Long Term Care Covid-19 Commission Mtg.

Commissioners, Knowlton and Connell
on Tuesday, February 2, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 2nd day of February, 2021, 8:58 a.m. to 10:21 a.m.

BEFORE:

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

PRESENTERS:

Jill Knowlton, Chief Operating Officer, Primacare Living Solutions Inc.;
Mary Connell, Dementia Advisor and Person-Centred Care Project Manager, Region of Peel.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;
Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat;
Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat;
Ida Bianchi, Senior Legal Counsel, Long-Term Care

Commission Secretariat.

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 8:58 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning.

JILL KNOWLTON: Good morning.

COMMISSIONER ANGELA COKE: Good morning.

MARY CONNELL: Good morning.

IDA BIANCHI: Good morning.

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning, Ida.

COMMISSIONER JACK KITTS: Good morning, Ida.

IDA BIANCHI: Everybody's here early. Early-ish.

COMMISSIONER FRANK MARROCCO (CHAIR): We have no life. You can be early for these things.

IDA BIANCHI: I guess -- are we ready to start? Is everybody --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think we're -- the commissioners are here.

IDA BIANCHI: And Ms. Knowlton and Ms. Connell are also here, the presenters, so I

suggest we get going.

COMMISSIONER FRANK MARROCCO (CHAIR):

All right. Well, then, good morning. I'm Frank Marrocco. I'm one of the commissioners. There's Dr. Jack Kitts and Commissioner Angela Coke. So we are the commission.

We tend to do these all pretty much in the same way. We are using the -- what amounts to, essentially, an interview format. We publish a transcript, and we do that because that was just the quickest way we could think of to get through all the people that we thought we had to talk to in order to do what we've been asked to do.

We've followed the practice of interrupting with questions as we go along not because that's, perhaps, the most pleasant way of doing it, but that way -- it is the most efficient way, and that way we don't end up going back over -- trying to go back to something you said.

The transcript is also serves a purpose of allowing people to follow along with what we're doing and adds as much transparency as we can given the more efficient or more summary process that we're obliged to follow.

So, with that introduction, we're ready

when you are. Well, we have had a briefing though. We have some idea of what you're going to say, so carry on.

IDA BIANCHI: So, Jill and Mary, why don't you put up your slides. Do you need some support with that?

MARY CONNELL: Well, I can tell you that in a minute.

IDA BIANCHI: Okay.

MARY CONNELL: I think I should be able to do it.

COMMISSIONER FRANK MARROCCO (CHAIR): We can see it now.

MARY CONNELL: Okay. So, Jill, we'll start, and I'll move the slides.

IDA BIANCHI: Sure.

JILL KNOWLTON: Are we ready, then?

IDA BIANCHI: Yes.

JILL KNOWLTON: Okay.

IDA BIANCHI: Go ahead, Jill.

COMMISSIONER FRANK MARROCCO (CHAIR): I think so.

JILL KNOWLTON: Thank you very much, and good morning, commissioners and team.

Both Mary Connell and I are happy to be

asked to speak to you about the Butterfly model and make a number of comments about it, describing it and then also talking about what needs to happen to scale this level of change in Ontario long-term care.

I'm Jill Knowlton, chief operating officer with Primacare Living Solutions. We are a private, for-profit operator that began our culture change transformation using the Butterfly model in 2016.

We have two fully-accredited Butterfly homes in Ontario with the third one undergoing its year-long transformation right now. We also have a home -- a new-bed award in Clappison's Corners which is Hamilton, Ontario, where we will be building it the spoke Butterfly home, and work on that property there has already begun.

And then in addition to those homes, I also operate -- manage for other operators' homes through a variety of arrangements either under mandatory management orders, voluntary management agreements, or just -- we've been asked to assist an operator in managing.

So that's a little bit about me. 38-year career in long-term care and happy to say

that I was able to build my career in long-term care. I am a nurse, registered nurse, clinical nurse specialist in gerontological nursing and, again, very proud to say that my career has largely been in long-term care.

And I'd like to introduce my colleague Mary Connell who is a dementia advisor for the Region of Peel. Also a master's-prepared registered nurse who has a really interesting background coming from public health -- and we'll talk about IPAC today -- but also the leader in Ontario around this culture transformation.

And Mary is who really inspired and supported Primacare as we began our journey forward, and we're fortunate to have the guidance of Mary in the Region of Peel in the work that we've been doing and we continue to do.

Mary, can I have the next slide, please? Thank you.

So just as an overview of what we're going to talk about, we did receive questions that we've been asked to respond to. So we will be talking about what is Butterfly. I will do that, and I'm being very careful here to say "being a Butterfly," and I want to point that out.

You don't do Butterfly. I think that's the one thing that really irritates us the most is when we hear people saying "we're going to do Butterfly."

Butterfly is not a program. Butterfly is a culture change. And if you think about the multiple programs that are involved in long-term care, I liken it to a stack of pancakes. We have this and hundreds of thousands of dollars, millions of dollars invested in these programs, and yet they don't work. And eventually the stack of pancakes falls over because the foundational element, which is the culture, continues to be toxic and has not been addressed.

I'll talk about relational changes, emotion-focussed care and philosophy. Both Mary and I are not selling the Butterfly in any way, shape, or form. It is the model that our organization strategically aligned with to move forward towards emotion-focussed care.

We know that there are other models that are available and that people are selecting and using or sometimes bringing your own model. No different than the City of -- what the City of Toronto is doing. It's around getting to the point

of emotion-focussed care.

I'll also speak about design, the household model, and I'll do that in two different ways: one around well-being and then a second around IPAC, infection prevention and control and safety.

And then resident staff and family outcomes and, again, IPAC safety. And then Mary will speak about the blueprint to quality. So executing a change management plan, we feel very strongly that the pilots are done. There are these local pockets of innovation doing emotion-focussed care and implementing the Butterfly model.

Those pilots are done, and we've had these done for a couple of years now. Talking about managing regulatory and other risks, and then what needs to be true to be able to scale this model across Ontario to create this substantial culture change that's required in long-term care.

And the next slide, Mary.

This is actually my favorite slide. And every time I have an opportunity to speak, this is a slide that I use because good dementia care is good care for everyone.

And often the Butterfly or

emotion-focussed care is considered to be about dementia and only for people who have dementia or who live in dementia-home areas within long-term care. It is not. There is not a thing that we're going to talk about or we'll tell you about or that we see or we do that just is not good care for everyone.

And I challenge people as we talk about this and look at it to think about anything that I've said or anything that they see when they come to our homes that you wouldn't want for yourself.

It's just really about good care and connecting with people at the point that they're at in their journey and allowing people their basic rights to be able to make decisions about what they want to do and when they want to do it. Being appropriately resourced to be able to support that as well.

Mary -- thank you.

So what is Butterfly? Butterfly is a social interaction model. It's represented in Europe, Australia, the US, and Canada. Again, Ontario -- our view is really behind on this. I mean, there are a few local -- I call them "local pockets of innovation" and yet not been able to

sort of get it out of those -- out of those local pockets and adopted across the board. And when Mary speaks, she'll talk about some of the things that need to be true to be able to do that.

But the outcome of the Butterfly or emotion-focussed care is emotional well-being so that those living with dementia or without dementia and staff who care for them -- their well-being together is equally as important, and the effect of well-being is experienced by both.

So as you create your Butterfly home, staff and residents and families are a triad. And the triad is person-centred together. We do not view any of those three groups to be opposing in any way, shape, or form. We all share the same goal which is to -- for residents to live well, for staff to work well, and for families to do well.

And when we look at it that way, we understand that we may come from different perspectives, but we're not opposing. And so there's much more of a cooperative approach, collaborative approach to working together to make sure that we all experience well-being.

