Long Term Care Covid-19 Commission Mtg.

Meeting with Michelle DiEmanuele and Trillium Health Partners
on Wednesday, November 4, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 4th day of November, 2020, 8:30 a.m. to 9:41 a.m.

BEFORE:

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

PRESENTER:

Michelle DiEmanuele, President and CEO of Trillium Health Partners

OBSERVERS:

Stephanie Joyce, Vice President of Patient Care Services and Health System Integration
Nicole Vaz, General Counsel and Chief Compliance Officer
Dr. Tamara Wallington, Chief of Primary Care, Rehab, CCC, Palliative Care, and Senior Services

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead of the Long-Term Care Commission
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

-- Upon commencing at 8:30 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): So we released our interim report, and we're now trying to turn ourselves to more long-range or more fundamental, perhaps, consideration, and I suppose staffing was fundamental and some of the matters we mentioned were fundamental.

But we're on to the second stage of what we're going to do in terms of trying to resolve or try to make constructive recommendations.

The way we've tended to conduct these, there's a reporter and there's a transcript, and we post the transcript usually a couple or a few days later, try to give some sense of transparency to people as to what we're doing and what information we're receiving and so on, and seems to be working reasonably well so far.

So we're here. We tend to ask -- if it's all right, we tend to ask questions as we go along rather than wait to the end. So it's just topical at the moment, and then we ask whatever question we want to ask. So don't think that we're sort of rude for interrupting, but that's kind

of -- if that's okay, that's the way we've been doing it, and it seems to have worked so far.

I think basically that's it. We're ready when you are, if all your people are here, if everyone's here.

MICHELLE DiEMANUELE: We are. We are.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

MICHELLE DiEMANUELE: So let me just introduce Nicole Vaz, who's our general counsel for our organization.

COMMISSIONER FRANK MARROCCO (CHAIR): Hello, Nicole.

NICOLE VAZ: Good morning.

MICHELLE DiEMANUELE: And to my left, which looks, I think -- I can't tell if that looks like my right to you, but that's Stephanie Joyce, and she's our senior leader who's been really managing our work in long-term care during COVID-19, and Dr. Wallington on my -- which is really my left is our chief of a whole bunch of things, which also includes our work in complex continuing care, primary care, et cetera.

So they've been, I would say, instrumental in the work that's been done out here

in Mississauga.

Maybe what I'll suggest for flow is I do have about -- I have a fairly substantive statement I want to make because I wanted to capture a lot of things, but it's nicely divided into sections. So maybe what I'll do is pause after each of those sections and --

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine.

MICHELLE DiEMANUELE: -- we can reflect on what's in there. Okay.

So let me start out and just say that I always would want to acknowledge that we are in solidarity with our Indigenous People and acknowledge the land on which we are gathered. We also knowledge the many First Nations, Inuit, and Métis and other global Indigenous Peoples who now call this area their home. We are grateful for the opportunity to be working on this land.

Thank you for allowing us to contribute today. I'd like to start by first thanking the residents, the family members, and the loved ones, in particular at Camilla Care Community, and to all the residents that we have had the privilege of serving. It has been a true privilege in our

organization to be able to have support during this incredibly challenging time. It has been a profound experience, and we are grateful to have been a part of what we hope is a moment where we begin to see needed change.

Commissioners, we're here to share our story with you and the recommendations that stem from that very specific experience. You know, I've had the benefit of having been on your side of the table, as some of you know, in the past, looking at things from a provincial and a public policy perspective. And given you're now looking at that [meeting] (ph) to long term, I think this intersection is now, I think, most appropriate because we really have tried to take both an operating viewpoint but also a viewpoint from a public policy perspective.

And so I really do make my comments today as not just the CEO of Trillium Health Partners but also from a broader prospective from my provincial background and also in working in both the private and the public sector, not just in social services and healthcare but in other sectors as well.

You know, governing is about making

choices, and decisions are often made with imperfect information and limited resources. Public policy is a vehicle used to enshrine those choices that are made. Your work is now part of an important process that will lead to these public policy changes, and we saw that with your interim letter a week ago.

I just want to say thank you for your initial findings and for the difference that that is already making. I, as you know, had the privilege of being with the minister this week to announce some of the changes that they've already accepted.

I also, though, want to say and ask of you, as you deliberate, that you also think about the change management needed and whether we are also building the foundations for your work to endure over time.

The Commission's role is well positioned in this area when I think of Dr. Kitts and Angela Coke as part of the Commission. Both of you have been involved in doing large-scale substantive change that has had to endure, and you know that that is more than just a list of recommendations.

My presentation, as I said, is divided into sections, three in particular -- Angela, you'll remember, I like three -- and the first part is really providing an overview of context at THP and how we became involved in LTC and our observations regarding our work.

Secondly, we have offered some advice on what changes are required to govern and operate in the future.

And finally, we'd like to share our thoughts about leadership and culture change, the endurance, and the enduring factor which I've just spoken about. So that's how we weight it out.

So let me tell you just a little bit about our hospital, mostly for Mr. Marrocco. We're made up of 12,000 staff, professional staff, volunteers, and learners who deliver across three main sites, and we have a number of other locations in addition to that.

We're the largest community-based hospital in Canada, a teaching hospital affiliated with the University of Toronto, and home to a number of regional programs -- cancer, cardiac, stroke, neurology, senior services, to name a few -- but I particularly want to point to the fact

that we have a renowned geriatric program.

Teaching and COVID-19: So I'd like to give you a sense of the context that we were working in. I think this is important.

