

Long-Term Care COVID-19 Commission Meeting

Cynthia Davis
on Friday, February 5, 2021



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 5th day of
February, 2021, 1:00 p.m. to 2:00 p.m.

1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

8

9 LAKERIDGE HEALTH:

10 Cynthia Davis, President & Chief Executive Officer

11 Susan deRyk, Executive Vice President & Chief

12 Transformation Officer

13

14 PARTICIPANTS:

15

16 John Callaghan, Co-Lead Commission Counsel, Gowling

17 WLG

18 Lynn Mahoney, Counsel, Gowling WLG

19 Alison Drummond, Assistant Deputy Minister,

20 Long-Term Care Commission Secretariat

21 Rose Bianchini, Senior Policy Analyst, Long-Term

22 Care Commission Secretariat

23 Derek Lett, Policy Director, Long-Term Care

24 Commission Secretariat

25

1 ALSO PRESENT:

2 Deana Santedicola, Stenographer/Transcriptionist

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1 -- Upon commencing at 1:00 p.m.

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3 LYNN MAHONEY: So, Commissioners, Cindy
4 Davis, the CEO -- President and CEO of Lakeridge
5 Health is here again. You'll recall that we heard
6 from the panel at Lakeridge Health, and Ms. Davis
7 kindly offered to come back and speak with you and
8 talk about other models of care, which include
9 long-term care that she has experience with.

10 So here she is, and Susan deRyk -- is
11 it "de-rik" or "de-rike"?

12 SUSAN deRYK: If you were to ask my
13 parents, it would be "de-rike", but if you were to
14 ask me, it would be "de-rik".

15 LYNN MAHONEY: Okay.

16 SUSAN deRYK: Thank you.

17 LYNN MAHONEY: So Susan deRyk is back
18 as well.

19 So Ms. Davis has a presentation, a
20 slide deck, and I believe someone from the
21 Secretariat is going to run the slide deck for her,
22 and so that is the agenda for the next hour,
23 Commissioner.

24 LEAD COMMISSIONER FRANK MARROCCO:

25 Well, thank you, and go ahead. Well,

1 Ms. Davis, you know the drill, so go ahead.

2 CYNTHIA DAVIS: Thank you so much for
3 inviting me back, and, you know, I just want to
4 reflect on when I was sitting in Newfoundland and
5 Labrador and seeing what was happening throughout
6 Canada and really the world in terms of some of the
7 vulnerable populations affected by COVID, and
8 particularly those in long-term care and congregate
9 settings, I never thought that I would have an
10 opportunity to come and talk to you about what a
11 different experience could look like.

12 And I feel quite fortunate that I am
13 here today.

14 So I want to walk you through a model
15 of care that I was involved in, but I want to say
16 up front, as I did when I was here before, that
17 there is no system that is perfect, and I would not
18 want to indicate that the system in Newfoundland is
19 perfect. But I can tell you it is different, and
20 our reaction was very different.

21 So if you could go to the next slide,
22 please.

23 So over the next hour or so, I hope we
24 can have lots of dialogue, and I am going to
25 quickly go through these slides, but this gives you

1 an overview of what I am hoping to cover and then
2 happy to answer any questions.

3 I just want to talk about the evolution
4 of an integrated system, based on my experience,
5 again, in Newfoundland and Labrador, what some of
6 the advantages were of that model as we started to
7 address the issues of COVID, and then really to
8 talk about where I see opportunities, particularly
9 within the Durham Region. And hopefully, you know,
10 a pause in terms of how we can look at integration
11 and support of communities at large differently.

12 Next slide, please.

13 So if I could just give you an
14 overview. Newfoundland is small. It is very small
15 compared to Ontario. The total population is just
16 a little over 500,000. 30 percent of the
17 population lives on the Avalon Peninsula, which is
18 the pink area on the map.

19 And so what I would say in Newfoundland
20 is that the journey of regionalization began in the
21 early 1990s, and what happened was that around 1998
22 there were essentially three health boards that
23 were left. There was the institutional boards,
24 which are the ones that you traditionally would
25 think of in terms of acute care services. And then

1 there were integrated boards, and those were the
2 ones that there were some acute care hospitals
3 actually had long-term care homes, similar to some
4 of the experience of Ontario. And then the final
5 board related to health was health and community
6 services.

7 And so the early stages of integration
8 was really about collapsing these boards into
9 entities that provided levels of service to
10 distinct populations, and it was only in 2005 then
11 that Newfoundland, through legislative changes,
12 actually moved towards collapsing the 14 boards and
13 moving into four divided regional health
14 authorities.

15 So it is interesting, because when we
16 talk about regionalization and models that are out
17 there - and I am not going to talk to this
18 Commission about what is across Canada, but you can
19 see that the evolution really started with
20 collapsing and consolidating acute care. Then they
21 looked at how they could bring in those other
22 continuums of care.