Again, for residents, when I talk about outcomes, you'll see -- and we're using realtime

data that -- and largely from the MDS-RAI. So it's not coming from us sort of creating, you know, outcomes or whatever. It's coming right off that MDS -- or RAI-MDS data, sorry.

But also staff do better. It's been a large -- a huge concern of ours and of the system of people that live and work in the system, that staff, very early on in their careers, have caring and well-being and really why they've become healthcare workers. And I'll use the term "beaten out of them" very quickly.

In a very toxic culture, they're too rushed; they're too hurried; they're too focussed on tasks; they're driven by some legislation that really focusses on outputs and not outcomes; and, therefore, they can't do well, and people want to do well, and so they leave.

And I sort of -- sometimes I jokingly refer to -- you know, every time Costco opens up a mass hiring, we lose a large number of people. I have had a 38-year career in long-term care. Back in 1982 when I started, I saw the opportunities that were there. And I had people believe in me, and I was given opportunities to really build a very strong and interesting and satisfying career.

That isn't necessarily available, and people don't see that now. They see it just as a place to stop as they move onto other destinations in their career.

So we'll talk about well-being.

Care approach, then: So the Butterfly is a care approach that responds to people in a human, dignified way rather than an objectified manner.

And if you think about long-term care and how rushed people are, responding sometimes to some legislation that really focusses on outputs and not outcomes, residents become lists. Residents become a commodity.

So if you can think -- you know, I have to say words are important. And if you think about -- and I've had to be very careful. I've really changed the way I -- the way I speak over the last couple of years because I would have referred to my home in London, for example, as a "192-bed home" or "I've got 60 beds up in Wiarton" or "I've got 100 beds over here."

This is a home for people. People are not beds. So I'm changing the way I speak. I am a home to 192 people. Now -- and that's moving away

from objectifying people to understanding that even though we have a care -- we are on a care platform, we are fundamentally a home.

Residents, very typically, in a home become a list, and we talk about "the lists." There's the low-fluid intake list. There's the BM list. There's the doctor's list. There's the footcare's list. There's the bath list. There's the hairdressing list. You become a list. A person is not a list. A person is a human being. And, again, we organize ourselves largely around these lists.

So I'm going to give you a real example just to put this into perspective. So right now in the legislation, the Long-Term Care Homes Act, residents are to have a minimum of two baths or showers a week. They need to be scheduled and, again, the list is the bath list.

We go into the nurse's station, and you look at the list on the wall, and you see for Tuesday and Friday, Mrs. Jones is going to have a shower at 4 o'clock. And you typically, because the PSWs have to stick to the list, are basically going to get that shower at 4 o'clock on Tuesday and Friday whether you want it or not. And you

don't have, really, a choice in that other than your initial declaration around that.

If that resident does not want to have their shower or bath that Tuesday at 4, there's four places that needs to be documented, and that PSW has to ask for permission from the charge nurse to be able to change that bath schedule. It needs to be documented in four different places. It's not an easy thing to do.

And yet under the Butterfly where we deal with people on a human -- at a human level and our PSWs -- again, a minimum, one-year long training get to this point -- this culture change -- the PSWs are empowered. Our frontline staff are empowered. The hierarchy -- there is no hierarchy. It's reduced.

Large -- sometimes the home action team leader is a PSW and not the registered nurse or registered practical nurse. That PSW knows their residents so well they may end up bathing that resident every single day. If a resident --

So this is a real example I'm going to use from one of my homes. We have a resident who has some aggressive tendencies. We don't use the term "behaviour." We only use strength-based care

plans with Butterfly. We don't talk about -- you're not a behaviour, so you won't see that on the care plans.

But has some aggression and some agitation. And so that PSW will bathe that resident seven days a week because he knows -- Wes knows that that resident responds very well to a nice, warm, calm bath.

He has the time to do it. He has the ability to make that decision. And so what's the outcome? Our resident is bathed seven days a week, not two times a week, according to a list, and use of certain harmful medications are not implemented because you're not trying to control a behaviour that way. You're doing it in the -- because with you've connected with that resident, and you know what's important for that resident.

So that's how this model really shifts even with our staff to -- where they're really involved and looking at residents in this -- in this very human approach.

Next slide, Mary, please. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you there for a minute?

JILL KNOWLTON: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you need more -- do you need more staff to do this?

JILL KNOWLTON: Yeah, so thank you, commissioner. I would say -- I would say yes. So we're a private, for-profit operator. We have done it because we have taken a universal care provider approach.

So dietary aides, housekeepers, recreation, physio aides, PSWs, nurses are all considered part of the home action team and all have equal weight on that team.

So we actually exceed a 1 to 5 ratio. You say you need a 1 to 5 -- a 1 to 5 ratio for this. And so I wouldn't want, though, to mislead you in any way to say that you don't need people. You need people, and you need humans to do this. This is about people.

So the tremendous opportunity that we have right now is around the average four hours of care. You know, that's really transformational. And, again, how is that average four hours of care defined? How is care defined? What's the skill mix, and what needs to be true to be able to get that right so that the average four hours of care

does not become a checkbox as an outcome, right?

"Oh, we met four hours." You haven't fixed the toxic culture over here. You're just going to do four hours of to toxic culture.

But you're going to change that, and you're going to use the four hours of care as an enabler. It becomes an enabler -- not an outcome, an enabler -- to this well-being and to this emotion-focussed care. That's where you start to really change outcomes that make a difference to resident, staff, and families.

COMMISSIONER FRANK MARROCCO (CHAIR):

So if I look at the -- what I might call the conventional --

JILL KNOWLTON: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR):

-- staffing, the conventional model --

JILL KNOWLTON: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR):

-- and the Butterfly model, the Butterfly model will require more staff to make it work, if I understood you correctly. You're a private, for-profit home.

JILL KNOWLTON: M-hm, yes.

COMMISSIONER FRANK MARROCCO (CHAIR):

So do I understand, then, that you can still function in a profitable way providing more care, more staff?

JILL KNOWLTON: Absolutely, yes, 100 percent, and we're demonstrating it every day. I have two fully-accredited Butterfly homes operating right now.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

JILL KNOWLTON: Yes, yes.

MARY CONNELL: Can I just add, commissioner, that the other component of this is to support staff to work to their full scope and to use staff differently.

So one of our most fantastic people who work in the home are housekeepers. So they're not traditionally thought of as part of the care team. But under this model, we use the personal abilities of people and their trained abilities to scope.

So it's not just about hiring more nurses or PSWs. You may already have enough staff within the home area. You just need to use them differently.

JILL KNOWLTON: Yeah. And that's largely what we've done, commissioner, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Dr. Kitts?

You're on mute, doctor.

COMMISSIONER JACK KITTS: Sorry, my apologies. Just a follow-up on the type of resident and how residents are admitted to your home.

So, first off, is there a waiting list, and is there a criteria by which long-term care patients are admitted to the home?

Because we're learning that many of the residents have high acuity and high -- more complex healthcare needs. Do you admit those residents, and how do you manage the diversity, then, of resident needs?

JILL KNOWLTON: So I'll -- if I could wait, Dr. Kitts, to a slide -- our next slide where I'll talk about matched households. Would that be appropriate if we just held your question?

COMMISSIONER JACK KITTS: Yeah, yeah, that's fine.

JILL KNOWLTON: And I'll speak about matched households.

COMMISSIONER JACK KITTS: Okay. Thank you.

JILL KNOWLTON: Yes. So that will be coming. Thank you.

So the key elements, then: You must be person-centred, and we talked about the triad. Resident, staff, and families are person-centred together. I have to be person-centred as the chief operating officer. My organization has to be person-centred. It's not something that you do. It's about being.

Feelings matter most: So services are based on outcomes. We measure the quality of interactions. We are obligated to report on a lot of data, a lot of indicators, which we do because we're obligated to do. But our Butterfly indicators are different. We report on different indicators, and I'll talk about those shortly.