In January of 2020, like hospitals across Ontario, THP was monitoring the development of COVID-19 closely. We set up a command centre to ensure we were tracking all new developments, shoring up supplies, and following the most up-to-date guidance on infection prevention and control to keep patients, staff, and the community safe.

In February, we began to meet more regularly at the executive level to discuss and ensure preparedness for COVID-19 at this hospital.

On March 4th, the first COVID-19 positive case was confirmed at Trillium Health Partners of Mississauga emergency department. Since then, we have not had a single day without a COVID-19 case in our hospital.

On April 25th, we had 125 patients with COVID-19 in our hospital. That was our highest number to date. Today, we are starting to see those numbers increase again and are in the neighbourhood of 25, 26 patients to date.

We began operating an Incident Management System and structure to ensure a coordinated interim response to COVID-19. When we saw that first case during the month of March and into the beginning of April, THP implemented its full pandemic plan to ensure we were able to continue to provide care for this community in a safe environment.

This plan, guided by the direction of the province, included postponing all non-urgent and emergent surgeries, consolidating our Queensway Urgent Care Centre to the Mississauga Hospital site emergency department -- just for reference, that urgent care centre sees 60,000 people a year -- converted the Queensway Health Centre into a hundred-bed inpatient site; added 36 critical care beds; converted 60 percent of our ambulatory platform to virtual care; built three assessment centres and readied a fort, including a drive-thru option to test for COVID-19; 600-plus physicians provided virtual care including specialized support; opened three COVID units with a 160-bed capacity and dedicated expertise, which we had to skill; up-skilled over 400 staff and physicians to provide care to higher acuity patients; re-deployed

over 650 staff to new roles, including long-term care; developed a PPE and practice handbook for staff as a single source of truth on PPE and point of care risk and AGMPs; enhanced PPE coaching with teams, new tools, and supports; increased our supplies; created a Keeping You Safe Taskforce and strategy to audit hospital spaces and ensured best practice for IPAC, such as posting maximum occupancy for every space; confirming appropriate numbers and locations of sanitizers and so on; consistently communicated updates and changes to 10,000-plus staff daily.

This was no small task to accomplish in a matter of weeks. During this time, we also saw the hospital, like many others, move to really create space within the hospital; this concept of decanting, which I'm sure you've heard before, but there's a couple of data points I want you to know about our hospital, and you will make your own conclusions on this.

On March 16th, THP had a total of 85 ALC patients waiting for long-term care. We had emptied out 166 beds at that point.

By April 15th, we still had, now 86, one additional ALC LTC patient, but we had 413

empty budgeted beds. I think this is an important data point around where we were able to create space. This shift, plus our change at the Queensway Health Centre and the creation of a Pandemic Response Unit, created a thousand spaces for the expected surge.

Here's the next point I'd like you to -- again, from our context -- understand the decision environment we were in. As the CEO, I knew we had created 1,000 inpatient spaces, but you should know, at that time, our modelling specific for our hospital in this region and area of Mississauga said I needed to plan for 2,000 spaces.

That delta is significant, and one we knew at that point we could never close the gap on and began to work with our region and our city on continued contingency plans.

In the last several weeks, we have only begun to resume our planned surgery and clinics where possible, and we've seen ED volumes and inpatient occupancy begin to increase to pre-pandemic levels while we also tried to maintain capacity to manage the future waves.

Throughout this, we have played a leadership role at the provincial, regional, and

local levels. It's a lot of work, and it was a lot of work, and I just want to thank all the staff of this organization for their commitment.

I'd like to pause here, though, and say that the initial findings of the Commission have been well very received, and we do appreciate the work you are doing. But I do want to acknowledge that your recommendations regarding mandating a collaboration model to support LTC by hospitals should be carefully considered.

As the only hospital in Mississauga with 19 long-term care homes, we are not equipped to hold this kind of role in a sustained kind way given the level of COVID prevalence and potential risk. The spirit of your recommendations to support at the highest level, we can; it's definitely consistent with our approach, as you will hear in the next section.

So maybe I'll just pause there and ask if there are any questions before I talk about LTC and our work during COVID-19.

COMMISSIONER JACK KITTS: Michelle, it's Jack. Did you just say that the collaboration between Public Health, long-term care homes, and hospitals is a model that works, but because you're

the sole hospital for 19 homes, that's not a solution that is workable in Mississauga; is that correct?

MICHELLE DiEMANUELE: For example, because I think the spirit of your recommendation is -- and I think you're correct, by the way, to be worried about stability while we're still in the pandemic. So this is not to quarrel with the principled argument.

COMMISSIONER JACK KITTS: Yeah.

MICHELLE DiEMANUELE: But rather, that if in the event -- in Mississauga, as you know, we are a hotspot, that in the event five or six or seven homes were to be significantly compromised, to expect the only hospital in that region -- which has a logical connectivity, proximity -- to hold that risk at the same time it is holding the risk of 1,400 patients I do not believe is practical.

And I would not want to give us a false sense of security by virtue of the recommendation, which again, the spirit is correct, but if you want us to move, we need to start thinking about how we're going to practically implement that.

COMMISSIONER JACK KITTS: Right. And that makes infinite sense. I mean, you've been,

like every other CEO for the past couple of years, watching the slow evolution of Ontario Health Teams. Do you think that there are any Ontario Health Teams in your area that are mature enough to be able to pick up a lot of that, or do you think there will be?

MICHELLE DiEMANUELE: So Trillium Health Partners is a member of the only Ontario Health Team. It is the largest in the province, covering some 859,000 people, and as the major contributor right now to helping lift that along with our primary care partners, I can say very confidently we are not ready.

And I just want to remind everybody that the province's commitment right now is $350,000 to help lift that for the remainder of this year. And we -- you know, it is, I think you said, a slow process, if I can just quote you there, Dr. Kitts --

COMMISSIONER JACK KITTS: Yes.

