order to increase, aside from
5 hiring, is using -- it's not additional monies,
6 it's existing monies -- is using these monies to
7 hire these nursing students back into the hospital,
8 to help support our staff.

9 You have to remember, a lot of these
10 nursing students are working as PSWs in long-term
11 care retirement homes as we speak. And a lot of
12 them are looking for jobs, in addition. Aside from
13 those working there, which stay there, there's more
14 out there looking for jobs. So you have to do
15 creative things like that in order to help support
16 your staff.

17 So we're ready to go again. If we have
18 to flip the switch again, we have staff ready to go
19 from our various areas, even though our hospitals
20 are at 100 percent capacity, to go back in very
21 swiftly for the first 30 patients that go in.

22 It gets tighter after that, but part of
23 it as a result of having the nursing students
24 available to help support our acute care hospital
25 staff, as well as the staff here, at the field

1 hospital, taking care of quote, "long-term care
2 retirement home patients".

3 COMMISSIONER MARROCCO: And that piece
4 was worked out during the period from March to
5 today, somewhere in there you address this problem
6 that way?

7 MR. MUSYJ: Yes. So as, you know, we
8 started ramping back up surgeries and, of course,
9 the hospital started filling up, we have to think
10 about, okay, where are we going to find the staff
11 to restart the field hospital? How are we going to
12 do this?

13 And working with our college, who is
14 amazing, St. Clair College, Patti France, she said
15 "Hey, what about this?" We're like, "Bingo,
16 perfect". And it's existing dollars, it's not new
17 dollars. It's existing programs. And, again,
18 everyone should be taking advantage of it and, you
19 know, working and getting these students in to the
20 hospitals and to the long-term care retirement
21 homes.

22 COMMISSIONER MARROCCO: Okay.

23 MR. MUSYJ: So this slide here shows
24 the statistics that we talked about. I mean, some
25 examples, pre-COVID, we had patients that couldn't

1 walk. Came into the field hospital, clearly in
2 wheelchairs and/or stretchers. They walked out of
3 the field hospital. So that's the level of care
4 that Dr. Chevalier and the team provided is, they
5 weren't walking, it had nothing to do with COVID;
6 they started walking again.

7 So our focus, you know, lessons
8 learned, the first one is communication is
9 critical. What we made sure is we communicated, as
10 stated, about the consent and getting consent. I
11 called every single POA that her family member
12 moved in.

13 Dr. Chevalier called them first, the
14 clinical team, to say "They're here", boom, boom,
15 boom, "This is what we're going to do. Here's the
16 game plan". As Dr. Chevalier stated -- and I state
17 it for the record, she should be sainted as a
18 result of this because she called the families
19 every day, which was critical. And I called them
20 when they came in, to say, "Thank you for trusting
21 us".

22 What we did, here is a photo of a
23 patient's room. We wanted them to send us all the
24 photos they had of their loved one and their family
25 members, and we plastered it as wallpaper in their

1 rooms so the resident can see that. And also
2 you'll see a photo there: We made it look as if
3 there was a window or windows, and each of the
4 rooms had two of these. They could look out and
5 look at an outdoor field or garden, so it made it
6 look like they were in a house or in their room.

7 Of course, like I said, we had the
8 iPads, etcetera. But communication, communication,
9 communication. And we called on discharge,
10 unfortunately, when they passed away, called as
11 well, and to a person.

12 First of all, they all wanted to thank
13 Dr. Chevalier and the team, but to a person, even
14 when they lost their loved one, they said they were
15 able to spend time with their loved one. And they
16 knew going in -- and there's some that went in and
17 are shocked to this day their loved one's alive.

18 DR. CHEVALIER: True.

19 MR. MUSYJ: And they can't believe it,
20 because they knew going in, their loved one was not
21 in a good spot.

22 So our second point on lessons learned
23 is physician leaders like Dr. Chevalier and others.
24 I mean, it's endless, but you need that.

25 Again, when we did the costing on this,

1 we were staffed "rich"; it was 700 bucks a day. So
2 we're not talking about a considerable amount of
3 money for taking care of individuals in the field
4 hospital. It was an amazing thing.

5 Goals of care, I don't know if
6 Dr. Chevalier wanted to talk about the importance
7 of that.

8 COMMISSIONER MARROCCO: Just before you
9 do that, two things. First of all, Dr. Chevalier,
10 we all heard what was just said. There's a
11 transcript in case you need it in the future to
12 prove what was said.

13 Secondly, what did it cost -- I think
14 you gave us this figure a few minutes ago, but I
15 just want to be clear about it. What did it cost
16 per bed to do this? What did it cost to do this?

17 MR. MUSYJ: Yes. So our cost was, per
18 patient, \$700 per day. Right now, you use a
19 cost -- Dr. Kitts would know this, it's about --
20 the Ministry uses about \$1,300 a day for acute
21 care, about \$500 a day for sub-acute/ALC. So we
22 were at \$700. And that's with, you know, staff
23 beyond appropriately, far greater than of course
24 what they would get at a long-term care home, but
25 again they were sick.

1 And we wanted to make sure the trust
2 and the confidence, to say, number one, there's
3 going to be communication; number two, you're going
4 to be able to see your loved one, via virtually;
5 and number three, you're going to be confident of
6 the staffing. From a physician point of view, as
7 well as a nursing point of view, that you're going
8 to be confident they were going to be taken care
9 of. And again, for \$700 a day, I think it was an
10 amazing investment. Aside from the construction
11 costs.

12 COMMISSIONER MARROCCO: Okay.

13 DR. CHEVALIER: So, following along our
14 lessons learned there. The goals of care, you
15 know, to make the transition of patients smooth
16 required some thought-out efforts, actually, which
17 is well worth it and, quite honestly, you guys are
18 looking at long-term care overall, and these things
19 truly should be already in patients' charts and
20 updated regularly. But clear goals of care, or
21 resuscitation wishes by families.

22 There needs to have updated medications
23 lists, and their complex medical history list
24 should all be updated in a concise way, to be
25 handed off to either acute care or a field hospital

1 or wherever they're going.

2 So every family member needed to have
3 that goals-of-care conversation prior to coming to
4 us while they were getting consent, because that
5 did make a difference.

6 I did ask that every patient have
7 somewhat of, if you would, a friendly summary of
8 who they were. So, you know, if David came into
9 the hospital, I wanted to know what did he go by.
10 Did he go by "Dave"? Did he go by "David"? Who
11 was his contact, where he grew up, what he liked to
12 do. So that when we quickly walked into a room and
13 they were scared and they were being moved, that we
14 could quickly communicate with them in a friendly
15 sort of way, as we were all new team members to
16 them.

17 We pasted those right on the outside of
18 the doorway on your way into the patient's room, so
19 that everybody had access to that, whether that was
20 the dietary staff delivering breakfast, lunch or
21 dinner, or an ambulation person, or me as a
22 physician, or the nursing staff.

23 So I think it provided us with a warm
24 environment so that we could, you know, talk to
25 them about things that they liked. Remember, many

1 of these patients had dementia. So you had to
2 quickly make some ground to be friendly and make
3 them feel safe and cared for, comforted.

4 We did have to move one patient out
5 from the field hospital that rapidly deteriorated
6 and he was a full resuscitation, but only one,
7 actually. So that was good, I guess.

8 The second or fourth point there is to
9 make it friendly, so that was with our family
10 pictures, and we had a big colour printer. Of
11 course, we were receiving patients all the time so
12 this was an ongoing thing to be pasting up
13 pictures. And we had young man who was
14 mid-fifties, developmentally delayed. So he was a
15 big draw'er. So we had endless stacks of paper and
16 magic markers, and then his room was literally
17 plastered with his pictures that he would create
18 for all of us.

19 And then again five is our "prevention
20 is key". Our SWOT teams that went in to, you know,
21 Heron Terrace to help them clean up, because it
22 took 50-some days for them to get out of outbreak,
23 which, you know, that was a long time. And we were
24 still receiving patients in waves from them as they
25 were trying to clean up and cohort their patients

1 so they could get themselves out of outbreak.

2 Again, Commissioner, you have to
3 remember, when we look back at April, now moving
4 into May and June, we were not yet as a province,
5 our Public Health was not making a statement of how
6 we clear these patients and decant them. So what
7 do we do with them? Even when they were in the
8 hospital, how do you clear them of their infection?
9 Do you need two negative swabs to send them back to
10 long-term care? Do we need just time-based?

11 That was still up for debate, which was
12 a part of our dilemma, if you would, at the field
13 hospital. Because now we had this cohorted patient
14 at the end, and what do we do with them? And Heron
15 Terrace was still in outbreak.

16 So we've moved a long ways from that
17 knowledge base back in May and June to where we're
18 at now. And now we have time-based clearance. You
19 know, if you had COVID now, 14 days and you're
20 cleared, and then you can go back to your nursing
21 home or long-term care retirement home, or wherever
22 it is; go back to work, if you're working. But we
23 didn't have that back then. So family members were
24 anxious still about their family member still
25 being, you know, deemed not well enough to go back

1 to long-term care.