Family-like care: Services move away from tasks. We don't have a calendar that says, you know, Tuesday at 10 o'clock, we're going to hymn-sing down in the -- down in the chapel. That's moving people to a program, doing something, and taking them back.

The program, if we want to use that term, is really our day. It's the natural day. We have home areas that are colourful, that are

bright, that have access to a lot -- we call it the "stuff of life." Virtual realty, as well, is used for people where we can't recreate certain situations and -- so that people are met in their journey where they need to be. And the day becomes part of normal living.

So domestic kitchens, for example: We prepare our vegetables. We prepare our food for our meals. That's what a normal home -- what you do in your home.

Emotional labour: Staff are person-centred and receive person-centred care and support. Our staff become family members in the household. We don't refer to them as "staff." They're family members, and they work as family members with the residents at the household.

New culture staffing: We developed staff leaders. I said earlier that a PSW may be the home action team leader. That isn't necessarily the hierarchy.

And emotional intelligence is the core competence. When we hire for the Butterfly areas, it's a different hiring process. We can see on a resume that you have a certificate as a PSW, but we need to know that you can really be vulnerable and

that you can be -- really connect with people at an emotional level. So it's a different interview process that's used.

And, you know, Mary and I talk about this all the time. We don't want to label people as "good," "bad," or "ugly" because you are not able to be open and express yourself that way in a Butterfly home area.

It just means that a Butterfly home area is not the right place for you. There's other areas that you may be more suited to. But Butterfly, really -- you have to be able to be open because you're living as part of the -- you're living and working as a family.

And action based: Increased quality of life is the main indicator in Butterfly. We care about a lot of things. We care about a lot of indicators. But bottom line, if you want to have a bowl of cornflakes at 9 o'clock -- you didn't want to have dinner; you wanted to have cornflakes at 9 o'clock -- that's probably what quality of life means to you. And so that's important to be able to -- be able to make those decisions and live in an area no different than you would have in your own house.

Next slide, please, Mary.

Okay. So Butterfly is small, domestic households, 8 to 12 people, and everybody has their own front door. And I'll show you some photos of front doors shortly.

A house works best when people are matched. So this would be your question, Dr. Kitts. We try to create matched households.

So I talked here specifically about dementia where -- so the moderate stages of dementia would be sort of located together in the small households. There would be another small household that would have later stages of dementia.

It doesn't work well mixing. And the other way we're using this now is around culture. So if you create a small 8 to 12-bed household, perhaps, based on Indigenous or First Nation culture, that group is going to get along better than the mixed sort of approach.

So when you talk about acuity, again, we try to put -- match people together. So moderate, typically, is ambulatory, walking, able to engage in, you know, a lot of outdoor activities like that where later stages -- we would -- we would have a different household for them.

Next slide, Mary, please.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke?

COMMISSIONER ANGELA COKE: Sorry.

JILL KNOWLTON: Oh, sorry.

COMMISSIONER ANGELA COKE: So just to ask a question. In terms of as people's needs change, as things -- you know, their acuity level changes, is it a simple process or easy process to move people to a better grouping?

JILL KNOWLTON: Yes, commissioner. That's what we do. We do a lot of work with the families. So, again, when I talk about the triad, we have to arrive at the same place together.

So as we go through that initial year-long culture change program, which is very intensive -- a lot of education, a lot of coaching, a lot of work done; we do that with our families as well -- we have regular family meetings.

Because when you start at this with families, what do you -- what do families know coming into long-term care? They know the Long-Term Care Homes Act. They know compliance. They know inspection reports. And so you're really putting something in front of those families that's

different, right?

And so families have to equally be educated and be supported and coached in this process as they're learning throughout that -- throughout that year. So it -- it's not going to a family and saying "okay. Well, your loved one is changed now. We're moving them over here." They understand the process and the theory and the philosophy behind a very coherent care model.

COMMISSIONER ANGELA COKE: Okay. Thanks.

JILL KNOWLTON: Mary, next slide, please.

MARY CONNELL: Can I just give an example, Jill --

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, if I could --

MARY CONNELL: Oh, sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): Dr. Kitts.

COMMISSIONER JACK KITTS: Yeah, I was thinking about the progress because a lot of people come into long-term care with, as you say, early dementia or some dementia or a chronic illness or even multiple chronic illnesses.

And I'm just trying to wonder how the Butterfly model works with the progression of either disease or acuity right through to end of life. Just give me an idea. Is that all happened in the Butterfly model?

JILL KNOWLTON: It has, and I would say some -- for some of our residents -- again, we live in a family in the small -- staff live and work in the family in the small households.

So residents aren't -- if they become end-of-life or they're deteriorating, although we talk about matched households, we don't always move people. Because, again, it's part of the journey of the family, that it's, you know, towards end of life and towards supporting that resident and their family members towards end of life.

Mary, did you want to say something about that?

MARY CONNELL: Yeah. Just had a little story that might, you know, illustrate what we were talking about. When I started at the Butterfly home at Malton Village, when I first got there, there was a lovely woman from Newfoundland. And -- but she was in the later stages of dementia, and she used to do what she referred to was -- she used

to love to sing Newfie drinking songs, and she used to drop the f-bomb all the time. And she was at the dinner table, and her dinner partner was a Baptist minister who was in the early stages of dementia.

So you can see that these two are constantly fighting at the table. And if you've been to a long-term care home, you know that meal times can be problematic. So they were both physically, from a medical perspective, in the same state, but she was much further along.

So we have to protect both of those. She's happy singing those songs. We need to protect her. So she needs to be in an environment with people who are doing the same thing.

And then he's in the early stages of dementia. He's terrified. "Is that going to be me in three years?" So we need to protect him, too. So we have him with a group of people that he can engage with, and he doesn't have those frightening experiences. So just a little funny story.

JILL KNOWLTON: Thank you, Mary. Thank you. Butterfly homes have open access to domestic kitchens, and we do family-style dining. And I think, you know, when you look at the current

design standards, nobody eats with 31 other people in a dining room of 32. None of us grew up that way, and none of us grew up being served restaurant-style. And that's currently what is, you know, typical long-term care today.

So a lot of work around dining. It's probably, over the course of the year of the culture change, the most difficult thing to move. And, again, if you don't get there at the end of your six month, you back up, and you start all over again, and you do all that work again.

I know Malton Village, Region of Peel with Mary, that was probably their biggest area -- hurdle to get over was around the family-style dining.

So we have people sitting together at tables. People serve themselves. The plates and the dishes and the platters go down the centre of the table. You largely have participated in preparing the food.

We take that away from residents in long-term care because, again, you're served restaurant-style from a servery. But preparing food is a big part of our day and what's important to us where we -- when we lived in our homes.

So, again, some residents can do more. For example, if we're peeling carrots, some people can work the peeler to peel, and other residents may not have the dexterity to do that. But they're part of the group, if they want to be, that's participating in the preparation. You might do some -- another aspect of food.

We're often asked about the public health restrictions around this and multiple hands going into a platter, let's say, of sandwiches down the centre of the table.

But remember, people are living in these small households, and your staff are dedicated to your households. So because people aren't moving and mixing in larger groups, it's like living in your own family.

Staff sit down with residents and have their meals with the residents because they're part of the household. And this is probably the biggest hurdle to get over because if you say to a PSW "okay. Now, I want you to sit down with this resident, and I want you to eat the food that's on the table and take as long as you want."

You know, breakfast in our Butterfly homes may start at 8 and go to 10:30. It's not an

8 to 8:30 and then you come back at 12 to 12:30 for lunch. It could go on for a long time. That PSW will say "I will not sit down. I have to stand. I'm not going to eat the food. That would be theft. I could be charged with theft."

