

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.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

9

10 Jill Knowlton, Chief Operating Officer, Primacare

11 Living Solutions Inc.;

12 Mary Connell, Dementia Advisor and Person-Centred

13 Care Project Manager, Region of Peel.

14

15 PARTICIPANTS:

16

17 Alison Drummond, Assistant Deputy Minister,

18 Long-Term Care Commission Secretariat;

19 Lynn Mahoney, Counsel to the Ministry of Health and

20 Long-Term Care;

21 Rose Bianchini, Senior Policy Analyst, Long-Term

22 Care Commission Secretariat;

23 Adriana Diaz Choconta, Senior Policy Analyst,

24 Long-Term Care Commission Secretariat;

25 Ida Bianchi, Senior Legal Counsel, Long-Term Care

1 Commission Secretariat.

2

3 ALSO PRESENT:

4

5 McKaya McDonald, Stenographer/Transcriptionist.

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

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Good morning.

5 JILL KNOWLTON: Good morning.

6 COMMISSIONER ANGELA COKE: Good

7 morning.

8 MARY CONNELL: Good morning.

9 IDA BIANCHI: Good morning.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Good morning, Ida.

12 COMMISSIONER JACK KITTS: Good morning,

13 Ida.

14 IDA BIANCHI: Everybody's here early.

15 Early-ish.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 We have no life. You can be early for

18 these things.

19 IDA BIANCHI: I guess -- are we ready

20 to start? Is everybody --

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Well, I think we're -- the

23 commissioners are here.

24 IDA BIANCHI: And Ms. Knowlton and

25 Ms. Connell are also here, the presenters, so I

1 suggest we get going.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 All right. Well, then, good morning.

4 I'm Frank Marrocco. I'm one of the commissioners.

5 There's Dr. Jack Kitts and Commissioner Angela

6 Coke. So we are the commission.

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

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

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

25 So, with that introduction, we're ready

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

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

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

9 IDA BIANCHI: Okay.

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

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

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

16 IDA BIANCHI: Sure.

17 JILL KNOWLTON: Are we ready, then?

18 IDA BIANCHI: Yes.

19 JILL KNOWLTON: Okay.

20 IDA BIANCHI: Go ahead, Jill.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 I think so.

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

25 Both Mary Connell and I are happy to be

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

6 I'm Jill Knowlton, chief operating
7 officer with Primacare Living Solutions. We are a
8 private, for-profit operator that began our culture
9 change transformation using the Butterfly model in
10 2016.

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

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

24 So that's a little bit about me.
25 38-year career in long-term care and happy to say

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

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

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

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

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

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

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

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

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

1 of emotion-focussed care.

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

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

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

20 And the next slide, Mary.

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

25 And often the Butterfly or

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

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

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

19 Mary -- thank you.

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

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

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

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

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

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

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

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

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

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

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

5 So we'll talk about well-being.

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

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

15 So if you can think -- you know, I have
16 to say words are important. And if you think
17 about -- and I've had to be very careful. I've
18 really changed the way I -- the way I speak over
19 the last couple of years because I would have
20 referred to my home in London, for example, as a
21 "192-bed home" or "I've got 60 beds up in Wiarton"
22 or "I've got 100 beds over here."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Next slide, Mary, please. Thank you.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 Can I just stop you there for a minute?

25 JILL KNOWLTON: Yes.

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

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

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

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

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

1 does not become a checkbox as an outcome, right?

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

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

12 COMMISSIONER FRANK MARROCCO (CHAIR):

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

15 JILL KNOWLTON: M-hm.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 -- staffing, the conventional model --

18 JILL KNOWLTON: Yeah.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

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

24 JILL KNOWLTON: M-hm, yes.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

4 JILL KNOWLTON: Absolutely, yes,
5 100 percent, and we're demonstrating it every day.
6 I have two fully-accredited Butterfly homes
7 operating right now.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay.

10 JILL KNOWLTON: Yes, yes.

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

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

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

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

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Dr. Kitts?

3 You're on mute, doctor.

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

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

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

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

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

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

24 COMMISSIONER JACK KITTS: Okay. Thank
25 you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Next slide, please, Mary.

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

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

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

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

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

1 Next slide, Mary, please.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Commissioner Coke?

4 COMMISSIONER ANGELA COKE: Sorry.

5 JILL KNOWLTON: Oh, sorry.

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

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

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

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

1 different, right?

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

10 COMMISSIONER ANGELA COKE: Okay.

11 Thanks.

12 JILL KNOWLTON: Mary, next slide,
13 please.

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

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

18 MARY CONNELL: Oh, sorry.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Dr. Kitts.

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

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

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

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

17 Mary, did you want to say something
18 about that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 8 to 8:30 and then you come back at 12 to 12:30 for
2 lunch. It could go on for a long time. That PSW
3 will say "I will not sit down. I have to stand.
4 I'm not going to eat the food. That would be
5 theft. I could be charged with theft."