2 So it was important for us to, of
3 course, care for them and make it an enriching
4 environment for them, which we did, and it was fun,
5 actually. Those were nice times to celebrate,
6 quite honestly, after coming through that dark
7 time.

8 MR. MUSYJ: Yes, so Dr. Chevalier had
9 tea parties, balloon parties.

10 DR. CHEVALIER: Oh yes. We had
11 birthdays to celebrate.

12 COMMISSIONER MARROCCO: Were you able
13 to do testing at your own lab?

14 DR. CHEVALIER: No. Unfortunately,
15 Commissioner, Windsor does not have a public health
16 testing facility here. That was closed,
17 unfortunately. I don't know how many years ago,
18 David, maybe seven years ago here.

19 So all of our testing has to go to
20 London. Of course, that was part of our problem
21 with all of the outbreaks at the beginning. The
22 backlog and the turn-around time for testing was
23 extraordinarily long. So that was part of Heron
24 Terrace's problem. They would test and they
25 wouldn't get their test results back for five days.

1 Well, in the meantime, the virus is just
2 replicating in the long-term care home.

3 So we don't have any testing available
4 locally in Windsor. It all goes to London. And at
5 the time, I don't even think they were going to
6 London, David, back in April. I think they were
7 going to Toronto. So London wasn't even an option
8 for us.

9 So that, you know, it was just -- it
10 was the perfect storm for a lot of problems.

11 COMMISSIONER MARROCCO: Did your lab at
12 the hospital have the capability of doing the test?

13 DR. CHEVALIER: No.

14 MR. MUSYJ: No, no. At the time you
15 needed, I forget the levels, I think it was Level 3
16 lab. We don't have that.

17 COMMISSIONER MARROCCO: Okay.

18 MR. MUSYJ: So I mean, now we've
19 acquired a PCR machine, because since then they've
20 developed the stand-alone machines. We've acquired
21 it. Just like everyone else, we're waiting on test
22 kits now to use it.

23 But London is a great partner. Their
24 turn-around time on the hospital side right now is
25 very tight. You know, within 24 hours basically,

1 36, we get turn-around time.

2 The Public Health side to which
3 long-term care runs through has struggled from the
4 start. And that's .6 is, because there's delays --
5 you know, the approach we've taken is: You get a
6 positive, you go in and test everybody, cohort
7 test, cohort test.

8 There's multiple studies on this across
9 the world that it works; if you can't cohort, you
10 extract. And I know, you know, there's studies,
11 you know from Hong Kong, let's say, you just
12 extract, forget about cohorting. And you know, I
13 think we lean towards that, too, because again, as
14 stated in point 6, our position is: If you have
15 five positives in long-term care or retirement
16 home, you have to assume you've got ten.

17 We indicate there, yes, moving creates
18 risk. However, the conditions in which they're in,
19 the goal is survival, and that's our focus.

20 COMMISSIONER MARROCCO: It wouldn't
21 only be an assumption. I mean, there is a
22 precautionary principle that has been suggested as
23 an approach and that you're supposed to apply,
24 which would be you assume ten and you don't wait
25 for the science. You make the assumption.

1 MR. MUSYJ: Yes. As I stated, plan for
2 the worst. So that's the purpose.

3 Sorry, Dr. Chevalier.

4 DR. CHEVALIER: I was just going to
5 say, and again you have to kind of go back in time.
6 But Heron Terrace was having such a hard time
7 getting their testing turned around quickly enough,
8 that I remember our VP in charge of the field
9 hospital, Karen Riddell, who is the lead for our
10 IPAC and the SWOT team, and I am also in charge of
11 the testing centre, the COVID assessment centres,
12 as the lead physician.

13 I remember Karen and I being so
14 frustrated trying to track these tests that were
15 getting done at Heron Terrace. And I said, "Karen,
16 we need to stop and we need to put them all through
17 the hospital, put them all under my name and make
18 them as if they're a hospital patient", because we
19 could get priority in the broken system at the
20 time.

21 And that actually helped because we
22 would get the test results back quicker, as opposed
23 to just having them go through the normal testing
24 of long-term care patients at the time. And that
25 did, I think, swing the tide a little bit because

1 we could actually get the tests and get the
2 patients out. Because at one point, honestly, it
3 felt like we were in a sinking ship because we
4 could not get them out of outbreak. But it was
5 largely because of that long turn-around time in
6 the testing.

7 MR. MUSYJ: So, Commissioners, that's
8 the end of our "formal presentation". And if you
9 have any more questions, we can talk, we can
10 answer, try --

11 COMMISSIONER MARROCCO: Commissioner Coke?

12 COMMISSIONER COKE: I'm just curious,
13 given the success that you've had with this model
14 and how you've approached it here, if there's been
15 a lot of sharing with your colleagues across the
16 Province or through some mechanism in terms of
17 lessons that others can learn?

18 MR. MUSYJ: Yes. So we received phone
19 calls from various jurisdictions about it, about
20 the field hospital, how it was created, how it
21 works. And Dr. Chevalier and I trying to recreate,
22 remember history, it was late June we got a call
23 from the Ministry, and I think maybe the pressure
24 in the system alleviated a little bit and now we're
25 getting far more calls about the field hospital and

1 the concept. But again, unfortunately, I'll be
2 frank, is I think some of those comments out there
3 of not moving were very strong and have not allowed
4 people to really aggressively look at this. So,
5 hopefully, that goes away.

6 COMMISSIONER MARROCCO: Which Ministry?

7 MR. MUSYJ: It was Health reached out
8 early. Long-Term Care reached out recently.

9 COMMISSIONER MARROCCO: Did you ever
10 hear back from them?

11 MR. MUSYJ: Just I don't know,
12 Dr. Chevalier, the phone calls were, you know,
13 positive. We shared all the information we had,
14 basically shared what we shared here, and we
15 haven't heard anything. You know, other
16 municipalities have called, other provinces have
17 called. So we shared exactly what we shared here
18 and how we set it up and all that type of
19 information.

20 Chatham-Kent Health Alliance has built
21 one themselves, used the same contractor we did,
22 got the same price. So good for them. And so
23 they're ready to roll, too, if needed.

24 Again, our goal is we hope to never
25 have to go back into the facility, to care for

1 long-term care patients or retirement home
2 patients, or any patients for that matter, because
3 we're really focusing on the prevention phase, and
4 that's been relatively successful so far in our
5 region. But we're ready to go, if need be, and
6 it's there. And we know it works. And I know the
7 minute we say to staff this time, "Are you
8 interested in going to work in a field hospital?",
9 we'll probably have 5,000 hands in the air, saying,
10 "Let's go". Because they know how successful it
11 was.

12 COMMISSIONER MARROCCO: Well, I don't
13 think we have any further questions. It was a very
14 complete presentation. It's very helpful to us.
15 We have been struggling with this, and it's very
16 helpful to actually talk to someone who actually
17 did it, and understand the results. It's very,
18 very helpful, makes it real.

19 So thank you very much for the time,
20 and with your permission, we may circle back if
21 we're missing a piece of information.

22 DR. CHEVALIER: It's been my pleasure,
23 Commissioner, to share this.

24 I think there's a lot of changes that
25 need to come to long-term care that COVID has

1 uncovered. So they're a long time coming. So you
2 have great responsibility on your shoulders, and if
3 I can ever be of help, please don't hesitate, I
4 would love to participate in it. And I wish you
5 the best pulling together your report.

6 COMMISSIONER MARROCCO: Well, there's a
7 transcript of that comment, too, Doctor. We'll
8 remember that. Thank you for the offer. Much
9 appreciated.

10 DR. CHEVALIER: You're welcome.

11 MR. MUSYJ: Thank you, everybody.
12 Please stay safe. And we're there for you if you
13 need anything; just holler, we'll respond.

14 COMMISSIONER MARROCCO: Thank you.

15

16 -- Concluded at 10:25 a.m.

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1 REPORTER'S CERTIFICATE

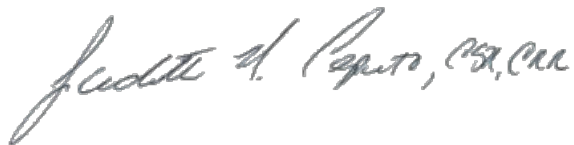
2
3 I, JUDITH M. CAPUTO, RPR, CSR, CRR,
4 Certified Shorthand Reporter, certify;

5
6
7 That the foregoing proceedings were
8 taken before me at the time and place therein set
9 forth;

10
11 That all remarks made at the time
12 were recorded stenographically by me and were
13 thereafter transcribed at my direction;

14
15 That the foregoing is a true and
16 correct transcript of my shorthand notes so taken.

17
18
19 Dated this 20th day of November, 2020.