And we have to work with our staff to get them over that hurdle to understand you are a family member, and it's important that we all sit and eat our meals together.

It is a -- it is a huge, huge shift to make, but it is amazing when you see the participation that residents have in serving themselves, serving co-residents, serving staff. It's really phenomenal.

And people that you don't think have any interest or ability to even do this are actually very capable of participating. And if they're not, then they're supported by the person that is sitting beside them.

Height and colour: Sometimes Butterfly really gets focussed on the environmental changes. You know, the very vibrant colours; segments, 10 to 12-foot segments. The segments mean something. They call it a sequence. A lot around wayfinding. People know if they live in the pink sections,

they've gotta stay in the pink section and gotta get back to the pink section to find their room.

But, really -- you know, there is some theory behind that, but we don't like to really focus entirely on these vibrant colours because we want to make sure that people understand that it's the model, not just the pink colours.

Personalized bedroom doors: So everybody picks their own bedroom door. We have catalogs that families can choose from. So -- or they can bring in a photo. They may bring in a photo of their family home from 1940. Or we've had a bakery's door. We've had a barn door, if it's been a farmer, that a family has selected.

And then residents can find their room because they're looking for their door. They're looking for the yellow front door with the glass in it that they had on their street in 1940. Or the farmer's looking for the barn door.

And filled-up environments: so stuff of life. So sometimes Butterfly homes can be viewed as cluttered, and we'll talk about that with IPAC. But it's really around the stuff of life and having the things that are meaningful to you so that you can live in your life in the journey that you're

in.

And this is why there's no responsive behaviours or few responsive behaviours in Butterfly homes. It's because -- you know, if you -- if you were a -- if you were a secretary, for example, and -- or an executive assistant, and, you know, it was important to you to type and to take phone messages and answer the phone, we'll have a desk set up with a phone, and we have -- Mary knows this example very well where the staff will call that phone line, and that resident will take phone messages and hand out the phone messages. And they're active -- like, they're busy, and they're being -- you know, feeling very accomplished in their day because they're doing what they know they should be doing.

And the next slide, then, Mary, please.

So the new culture staffing approach: We talk about the ratio of 1 to 5. That's the goal, but that's using a universal care provider. That includes your housekeepers, rec aides, PTs, dietary aides, and your PSW and nursing staff.

Reducing the use of antipsychotic medications to a target of 10 percent: This is one area that Butterfly homes have been hugely, hugely

successful.

So when I started with my home in St. Catharines in 2018, we -- in our Butterfly home area, we had a 57-percent use of antipsychotics. Very intentional approach. Dropped them down to 8.2 percent.

And, again, as the population changes, that will shift. It's not "you must be at this or you're not doing well." It's a work in progress. It keeps it on the radar every single day. And what we've done is we've removed those antipsychotics.

"I call it lifting the drug fog." The drug fog is lifted. All of a sudden, people can engage in their lives. And then what do you see in the a Butterfly home? You don't see -- you don't walk in and see wheelchairs lined up and people staring at their feet. You see people openly engaged with the staff, the other family members, and you see zero weight loss. You see zero use of nutritional supplements.

Through COVID, I thought my dad and my indicators would go completely in the wrong direction. I -- my home in London, over those three months in Wave 1, zero responsive behaviours.

And why? Because we've lifted the drug fog. Our staff leaned in even harder and in the very normalized family-like approach.

And, again, then with the staff, reducing the use of "us" versus "them." We don't use that term. We're all part of the family. And I -- you know, I see it on social media, our staff tweeting things all the time about "the family." And you know you really get it when that's how they describe themselves and no longer as -- no longer as "staff."

So, Mary, we'll just quickly go through some photos. So this is where we started. You can see this bowling alley approach. This was a home that was built in 2003. It is an A home but horrible.

Every home as a front door. So every Butterfly area, our home area, will have its own front door, and this is the front door to our home in London.

Next one.

Every home has a vestibule. You have a spot to hang your coats and hats and put your umbrellas and sit down and put your shoes on.

And then every -- and this is the

dining room. So you can see how we don't sit at individual tables. We sit in family-style, and you can see all of the stuff down the centre of the tables because residents help themselves and serve themselves. And when the food is served, it goes down the centre of the -- down the centre of the table.

As I said earlier, we don't really stick to meal times. Typically what I find, particularly around breakfast, is that it often goes from 8 till about 10:30 because -- and I'll just show the next photo, Mary, please.

This is a real resident. These are not staged photos in any way. This is one of our residents in our home in London. You know, she's having another cup of tea, and she's reading a book. And, you know, the staff are there with her. And, again, we are showing zero weight loss and zero use of nutritional supplements, and that's over two years now.

And, Mary, the next one.

So this is an example of front doors. So these family members have selected the front door for these residents. So you don't have to necessarily have a room number or being directed.

They -- these residents would know they live in the purple area, and they would look for their front door, and it's a tremendous wayfinding approach and so interesting. So interesting when every door is different.

So that great big, long corridor has now transformed into this. And, again, we're not talking about a spoke-built Butterfly home. This is a transformation of a home that's been around since 2003.

You can see the colour segments as you look down the hall, and that's really what I wanted this slide to show you. And those segments are in a certain order for a reason, and people know "I live in the blue" or "I live in the purple" or "I need to get to the green."

Next slide, Mary.

So here's the stuff of life. Here's one of our residents, and this is when we brought the plants in from outside. And one of -- this is what staff did. They went and they bought these washtubs, plastic washtubs, painted them, and we painted all the plants from outside indoors for the -- in the fall for the wintertime, and they'll go back outside in the springtime.

And Butterfly uses all natural and real materials. So plants, for example, nothing plastic. And I have to tell you nobody's eaten the dirt. That's what's always been said to me. "Well, people eat the dirt. People eat the plants." I have not had one single person eat the dirt. People know you don't eat dirt.

And, again, here's another photo. This is just playing the -- this is at our home in London, just playing the piano. This is one of our staff members. Staff members wear street clothes. At night, they wear nightwear. They wear pajamas and bathrobes. They'll lie down with a resident to help a resident stay in bed at night, if necessary.

Next one, Mary.

So here's the plants again. This is a resident checking the plants. Again, all real. Nobody eats the dirt.

And here's around the stuff of life. This is on some of the walls. This particular resident is hanging up the washing.

And this is Sonny. And Sonny's -- you know, this was in the fall. He was husking the corn because, again, we all -- we work on meal preparation like a domestic kitchen.

And this is just at the end of one of -- of that great big, long bowling alley-looking hallway. This is a resident and his spouse and just enjoying some time together at the end of the corridor.

So outcome indicators, then:

Antipsychotic medication use is as an indicator we report on. We work very hard to try to get it down to around 10 percent or below.

Behavioural incidents: So also called responsive behaviours. Again, I'm just amazed. In our Butterfly home areas, we have zero. And people are not on all these medications, and we have zero.

Falls.

Family satisfaction: And we use something called the Herth Hope Index. We don't measure satisfaction as a satisfaction tool which is just a reaction. It's around hope and confidence.

Staff engagement: We measure staff engagement at this point around absenteeism, workplace injury, and turnover and, again, showing huge improvements on that.

Pain.

Social engagement of our residents: So

being involved in daily activities.

Unplanned weight loss.

And use of nutritional supplements are the indicators that we're reporting on for Butterfly.

Mary?

So what have we seen?

Reduction in pain from 15 percent to 5 percent.

Reduction in use of antipsychotic medication by greater than 50 percent. And, in fact, I have that one home that went from 57 percent down to 8.2 percent.

Zero responsive behaviours through COVID and with the -- you know, we were under order. So we had to have residents remain in the rooms. That's very un-Butterfly. I think our staff leaned in harder. Not -- didn't lean out. They leaned in harder.