23 There are some provinces that have gone
24 completely with single boards. There are others,
25 like Newfoundland, that have subdivided the

1 province into what they believe are distinct groups
2 or service levels based on the population they are
3 trying to serve.

4 So, you know, when we think about how
5 do you find a local solution to some of these
6 problems, well, I think that the successful
7 provinces that have done this have really started
8 with smaller subsections of their province. And
9 those that haven't, Nova Scotia and Alberta, they
10 are now going back to try and figure out how they
11 allowed central standardization but at the same
12 time local nuances in decision-making.

13 So when you look at this map of
14 Newfoundland, Labrador, which is the blue in the
15 very tip of the province, the smallest section,
16 probably about 35,000 people, but the largest land
17 mass and the largest population of Indigenous and
18 Aboriginal. And so how you serve those is very
19 different than how you serve the metro St. John's
20 area that I say -- you know, the GTA itself is
21 about 200,000 people. So it is not even anything
22 that can be replicated throughout the province.

23 And then central has its own unique
24 nuances, and then the part that I was responsible
25 for is the green portion, which was the west coast

1 of the island.

2 And so what we know and from our
3 experience is that one size doesn't fit all, and in
4 actual fact, you have to find local solutions. And
5 I honestly think, in terms of the evolution of
6 Newfoundland -- as I said, it started in the '90s.
7 Where we are now, I actually think that the RHAs
8 are on solid footing and understanding, and we all,
9 in terms of the CEOs that were in those jobs or are
10 currently there, we believe that there was now
11 opportunity to even move to another level of
12 integration within the province, and we'll see what
13 happens with that.

14 Next slide, please.

15 So if I could just talk a bit about the
16 Regional Health Authority that I was responsible
17 for. As I said, it was one of four RHAs in the
18 province. The population base was small, 78,000
19 people, but the RHA was responsible for the whole
20 continuum of care, so hospital care, long-term
21 care, community services, Public Health, continuing
22 supports, virtually everything that you can think
23 of.

24 And what I say to people in Ontario --
25 because it is interesting. I come, and they say,

1 You have come to a really big organization, and I
2 say, Absolutely, it is very big, but it is a lot of
3 the same. It is a lot of hospital care, and
4 hospital care can be small or big, but the
5 principles stay the same.

6 But when you look at the continuum of
7 care, the complexities of that create a whole
8 different challenge in and of itself. And while
9 the population base was small, the budget for this
10 RHA was a little over \$400 million annually, which
11 is, you know, a little bit less than half of where
12 I am right now in Lakeridge. And I think that that
13 is a reflection of the service level that we were
14 actually providing.

15 And population was low. Geography was
16 absolutely a challenge. When I think of -- the
17 main Regional Centre was in Corner Brook. I had as
18 far as Port Saunders, which you can see on the map,
19 which was four and a half hours away. Luckily it
20 was through a national park that was gorgeous. And
21 through the south, it went as far as Burgeo, which
22 was about three hours away, and then I would have
23 to get on a ferry ride for another hour to go to
24 Ramea and François. So the geography was
25 absolutely tremendous.

1 What is to the advantage, I believe, of
2 Ontario is the fact that we have compact population
3 bases. We have natural subsets where people go for
4 care and services. And I think there is lots of
5 opportunities for us.

6 Next slide, please.

7 So if I could talk about the Regional
8 Health Authority then in terms of what specifically
9 we were doing - and I am just going to move my
10 slide here - that we were responsible for the whole
11 assessment of what was happening. So you think
12 about the community side and then residential
13 options.

14 So the professional staff that we had
15 would have been responsible for the assessment and
16 placement into personal care homes, long-term care
17 homes, or any other residential options. All of
18 the long-term care homes in Newfoundland and
19 Labrador, with the exception of one, which is
20 located in St. John's, is actually -- and that one
21 is private. All the others are public. The one in
22 St. John's that has the exception, Eastern Health
23 would have dedicated subsidized beds within that
24 long-term care facility, and they would also be the
25 licence-holder for that long-term care facility as

1 well. And I am going to talk a bit more about
2 that.

3 All the personal care homes are private
4 or not-for-profit, but again, whether it was
5 personal care homes or long-term care homes,
6 Western Health or the Integrated Health Authorities
7 were actually the licence-holders for all of the
8 agencies that had any responsibility associated
9 with health.

10 So on the personal care home, every
11 year, as the CEO of our health authority, I would
12 get a report from the staff that were connected and
13 associated with those personal care homes. There
14 would be compliance reports that I would see, and
15 then I would sign off on the licence for that
16 agency for the next year.

17 So we were there all the time, and when
18 I say "we", it was our staff.

19 On the personal care home, the personal
20 care home -- and again, these models are a little
21 bit different than what I have seen in Ontario, is
22 that this was supportive housing for seniors and
23 adults with special needs, and they were
24 categorized as Level I and Level II care. And then
25 most recently, over the past couple of years, there

1 were some homes that had demonstrated success that
2 were actually funded for enhanced Level II care.