20
21 

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<u>WORD INDEX</u>				
< \$ >	400,000 5:1	Afghanistan	appreciated	authority 8:25
\$1 19:22	42 17:3, 11	18:3	67:9	17:4
\$1,300 55:20	< 5 >	after 24:15, 18	approach 8:1	available 20:1
\$30,000 23:18	5 37:16	41:1 51:22 60:6	49:7 62:5, 23	50:19 51:24
\$50,000 48:15	5,000 66:9	agenda 4:15	approached	61:3
\$500 55:21	50-some 58:22	aggressive 22:5	64:14	avoid 32:21, 22
\$700 55:18, 22	53 47:22	30:4 44:20	appropriate	
56:9	5th 22:25	aggressively	27:15 35:11	< B >
\$800,000 23:13	< 6 >	65:4	43:17	back 5:9, 13, 17
< 1 >	6 62:4, 14	ago 7:8 55:14	appropriately	6:12 7:3 10:16
10:25 1:7 67:16	< 7 >	60:17, 18	55:23	12:1 13:5, 14
100 23:23	70 25:13	agree 9:17	approval 42:21	15:18 16:10
37:18 40:19	700 55:1	40:5 49:13, 20	approved 10:9	17:14 19:19
51:20	< 8 >	agreement	17:2	20:3, 5, 7, 11
10th 21:21	80 25:14	17:13	approximately	21:16 22:20, 21,
22:12 24:5	< 9 >	agri-food 22:18	5:1 22:1	23 24:7, 11
25:25	9:00 1:7	ahead 8:19	April 13:15	27:9, 25 28:6
13th 22:22	95 37:15	35:4 48:22, 25	14:4 19:21	29:8, 11 31:2
14 33:22 59:19	< A >	50:21	20:19, 23, 24	32:20, 21 33:25
140 22:1 25:20,	a.m 1:7 67:16	air 66:9	21:13, 16, 21	41:3, 25 42:3
22	ability 18:13	alerted 21:22	22:12, 22, 23, 25	44:23 50:19, 25
150-bed 47:22	39:15 41:6	align 10:4	24:5, 10, 18	51:7, 20 52:8
15th 25:23, 25	abundant 30:23	alive 54:17	25:23, 25 27:9	59:3, 9, 17, 20,
16th 24:18	access 8:11	alleviated 64:24	32:6 39:6	22, 23, 25 60:25
26:12	34:12, 15 45:18	Alliance 10:7	44:24 59:3 61:6	61:6 63:5, 22
17 20:25	57:19	65:20	area 19:13	65:10, 25 66:20
17th 26:6, 8	acquired 61:19,	allow 32:19	45:15, 17	backlog 60:22
18th 20:24	20	allowed 65:3	areas 45:18	back-up 19:16
26:7, 10	Act 17:4	alternative 17:20	50:14 51:19	45:14
19 34:19	action 8:12	amazing 33:20	arena 19:8, 11,	Bahal 2:11
19th 1:6	actively 13:12	47:5 52:14	12, 13 30:16	balloon 60:9
1st 19:21	actual 17:13	55:4 56:10	Armed 17:19	bandwidth 18:16
20:19, 23 22:23	acute 15:23	ambulance	Army 17:18	base 59:17
< 2 >	16:1 39:4	22:16 45:20	aside 45:13	based 36:25
2020 1:6 68:19	43:19 44:11	ambulation	51:4, 12 56:10	Basically 16:23
20th 68:19	51:24 55:20	57:21	asked 3:4	26:11 45:21
21 35:24 36:4	56:25	amount 26:25	12:20, 22 13:22,	61:25 65:14
24 19:22 24:20	Addictions 8:4	51:1 55:2	24, 25 14:2, 10	basketball 19:9
46:12 61:25	addition 51:12	and/or 15:24	24:7 49:9	20:5
25 34:19	additional 39:3	53:2	asking 13:18	bed 12:20, 23
< 3 >	51:5	Andy 17:17	assessment	14:3 55:16
3 61:15	address 52:5	18:1 19:1	21:8 63:11	beginning
30 51:21	ADM 16:24	Angela 1:13	assessments	28:25 60:21
30,000 23:19, 22,	adopted 15:13	anticipated	33:2	believe 16:21
23	Adrian 2:8	50:12	assets 19:25	54:19
36 62:1	advantage 52:18	Anxieties 30:19	Assistant 16:24	benefits 45:12
3D 30:2	advice 40:4	anxiety 26:22	assume 14:1	best 16:15
< 4 >	affairs 49:16	29:16, 18 31:1	19:5 28:3	17:23 47:1
	affect 30:19	anxious 59:24	62:16, 24	48:12 67:5
		anybody 27:21	assumption	better 36:19
		anyway 7:18	62:21, 25	43:20
		application 17:3	attached 17:12	Bianchi 2:23
		apply 62:23	attended 26:2	big 35:20
		appreciate 26:17	attending 1:6	42:10 58:10, 15

bigger 18:10
Bingo 52:15
bioethics 6:5
birthdays 60:11
bit 17:14 22:23
28:22 37:17
63:25 64:24
blazing 37:22
Bluewater 6:10
10:8
blunt 47:3
boardroom 13:2
boards 18:5
body 7:13
boom 53:14, 15
bought 46:9
break 39:9
breakfast 57:20
brief 3:5
briefly 4:23
bring 25:2
British 17:18
broader 12:11
broken 63:19
brought 30:23
45:24
bucks 23:11
55:1
build 20:20
23:2, 25
building 24:25
38:24
built 23:6, 8, 16
50:4 65:20
bunch 18:5, 19
buy 23:5

< C >
call 5:23 11:6
37:6 40:24
64:22
Callaghan 2:14
called 5:14 6:3
11:9 12:22
17:3 19:3 46:2
53:11, 13, 18, 19
54:9, 10 65:16,
17
calls 22:3, 6, 7,
12, 13 33:8
36:2 43:9
64:19, 25 65:12
calm 30:9
campus 5:3

campuses 5:2,
4, 5, 6 17:6
28:10
Canada 48:3
Canadian 17:19
cancelled 20:9
capability 61:12
capacity 12:20,
24 14:3, 12, 18
15:19, 25 16:13
40:16, 19 42:2,
8 51:20
Caputo 1:25
68:3
CARE 1:1 2:3,
6, 8, 11, 15, 18,
21, 24 6:6 8:3,
4 15:9, 11, 15
21:15, 17 22:1,
19 24:14 25:5,
22, 23 26:1
27:14, 22 29:1
31:1, 5, 13, 20
32:2, 8, 16 33:3
34:10, 19 35:24
38:13, 21 39:5,
9, 19 40:2
41:19, 20 42:2,
7 43:11, 19, 20,
24 44:11, 18, 19
46:22 47:10
48:18 51:11, 24
52:1, 20 53:3
55:3, 5, 21, 24
56:8, 14, 18, 20,
25 59:10, 21
60:1, 3 61:2
62:3, 15 63:24
65:8, 25 66:1, 25
cared 30:14
48:3 50:6 58:3
caring 47:7, 8
case 55:11
celebrate 60:5,
11
centre 21:9
63:11
centres 63:11
CEO 1:19 5:18
CEOs 6:23
7:11 9:13, 17, 19
certain 31:22
50:14 51:1
certainly 30:13

CERTIFICATE
68:1
Certified 68:4
certify 68:4
chairs 8:8
chance 24:12
chances 20:2
change 35:22
changes 66:24
charge 63:8, 10
charged 19:22
chart 11:18
charts 56:19
chasing 31:21
Chatham 10:11
Chatham-Kent
6:11 10:6, 7
65:20
Chevalier 1:21
26:20 27:5, 6
28:8 31:4
33:12 34:1, 4,
18 35:7 36:24
38:2 40:22
41:1, 16 43:5, 6
44:4, 8 47:13,
15 48:24 49:20
53:4, 13, 16
54:13, 18, 23
55:6, 9 56:13
60:8, 10, 14
61:13 63:3, 4
64:21 65:12
66:22 67:10
Chief 1:22 9:3
29:2, 21
chiefs 9:3
circle 66:20
circumstances
46:14
citizens 48:4
City 16:6
Clair 6:2, 9
7:12 11:11
18:20, 23 19:2,
19 24:23 51:4
52:14
clean 15:7
58:21, 25
clear 26:9 37:5
42:13 55:15
56:20 59:6, 8
clearance 59:18
cleared 41:2
59:20