They have to wear their masks. Universal masking; universal eyewear. And yet we continued to have zero responsive behaviours demonstrated.

Increased social engagement of our residents, and the zero weight loss and zero use of

nutritional supplements. And you if you think nutritional supplements, for a home, a bigger home, it could be 125-$130,000 a year in supplements. That's funded by the government. And we're not using them because people aren't losing weight because they're not taking all -- you know, they're engaged in dining, drug fog's lifted, and they can eat.

And then IPAC, Mary, please. Next slide.

MARY CONNELL: Okay.

JILL KNOWLTON: IPAC, so, again, I want to speak specifically about this. When we started Butterfly a few years ago, we were really thinking about well-being, our residents, our staff, and our family well-being.

And with COVID, with the pandemic, we've learned that it's also around infection prevention and control. And, you know, long-term care homes are very interesting because, really, on a continuum of 0 to 10 -- 0 being a home and 10 being a healthcare facility and strict infection prevention and control requirements -- we have to -- we can't sit at either end of that continuum.

We have to somehow come together and

arrive at a space on that continuum where we have the safety around infection prevention and control but yet we continue to be a home.

So when you look at some of the IPAC assessments that are coming in that tell you to remove all the paper, remove all the stuff of life, remove everybody's fabric lazy boy chair in their room, you can't -- you can't arrive at that point because you have to get to a balance where you continue to be a home because, again, fundamental principal is that we're a home.

So what does Butterfly do? Creates small households, and the households become safer because you limit the number of interactions between residents and staff. Residents are dedicated as part of the family to their households, and staff are part of that family.

They are not -- even within the home, they are not moved. It's a different way of looking at staff. They don't want to move. They don't want to move out of their family. And so we don't just look at staff as a pair of hands to shift over here when we're short or move over here. You are part of that family, and you stay in that family.

And under IPAC, what's a term that we know? We know the term "cohort." What is a cohort? Cohort your family, is your household. That's your cohort, and you stay in your cohort.

So staff is dedicated to the household or the cohort. The ability to close off households -- so the small households, you can compartmentalize. So if you did have an outbreak -- and it may be COVID and it may not. We can get other things like influenza, rhinovirus, all sorts of other pathogens -- you can close off that household. You've got a small group of staff and residents. That's not being spread and moved throughout the home.

Zonal isolation and HVAC systems: So if you're building new homes, then the design standards should address zonal isolation so that there isn't that sharing of air flow. That's what, brilliantly, these small households do.

Reduced number of people touching things: Cross contamination, all those high-touch -- that high-touch cleaning you need to do, all that hands and environmental contamination is reduced because those people stay in their -- people stay in their household.

Reduced outside --

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just -- can I just stop you for a second?

JILL KNOWLTON: Yes, yes, m-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): Going back to the staff --

JILL KNOWLTON: M-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- do you use part -- how do part-time staff -- we've heard a lot about "there are too many part-time staff" and so on. How does that work in your model?

JILL KNOWLTON: So we largely have full-time, dedicated staff members because they're really -- you know, this is over a year of training. This is a big investment for them as well, so it's largely full time. But we do have a part-time complement that's dedicated to that home area because, again, they have to be trained as well.

Butterfly gets watered down very quickly if you don't -- if you bring people in from the outside that haven't gone through that culture transformation. So when they are part of that

cohort to that -- or that household, they stay in that household. The part-time staff also supports that household.

So we're not pulling people and moving them all over the home. It's not -- we don't look at it as a pair of hands. We look at it as you're a family member.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

JILL KNOWLTON: Okay. And then reduced outside source interaction to the household: Again, if you're building new homes and you're looking at design standards, you know, these households can be really self-contained.

You could do this really smart by having double-sided cupboards, you know? The linens are delivered from the outside service area into the cupboard and then it can go into the household. Or, you know, the opposite is, you know, garbage and dirty linens and things going out can be done the same way.

So, again, you limit the number of people going in and out with carts that can be cross-contaminated moving in and out of the home area.

This is a really important point and, really, probably one of the most important points around Butterfly is access to open and natural outdoor areas. Homes, again -- I have them myself -- that were built in the early 2000s -- we thought we were really clever then around the use of courtyards and interior courtyards. We call that, now, prison yards because they get too hot in the summer, and the snow load in the winter -- and they're just not used, and they're not natural.

People need -- nature is restorative, and people need to be outside and have access to outside areas in a natural way. You should not be in a long-term care home and not be able to hear the school children going home from school or seeing the buses. Or if you're in a rural area, seeing the combines or the grain tractors going down the road. You need to be outside in very natural areas.

And I always say "we're Canadians, and so we know the four seasons." And if you want to go outside in the winter, you should have an opportunity to be able to get bundled up and go outside and experience the cold in the winter and the snow. And, largely, in a long-term care home,

you know, from November, I would say, through to the spring, you don't go outside. And so we really promote the access and the open access to outdoor areas.

Walking routes that provide an anchor for wayfinding: I've talked about how the colours create that anchor, but this approach with the courtyard in the middle and, like, a block, people going around -- I call that "people going around in circles."

We know that, actually, to be very dangerous because people with dementia continue to go around in a circle because they're looking for their anchor. They're trying to wayfind. When they can't find it, they burn a lot of energy just going around in a loop, and you start to see falls. You see falls with injury. You see weight loss.

And so people need -- homes need to be designed so that you can see where you're going, and you can find your anchoring point.

And, finally, around other safety is these small households work beautifully in terms of a culturally-appropriate design and approaches. I have a proposal in for a home with households that an Indigenous group is -- will be taking two

households, and that will be codesigned with the group so that it's designed, it's decorated, it's specific to that culture.

I have another proposal in for a home in Milton with a South Asian group and cultural group. And, again, they will -- they've asked to take two households that they design and decorate and support as culturally appropriate for their community.

And at that point, I will turn it over to Mary.

Mary?

MARY CONNELL: Okay. So I'm just going to mention about myself that unlike Jill, I don't have an extensive background in long-term care. I come from intensive care and public health.

Everything that I know about long-term care and dementia, I learned from my father who had Alzheimer's for 16 years. So my learning is from him.

So we need to shift -- and this is what person-centred care does is shift the paradigm. So from everything we believe and understand about long-term care to be -- and I think these pictures illustrate it.

So you see what most people typically think of long-term care and what long-term care is about on the left, and then you see my friend Bruce who was a junior semi-pro tennis player playing tennis in the living room.

So if, tomorrow, I was to mail tennis racquets and balls to all 600 plus homes in the province and said "okay. Go at it. You know, be a Butterfly home," this wouldn't work because we need to change some of these foundational beliefs. In order to have the change happen, we need to have, you know, those seeds falling on fertile ground. So I'll talk to you a little bit about the change.

This is my friend Emeline who is the mother of eight and looking after babies. You can see she, very interestingly, has been able to maintain her language skills even though she's in the advanced stages because she sings everything. She was a singer in her church choir.

So what needs to change is the discourse on ageing and how people view being older and how they view seniors. I heard someone on Twitter -- I saw someone on Twitter the other day saying that Anthony Fauci shouldn't be trusted because he's over 80.

So we need to change this kind of feeling. Even the things that we see happening in the papers today are shocking and horrific. If these same issues were happening at the Hospital For Sick Children, it would be unheard of. That would also be horrific. But we need to see the value of these lives as being equal.

One of the things that needs to happen in order for this person-centred model and effective culture change to happen is opening the Act. We need to change things within that Act, assumptions that we make about what good care is.

So we need to have a definition of what "emotional care" is. We need to have a validated tool to assess care. We need to hold people responsible. When an inspector goes into a home and sees 30 people sitting in front of a television set, that is not emotional care. That's not good care.