MICHELLE DiEMANUELE: -- and I think it is an evolutionary process. And there is no doubt our health team has provided really important support in a number of areas, but it requires -- the level of sophistication needed if a home goes

into outbreak, and you'll hear me talk about that next, is not a level of sophistication, I believe, the health teams have to date, but they are absolutely a contributor to that solution.

COMMISSIONER JACK KITTS: And do you feel that with time and appropriate resources and maturity, these will be an important response to a future pandemic?

MICHELLE DiEMANUELE: Yes.

COMMISSIONER JACK KITTS: Okay. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): One of the things that concerns, though, is the fact that we're in a situation which can easily be called an emergency. There really isn't time for an alternate structure. And so I guess it may not be sustainable in the long term, but I wondered if some variation on that theme, if there are hospitals -- if there are homes on the exterior of the region that could be assigned to other hospitals?

Because it just seems to me that if you do nothing -- you don't invent -- there's just not the expertise to deal with it. I guess that's where -- I agree it might not be sustainable in the

long term, and I don't think we suggested that.

But in the short term, you know, there's a management problem if these outbreaks occur.

MICHELLE DiEMANUELE: Yeah. So let me step back and -- well, actually, let me just, for context, our northern -- so our periphery would be the William Osler Hospital. I believe they have 17 homes that are in their catchment area. So there isn't a natural, peripheral reach-out.

Now, there would be some capability of reaching into Toronto, which we did during Wave 1.

Fundamentally, the ability to support long-term care in a crisis is a staffing issue. Fundamentally, there's certainly issues of PPE, which I think we're feeling more confident on, but at the staffing level, it requires us to re-deploy staff there, and therefore, we have to have an ability to shut other things down. And it requires a companion set of recommendations, and that's why I chose my words very carefully.

There has to be greater consideration because you have spoken about one side of the equation, which is how do we support long-term care, but we need to recognize, in doing so, to

your very point around crisis, it means you have to grab from somewhere else.

And the hospital is the anchoring organization for that, and I think Dr. Kitts' suggestion on OHTs, while there may be a very small number of OHTs that could lift, I would say that the hospital in crisis -- at this point in time, having not built out that other infrastructure and why I believe you've recommended it -- is the logical choice, but it means other things will need to give.

And that's really at the heart of my caution is to make sure that we think about both sides of that so that we don't find ourselves pendulum swinging to one side, only to have unintended consequences on the other.

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

MICHELLE DiEMANUELE: And I think when I go into this next section -- and again, I want you to remember, we have over 400 beds empty as I go into this next section, and we have shut a number of services down. We'll see what we were able to manage, and had we not done that, could we have. Could we have? So maybe I'll just continue.

So prior to the pandemic, we didn't have a formal relationship with long-term care. We didn't operate long-term care, albeit, I think we have a few licenses at one of our Complex Continuing Care centres, but we did work together with long-term care in our region. It wasn't the first time we had talked.

In the face of COVID-19, THP was able to provide substantial support to long-term care in the community. In total, our hospital did an onsite assessment of all 19 long-term care homes and provided support or assistance to several of them in partnership with Ontario Health and Toronto Public Health, Public Health Ontario, and other key stakeholders.

The Mobile Assessment Team that we had consisted of three physicians from our hospital, hospitalists and geriatricians, and a THP manager who is also a nurse practitioner.

The team's function was to do a rapid risk assessment across the domains of COVID testing; infection prevention and control; availability of PPE; leadership; staffing; medical coverage; provide in-the-moment education on proper IPAC practices; urgent onsite medical assistance;

symptom management for either confirmed or suspected cases of COVID; complete goals of care discussions with families of residents with COVID; educate long-term care staff about PPE; and facility, staff, and resident COVID-19 testing is needed.

THP completed onsite assessments of all 19 homes. We did that by early May.

By April 20th, 55 percent of long-term care homes within our catchment had confirmed COVID-19 outbreaks, and 40 percent of the homes within our catchment were considered at high or moderate risk on the assessment of Public Health.

THP provided direct supports such as staffing; PPE coaches; resident staff swabbing; return-to-work clearance calls; onsite physician assessments; N95 mask fit testing; training; assistance in feeding residents via our Supper Club to eight long-term care homes, in partnership with our Central Region of Ontario Health, Peel Public Health, Public Health Ontario, and other stakeholders.

We also established a library of COVID resources for long-term care homes such as posters; electronic forums; videos; provided links to all

long-term care homes of this information from late April to June; we deployed 52 staff to cover almost 650 shifts; deployed 12 physicians to provide onsite medical assessments and symptom management for COVID-19-positive patients; and had 60 THP leaders who volunteered to provide meals to residents during 233 meal shifts through our Supper Club.

From April 23rd through to early June, THP supported long-term care homes in the following ways specifically:

Eatonville: Completed staff swabbing, onsite physician support, IPAC coaching, deployment of direct care, THP Supper Club, and occupational health return-to-work calls.

Westbury: Provided IPAC coaching, onsite physician support, occupational health return-to-work calls, and deployed direct care staff.

Cooksville Care Centre: Provided IPAC coaching and the THP Supper Club.

Labdara: Staff COVID swabbing.

Erin Mills Lodge: N95 mask fit testing.

Villa Forum: Onsite physician support.

Finally, in my next section, I will detail the significant and ongoing supports at Camilla Care Community in greater detail.

So I'll pause there but also just from our previous conversation, you can see that this is a significant amount of both preventative opportunity as you go in to do assessments, et cetera, but I just detailed six, and I'm about to detail a seventh home. This was while we had over 400 beds closed, and I was able to deploy staff into those areas.