Clearly 38:11
53:1
clinical 5:20
28:12 43:23
53:14
clinically 43:14
close 26:4 37:2
closed 60:16
closely 51:3
closer 3:25
cohort 31:23
36:10 38:20
39:15, 20, 21, 22
42:1, 5 58:25
62:6, 7, 9
cohorted 59:13
cohorting 35:12
38:19 39:14
41:7 62:12
Coke 1:13
13:20 42:15, 16,
23 64:11, 12
cold 45:15, 16
colleagues 29:4,
25 64:15
collective 7:25
9:8
collectively
9:16 40:3
College 18:20
24:23 50:24, 25
51:4 52:13, 14
colleges 19:5
50:23
Colonel 17:17,
25 19:1
colour 58:10
combination
41:16, 18
come 9:11
15:3 18:25
31:2 37:6, 21
45:19 49:14
66:25
comes 12:1
comforted 58:3
coming 12:4, 5
16:10 21:16
22:20, 21 28:6
29:4 32:11
37:7 43:10
44:18 57:3
60:6 67:1
comment 67:7

comments
47:16 65:2
COMMISSION
1:2 2:6, 9, 11, 15
Commissioner
1:12, 13, 14 3:9,
22 4:2, 8, 11
6:15 7:17 8:16,
17, 18, 19, 21
9:22, 25 10:1, 2,
17 11:3 13:20
14:6, 14, 16
16:18 20:16, 25
21:3 26:13
28:2 30:22
32:23 34:9, 18
35:4 36:17
37:3, 24 38:3,
18 39:13 40:15,
20 41:15 42:12,
14, 16, 23 44:2,
5 48:22, 25
49:1 50:9 52:3,
22 55:8 56:12
59:2 60:12, 15
61:11, 17 62:20
64:11, 12 65:6,
9 66:12, 23
67:6, 14
Commissioners
4:13 47:21 64:7
committees 8:8
communicate
46:10, 12 57:14
communicated
53:9
communication
53:8 54:8, 9
56:3
communications
6:6
communities
41:19
community
17:21 21:5, 6
25:17 33:23
35:1 41:9
48:13, 17
company 23:7,
17 24:23 68:23
competent 49:9
complete 66:14
completed 26:12
completion 26:4

<p>complex 20:21 43:12 56:23 component 50:16 computer 46:1 concept 13:7, 10, 12 15:2 31:17 50:22 65:1 concern 14:17 28:21 concerned 14:9, 12 27:4 38:7 concerns 25:19 concise 56:24 Concluded 67:16 condition 44:3 conditions 17:10 62:18 confidence 33:11 35:9 56:2 confident 56:5, 8 connected 18:4, 19, 20 19:19 connections 12:7, 8 consensus 9:12 consent 43:7, 22 49:9, 11, 12 53:10 57:4 consented 49:10 considerable 55:2 construction 23:7, 17 24:23 26:11 56:10 contact 17:24 57:11 continually 34:1 50:21 continue 32:11, 13 continued 10:11 contractor 65:21 control 35:20 36:15 49:16 conventional 12:23, 24 13:5 conversation 57:3 convert 20:21 convincing 37:17</p>	<p>corporation 40:10 correct 68:16 cost 23:25 55:13, 15, 16, 17, 19 costing 54:25 costs 56:11 Counsel 2:14, 17, 20, 23 counts 49:12 couple 8:6 24:2 course 7:21 27:24 31:17 35:14, 22 41:23 42:6 43:7 44:18, 22, 23 52:8 54:7 55:23 58:11 60:3, 20 courts 19:10 COVID 5:8 12:4, 5 14:24 15:2, 13, 16, 22, 23 16:17 26:21 32:12 33:15, 18 35:12 44:14, 23 48:11, 17 53:5 59:19 63:11 66:25 COVID-19 1:2 COVID-positive 15:6 38:20 44:25 COVID's 45:16 crash 44:15 create 6:16 7:1, 6 13:8 14:12, 23 15:25 16:12 17:5, 16 39:3 58:17 created 5:14, 16 7:20 12:6 38:20, 22 39:2 46:5 50:14 64:20 creates 62:17 creating 7:8 17:9, 11 34:14 creative 51:15 crisis 21:25 25:6 critical 6:6 15:15 53:9, 19</p>	<p>critically 15:14 criticize 37:12 CRR 68:3 CSR 68:3 curious 26:18 64:12 current 5:18 < D > daily 11:13 12:9 dark 60:6 Dated 68:19 Dave 57:10 David 1:18 3:12, 20 4:6 10:2 28:23 29:2 57:8, 10 60:18 61:6 day 1:6 19:25 26:8, 9 28:13, 23 31:18 33:21 46:12 48:9 53:19 54:17 55:1, 18, 20, 21 56:9 68:19 days 15:12 20:25 58:22 59:19 60:25 deal 5:22 33:12 dealing 5:8 38:4 dealt 6:4 death 33:16 deaths 32:22 debate 59:11 decant 26:5 59:6 decanting 25:19 31:17 decided 25:8, 12, 14 decision 26:5 39:21 40:3 42:18 44:7 decisions 8:22 44:9, 13 deemed 59:25 definitely 50:1 delayed 58:14 delays 62:4 delivering 57:20 delivery 23:11, 13</p>	<p>dementia 58:1 Deputy 16:25 Derek 2:5 deserve 48:4 designated 14:22, 23 deteriorated 58:5 Detroit 16:6, 7 26:25 27:13 developed 36:8 37:19, 20 61:20 developmentally 58:14 diagram 5:16 dial 36:3 40:12 dialogue 32:17 Diaz-Choconta 2:8 die 47:3, 24 48:10 died 48:4 dietary 29:3 57:20 difference 57:5 differences 38:9 different 18:5, 22 23:1, 4 differently 38:12, 16 50:13 difficulty 49:2 dignity 48:5 dilemma 59:12 dinner 57:21 direction 68:13 directly 10:24 46:4 Director 2:5 25:23 26:1 40:1, 2 discharge 54:9 discussion 3:6 6:21 discussions 11:24 13:6 14:22 25:10, 18, 25 disease 26:17 dispute 9:12 disregards 49:15 disrespect 47:9 divert 43:18 divided 32:8 36:23</p>	<p>Doctor 35:5 48:23 67:7 doctors 29:25 doffing 29:9 45:18 dog 28:23 doing 10:24 17:22 22:9, 18 23:25 29:17 37:7 49:12, 18 61:12 dollars 52:16, 17 donning 29:9 45:17 doorway 57:18 draw'er 58:15 drew 23:22 dropped 46:4 drugs 46:1 < E > early 13:15 14:4 19:20 21:13, 16 22:22 26:6, 21 34:23 39:6 65:8 earn 37:20 easier 50:19 Easter 21:1 22:13 24:15, 18 easy 24:3 45:18 ED 15:3 education 33:17 35:9, 11 36:5 effect 9:9 10:23 32:24 effective 10:5 effectively 42:1 effort 24:22 efforts 56:16 eggshells 33:15 electricians 24:25 electricity 45:24 elementary 18:8 eliminated 15:1 employed 50:15 employees 31:7 EMS 8:3 22:15, 16 endless 54:24 58:15 engaged 17:17, 20 22:15</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

enhanced 46:8
enjoyed 46:20
enriching 60:3
ensure 11:25
environment
10:5 47:7, 9
57:24 60:4
equipment
30:24
equitably 36:24
Erie 6:8, 10
34:25
Erie-St 7:12
11:11
Especially 31:22
etcetera 18:3, 6
19:9, 16 24:25
28:20 38:10
43:14 51:2 54:8
eventual 32:22
Eventually
32:12 37:18
everybody 3:15
27:23 29:23
30:13 39:17
44:16 57:19
62:6 67:11
Everyone's 8:11
evolved 46:17,
21
evolves 10:20
exactly 10:25
17:11 26:23
33:1 65:17
example 43:21
examples 23:4
52:25
exchanged 3:2
excuse 49:17,
18
executives 9:3
exhausted 14:18
exist 34:16
existing 17:5
51:6 52:16, 17
expectation
43:24
expenses 48:15
experience
44:25
expertise 34:12
explain 21:4
explained 18:23
explains 17:15

express 37:10
extent 26:23
exterior 25:2
extract 31:17
62:10, 12
extracting 25:10
extraordinarily
60:23
extremely 29:13
extrication 42:9

< F >
facilities 19:6, 7
31:23 47:1
facility 23:3
25:11 38:13
39:20, 22 43:19
45:13, 22 47:22,
23 60:16 65:25
facing 4:21
fairly 44:15
families 30:19
35:10 45:5
49:8 53:18
56:21
Family 1:22
13:3 43:15, 22
46:13, 15 48:5,
8 53:11, 24
57:2 58:9
59:23, 24
family's 42:21
fans 16:5
farms 22:18
fashion 47:5
fast 21:20
36:16
fear 28:1 31:2
49:22
fearful 27:22
fee 50:22
feed 10:12, 15
feel 29:17
48:14 58:3
feeling 22:8
feels 29:11
fell 21:1
felt 37:9 43:8
64:3
field 4:20
13:10, 12, 17
15:20 16:2, 21
17:2, 21 20:7,
12, 13, 20, 21
22:24, 25 23:3

26:2 28:11, 16
29:12 30:1, 8,
12 31:5, 8, 12,
14 34:3 38:25
39:1 40:6, 15,
18 41:3, 10
42:8, 20 43:2,
18, 25 44:6
45:9 46:3
47:19 48:11
50:15 51:25
52:11 53:1, 3
54:5 55:3
56:25 58:5
59:12 63:8
64:20, 25 66:8
figure 55:14
filling 40:17
52:9
find 21:21
52:10
fine 18:9 24:10
37:15
finish 35:5
fit 23:16
flip 51:18
float 28:19
floors 30:7
fluid 11:23
focus 4:19 7:6
12:20, 22 14:3
21:14 24:13
35:21 53:7
62:19
focused 7:2
focusing 66:3
folks 24:8
followed 20:8
following 4:16
56:13
food 45:18
fool 3:20
forced 12:11
Forces 17:19
foregoing 68:7,
15
forget 61:15
62:12
formal 11:25
64:8
formalized 32:15
former 5:18
7:12
forth 10:16