It needs to be a continuum of care. We need to stop thinking about the care for seniors stopping at the property line of a long-term care home. It should include everything. It should include community care, care at home. Anywhere where seniors require service, we need to think of

it more holistically, not just in the long-term care homes.

We need to change societal expectations. And, unfortunately, I think that's -- well, fortunately/unfortunately, something that's happened as a result of the pandemic is that people expect better for their loved ones. And we need to support that, and I'll talk about how we can do that from a change management perspective.

We need to define "care" differently. When we think of care, we think of just the -- you know, the watering and feeding of people and making sure they're medically safe. We don't make sure they're emotionally safe, and we know who people aren't emotionally safe and well looked after die three years sooner. We need to add this.

We need to value the work of staff and the work that they do. As Jill has talked about, within the Butterfly home, well-being is about everybody. It's about leadership, it's about staff, and it's about people who live there.

You can't have this great care going on in the home and then staff don't treat each other caringly or respectfully. That can't happen. It

has to be all around.

Design standards, Jill has already spoken about this.

Availability of resources: So the increasing of staff, the increasing of funds that homes can use and put towards in ways that they know services their people the best.

The collaboration of stakeholders: There's lots of people -- and you see this on Twitter daily -- where there's a lot of arguing among groups about what the solution is. What has to happen is people need collaborate and say "okay. We need to find a solution that is best to the people that we take care of." It's not about our own self-interests or the interests of our group. It's got to be about the people.

Uniformity of compliance expectations: Why can you have a clothesline on the wall at Jill's home in London, but in Ottawa, the fire department won't let you have one? So that's something that needs to change, and we need to come together and ensure that we have great care and that we're all on the same page or culture change isn't going to happen.

Something that is often missing in a

lot of our strategies and work is authentic involvement of people living in the homes, community, and their families.

So it's often a last thought where we very selectively put a family member on a committee where we feel like it shows that we're allowing them to participate, but it's not really genuine or authentic. They need to be involved from the very beginning. And you can involve people with dementia on these -- on these working groups or in the problem solving.

We have a gentleman -- you know, Bruce, who you saw with the tennis racket, he comes to our meetings and takes minutes, and he does a great job of it.

So change management: So for change to happen, it's just not going to happen magically. Like I said, I mail out the tennis racquets or we paint the walls, and we've got Butterfly. You need a really robust management strategy that uses a validated model.

At the Region of Peel, we use ADKAR. That's just something that we use within our corporation. So what I did when we rolled out the Butterfly model -- and one of the reasons I chose

the Butterfly was because you can layer a change management strategy on top of it, and it worked out very nicely. But you have to have one. And a change management strategy is not a communication plan. Two different things.

In order for change to happen successfully, you need buy-in from all levels but, particularly, the leadership. Throughout my projects, the thing that caused me the most stress was trying to get leaders to buy into the change.

Frontline staff get it. They see the rewards. Family get it. They see. It's usually leadership. And most change models or change strategies fail because leadership is not buying into it.

Academic detailing of trusted advisors: So most people, when they're thinking about good care for someone or a senior's thinking about their own care, they'll go to their family doctor. Now, if those -- or the nurse practitioner.

If those individuals don't have great information about care, then they're not going to get it. So we need to start with getting our advisors up to speed.

Collaboration with novel partners: If

you continue to research and strategy in exactly the same way, you will always get the same thing, the definition of insanity.

One of the things we did in the Butterfly model was we used the Toronto Star and an investigative reporter as part of our knowledge translation strategy. That's a very scary and not traditional communication tool, but it really worked.

One of the reasons I'm here today and Jill's here is because of the work of the Toronto Star and getting it out there.

That is Minister Cho with one of my friends Mikala who was a hundred years old, and she was playing golf with Minister Cho in our courtyard.

One of the things we need in order for change to happen is have an agile structure so that when you're rolling out the project, you make changes on the fly. As challenges happen, you don't wait until the very end to make those corrections or changes.

You want staff to see that things are going well in order for them to continue. You need metrics in realtime. You need to be showing your

progress all the way along. You need realistic timelines. Rolling out a person-centred strategy in Peterborough might be very different than rolling it out in North Bay and not being locked into a prescriptive way of doing it. It has to work for that culture and that home.

Having a provincial tiger team of experts that understand person-centred care and can support and help homes throughout the province to make this change, and it has to be a really collaborative, equal partnership. It can't be a fear of being evaluated or repercussions for doing things wrong.

Using a champion model. Already, right now, we have eight home groups throughout the province who are already doing a person-centred model. These people very strategically could become champion models for people in their area.

Again, accountability: That which gets measured and you're held accountable for, you will do. So, again, in the Act, we need to have assessments for this, or people will not do it.

And then social marketing: Having some kind of social marketing campaign that changes societal images and thoughts about seniors and

their value within our society and why they deserve better than we've been able to give them.

So the pandemic has taught us a lot of things. It's taught us about, you know, being able to do things virtually. But the thing that I've noticed, things that used to take months to get people to do, all of a sudden they can do it in hours or days.

Let's do that. All of these things can happen together. So we can work on a change management plan, role out person-centred care, and research it at the same time. Let's not talk about it too much. Let's get on it.

This is my friend Harold who celebrated his hundredth birthday. He's one of the few surviving Canadian members of the D-Day invasion.

So scaling and innovation: So what are some of the challenges, and what did we do? So, of course, for any innovation to be scaled, it needs to be piloted. So we know it has been piloted successfully in the Region of Peel and at Primacare. So we're ready to go. Let's go with it.

But one of the things, though, that we have to decide is the innovation. We also know

that there are innovations that came out of this pilot. We have to select which ones those are that we would move forward. I've done vertical scaling already in the Region of Peel. We have five homes. I've rolled it out to five homes.

Our spontaneous scaling: As I mentioned, I didn't have to do anything, and people came to me. Eight home groups in the province were already doing the Butterfly with very little effort on my part.

So one of the challenges is defining innovation because not everybody's going to choose to do the Butterfly model. Although, as I say, it's the full-meal deal. Everything comes together in one package, and it's very easy to roll out.

People may choose to do other things, but how do we define the innovations that we're going to move forward to the home? How do we address uniqueness? I rolled out a Butterfly model in two home areas in the same home, and they were completely different cultures. How do we address that in scaling up?

Diversification: I've done a lot of work with the First Nations community. The things that they're going to want to do in their

person-centred care is going to be different than we did in Peel.

Ensuring capacity: When you're scaling up and -- smaller homes in -- throughout the province like Peterborough, for example, do they have people on site that have the capacity and ability to do this? That would be a challenge.

And adequate resourcing: Will we receive the funding and the resources they need to scale up? We need to have that because this is not something somebody can do off the side of their desk. You need a dedicated person to manage this.

Again, challenges for scaling up: Do we do a centralized or a decentralized model of person-centred care in the province? I would say it should be a combination of both, again, with equal relationships between people who are leading it and people who are trying to initiate one.

Again, leadership buy-in: huge, huge, huge, huge.

Strategic rollout of a person-centred model: We know with vaccination there's a way to do it, and there's a way not to do it. How would we roll it out in a way that would get us the greatest wins, the most low-hanging fruit? Would

we start with people who are most interested in doing it, or would we start with people, for example, who are most challenged during the pandemic. That's the challenge, deciding how to do it.

Competing priorities: This is not the only thing that people have going on in their homes. We need to vet the inventory of things that we are currently doing. Jill talked about the analogy of the pancake of programs. We need to wipe the slate clean. We spend a lot of money on some of those programs that maybe could be redirected to this. Because if you don't change the culture, those programs are not going to work.

And deciding what to measure and how we measure it.

So I went through that very quickly. I kind of gave you the drive-through version. I could -- this is my favorite topic. I could talk about this for days, but I've given you just some of the highlights.