And again, I would just say the spirit of your recommendation on the necessity to have a plan in the immediate term is one we agree with. I would just ask, again, that as you deliberate further the considerations of what needs to happen so that plan is successful should be taken in the context of what we've learned and how we did the first time.

So I'll pause there before I speak about Camilla specifically. As I also get a tea, if that's okay.

COMMISSIONER JACK KITTS: It is, absolutely. Michelle, you've listed off a whole lot of preventative measures that you can do when

you bring in the expertise that the hospital has that long-term care don't have, bringing them in before the crisis, if you will, or without a crisis.

I'm going to ask you your opinion on whether that is a big help in preventing spread within the homes using -- with all the IPAC and all of the things that you've done.

And it struck me that the one thing that the hospitals are concerned mostly about is not about, I think, providing the leadership, the expertise, the IPAC, the specialist advice, and care. It's really if the hospital has to staff these homes, that's a big problem. Am I reading you correctly?

MICHELLE DiEMANUELE: Two nuances to that. The first one, I would say, is, at this stage, we are not talking as much about prevention. This was corrected action. Like, we went into these homes. They were not practicing effective IPAC. There was not cohorting, as an example, and so a lot of these assessments resulted in corrective action.

And again, to your point, had they been done much earlier, potentially that would have been

more preventative in nature. So we are in the midst of the pandemic in a hotspot.

So I'll just pause before I get to the staffing issue.

Is that a fair comment, Dr. Wallington?

DR. TAMARA WALLINGTON: Absolutely. Yeah.

MICHELLE DiEMANUELE: Yeah.

DR. TAMARA WALLINGTON: Absolutely.

MICHELLE DiEMANUELE: So I would want to make that small tweak to your characterization of prevention at this time. It was corrected.

COMMISSIONER JACK KITTS: Can I just ask: So what I'm saying is, you said 55 percent of homes had outbreak; 40 percent were moderate to high risk of having outbreak.

MICHELLE DiEMANUELE: Yeah.

COMMISSIONER JACK KITTS: What I'm asking is, today, we're in the midst of, I think, Wave 2 --

MICHELLE DiEMANUELE: Yeah.

COMMISSIONER JACK KITTS: -- and we know that the more virus that's in the community, the more likely it's going to enter the long-term care homes.

So my question was that, even still, there are homes without outbreak, and even the homes that had an outbreak, do you feel any confidence that going in before the outbreak on a second wave will make a big difference in whether they actually have an outbreak or not, in prevention?

MICHELLE DiEMANUELE: So I would answer that question this way, and I'm going to speak to that towards the end of my submission.

There's no doubt getting in and having an ability to calibrate, refresh, support can make a difference. Whether it's a material difference or a marginal difference depends on a couple of factors.

One is whether or not you have the leadership receptivity at the home to accept that support and then to embed it and continue it.

And the second is, to the extent the condition in which the home is that you're entering, and this somewhat reflects my first point -- because are you really going in to refresh and to support and to fine tune, or is it built, and are you finding things that somehow escaped the first wave? So I only have those two caveats. I

just --

COMMISSIONER JACK KITTS: Yeah, that --

MICHELLE DiEMANUELE: I want to just answer your second part, Jack, with respect to hospitals and leadership.

I think you're 100 percent correct. We are part of a system, and I'll speak for this hospital and only this hospital. We are part of a system, we are the only hospital, and we take it very, very, very seriously the responsibility we have to support this community and the fact that we have some of the most sophisticated resources to do that.

And so this is not a question of "if." We believe we have to show the leadership. We believe it is in our responsibility, and I think, you know, you've said in your various deliberations that it is a necessity that we do, given the nature of where we're at in the pandemic.

But to your other point, you can have the greatest will, but if I keep stretching myself, I can only stretch so far, even if I really try.

And so at some point, back to my earlier comment, if I'm stretching and you want me to go this way, you gotta let me release something

to allow me to do that. It's a simple, simple analysis, and yet you know today that you're sitting in an environment where hospitals are basically at capacity again, and in some cases, catching up.

I might also just reference right now, and I believe we are not the only hospital -- there could only be one or two others -- and I think the only other hospital I would even remotely know could be in this position would be Ottawa, a hospital I think you know quite well, but I only opened our surgical -- our day surgical centre that does some 17,000 surgeries a year last week. And I believe Ottawa opened theirs a few weeks earlier.

I think we were the only two hospitals that had that level of capacity not operating in this "return to normalcy." That is an actual example of what I mean. If we had tried to open that in August or September while we were still holding some of these other things, it would not have been possible. Something would have given.

COMMISSIONER JACK KITTS: Yeah. Well said, Michelle. Thank you.

MICHELLE DiEMANUELE: Any other questions before I talk about Camilla?

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, Commissioner Coke?

COMMISSIONER ANGELA COKE: Yeah, just one question, Michelle. I understand what you're saying in terms of you can't stretch beyond your capacity, but in terms of looking forward, what is it that would practically enable a closer collaboration on a more sustainable basis? Is it a matter of what additional capacity resources the hospital would need to be given to support them?

MICHELLE DiEMANUELE: Well, you know, fundamentally, and I'll speak -- we've dealt with a number of the homes, so I'll speak generically, and I would not want this to be characterized as Camilla or any one home; I'll speak generically.

Fundamentally, the homes pre-COVID had staffing. I think we are far better to build strength from within than to try to find it from without.

And so you will see one of the strategies we took was not to decant these homes unless there was a reason medically to do so but to actually, on the ground, build capacity and muscle with leadership and the staffing and the nursing staff and to shore up where we needed to so that

they would not fall down but to ensure the longer-term viability of the home in this moment while keeping our residents safe.