68:9
fourth 58:8
France 52:14
Frank 1:12 65:2
Franklin 2:2
frankly 27:18
35:15 45:3
49:10, 17
Friday 26:6
friendly 57:7, 14
58:2, 9
front 30:18
frustrated 63:14
full 24:22
43:16 44:19
58:6
fun 60:4
functioning 10:3
funded 38:12, 16
funding 38:14
funny 29:11
future 10:18
33:5 35:22
55:11

< G >
G15 11:9, 19
G5 11:6, 8, 19
22:6 26:1
game 53:16
garden 54:5
gearing 50:13
gears 39:10
gender-specific
49:6
general 5:5
37:15
generator 19:16
45:14
genesis 14:6
geographically
37:1
geriatrician
47:18
give 4:22 8:25
17:9 20:14
21:7 30:9
given 31:12
64:13
gives 45:11
gloves 35:16
goal 9:10
44:17 47:4
62:19 65:24

goals 43:23
55:5 56:14, 20
goals-of-care
57:3
Good 3:4 7:18
20:4 24:12
39:17 49:3, 4,
14 54:21 58:7
65:22
Grace 6:11
34:23
grants 17:4
great 12:10
14:21 24:3
47:2 61:23 67:2
greater 55:23
grew 57:11
ground 58:2
group 11:12
22:6 34:21
grow 18:13
guess 30:4
36:18 50:24
58:7
guide 3:6
guns 37:21
Guys 30:9
48:15 56:17
gymnasium
18:8, 9 30:16
48:1

< H >
Hamilton 5:12
6:25 12:7, 9
handed 56:25
handful 12:4
hands 66:9
hang 40:24
happen 12:12
21:6
happened 5:13
21:5
happening
10:10 20:12
29:14 39:7 43:2
happens 11:4
happy 50:7
hard 63:6
head 18:6
Health 2:18, 21,
24 6:10 7:4
8:3 10:3, 6, 8,
14, 18, 22 12:2,
21 13:16, 22

14:8 17:8 21:23 22:15 39:24, 25 48:16 59:5 60:15 62:2 65:7, 20 healthcare 7:23, 25 34:23 41:6 48:15 hear 65:10 heard 38:23 43:1 47:13 50:10 55:10 65:15 hearing 24:6 27:11 46:24 heating 24:6, 12 heavy-handed 47:16 Heenan 16:24 Held 1:5 help 8:14 17:20 24:14 31:13 32:21 35:12, 13 37:7, 13, 23 38:20 41:19 46:11 49:25 50:1 51:8, 15, 24 58:21 67:3 helped 63:21 helpful 42:6 66:14, 16, 18 Heron 21:22, 25 22:13, 20 24:6 25:6, 15, 24 26:2, 15 31:7 32:3, 5 37:24 39:18 41:2 42:25 58:21 59:14 60:23 63:6, 15 hesitate 67:3 Hey 52:15 high 30:20 43:15 higher 15:10, 15 highlights 4:18 hire 51:7 hiring 51:5 historically 31:10 history 29:11, 12 56:23 64:22 holds 50:25 holler 67:13	Home 8:3 15:24 22:1 25:6, 17 31:1 36:6, 8, 16 40:1, 2, 25 41:20 42:2 46:22 47:10 49:24 52:2 55:24 59:21 61:2 62:16 66:1 homes 21:15, 17 22:19 24:14 27:14, 22 32:8, 15, 16 33:4 34:10, 15, 19, 20 35:25 36:6 38:11, 15, 17 39:15, 16, 19 40:7 51:11 52:21 honest 12:3 18:6 41:14 47:20 Honestly 50:3, 8 56:17 60:6 64:2 Hong 62:11 Honourable 1:12 hope 65:24 hopefully 3:6 10:21 16:13 18:14 33:11 65:5 horrific 47:25 Hospital 1:19, 22 4:20, 24 5:6, 14 6:3, 5, 11 7:10 9:1, 18, 19 11:21 12:20, 25 13:2, 3, 13 14:3, 18, 25 15:5, 7, 12, 17, 18, 21 16:2, 21 17:2, 5, 23 20:7, 13, 14, 20, 21 22:24 23:1, 4 24:22 26:2 28:3, 9, 11, 17 29:13, 17, 19 30:1, 8, 12 31:5, 9, 12, 14 33:19, 22, 24 34:3, 11, 24 35:1 36:25 38:13, 25 39:4, 20, 22 40:6, 16, 18 41:3, 10	42:8, 20 43:2 44:1, 6 45:9, 21 46:1, 2, 3, 6 47:19 48:11 50:15 51:7, 24 52:1, 9, 11 53:1, 3 55:4 56:25 57:9 58:5 59:8, 13 61:12, 24 63:9, 17, 18 64:20, 25 66:8 hospital-centric 7:22 hospitalist 28:9 hospitals 5:6 6:23 7:23 8:6 13:10, 17, 18 14:24 17:4, 21 31:12 32:7, 15 34:13 36:22 37:2 43:18 50:11, 13 51:19 52:20 hot 45:15 Hotel-Dieu 6:11 34:23 hotels 30:17 hound 28:23 hours 19:22 24:20 40:13 46:12 61:25 house 33:5 54:6 huge 35:14 hundred 23:21 46:8 hurtful 47:17 husband 30:1 hypersensitivity 36:13 < I > ICU 43:21 44:21 Ida 2:23 idea 4:22 14:7, 19 49:2 ignorance 49:22 ill 15:14 immediately 22:11 24:4 32:20 39:10 importance 42:11 55:6	important 29:13 30:14 35:8 37:9 39:14 41:17, 22 46:7 60:2 imposed 6:17, 19 impressive 25:4 inability 49:23 incident 5:25 include 13:1 includes 9:2 including 25:6 increase 51:4 increased 8:9 indicate 26:15 62:17 indicated 40:11 individual 9:8 40:9 46:6 individually 9:16 individuals 7:14 10:14 11:12, 16 49:8 55:3 indoor 19:6 infected 47:24 infection 35:20 59:8 information 11:25 27:11 65:13, 19 66:21 infrastructure 18:17 initial 16:2 initially 43:1 instance 9:1, 6 intake 44:9 intensive 15:8, 11 interested 66:8 interior 25:3 interrupt 3:7, 10 20:17 35:5 intervention 34:23 introduce 3:16 Introductions 3:1 intubating 44:25 intubation 45:2 invaluable 24:24 investment 56:10 invite 37:17	invited 31:2 involved 10:15 IPAC 32:3, 5 34:22 39:14 41:7, 21 63:10 iPads 46:9 54:8 issue 4:19 9:5, 24 12:19 13:23 31:25 35:14 36:7 43:7 issues 5:22 37:16 50:21 Italy 27:12 items 8:12 < J > Jack 1:14 Jay 2:11 Jeopardy 16:5 Jessica 2:2 job 33:20 jobs 51:12, 14 John 2:14 joined 28:16 Judith 1:25 68:3 jump 20:13 26:21 June 59:4, 17 64:22 jurisdictions 20:1 64:19 < K > Karen 63:9, 13, 15 Kate 2:20 key 58:20 kicked 33:19 kind 8:7 11:14 16:20 21:4 29:11 30:8 50:14, 16 63:5 kinds 34:13 kitchens 12:16 kits 61:22 Kitts 1:14 8:17, 18 10:1, 2, 17 11:3 28:2, 8 30:22 35:18 38:18, 23 39:13 40:15, 20 41:1, 15 42:12 55:19 knew 24:25 25:1 26:23
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

