

# 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

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--- 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.

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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTER:

8

9 Michelle DiEmanuele, President and CEO of Trillium

10 Health Partners

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12 OBSERVERS:

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14 Stephanie Joyce, Vice President of Patient Care

15 Services and Health System Integration

16 Nicole Vaz, General Counsel and Chief Compliance

17 Officer

18 Dr. Tamara Wallington, Chief of Primary Care,

19 Rehab, CCC, Palliative Care, and Senior Services

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1 PARTICIPANTS:

2

3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

5 Ida Bianchi, Counsel, Long-Term Care Commission

6 Secretariat

7 John Callaghan, Counsel, Long-Term Care Commission

8 Secretariat

9 Derek Lett, Policy Director, Long-Term Care

10 Commission Secretariat

11 Adriana Diaz Choconta, Senior Policy Analyst,

12 Long-Term Care Commission Secretariat

13 Jessica Franklin, Policy Lead of the Long-Term Care

14 Commission

15 Lynn Mahoney, Counsel, Long-Term Care Commission

16 Secretariat

17

18 ALSO PRESENT:

19

20 Olivia Arnaud, Stenographer/Transcriptionist

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

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 So we released our interim report, and we're now  
5 trying to turn ourselves to more long-range or more  
6 fundamental, perhaps, consideration, and I suppose  
7 staffing was fundamental and some of the matters we  
8 mentioned were fundamental.

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

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

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

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

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

6 MICHELLE DiEMANUELE: We are. We are.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 Okay.

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

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 Hello, Nicole.

14 NICOLE VAZ: Good morning.

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

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

1 in Mississauga.

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

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

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

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

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

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

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

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

25           You know, governing is about making

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

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

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

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

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

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

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

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

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

1 that we have a renowned geriatric program.

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

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

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

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

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

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

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

1 over 650 staff to new roles, including long-term  
2 care; developed a PPE and practice handbook for  
3 staff as a single source of truth on PPE and point  
4 of care risk and AGMPs; enhanced PPE coaching with  
5 teams, new tools, and supports; increased our  
6 supplies; created a Keeping You Safe Taskforce and  
7 strategy to audit hospital spaces and ensured best  
8 practice for IPAC, such as posting maximum  
9 occupancy for every space; confirming appropriate  
10 numbers and locations of sanitizers and so on;  
11 consistently communicated updates and changes to  
12 10,000-plus staff daily.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 COMMISSIONER JACK KITTS: Yeah.

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

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

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

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

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

14 And I just want to remind everybody  
15 that the province's commitment right now is  
16 \$350,000 to help lift that for the remainder of  
17 this year. And we -- you know, it is, I think you  
18 said, a slow process, if I can just quote you  
19 there, Dr. Kitts --

20 COMMISSIONER JACK KITTS: Yes.

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

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

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

9 MICHELLE DiEMANUELE: Yes.

10 COMMISSIONER JACK KITTS: Okay. Thank  
11 you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 THP completed onsite assessments of all  
8 19 homes. We did that by early May.

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

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

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

1 long-term care homes of this information from late  
2 April to June; we deployed 52 staff to cover almost  
3 650 shifts; deployed 12 physicians to provide  
4 onsite medical assessments and symptom management  
5 for COVID-19-positive patients; and had 60 THP  
6 leaders who volunteered to provide meals to  
7 residents during 233 meal shifts through our  
8 Supper Club.

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

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

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

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

22 Labdara: Staff COVID swabbing.

23 Erin Mills Lodge: N95 mask fit  
24 testing.

25 Villa Forum: Onsite physician support.

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

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

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

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

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

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

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

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

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

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

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

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

5 Is that a fair comment, Dr. Wallington?

6 DR. TAMARA WALLINGTON: Absolutely.

7 Yeah.

8 MICHELLE DiEMANUELE: Yeah.

9 DR. TAMARA WALLINGTON: Absolutely.

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

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

17 MICHELLE DiEMANUELE: Yeah.

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

21 MICHELLE DiEMANUELE: Yeah.

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

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

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

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

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

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

1 just --

2 COMMISSIONER JACK KITTS: Yeah, that --

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

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

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

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

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

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

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

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

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

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

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Yes, Commissioner Coke?

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

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

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

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

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

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

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

17 COMMISSIONER ANGELA COKE: Okay.

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

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

1 in Camilla Care on April the 14th, 2020.

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

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

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

1 families.

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

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

1 equipment such as portable oxygen and large garbage  
2 cans.

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

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

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

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

1 and we increased regular communications with  
2 families.

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

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

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

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

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

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

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

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

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

1 17 unreported past critical incidents were  
2 identified and reported to the Ministry of  
3 Long-Term Care. These included allegations of  
4 abuse, neglect, incompetent care, unexpected  
5 deaths, and failure to report respiratory  
6 outbreaks.

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

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

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

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

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

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

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

13 MICHELLE DiEMANUELE: Any questions?

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

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

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

1 include nursing and physician representation.

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

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

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

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

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

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

7 COMMISSIONER JACK KITTS: Yeah. Thank  
8 you.

9 MICHELLE DiEMANUELE: Pardon me?

10 COMMISSIONER JACK KITTS: I agree,  
11 yeah.

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

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

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

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

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

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

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

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

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

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

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

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

6 I'll pause there.

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

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

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

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

25 COMMISSIONER JACK KITTS: Okay.

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

4 COMMISSIONER JACK KITTS: Yeah.

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

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

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

1 MICHELLE DiEMANUELE: Yeah.

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

8 MICHELLE DiEMANUELE: Correct.

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

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

18 COMMISSIONER JACK KITTS: So wrong  
19 indicators?

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

22 COMMISSIONER JACK KITTS: Thank you.

23 MICHELLE DiEMANUELE: Angela?

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

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

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

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

18 COMMISSIONER ANGELA COKE: Mm-hm.

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

25 But this space now is occupied often by

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

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

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

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

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

2 COMMISSIONER ANGELA COKE: Mm-hm.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14           So I'll pause there.

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

18           COMMISSIONER JACK KITTS: That's good.

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

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

1 pandemic in the first wave.

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

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

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

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

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

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

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

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

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

25 In a number of instances, LTC teams,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 reflected as best we can the voices we have heard.

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

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Well, thank you very much. I don't know if there  
10 are any further questions. I think people asked  
11 them as we went along.

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

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

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

1 come back.

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

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

6 MICHELLE DiEMANUELE: Take care.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 Bye-bye.

9 COMMISSIONER JACK KITTS: Bye,  
10 Michelle.

11 COMMISSIONER ANGELA COKE: Thank you.

12 COMMISSIONER JACK KITTS: Bye.

13

14 -- Adjourned at 9:41 a.m.

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1 REPORTER'S CERTIFICATE

2  
3 I, OLIVIA ARNAUD, CSR, Certified  
4 Shorthand Reporter, certify:

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

9  
10 That all remarks made at the time  
11 were recorded stenographically by me and were  
12 thereafter transcribed;

13  
14 That the foregoing is a true and  
15 correct transcript of my shorthand notes so taken.

16  
17  
18 Dated this 4th day of November, 2020.

19  
20  
21 

22 \_\_\_\_\_  
23 NEESONS, A VERITEXT COMPANY

24 PER: OLIVIA ARNAUD, CSR

25 CHARTERED SHORTHAND REPORTER

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