And so I would say the long-term game or the medium-term game should start with: How do we take the assets sitting in these homes, the physical assets, the human resource assets, and the head office assets and ensure that they are firing on all cylinders to support effective delivery?

And where can the hospitals coach? I think that was a word you used in some of your deliberations. Where can the hospitals coach? Where can we co-create leadership competencies? And ultimately, how are we filling gaps where necessary as opposed to trying to replace or reinvent?

COMMISSIONER ANGELA COKE: Okay.

MICHELLE DiEMANUELE: Okay. Let me talk about Camilla. You know, Camilla is probably one of the most recognized names now during the pandemic. It's been worldwide spoken about; made the first line of The Economist in their work on diagnosing long-term care worldwide.

We were first contacted around Sienna Senior -- by Sienna Senior Living to assist

in Camilla Care on April the 14th, 2020.

On April the 15th, we began supporting mass staff testing. So we got back to them immediately on the evening of the 14th. We began to support mass staff testing and started working with Sienna to understand their staffing needs and impacts.

By April 17th, as I spoke about, we had created a Mobile Assessment Team to complete onsite risk assessments of all the 19 homes, and we completed our first one at Eatonville on April 17th, and the first outbreak at Camilla was on April the 6th. So you can sort of see that I'm going back and forth here. We're in our work in long-term care, and Camilla comes into play around mid-April, but their first outbreak is on April 6th.

Tragically, as we know, the outbreak at Camilla resulted in 254 people testing positive for COVID-19, including 186 residents and 68 staff. Of those 186 residents, 74 residents died. Several staff became seriously ill, and I just want to reflect on the loss of life that has occurred and the tragedy that has occurred. We have had an opportunity to pause and reflect with those

families.

As I've said on April the 14th, we received a letter from the president and CEO, the former president and CEO of Sienna requesting staffing support, and we immediately began to work with them. We determined a comprehensive view on their needs and began testing, and on April 22nd, we moved our Mobile Assessment Team to complete the risk assessments like I had talked about in other homes, and we classified them as high risk.

At that point in time, we initiated the following steps: Re-deployed voluntary staff, nurses, and personal care assistants to support residents' basic care needs; personal protective equipment coaches to teach and reinforce appropriate PPE usage; provided additional physician support to assist and manage residents' medical needs, as their own physicians were not coming onsite; facilitated the mealtime assistance program, what we call the THP Supper Club, to ensure residents were being fed and receiving the assistance they required to be able to eat; prepared meals and snacks in our kitchen at the hospital and delivered them to Camilla, given the lack of cooks and dietary staff; provided required

equipment such as portable oxygen and large garbage cans.

Jack, when I went into the home myself for the first time, the cans were like what you'd put under a kitchen sink to dispose your garbage, to doff your PPE, and you know that's a high-risk environment when you do that.

In the hospitals, just for the other Commissioners, we have very, very large containers that are pretty much almost the size of me. They probably come up to my shoulder, and you can just take it off, and it nicely falls in. I actually had to ask one of our nurses to assist me; I felt unsafe in that environment when I was in.

From April the 24th to May 30th, we continued to support Camilla under the direction of their leadership; however, on May 27th, the government announced the appointment of various hospitals to assume temporary management, including the assignment of us to manage Camilla.

A voluntary management agreement between the Ministry of Long-Term Care, Sienna, and THP became effective May 31st. In the days that followed, medical and well-being assessments of all Camilla residents were completed by THP clinicians,

and we increased regular communications with families.

I just want to comment and thank Dr. Wallington and her team. Our team of physicians went in and went to every single patient, had a conversation with every single family or substitute decision-maker in a very short period of time.

A number of the THP senior leaders and I spent time walking through the home, as I've just discussed, to get a better understanding of the situation.

THP issued an initial report on June the 15th, so about two weeks later, that detailed three areas of focus: Safe, high-quality care, ensuring the delivery of high-quality care in a safe environment. We observed such things but not limited to resident safety and clinical practice issues, infection prevention and control issues, and the availability of supplies and equipment was fragile.

On the leadership, staffing, and teamwork, we observed Camilla leadership unable to provide clear answers to questions about current status of COVID-19 outbreaks; staffing; IPAC

processes; a lack of visible leadership rounding; a lack of understanding resulting in staff not having time to provide basic care to residents.

Communication and engagement: Initial observations included lack of standardization and regular communication approach with families and residents regarding resident care; outbreak status and general information; inconsistent processes for communicating COVID-19 test results to families, resulting in some people not having results in a timely way. Some staff stated they felt nobody in the system cared about what was happening.

Following this initial assessment, THP implemented a staged approach to assessing and putting in place an immediate risk mitigation stabilization plan, ultimately to lead to a transition back.

Areas of focus have included but are not limited to oversight of operations, infrastructure, quality and clinical practice, IPAC, PPE, leadership staffing, and improved communications and engagement.

Within the first two weeks of THP assuming management, 17 unreported past -- prior to us taking official control of the home on May 31st,

17 unreported past critical incidents were identified and reported to the Ministry of Long-Term Care. These included allegations of abuse, neglect, incompetent care, unexpected deaths, and failure to report respiratory outbreaks.

THP launched two third-party investigations, and the Ministry of Long-Term Care deployed compliance officers to be onsite to investigate the reported incidents. These investigations uncovered additional potential past critical incidents, which, in turn, required investigation.

Due to the increasing number and range of quality of care concerns, incidents that were being identified in July, THP initiated a structured quality review with the support and cooperation of Sienna. As of October 30th, 63 critical incidents -- almost all of which occurred before May 31st -- have been submitted while THP has been the manager of Camilla.