30:13, 21 54:16, 20 knock 33:22 34:7 knowledge 59:17 Kong 62:11 < L > lab 45:20 60:13 61:11, 16 landed 7:8 large 7:2 18:22 33:22 largely 64:5 larger 5:24 6:22, 23 18:13 32:22 late 19:18 64:22 laugh 28:24 launching 31:11 Lead 1:12 2:2, 14 5:20 21:25 28:11, 12, 13 63:9, 12 leaders 54:23 Leadership 5:14 11:7 27:21 30:23 leading 22:12 leads 12:18 Leamington 35:1 lean 62:13 learn 64:17 learned 53:8 54:22 56:14 learning 27:8 lease 17:13 19:21 20:19 23:6, 13 leave 40:5 left 31:1 42:4 lessons 53:7 54:22 56:14 64:17 Lett 2:5 letter 16:19, 23 17:14 level 8:22 11:11 15:11, 15 32:1 53:3 61:15 levels 61:15 leverage 7:6	LHIN 5:19, 21 6:9 7:5, 13, 15 Lieutenant 17:17, 25 19:1 life 4:3 45:1 lights 12:16 36:14 41:10 48:20 liked 46:18 57:11, 25 Listen 24:11 lists 56:23 Literally 18:21 23:3 58:16 living 17:24 18:2 30:17 lobby 19:13 45:17 local 41:4 locally 61:4 located 4:24 location 18:12 London 6:9, 24 15:10 60:20 61:4, 6, 7, 23 long 20:18, 20 24:1 32:5 58:23 59:16 60:23 64:5 67:1 longer 20:3 LONG-TERM 1:1 2:3, 5, 8, 11, 14, 18, 21, 24 8:3 21:14, 17 22:1, 19 24:14 25:5 27:14, 22 31:1, 5, 13, 20 32:8, 16 33:3 34:10, 19 35:24 38:12, 21 39:9, 19 41:19 42:2, 7 43:11 44:19 46:22 47:9 48:17 51:10 52:1, 20 55:24 56:18 59:10, 21 60:1 61:2 62:3, 15 63:24 65:8 66:1, 25 looked 5:9 11:18 18:22 36:6 45:12 looking 13:9 16:3 23:1	51:12, 14 56:18 loose 39:9 lose 32:14 lost 54:14 lot 8:25 12:12 26:22 31:22 36:12 39:14 40:7 45:5 47:16 50:19 51:9, 11 61:10 64:15 66:24 lots 28:20 love 67:4 loved 45:6 53:24 54:14, 15, 17, 20 56:4 lunch 57:20 Lynn 2:17 < M > machine 61:19 machines 46:1 61:20 made 21:6 26:5 34:4 42:18 44:8 53:9 54:2, 5 68:11 magic 58:16 Mahoney 2:17 3:10, 19 main 5:2 46:2 major 17:19 majority 25:7 making 27:21 30:2 37:5 45:17 59:5 man 58:13 managed 41:5, 13 44:4, 6 management 5:25 44:21 mandate 31:13 mandatory 29:20 manner 22:5 map 5:11 18:21, 22 March 5:9, 13, 17 6:13, 14 7:20 12:19 13:11 17:15 19:19 21:9 27:9 29:15	44:23 52:4 Marguerite 1:21 Mark 5:19 markers 58:16 Marrocco 1:12 3:9, 22 4:2, 8, 11 6:15 7:17 8:16, 20, 21 9:22, 25 14:6, 14, 16 16:18 20:16, 25 21:3 26:13 32:23 34:9 35:4 36:17 37:3, 24 38:3 42:14 44:2, 5 48:22 49:1 50:9 52:3, 22 55:8 56:12 60:12 61:11, 17 62:20 64:11 65:6, 9 66:12 67:6, 14 Mary's 6:24 masks 29:19, 20, 22, 23 massive 25:7 matter 38:3 66:2 mature 10:22 maturity 10:18 McGrann 2:20 meaning 5:5 7:7 12:24 14:24 15:14 20:4 36:14 45:15 means 20:6 meant 37:12 measure 39:14 measures 32:9 mechanism 64:16 media 16:11 medical 30:23 39:25 40:1 43:17 44:21 56:23 medications 56:22 meet 8:7 11:13 MEETING 1:1 13:3 meetings 6:12 8:12 22:3	member 33:25 48:8 53:11 57:2 59:24 members 9:21 21:14 33:23 53:25 57:15 59:23 memo 17:7 Mental 8:3 Met 5:2 8:5, 6 11:13 43:20 middle 13:11 17:15 19:18 21:9 39:1 45:24 mid-fifties 58:14 Mike 16:24 million 23:11 mind 3:8, 13, 21 16:12 39:3 Minister 16:25 Ministry 2:2, 17, 20, 23 13:16 14:4, 5 17:4 55:20 64:23 65:6 minute 18:25 19:2 66:7 minuted 8:12 minutes 55:14 missing 66:21 model 38:4 64:13 modular 23:5 moment's 41:11 money 34:14 55:3 monies 51:5, 6 month 7:20 36:1 months 8:6 12:14 27:8 Mooshay 4:6 M-O-O-S-H-A-Y 4:7 morning 3:4 11:14 30:7 mother 50:6 motivation 14:17 move 20:23 39:18 43:7 44:10, 16 46:25 49:4 58:4 moved 28:3 30:12 45:9
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

47:23 48:1
53:12 57:13
59:16
moving 43:25
47:18 59:3
62:17 65:3
multiple 18:12,
15 21:17, 18
22:3, 6 62:8
municipal 37:25
38:11, 15
municipalities
65:16
music 45:14
Musyj 1:18 3:3,
17, 22, 24 4:5, 9,
10, 14 6:15, 18
7:19 8:24 9:23
10:6, 20 11:4
14:1, 10, 15, 20
16:19 20:22
21:1, 4 26:20
31:16 33:1
34:17 35:23
36:21 37:4
38:1, 7, 22
39:23 40:18, 23
42:22, 24 45:4
50:17 52:7, 23
54:19 55:17
60:8 61:14, 18
63:1 64:7, 18
65:7, 11 67:11
M-U-S-Y-J 4:6

< N >

names 11:12
nature 26:17
nay 9:19
near 24:10
neat 19:14
necessarily
44:16
necessary 44:6
50:16
neck 29:21
needed 9:13
19:17 30:20
39:5 40:14
57:2 61:15
65:23
needing 43:15,
21
needs 11:15
32:11 43:20

44:17 49:19
56:22
NEESONS 68:23
negative 59:9
negatives 25:11
neglect 47:24
nervous 27:3
33:13
nervousness
26:22
Netflix 46:19
New 27:12
52:16 57:15
nice 19:14
23:14 60:5
nicely 29:6
nonconventional
12:23 13:1, 8
14:7 17:16
non-
conventional
13:17
non-hospital
7:20 8:5 11:22
21:23, 24
normal 63:23
north 16:6
NOTE 3:1
notes 68:16
notice 28:6
41:11
noticeable 28:7
notification
17:10
notion 49:3
November 1:6
27:8 68:19
number 25:13
41:8 56:2, 3, 5
numbers 42:4
nurses 28:19
30:6 48:7
nursing 9:3
29:4 51:7, 10,
23 56:7 57:22
59:20

< O >

obvious 25:15
occurred 22:3
o'clock 11:13
offer 67:8
offered 20:14
Officer 39:25

offices 12:15
old 5:21 7:5
ones 21:10
one's 23:11
54:17
ongoing 25:25
33:18 58:12
Ontario 4:24
7:4 10:3, 8, 14,
18, 21 12:1, 21
13:22 14:8
17:8 19:6
open 4:16
21:11
opened 21:8
operate 38:14
operating 38:15
operation 9:14
operations 6:5
9:2 25:16 37:13
opinion 19:4
43:17 47:25
opposed 63:22
option 61:7
order 17:1
51:4, 15
org 11:18
organization
31:15 33:14
organizations
18:5, 20 41:6
original 15:20
originally 39:2
originated 14:8
other's 9:9
12:15
Ouellette 5:3
outbreak 21:18
42:10 48:17
58:22 59:1, 15
64:4
outbreaks
32:19, 22 34:22
38:9 39:19
40:12 41:4, 8,
13 60:21
outdoor 54:5
outline 14:21
outlined 45:10
outset 44:17
outside 17:5
19:12 45:16
57:17
outward 13:9

overall 56:18
overhead 45:13
overspeaking
40:25
oxygen 43:15

< P >

paid 19:23
27:18
pair 35:16
pairing 36:18,
19 38:8
palpable 29:18
paper 58:15
paramount
42:10
pardon 49:6
part 5:10 28:19
33:4, 10 36:4
44:2, 6 51:22
59:12 60:20, 23
participants 1:5
2:1
participate 67:4
particular 4:19
5:22 9:5 12:18
14:25 36:8, 16
40:1, 2 47:16
parties 60:9
partner 61:23
partnered 34:11,
21
partnering 36:18
partners 32:10
partnership 37:8
partnerships
32:17 34:16
pass 47:7
48:10
passed 47:8
54:10
passing 46:14
pasted 57:17
pasting 58:12
paternalistic
49:7
path 19:11 20:8
patient 13:4
14:24 15:3, 14
42:3 43:25
55:18 57:6
58:4 59:13
63:18
patients 15:10,
22 28:13 33:15,

19, 25 35:10
38:21 39:3, 18
41:2 42:9 43:8
44:10, 19, 22
45:1 47:21, 22,
24 48:2, 8 50:5
51:21 52:2, 25
56:15, 19 58:1,
11, 24, 25 59:6
63:24 64:2
66:1, 2
patient's 44:18
49:2, 3 53:23
57:18
Patti 52:14
PCR 61:19
people 4:3 5:1
27:10 29:1
38:9, 25 43:13
44:14 50:12
65:4
pep 28:24 30:9
percent 25:14
37:15, 16, 18
51:20
perfect 4:14
52:16 61:10
period 52:4
permission
42:21 66:20
person 40:8
54:11, 13 57:21
personal 30:24
personally 33:3
person's 44:3
pharmacy 45:20
phase 15:23
16:1 39:4 66:3
phenomenal
18:1 32:17
phone 36:1
37:6 64:18
65:12
phonetically 4:7
photo 45:11
53:22 54:2
photos 53:24
Physically
35:25 36:1
physician 28:12,
14 40:9, 10
54:23 56:6
57:22 63:12