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

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

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

20 Height and colour: Sometimes Butterfly
21 really gets focussed on the environmental changes.
22 You know, the very vibrant colours; segments, 10 to
23 12-foot segments. The segments mean something.
24 They call it a sequence. A lot around wayfinding.
25 People know if they live in the pink sections,

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

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

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

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

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

1 in.

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

17 And the next slide, then, Mary, please.

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

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

1 successful.

2 So when I started with my home in
3 St. Catharines in 2018, we -- in our Butterfly home
4 area, we had a 57-percent use of antipsychotics.
5 Very intentional approach. Dropped them down to
6 8.2 percent.

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

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

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

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

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

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

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

21 Next one.

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

25 And then every -- and this is the

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

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

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

21 And, Mary, the next one.

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

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

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

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

17 Next slide, Mary.

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

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

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

15 Next one, Mary.

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

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

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

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

6 So outcome indicators, then:

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

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

14 Falls.

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

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

24 Pain.

25 Social engagement of our residents: So

1 being involved in daily activities.

2 Unplanned weight loss.

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

6 Mary?

7 So what have we seen?

8 Reduction in pain from 15 percent to
9 5 percent.

10 Reduction in use of antipsychotic
11 medication by greater than 50 percent. And, in
12 fact, I have that one home that went from
13 57 percent down to 8.2 percent.

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

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

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

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

9 And then IPAC, Mary, please. Next
10 slide.

11 MARY CONNELL: Okay.

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

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

25 We have to somehow come together and

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

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

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

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

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

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

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

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

1 Reduced outside --

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Can I just -- can I just stop you for a
4 second?

5 JILL KNOWLTON: Yes, yes, m-hm.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Going back to the staff --

8 JILL KNOWLTON: M-hm.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 -- do you use part -- how do part-time
11 staff -- we've heard a lot about "there are too
12 many part-time staff" and so on. How does that
13 work in your model?

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

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

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

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Mary?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 has to be all around.

2 Design standards, Jill has already
3 spoken about this.

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

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

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

25 Something that is often missing in a

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

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

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

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

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

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

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

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

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

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

25 Collaboration with novel partners: If

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 And deciding what to measure and how we
16 measure it.

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

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

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 I just -- Commissioner Kitts?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 COMMISSIONER JACK KITTS: Thank you.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

1 the needs of people.

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

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

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

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

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

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

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

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

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

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

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Commissioner Coke, did you want to...

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

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

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

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

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

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

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

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

1 staffing between the hospital and between --

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

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

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

22 MARY CONNELL: Oh, yeah.

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

1 breaking the bonds of your family when you leave.

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

6 MARY CONNELL: What we --

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

9 MARY CONNELL: Oh, sorry. Go ahead.

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

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

19 We actually had the president of CUPE
20 come through on a tour, and he absolutely loved it
21 because he could see the different it made to the
22 staff. Our incidental sick time went down by
23 75 percent, and it was one of the home areas that
24 had the highest sick time in the Region of Peel
25 homes.

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

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

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

15 COMMISSIONER ANGELA COKE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

19 COMMISSIONER JACK KITTS: Yeah.

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

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

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

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

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

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

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

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

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

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

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

1 work. It's...

2 COMMISSIONER JACK KITTS: Okay. No
3 doubt.

4 JILL KNOWLTON: It's work.

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

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

10 COMMISSIONER JACK KITTS: Yeah, sure.

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

16 JILL KNOWLTON: Oh, yeah.

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

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

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

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

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

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

21 COMMISSIONER JACK KITTS: Yeah, yeah.

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

25 COMMISSIONER JACK KITTS: It sounds --

1 MARY CONNELL: My doors are hope.

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

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Well, I think that we don't have any
6 further questions, and thank you very much for the
7 detailed presentation and also for the thought
8 there is innovation in the system and that there
9 are people who are trying to find a better way.

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

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

19 COMMISSIONER ANGELA COKE: Thank you.

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

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Good.

1 COMMISSIONER JACK KITTS: Excellent.

2 Thank you.

3 COMMISSIONER ANGELA COKE: Thank you

4 very much.

5 MARY CONNELL: Thank you. Have a good

6 day, everyone.

7

8 -- Adjourned at 10:21 a.m.

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1 REPORTER'S CERTIFICATE

2
3 I, MCKAYA MCDONALD, Chartered
4 Shorthand Reporter, certify;

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth, at which time the witness was put under oath
9 by me;

10
11 That the testimony of the witness
12 and all objections made at the time of the
13 examination were recorded stenographically by me
14 and were thereafter transcribed;

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

18
19 Dated this 2nd day of February, 2021.

20
21 

22
23 _____
24 NEESONS, A VERITEXT COMPANY

25 PER: MCKAYA MCDONALD, CSR

CHARTERED SHORTHAND REPORTER

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