Fundamentally, we've found that while COVID-19 shone a light on the problem, this home had systemic issues before the pandemic. These issues mirror the themes I described earlier:

Quality of care, leadership and engagement, and communications. This was happening at the same time that we were addressing needed acute care pressures for our community.

So I'll pause there because we now get into our recommendations in the next section.

There is a detailed report that we can provide the Commissioners. Our first interim report is a public document.

COMMISSIONER JACK KITTS: Yeah, I think that would be good if you could provide that, Michelle. Okay.

MICHELLE DiEMANUELE: Any questions?

COMMISSIONER JACK KITTS: I don't think so on that part. We'll come to the recommendations.

MICHELLE DiEMANUELE: Okay. So again, I have listed these recommendations in governance operations and leadership, so why don't I take those, again, three areas in each section, and then I'll pause.

So under governance, there should be a clear set of standards on the composition of members of boards of long-term care. Skills and terms should be mandated, and I believe it should

include nursing and physician representation.

Secondly, every governor should complete mandatory learning on roles and responsibilities related to long-term care governance to be on a board.

You know, when I was Deputy Minister of Consumer and Business Services, you were required as a board member of a condo to view 25 different videos and attest to that so that you would be able to manage a condo corporation. I think we should be thinking very similarly to the kind of learning that is essential for a governor of a long-term care home.

Long-term care oversight should be modernized with a menu of leading and lag metrics, inspection, and audit services, and a view to creating environments of continuous improvement, not simply serial interventions. The current system is designed to see the trees -- and really just the tree -- and not the forest.

Modern oversight should include but not be limited to the continuation of critical incident reporting, leading indicators that help predict future risk -- Jack, the thing I was thinking about is, you know, in a hospital, we often track

near-misses as something that gives us a leading indicator of where we may have a potential risk.

Dr. Kitts, I think, could give you much more insight into this, and I think you should be thinking about what leading indicators need to be tracked at a governor and at a leadership level.

COMMISSIONER JACK KITTS: Yeah. Thank you.

MICHELLE DiEMANUELE: Pardon me?

COMMISSIONER JACK KITTS: I agree, yeah.

MICHELLE DiEMANUELE: Annual submission of a risk report to the board on key risks and strategies to mitigate risks; this should include trending data to illustrate trending on issues. It should encourage staff to report issues at all levels.

Similar to, again, in a hospital, we track falls prevention. I remember when I first became a CEO -- to particularly Angela and Mr. Marrocco, when I first became a CEO, I would get this report on how many people had fallen in the hospital. And, of course, I was quite worried about that, but then I understood that the reporting of falls and understanding the inherent

nature of it, if you're rehabbing somebody and there is a natural point that you will see falls, and then there's a point where you know you have trouble, it requires you to create an environment of transparency that staff will report those falls so that they can be investigated in a way to help you create continuous improvement and quality.

If you create a culture that doesn't reward transparency, if you create a culture that doesn't encourage reporting, it will be very difficult for you to have a continuous improvement culture.

Modernizing inspections that include not simply an audit and compliance function but also promote education and creation of internal responsibility; having more inspections with the same tools will not be productive, in my view.

Finally, there needs to be greater clarity for the consequences of failing to comply with findings of an investigation.

Again, here, I think from a public policy context, I think we have a lot to learn from the Ministry of Labour and what we've done in the area of workplace safety and that culture of internal responsibility, two words I used earlier.

I think this is something we can mirror in long-term care and not simply -- and again, if you think about the Ministry of Labour, they absolutely have a responsibility to investigate. They investigate horrific critical incidents that often can result in someone's death.

And so I don't want to take away from the importance of investigating, but the Ministry also creates partnerships within the environment of the workplace where we all have responsibility for protecting each other, and I think there's a lot to learn from that particular area of public policy.

Finally, and most importantly, we need a reporting system where family and staff can feel safe to report without repercussions and also confident it will be acted upon. The current central ministry reporting tool simply does not work.

To reinforce my point on all of these current governing recommendations, a home like Camilla appeared to be in a good state based on metrics used prior to COVID-19, but that was not the case. THP, as I've said, has submitted 63 critical incidents since June 1st, almost all of which occurred before we became manager on

May 31st, which are related to abuse; neglect; incompetent care; unexpected deaths; a failure to report outbreaks. These were serious issues that were not identified by the existing inspection regulatory or governance system.

I'll pause there.

COMMISSIONER JACK KITTS: Just, Michelle, on that: So pre-COVID, I think you said that Camilla showed some serious issues that would reflect or forecast trouble.

Are you saying it wasn't recognized or it wasn't transparent? Is that the issue?

MICHELLE DiEMANUELE: Stephanie, is it fair to say that we went in, and after a few weeks, there was enough evidence and information either through reports or complaints or information that should have been a red flag?

STEPHANIE JOYCE: Yes, I would say that that's accurate. The things that we were uncovering and the findings in the critical incidents pre-dated COVID. So these were issues that were not because of COVID but were happening before COVID and likely contributed to the significance of the impact of COVID in this home.

COMMISSIONER JACK KITTS: Okay.

MICHELLE DiEMANUELE: Let me say to this -- Jack, let me answer it this way, and I'll take the levels of governance.

COMMISSIONER JACK KITTS: Yeah.

MICHELLE DiEMANUELE: If these things were occurring as the CEO in a hospital that you ran, you would have acted upon them, and if they hadn't been acted upon, I suspect you would have had a whistleblower or you would have had some form of information get out into the community or into a governor or into the Ministry that would have had somebody reach in to say, what's going on?