So if you have any questions about anything that I've said, I would be very happy to entertain those, if we have time.

COMMISSIONER FRANK MARROCCO (CHAIR):

I just -- Commissioner Kitts?

COMMISSIONER JACK KITTS: Yeah, just tying it back to COVID, how did the Butterfly homes do? I understand that your staffing levels weren't that as others, and I think you said to Commissioner Marrocco that you pay your staff more.

The PPE, the IPAC, all this stuff that you're hearing about in the media that were such challenges for long-term care homes, and then the outbreaks and deaths, can you just tell us how the Butterfly model dealt with COVID?

MARY CONNELL: Well, to be honest, I believe that a lot of it was good public health practice. And, again, my background is in public health, so it was very easy for me to marry the Butterfly model with good public health practices.

For example, one of our Butterfly activities was having people wash their hands all the time. They became really good at it. Sometimes you would lead them to do things, and they would say "oh, I have to wash my hands first." So doing things like that.

So it was about good public health practice. We were very fortunate as a region that we did have PPE supplies, but we were challenged in

the beginning just like everybody else. I will be honest to say that I think a little bit of it was good fortune. We didn't have staff that -- and I know, I think, with all of our homes, the cases came through staff contact, not through essential visitors, obviously, or people who live in the home.

So I think it was a balance of both, and I can say in our Butterfly home areas -- we have four of them -- we had two people who ended up with COVID. We had no COVID deaths in our Butterfly home areas.

But, again, was Butterfly the formula for that? I think it certainly helped, but I don't think it was the whole answer, to be honest.

COMMISSIONER JACK KITTS: So, really, you didn't have the staffing problems others had. You had sufficient staff. You had good -- had a good amount of PPE. You had good IPAC practices. Sounds look good leadership.

And with that, I notice that -- this is in the Region of Peel which had high community spread, so you did have small outbreaks but were able to contain them. Is that -- is that a summary for your homes?

MARY CONNELL: I would say so, but I would -- to be honest, we did have some staffing challenges. One of the things that happened was -- I work at the corporate office, and I was called into the home, because I was a nurse, to work for ten months because we did have staff that were sick and did go off.

Was it as bad as other homes? Certainly, certainly not. But one of the other things I have to say is that people who worked in the Butterfly homes felt very connected with their family members who live in the home.

And the lengths they went to to avoid contact with the community because they were worried about the people that they work for -- and I'm not saying that people in other homes were not. But when you're working a foot away from people eight hours a day, five hours a week, you have a relationship, and they felt that responsibility.

And we actually have staff that went and stayed in hotels to avoid getting contact with their families because they were worried about the little people they cared for, so...

COMMISSIONER JACK KITTS: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

What's the -- what would you say is the main barrier to the spread of the model?

JILL KNOWLTON: I've got to say, commissioner -- if I could answer that, I would say it's a rearview mirror approach. It's changing your paradigm. I speak to people all the time about -- long-term care is not going back to where it was nor should it go back to where it was.

The door is open now, and we need to be looking forward. This is a forward-facing model. You can't continue to live back in 1990 and expect things -- long-term care to operate that way. It's -- you can be --

I hear fear from people, I would say. You know, "oh, what would this mean? How much is it going to cost? There's no way I can do it." And I'm sitting here as a private operator saying "look, I can do it, and I'm doing it within the same amount of money that you have."

So I think it's around really shifting that paradigm and really understanding why that's -- why that's necessary and those design standards that are largely from the early 2000s don't work. The Long-Term Care Homes Act needs to be opened up. It's old, and it doesn't respond to

the needs of people.

Now, those are -- those are -- those are kind of scary things sometimes when you think about it, but you've got to be -- you've got to change your way of thinking yourself.

When we started Butterfly -- again, I'm a clinician -- I thought "I'm not buying this. They're going to have to show me a lot. I'm going to do it, but you're going to show me a lot of data to support this."

And I can honestly tell you now I would -- we would never go back. I would be the biggest supporter of this. You have to change the way you think, and you have to change the way you think about our residents and our families and our staff. It's equals. We are equal. And we're not, again, opposing forces, as I said earlier, and that hierarchy has to drop. And so that's changing a lot of structure.

As a registered nurse, I'm used to a lot of control. You know, I -- back in 1982 when I walked many, my staff used to stand up. You know, that's the way it was, but that -- it's a different -- it's a completely different approach now, and I think that's probably the biggest -- the

biggest barrier is people go "oh, we can't do that. There's no way we could do that. We'd never have the resources to do it. We'd never have the time or the people to do it."

MARY CONNELL: Can I just add, Jill, that the question that I get the most is "what will the Province say? They'll come in and write me up if I do these things."

But one of the things I did to demonstrate this to people was I took the Long-Term Care Act -- and believe me, it does need to be opened and things need to change -- and compared it to the components and the outcomes of the Butterfly model.

And out of 43 criteria or objectives, there was only three where it wasn't a perfect match. I have no background in long-term care, and I didn't really know the Act that well, so I used to just read it for exactly what it said.

But, unfortunately, people who have lived in long-term care for long periods of time have heard stories and sometimes interpret things in the Act that aren't actually there.

So I worked hand in hand with the Province on this. And whenever I had a question, I

phoned them, and they said "yeah, that's no problem. You're meeting objective of it." So I think there's this fear of the regulatory component of the -- of the Ministry. I think that's something that would help. If it was more collaborative, then people would -- I think more people would do it.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke, did you want to...

COMMISSIONER ANGELA COKE: Yes. And, actually, you answered one of my questions which was how do you sort of reconcile how the inspectors might be viewing what's right and not right versus, you know, your approach. But you've answered that.

I'm just curious about in -- are there ways in which you're influencing the way people are educated? They've come to your situation, and you need to retrain in a way.

You know, if you want something like this to take hold, people need that as part of the original education, different ways of looking at this work and how to interact and collaborate.

So I'm just curious if you've had any influence with institutions or areas that are training people, PSWs or whatever group?

MARY CONNELL: Well, so we, at the region -- and I know Jill has helped me with this -- has had a huge advocacy campaign. And what we did at first was just did, like, a shotgun approach. So I did over a hundred presentations across the province to every kind of group, even remotely involved with long-term care.

We did over a hundred tours of the home, and a lot of those involved, you know, postsecondary institutions. We have -- the Rekai Centre is -- you know, Sue Graham-Nutter is someone that I connect with regularly, and we're trying to get a living classroom within our homes so that we have housekeepers that want to be PSWs. We have PSWs who want to be registered nurses.

They just can't do it because they have to work three jobs just to try and make ends meet. We want to bring this into the home and help them skill up. So it's something that we are definitely working on, and it's a really important part of this.

When I worked at Mount Sinai in the ICU, Mount Sinai paid for me to do my degree, right? Now we should do the same kind of thing in long-term care so there isn't that disparity in

staffing between the hospital and between --

But, yes, that is a huge component, and it's something that I really want to focus on in the next year because it's just so important. If you have any ideas for me, I'd love to hear them.

JILL KNOWLTON: And I have agreements signed, in particular, with Georgian College to development Butterfly Living Classrooms. So specific to Butterfly, in two particular areas that we're hoping to be moving into and building the spoke Butterfly homes, we've partnered directly with Georgian College to establish Butterfly Living Classrooms so that all levels of staff, not just PSWs but also registered staff would be receiving their practicum within a Butterfly home area and learning those Butterfly principles. And then for us, the benefit of that is just linking directly into employment into our Butterfly home.

COMMISSIONER ANGELA COKE: So you're having a better time in terms of attraction and retention of staff?

MARY CONNELL: Oh, yeah.

JILL KNOWLTON: We have very little turnover. Because once you're in the Butterfly and you're part of the family, again, it's like

breaking the bonds of your family when you leave.