<p>physicians 27:20 29:24 30:6 pick 18:7, 12 33:5 picked 26:7 picture 19:7 pictures 58:10, 13, 17 piece 35:8 52:3 66:21 place 21:24 25:9, 14 31:24 34:14 37:23 39:22 42:24, 25 43:4 47:1, 3, 4 68:8 places 18:22 36:11 plan 4:16 9:8, 9 53:16 63:1 planned 50:21 plans 9:8 36:9 plastered 53:25 58:17 play 19:8 20:5 players 7:23 pleasure 27:7 66:22 plotted 23:20 plumbers 25:1 POA 53:11 point 3:7 4:1 7:10 19:24 25:21 26:3 31:22 32:4 37:8 46:13 54:22 56:6, 7 58:8 62:14 64:2 Policy 2:2, 5 poorly 44:15 pop 16:19 popped 21:19 populate 7:13 population 47:19 position 62:14 positive 12:4, 5 15:4 19:16 21:13, 16 25:8 27:2 33:14, 23 36:7, 10 62:6 65:13</p>	<p>positives 25:13 27:1 31:18, 20 36:14 62:15 possession 19:20 20:22 22:24 PowerPoint 3:6 PPE 27:15, 16 28:4, 20, 23 29:1, 8 34:4 35:13 Practice 1:22 34:22 41:7 pray 16:15 precautionary 62:22 pre-COVID 15:12 35:21 52:25 prefabricated 23:5 preparations 5:8 Prepare 16:14 preparing 16:9 38:5 PRESENT 1:24 presentation 64:8 66:14 PRESENTING 1:17 President 1:19 pressure 39:18 64:23 pretty 33:21 prevent 35:12 prevention 32:9, 16 35:8 41:21 58:19 66:3 prevents 41:23 previously 7:7 12:8, 14 price 45:13 65:22 primarily 9:2 Primary 8:4 principle 62:22 printed 30:2 printer 58:10 Prior 31:14 43:25 57:3 priority 63:19 private 37:25 38:1, 2, 16</p>	<p>problem 14:15 26:16, 19 52:5 60:20, 24 problems 61:10 proceedings 68:7 process 11:25 39:24 productive 8:15 profit 38:5 programs 51:2 52:17 promised 48:8 pronounce 3:16 pronunciation 3:14, 25 proper 32:3 34:4 45:17 49:25 50:1 properly 3:15 34:5 47:14 proportion 34:25 35:2 proportionately 36:24 protective 30:5, 24 prove 55:12 provide 4:18 33:11 provided 53:4 57:23 province 6:1 19:6 21:11, 12 32:7 59:4 64:16 provinces 65:16 provincial 19:25 37:25 PSW 35:21 PSWs 27:16 35:15 51:10 Public 17:3 21:22 22:15 34:13 39:24 59:5 60:15 62:2 pull 7:24 pulled 6:22 18:21 24:21 pulling 67:5 purpose 63:2 pursuing 13:12 purview 31:15 put 3:5 15:4 29:1, 5, 22</p>	<p>35:17 50:13 63:16, 17 Pyxis 45:25 < Q > question 8:19 13:21 14:21 30:25 38:19 39:16 42:17 questions 33:10 64:9 66:13 quicker 12:12 41:24 63:22 quickly 15:1 44:15 47:12 57:12, 14 58:2 63:7 quite 25:4 27:3, 18 35:15 41:14 45:3 49:10, 17 56:17 60:6 quote 52:1 < R > ramp 9:6 ramping 50:18 52:8 rapidly 25:18 58:5 reached 65:7, 8 ready 16:15 40:13 41:11 51:17, 18 65:23 66:5 real 21:20 66:18 really 4:22 21:6 23:15 26:13 31:11 32:9 36:16 41:17 42:10 46:18 48:14 49:22 50:7 65:4 66:3 recall 17:7 22:11 received 64:18 receiving 58:11, 24 recognized 30:15 recommendation s 9:15 reconnect 11:16</p>	<p>reconverting 13:5 record 3:2 38:25 53:17 recorded 68:12 recreate 64:21 refer 3:15 regarding 32:16 regime 7:5 regimes 7:6 region 4:25 5:10, 18, 24 6:16, 22, 24 7:21 8:2, 13 9:7 10:3, 7 11:10, 15, 17, 19 13:24 14:2, 9 15:9 18:16 21:15 22:17 32:7 34:11, 19 66:5 Regional 1:19, 22 4:23 7:5 15:12, 17 31:8 34:21 35:23 38:13 regionally 34:20 regular 6:12 regularly 56:20 reinvests 51:1 reiterating 34:2 relationship 12:11 41:5 relationships 7:7 11:24 12:6 32:13, 14, 19 37:19 50:4 relatively 66:4 remain 25:8 remaining 32:2 remarks 68:11 remember 16:4 22:25 24:5 29:16 31:10 41:18 45:4 51:9 57:25 59:3 63:8, 13 64:22 67:8 remembering 44:24 remotely 1:6 46:16 replaced 12:16 replicate 18:15 replicating 61:2</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

report 5:23 8:9
11:7, 8 67:5
Reporter 68:4
REPORTER'S
3:1 68:1
representation
6:8
require 42:20
required 15:15
56:16
requiring 15:10
45:2
researched 19:4
resident 34:12
42:20 46:10, 13
54:1
residents 20:23
22:2, 5 25:8, 19,
21, 22 26:5
27:1 32:1, 2
45:19 46:14, 18,
25
resolution 9:13
resources 24:24
respect 4:20
16:21 22:17
32:9
respectfully
29:6
respond 67:13
responsibility
28:14 35:24
67:2
restart 52:11
result 15:8, 17
50:18 51:23
53:18
results 22:19,
21 60:25 63:22
66:17
resuscitation
43:16, 24 44:20
56:21 58:6
retired 17:17, 25
retirement
22:19 32:8, 15
33:4 34:20
35:25 40:7
41:20 51:11
52:2, 20 59:21
62:15 66:1
returned 41:2
review 9:4
rich 55:1

Riddell 63:9
rightfully 27:3
risk 30:15
62:18
role 28:20
roll 65:23
room 13:4
35:18 42:5
53:23 54:6
57:12, 18 58:16
rooms 23:2, 21
54:1, 4
rounding 28:12
rounds 27:21
29:17
RPR 68:3
run 37:23
38:12 46:8
running 45:25
runs 62:3

< S >
safe 30:20
58:3 67:12
safely 31:23
32:2, 3
safer 28:5
safety 25:19
sainted 53:17
satellite 45:21
scale 12:11
scaled 42:3
scared 27:10,
16 33:16 57:13
scenario 43:23
school 18:5, 8, 9
science 62:25
screen 4:10
seasoned 44:12
Secondly 55:13
Secretariat 2:6,
9, 12, 15
Section 17:3
segregated
36:11
selfish 33:4
send 53:23
59:9
seniors 43:12
sense 7:16
11:23 22:9 28:4
separate 45:15
separation
19:14

seriously 28:15
serve 4:25
service 22:16
services 5:4, 7
15:15 25:2, 17
set 23:3 46:16
65:18 68:8
set-aside 50:23
share 4:10
66:23
shared 25:20
65:13, 14, 17
sharing 64:15
shields 30:2, 3
shift 15:5 39:10
shifted 39:6
shifting 24:13
ship 64:3
shocked 54:17
Shores 6:10
34:25
shorter 23:15
Shorthand 68:4,
16
shortly 8:10
shoulders 67:2
show 27:21
33:6, 9 34:6
50:12
showed 19:1
22:7
showing 25:7
26:17 27:4, 17
shows 52:23
sick 27:23, 25
50:6 55:25
side 9:1 14:5
50:10 61:24
62:2
sign 50:24
signed 9:9
20:19
significant 40:16
similar 5:25
8:1 19:6 21:11
simultaneous
20:12
single 6:7
14:24 36:2
46:9 48:9 53:11
sinking 64:3
sinks 45:25
sit 15:18 16:7
48:7

site 12:25 13:2
15:21, 25 46:6
sitting 10:14
16:5, 6 27:7
size 36:25
slide 45:11
52:23
small 35:1
smooth 56:15
snapshot 20:14
21:7
somebody
42:19 49:14
somewhat 57:7
sorry 6:14 8:17
14:14 24:19
63:3
sort 38:6 57:15
sorts 19:16
sound 45:14
south 16:7
space 13:3, 5, 8
14:7 17:5 39:3
spaces 12:25
17:11, 16, 20
speak 51:11
specialized 5:4
speed 36:3
40:12
spelled 3:18
spelling 4:3
spend 54:15
spends 34:13
spent 4:2
split 34:20
spoke 3:12
48:9
sports 19:8
20:9
sportsplex 19:3
23:21 25:3
spot 19:2 54:21
spots 36:11
spread 33:24
spring 20:9, 10
springtime
41:25
St 6:2, 9, 24
18:20, 23 19:1,
19 24:23 51:4
52:14
stabilize 22:4
32:21
stacks 58:15

staff 9:4 16:10
21:14 25:21
26:16 27:1, 2
28:5, 10, 16
29:3, 4, 18 30:5,
9, 17, 25 31:4, 6
32:24 33:9, 16,
23, 25 35:9, 10
46:11 48:2
50:11, 19 51:8,
16, 18, 25 52:10
55:22 57:20, 22
66:7
staffed 28:11
38:16 55:1
staffing 21:25
22:4 25:17
26:16 32:1
50:9 56:6
stage 45:1
stand 46:11
stand-alone
61:20
start 3:8 4:5,
15 13:9 36:14
40:11 44:14
62:4
started 5:17
6:21 13:12
16:3 21:13, 19,
20 22:20, 21
24:4, 5 25:18
26:9 33:14, 18
39:7 52:8, 9
53:6
starting 21:15
39:8
starts 47:11
state 53:16
stated 4:17
33:12 34:1
53:10, 16 62:14
63:1
statement 59:5
statistics 52:24
stay 25:14
47:1 51:13
67:12
stayed 43:3
staying 32:25
47:2
Stenographer/Tra
nscriptionist
1:25