And that just did not occur at a governing level. The governance structure seemed surprised, ultimately, that the home was this bad. The Ministry, while it had information, had either not triangulated it or, for other reasons, had not maybe acted, and I will let the Ministry speak for themselves. But family members believe that they had raised these concerns, and they had been unheard, including on the anonymous hotline that is used.

COMMISSIONER JACK KITTS: So these are lagging indicators about things that hadn't happened that would forecast trouble ahead.

MICHELLE DiEMANUELE: Yeah.

COMMISSIONER JACK KITTS: Now, you're talking about re-looking at how we measure long-term care quality of care and performance, looking for both leading and lagging indicators, and then have a clear process of transparency by which they get acted upon.

MICHELLE DiEMANUELE: Correct.

COMMISSIONER JACK KITTS: I think that's what you said?

MICHELLE DiEMANUELE: Correct. And I will go one step further to say while I think the lagging indicators are pretty clear -- critical incidents, reports on the hotline, investigations, inspection results -- those clearly did not get triangulated in a way that would have signalled a problem prior to COVID.

COMMISSIONER JACK KITTS: So wrong indicators?

MICHELLE DiEMANUELE: Or lack of action. I'll let others be the judge of that.

COMMISSIONER JACK KITTS: Thank you.

MICHELLE DiEMANUELE: Angela?

COMMISSIONER ANGELA COKE: So I'm just reacting to your comment about not seeing the

forest for the trees, that concept, and different ways that people should be thinking about how they're doing inspections, how they're doing oversight, how they're doing compliance support.

And I'm just interested in hearing a bit more from you in terms of how you think the role of the Ministry needs to change and how to support these organizations having a quality management approach.

MICHELLE DiEMANUELE: So I say this later towards the end, but I think there's a philosophical component to this that, again, I don't have a conclusion on, but I think it is an important context, and I'm sure you've heard this statement made through others who have come before you. We talk about residents, and we talk about this being their home, right?

COMMISSIONER ANGELA COKE: Mm-hm.

MICHELLE DiEMANUELE: And I think that's an important concept. It's an important principle. It's foundational to an individual. These are very personal places. They have a Bible. They have a picture of their grandchildren. This is a very personal space.

But this space now is occupied often by

people who have very complex medical needs, and so I would start by saying that we have to understand that the Ministry of Long-Term Care is not just their home. In some cases, this is also where they receive care, and they receive, as of Monday, more care, right?

And so those need to be balanced because I do believe the Ministry has an appropriate role in protecting that personalization of this residency, but they also have a role to play in ensuring that it is safe, and sometimes that means difficult decisions have to be made in moments like we've made in COVID.

Sometimes that means that triangulating information requires difficult decisions that can't wait, hoping that the home will respond to that inspection report, and so that's the first thing I'd say.

And the second thing I would say, Angela, is we have to fundamentally understand what is the role of the Ministry of Long-Term Care. Is it an operating ministry or is it a policy ministry or is it both? And I think you'll understand what I mean when I say that. I think it has been set up with a lack of clarity on that at this time, and it

certainly isn't staffed to do all three of them.

COMMISSIONER ANGELA COKE: Mm-hm.

MICHELLE DiEMANUELE: Should I continue, then, on operations? Okay.

So in order to address some of the challenges we have seen operationally, we would recommend the following: Enhanced medical coverage in long-term care with clear expectations for physicians with respect to level of care, regular in-person rounding, and required certification of the medical director to ensure common competency in long-term care.

To support this, the fee schedule for physicians doing work in long-term care needs to reflect the intensity and complexity of the care required. We also recommend a more standardized medical model that includes nurse practitioners embedded in or attached to the home, not just be an urgent/emergent NP team. A deep dive into the weaknesses of the medical model is warranted.

Finally, I want to say it is not simply a funding issue. It is also about really wanting to be part of that care team.

Care teams in LTC -- this is our second recommendation -- require more clinical knowledge

and skills than previously, given the increased complexity of the residents they serve. There must be a basic set standard for this which is consistent across the province. We should begin by investing in training current LTC staff to these standards. There were clinical knowledge gaps on basic care standards in the home that were exacerbated by COVID-19.

I want to just share a quick story. I was walking into our hospital a couple of months ago. We have a very large boardroom that allows for about 20 individuals to be socially distanced, and I walked by it where the glass windows are. And I went into my office where there's a small door, like a secret door that you can kind of go in the back door.

And as I walked in, I sort of thought, why are we training so many staff on something at this point? And it looked like we were doing training on something that we call our gentle persuasive techniques to work with many of our seniors who have dementia or other behavioural issues.

And so I opened the door, and I went to say hi to the educator and the team there, and I

said, hi, everybody, how are you? You know, during COVID, we didn't get to round quite as much as we usually did. And I realized very quickly that these weren't our staff, and I said to the educator, what are you doing? And she confirmed it was on our very specific skills training we do on gentle persuasion techniques.

And then one of the people who was sitting there -- masked, of course -- said, we're from Camilla, with such enthusiasm, and I said, oh. She said, we're all from Camilla. And I said, oh, what are you doing? She goes, we're getting training.

And I have to tell you, that's probably one of the proudest moments we've had, along with supporting the families during this last period of time. I just cannot emphasize enough the importance of training and development of all staff, not just the regulated staff, but all staff in the home. You could just see both the value they felt in being invested in it and the enthusiasm they felt to take this back to the residents and practice.

Finally, I just want to say, and this is always difficult when developing standards and

guidelines in creating public policy: One size doesn't always fit all, and that will be one of your greatest challenges is where you can create that standard but also create flexibility to shift funding, for example, between envelopes to ensure the right mix of staff with the unique designs of buildings and resident populations.