So, you know, success in terms of reduced absenteeism, no staff injury at all -- I'll touch wood when I say that -- and reduced turnover because you don't want to leave your family.

MARY CONNELL: What we --

COMMISSIONER ANGELA COKE: Sorry, last question just in terms of --

MARY CONNELL: Oh, sorry. Go ahead.

COMMISSIONER ANGELA COKE: -- how you engage the unions in this endeavor?

MARY CONNELL: Well, I engaged them from the very, very beginning. They were part of the planning process. And, you know, we didn't always love each other every day, but we came together, and we talked, and we always worked it out. And they knew because their staff were so happy there.

We actually had the president of CUPE come through on a tour, and he absolutely loved it because he could see the different it made to the staff. Our incidental sick time went down by 75 percent, and it was one of the home areas that had the highest sick time in the Region of Peel homes.

So, you know, we still jockey back and forth a bit sometimes, but we have a very respectful relationship, and we know we're in it for the same goal which is to support the people we care for, so...

JILL KNOWLTON: Yeah, I don't find it opposing at all. Yeah, you know, I agree with Mary that there's you know, just the normal day-to-day jockeying, sometimes, is the term you used, Mary.

But, you know, it's hard. How can you speak out against this, you know? It's very cooperative. You know, it's -- and, again, the staff are -- they want to be there. It's where people want to be.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Can I come back to Commissioner Marrocco's question about what are the barriers to having this home spread? And you indicated fear, a lot of fear of not really knowing.

But we just spent the last hour thinking this is a home we would go to or at least a loved one. And you said in your -- what people are concerned about is we wouldn't have the resources to do that, yet you said we get the same

funding as everybody else. Can you just expand a bit on that as to, you know, how you ensure that you have the staff, you have the IPAC, you have all that?

JILL KNOWLTON: Yeah, yeah. So this has to be part of your strategic plan. You cannot do this, just as Mary said, off the side of your desk. This has to be part of your strategic plan.

So you are making investments in it. You do need a -- we call it a "program manager" for Butterfly, but a dedicated person that supports the implementation around these projects and becomes the resource and does the recharge at the end -- you know, continuous recharge. We don't stop after a year. It's continuous recharge.

The pullback to the old culture is very, very strong, and you can get -- you can -- you know, you drop this for a day or so, and you can get pulled back very quickly. So you have to continue to recharge and work on it. It's really -- it's really a journey.

But because it's in your strategic plan, you're -- you know, you have to organize your resources around this. And this is what I say to people about the model or the paradigm or this sort

of very old -- this old sort of model approach: Drop it and think about it differently.

Because all I had to do -- not all I had to do. It was a loft work. I had to reorganize how we did things. I had to reorganize how we dedicated our staff, how we used our resources for training, for example.

I was getting money for BSO, for ERCC, for Residents First, for You First, for -- I was getting all that money. That's a lot of money. But I wasn't getting the outcomes out of it that I needed. So how did I take that, those resources and staff time, and reorganize them so that I could -- I could put them through this very intensive year-long program or process.

And so that's really, Dr. Kitts, what you have to do. It needs to sit on your strategic plan --

COMMISSIONER JACK KITTS: Yeah.

JILL KNOWLTON: -- so that -- and all levels of your organization, then, are dedicated to it.

COMMISSIONER JACK KITTS: Yeah. So in your plan, you're continuously looking for better value for your money. So you're -- through the

efficiencies and innovation, you're spending less and getting better results.

JILL KNOWLTON: And using our staff to -- as Mary said, to their full scope. You know, a housekeeper has tremendous value. She doesn't just push the broom and the cart down the hall. You know, she sits for lunch with the residents. She, you know, helps with peeling the carrots or whatever.

You know, we all -- again, we've changed the way we look at the work, and we're making sure that everybody has -- works to their full -- works to their full scope and is valued to do so. That's a big shift.

And, you know, the one thing did -- I don't want to leave the commission with any misunderstanding that this isn't a lot of work and this isn't a lot of effort and very -- it's intense. And there were times that -- and Mary and I often talk about this where we could have thrown our hands up and said "you know what? I can't -- like, this is just too much. This is too much. Like, we can go back to the old way."

And yet, you knows, you have to work with each other through that and get over those

hurdles. Because in the end, the end game is that it's worth it. But it is very -- it has to be intentional on your strategic plan. You have to be -- you have to have people dedicated to support this and to get you over those difficult -- those difficult times.

It is -- it's probably the most detailed change management plan I've ever had in my entire career and probably one of the most difficult things that I've done in my entire career. And yet you see, when you can get across that, the tremendous benefits of it.

And, you know, Mary spoke about the regulatory -- you know, you're sort of battling, again, paradigms there and the -- around regulation, and yet you have to work collaboratively. And I have found with the Ministry inspections branch, the inspectors, you know, they're interested in what's going on. They want know.

You know, it's not sort of "okay. We're going to issue on this and issue on that." It's "show me that. And how does that get to the outcome of well-being?" So, again, it's a different approach that you have to take, but it's

work. It's...

COMMISSIONER JACK KITTS: Okay. No doubt.

JILL KNOWLTON: It's work.

COMMISSIONER JACK KITTS: Thank you. Thank you very much.

MARY CONNELL: Dr. Kitts, can I just add something that I think is maybe a little controversial?

COMMISSIONER JACK KITTS: Yeah, sure.

MARY CONNELL: One of the reasons I think -- and this one always, actually, causes me a lot of pain personally -- that I often hear people say "we're not going to do that because you don't have the research to support it."

JILL KNOWLTON: Oh, yeah.

MARY CONNELL: So there's -- and the thing that always hurts me is what we're talking about is being kind and loving to people. And as human beings, we should just know that that should work. And what is the measurement I would use to measure that?

So we're always looking for outcomes. You know, did they say -- they'll say, "well, is there a reduction in falls?" But what does

reduction in falls have to do with quality of emotional well-being?

So Jill and I have been talking with the University of Western Ontario about trying to find actually true measures of well-being and not the things that already exist. And I always say to researchers who say you don't have any research, I -- "my doors are open. Come in and have a look. Help me find what that thing is that demonstrates it."

I'm seeing it. I feel it every time I go in there. So some people will say to us "you just don't have any research," and they won't do it. But I think that that's a mistake, and it's unfair to the people in the province who could -- who could benefit from it.

So I would just say to all those researchers, please help me out. For us to do a study was going to cost over $300,000 to get researchers. I spent that money on staff, right?

COMMISSIONER JACK KITTS: Yeah, yeah.

MARY CONNELL: But somebody help me, then. If you don't think I have research, come in and research.

COMMISSIONER JACK KITTS: It sounds --

MARY CONNELL: My doors are hope.

COMMISSIONER JACK KITTS: It sounds like you're doing fine with innovation.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think that we don't have any further questions, and thank you very much for the detailed presentation and also for the thought there is innovation in the system and that there are people who are trying to find a better way.

We spent so much of our time hearing what didn't work and what was tragic about what happened, and it's reassuring to know that there are at least some pockets of innovation, and it's helpful for us to be reminded of that. So thank you all, and good morning.

JILL KNOWLTON: Good morning. Thank you for having us, and we appreciate the opportunity.

COMMISSIONER ANGELA COKE: Thank you.

MARY CONNELL: And thank you on the behalf of the people that we look after. I'm going go to the home this afternoon and tell them that we had this conversation, and they'll be happy.

COMMISSIONER FRANK MARROCCO (CHAIR): Good.

COMMISSIONER JACK KITTS: Excellent. Thank you.

COMMISSIONER ANGELA COKE: Thank you very much.

MARY CONNELL: Thank you. Have a good day, everyone.

-- Adjourned at 10:21 a.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, Chartered Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed;

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

Dated this 2nd day of February, 2021.

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