<p>stenographically 68:12 stepping 30:15 Stewart 5:19 17:18 18:1 19:1 stop 37:14 49:23 63:16 stories 16:11 45:8 storm 29:14 61:10 story 32:6 strategy 16:14 stretchers 53:2 strong 65:3 strongly 48:14 Structure 5:15, 25 10:4 11:6 21:24 struggled 3:13 62:3 struggling 66:15 stuck 29:21 students 51:2, 7, 10, 23 52:19 studies 38:8 62:8, 10 stuff 46:21 sub-acute 25:11 34:24 sub-acute/ALC 55:21 submitted 9:17 subregion 7:10, 12 subregional 5:23 subregions 5:22 7:9 subsequent 33:8 substantial 26:25 sub-tables 6:4, 8 success 64:13 successful 66:4, 10 sufficient 28:4 suggested 62:22 suggestions 35:13 40:4 41:7 summarizes 16:20 summary 57:7</p>	<p>supplies 34:22 45:19 supply 30:23 35:13 support 8:14 9:20 25:17 27:19 33:6, 18 51:8, 15, 24 supposed 62:23 surgeries 9:7, 16 50:18 52:8 surplus 50:14 survival 62:19 survive 45:2 47:4, 6 48:17 sustain 25:16 swabbing 21:9 22:18 swabs 59:9 swiftly 51:21 swing 63:25 switch 51:18 switchboard 46:2 SWOT 33:2 58:20 63:10 sympathy 4:4 Syndrome 43:13 system 6:1 46:1 63:19 64:24 < T > Table 5:14, 24 6:3 7:10, 21 9:2, 4, 14, 18 tables 5:23 6:16 7:14 8:2, 5, 25 10:12, 15, 19, 23 11:7, 21 tabletops 33:17 tail 31:21 takes 42:24 talk 11:14 14:5 20:11 33:10 46:23 55:6 57:24 64:9 66:16 talked 6:25 10:21 11:1, 20 13:16 45:6 52:24 talking 12:19 17:15 55:2</p>	<p>talks 28:24 30:9 targeted 24:17 tea 60:9 team 9:20 10:8, 15 23:17 24:22 26:3 35:25 39:8 47:5 53:4, 14 54:13 57:15 63:10 teams 7:14 10:3, 18, 22 32:5 58:20 team's 33:20 teamwork 21:5 technically 9:18 11:8, 12 31:21 tent 28:3 31:3 38:20, 24 39:1 term 49:6 terms 17:10 32:24 38:4, 5 42:18 49:12 64:16 Terrace 21:22 22:1, 13, 21 24:6 25:6, 15, 24 26:2, 15 31:7 32:3, 5 37:25 39:18 41:2 42:25 58:21 59:15 63:6, 15 Terrace's 60:24 test 15:4 60:24, 25 61:12, 21 62:6, 7 63:22 testing 22:4 27:1 41:24 60:13, 16, 19, 22 61:3 63:7, 11, 23 64:6 tests 41:23 63:14 64:1 thanks 9:25 21:3 theory 20:2 31:19 thing 12:10 13:25 17:23 32:10 38:6 39:9, 12 40:11 48:13 49:21, 23 55:4 58:12</p>	<p>things 6:4 8:2 12:4, 5 19:17 20:4 24:12 38:8 41:12, 18 45:10 46:17 50:10 51:15 55:9 56:18 57:25 thinking 18:7, 24 thoroughly 46:20 thought 15:20 16:2 27:17 47:17 thought-out 56:16 Thursday 24:17 tide 63:25 tight 61:25 tighter 51:22 time 6:13 13:7 14:23 16:4, 8 17:7 18:6, 18 21:8 22:8 24:2, 7, 8 25:7, 9, 12 27:22 29:20 30:3 31:11 32:4, 20 33:9, 13 40:24 44:16, 24 45:5, 7 46:17, 20, 24 47:10 48:7, 12 49:23, 25 50:17 54:15 58:11, 23 60:7, 22 61:5, 14, 24 62:1 63:5, 6, 20, 24 64:5 66:7, 19 67:1 68:8, 11 time-based 59:10, 18 times 8:10 11:5 18:12, 15 60:5 timing 21:11 today 12:19 50:20 52:5 told 23:10 29:5 Tom 5:19 tomorrow 48:20 ton 22:16 top 5:17 19:11 27:2 40:10 topic 26:14</p>	<p>Toronto 47:18 61:7 totally 49:20 track 63:14 traditionally 15:9 tragedy 16:8 trailers 30:18 training 33:17 35:21 36:5 transcribed 68:13 transcript 55:11 67:7 68:16 transfer 40:6 42:19 transferred 15:11, 16 transition 7:4 56:15 travel 28:9 trouble 22:14 True 54:18 68:15 Truly 47:24 56:19 trust 36:22 37:4, 19, 20 56:1 trusting 53:20 trying 10:13 42:6 58:25 63:14 64:21 tuition 50:22 51:1 turn 41:9 turn-around 41:24 60:22 61:24 62:1 64:5 turned 63:7 TV 46:18, 19 type 15:19 65:18 types 17:11 23:2 < U > Ukrainian 3:24, 25 uncovered 67:1 underneath 6:4 11:20 understand 34:9 35:19 38:19 49:10</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

66:17
unfold 29:16
unfolded 5:9
unfortunately
54:10 60:14, 17
65:1
unit 15:9
units 23:5
universities
19:5 50:23
university 50:25
unwell 43:14
unwinding 47:12
upcoming 20:10
updated 56:20,
22, 24
uses 55:20

< V >
various 7:13
8:25 11:21
51:19 64:19
VERITEXT 68:23
view 4:1 7:11
19:24 32:4
37:8 46:13
56:6, 7
Virtually 1:5
56:4
virus 61:1
volleyball 19:9
20:6
voluntary 36:20
volunteered
28:17
vote 8:22
VP 63:8

< W >
wait 62:24
waiting 61:21
walk 53:1
walked 29:22
31:6 53:2 57:12
walking 19:10
33:15 35:16
53:5, 6
wallpaper 53:25
walls 13:9
14:11, 13 23:15
Walton 5:19
wanted 26:8
43:16 46:12, 15
53:23 54:12
55:6 56:1 57:9

warm 47:6, 8
57:23
waste 48:16
watch 46:15
watched 29:1
watching 27:11
water 45:24, 25
Waterloo 5:12
wave 15:22
50:12
waves 58:24
ways 59:16
wearing 29:19
webinar 13:15
14:3
website 8:11
week 8:9, 10
11:5 22:22
23:13 24:15
weekly 36:1
weeks 23:12
24:2, 9 45:8
well-known
28:10
West 5:10, 18,
24 6:22 11:9
12:21 14:2
whatnot 43:25
wheelchairs
53:2
wide 4:16
WiFi 46:7
wiggle 42:5
wildfire 49:24
willing 44:12
wind 9:15
36:15
window 54:3
windows 54:3
Windsor 1:19,
22 4:23, 24
5:11 14:20
15:11, 17 16:5,
10 26:24 31:8
34:21 35:23
38:13 60:15
61:4
Windsor-Essex
4:21, 25 10:8
21:15, 17
wish 67:4
wishes 56:21
wonderful 48:2
wonderfully
50:3

wood 33:22
34:7
word 6:19
36:19
work 6:20 7:11
8:23 9:7 10:11
22:9, 17 23:7
24:19 27:4
28:18 34:8
39:25 59:22
66:8
worked 12:2
16:16 18:2
30:1 31:5
39:23 50:2
51:3 52:4
working 16:10
32:10 51:10, 13
52:13, 19 59:22
works 62:9
64:21 66:6
work-study 51:2
world 62:9
worst 16:15
63:2
worth 48:18
56:17
wrap 16:12

< Y >
yards 30:18
yea 9:19
Yeah 14:10
year 7:8
years 12:14
60:17, 18
yesterday 3:12
York 27:12
young 58:13
younger 43:13

< Z >
zone 45:15, 16
Zoom 1:5 33:8