And I would just say that as a caution, operationally. While a standard is essential, there has to be some flexibility to use judgment, effective judgment, and that will require leadership, which I'll speak about in the last section.

So I'll pause there.

We purposefully tried not to replicate many of the other things that you've already said, so we've tried to just highlight a few.

COMMISSIONER JACK KITTS: That's good.

MICHELLE DiEMANUELE: Okay. Hearing no questions, I'll go to leadership and culture. This is the last section.

Communications and leadership accountability at all levels is critical for success. There is never a more important time than a crisis like we are in and certainly during the

pandemic in the first wave.

Based on our observations, there is often a disconnect that exists between corporate and central long-term care offices that develop the policies and provide direction compared to what is actually happening at the local home level.

Administrative offices can develop the best policies and communicate them out to the home by e-mail or conference calls, but that does not necessarily translate into standardized implementation of these policies at the frontline.

Similarly, there's a need for open lines of communication from the frontline to senior administration to ensure any challenges occurring on the ground are being properly shared with the corporate or central level so they can adapt policies and directions accordingly.

Leadership matters a lot. The long-term care homes with strong, capable, proactive leadership at the executive director -- also called the administrator -- the director of care, or DOC, and the medical director level were better positioned going into COVID-19 and did well.

Those will strong leaders, we found, had the ability to engage support and hold staff

accountable to enact IPAC practices and processes and maintain good communication with families. They were the homes that successfully mobilized versus the homes that seemed paralyzed.

We saw the full range in this respect, homes where leaders were observed to not correct staff wearing plastic bags as PPE, multiple masks, or said they couldn't get their staff to get tested for COVID-19 -- they just couldn't get them tested -- to homes where leaders stationed themselves at exits during shift change to reinforce messages and to simply say thank you for a job well done.

Homes where leadership teams were clearer, communicated with staff, created a culture of teamwork and transparency and set and held accountabilities were the homes that also tended to have fewer staff refusing to work, fewer staff selecting other homes as their single work site resulting in more staff shortages during COVID-19. We saw leadership in action.

Clarity of roles, responsibilities, and reporting structures is key. This is true for leaders and staff alike, but it starts at the top.

In a number of instances, LTC teams,

where observed, were not clear on where certain accountabilities lay, what actions they were responsible for, or how or whom to escalate to.

In order to address these challenges, we recommend the following: Improving the clarity of accountabilities at all levels in LTC, including between corporate and central offices and individual homes; create a core set of competencies to lead in LTC; enhancing offerings to long-term care homes' leadership to attract and retain executive directors and DOCs with the appropriate knowledge and skill. This will include leadership training or increased compensation, and investment is key.

Ensuring better clarity of organizational responsibilities and understanding of how to escalate from the frontline to the CEO, and better communication from the CEO through to the frontline; leadership that is supported to create transparency and encourage reporting from the boardroom on down; performance that is driven, balancing quality, financial health, and resident satisfaction.

Many submissions have referred to the size of a room, about different models of care,

about what we didn't have enough of or too much of. Ours is no different in some ways, yet we cannot lose sight that leadership is critical because what THP has learned is that many homes did well.

I believe at the heart of that rests leadership and how people were able to address things throughout the pandemic differently with the same level of tools or barriers stacked against them.

As I said when I began, it is an honour to be here. When I think about long-term care in the next 20 years, the truth is, I don't think it -- its changes are a lot at the foundation because I think it started out in the right place.

We all want our loved one, our friend, our mother, our brother, our cousin, we all want them to be somewhere where they feel like they are at home. We want them safe, we want them respected, to have dignity, and to be as vibrant as they possibly can at every stage of their life.

I don't think that should change, but I do think somewhere along the line, the foundation got lost, and we have to restore it.

I've asked the Commission to take the opportunity to really think about what it is that

we are trying to create. At the end of the day, it is important to remember that it does not cost money to treat people with kindness. It does not cost money to be respectful. It does not cost money to escalate something that needs more attention.

It is critical that those things not get lost in the important findings and recommendations that your report has detailed and will detail.

Please, as you make the important changes to operations and models, consider the underpinning of the values and the culture they must sit within and be sustained.

We should also be guided by the fact that these homes are homes of individuals. I equally believe we must begin to acknowledge that more complex care is taking place in these homes and adjust for this without losing the personal aspect.

There is an investment that we need to make in the care of our elderly, whether they are in long-term care or not. It has been long documented. We have offered our suggestions today on where those investments can be made. We have

reflected as best we can the voices we have heard.

Thank you again for inviting us here today and to share our observations with you. We do this on behalf of many residents and families in our community, and I cannot tell you what an honour it has been to do so. We have certainly been changed for good. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you very much. I don't know if there are any further questions. I think people asked them as we went along.

Thank you for a very thorough presentation. We will benefit from the fact that we have a transcript, and we'll be able to track many of the recommendations and the caution, I guess, that we try to see all sides of the problem and not just a specific solution in a specific situation.

I must say, we are struck by the fact that we are in the middle of something and we have to react and deal with that, and then we have to think in a more long-term way. We understand that.

But anyway, thank you very much, and thanks to your associates for the assistance I'm sure they gave, and with your permission, we may

come back.

MICHELLE DiEMANUELE: For sure. And it's nice to see all of you.

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

MICHELLE DiEMANUELE: Take care.

COMMISSIONER FRANK MARROCCO (CHAIR): Bye-bye.

COMMISSIONER JACK KITTS: Bye, Michelle.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Bye.

-- Adjourned at 9:41 a.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 4th day of November, 2020.

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