3 The other piece is that if there is
4 somebody who is actually a resident of the personal
5 care home who goes on to have a change in their
6 health status, they could actually avail of funding
7 up to Level III, which would be typically long-term
8 care homes, that would allow them to hold the
9 person in place until they were transferred to
10 long-term care.

11 Now, sometimes that worked and
12 sometimes it didn't, so I don't want to give you
13 the impression that the personal care homes were
14 actually keeping the residents. Sometimes, because
15 of their staffing, they just didn't have the
16 ability to bump up their level of staffing to
17 support that level of care, and again, what ended
18 up happening is the hospitals then would be the
19 safety net for the personal care homes.

20 On the long-term care side, as I said
21 before, with the exception of one, they are all
22 owned and operated -- owned, operated, and governed
23 by the RHA, which is very different than Ontario.

24 So when you heard the staff and some of
25 the Public Health people come and talk about their

1 experience that Lakeridge had with Orchard Villa
2 and with Sunnycrest and the need to get orders to
3 go in, to bring staff in, none of that happens when
4 it is under the same governance. You are there all
5 the time. The people that are working there are
6 part of your organization, and you quickly
7 understand when there is issues, no different than
8 if I knew there was issues in our emergency
9 department or in our surgical suites. I understood
10 completely if there was any issues within our
11 long-term care homes.

12 And the long-term care is a bit
13 different than Ontario as well. There is no
14 division between complex continuing care and
15 long-term care, so we take Level III and Level IV
16 care. And, you know, we might want to talk about
17 hours per resident day, and we can certainly do
18 that. But in terms of how these are funded, they
19 are funded through global budgets, and then the
20 hours per resident day are assigned on the
21 complexity of the care.

22 So we don't have single units of
23 complex continuing care. There would have been
24 units that would have had higher intensity,
25 probably block units, protected units, but if you

1 think about some of the those complex continuing
2 care folks that are currently waiting in the acute
3 system at Lakeridge -- we have several units filled
4 with people that have high needs; they may be
5 ventilated, they may have chronic diseases that
6 require more advanced interventions and treatments
7 like IVs or feeding. All of that would be absorbed
8 and integrated into the long-term care system in
9 Newfoundland, and you would adjust the staffing
10 accordingly.

11 Next slide, please.

12 So as I said, because community
13 supports was part of this continuum of care, there
14 was just actually one single entry point for
15 assessment and placement, and that would have been
16 done by the most appropriate professional staff
17 within the RHA. So it might have been a nurse. It
18 might have been a social worker, whoever was the
19 primary contact for the individual that was seeking
20 some support.

21 There was a standard assessment done,
22 which, again, is consistent with Ontario, the RAI
23 suite of products that really assesses people, and
24 then from that would identify what the options
25 were. So we would -- from the RAI assessments, we

1 would understand the care needs of the individual,
2 and then we would present to them and their
3 families or care providers what the options were.
4 So was it home, with home supports? Was it a
5 personal care home? Or was it long-term care? So
6 there was just one point of entry, one point of
7 assessment, and then we actually worked with them.

8 If you could think about a triage
9 system, we worked with them to triage the most
10 appropriate support that could be provided, and
11 then through that single entry process, we would
12 have activated whatever steps were needed.

13 And so it is interesting, because when
14 you think about owned and operated by the RHA, the
15 rules of single entry and placement based on
16 priority were still -- they were the standard for
17 the province, and it was how we all operated. So
18 the notion that you came to hospital and you got
19 admitted to long-term care or personal care home
20 faster did not happen. There was no jumping of the
21 queue. The queue was based on your level of need
22 and your level of priority. So similar to Ontario,
23 but managed through a single process and through a
24 single department within the RHAs.

25 And then the RHAs would have also

1 provided those other professional and clinical
2 services, whatever they would have been needed,
3 whether it was in somebody's home or within our
4 long-term care facilities.

5 And I would say, in terms of the
6 personal care homes, certainly when we moved to
7 Level II Enhanced for the personal care homes, we
8 started very slow. There was only a few homes
9 throughout the whole province that were actually
10 approved for that, and there was strict criteria in
11 terms of quality and clinical care that would be
12 provided. And then our staff actually within the
13 RHA would have been responsible for the ongoing
14 compliance and audits associated with that.

15 And then the other pieces around the
16 RHA is the fact that we would also provide whatever
17 was needed in terms of this single entry process
18 for any special needs or special equipment or
19 anything else that was needed in terms of
20 supportive services across that continuum of care.
21 So wherever people were, we would try to meet their
22 needs wherever they were.

23 Next slide, please.

24 So if I talk then about the long-term
25 care and personal care homes, as I said, the

1 personal care homes were actually privately owned,
2 but we were the licence-holder for that. Within
3 the RHA, there would have been dedicated staff on
4 the community support side that would have been
5 responsible for going to these homes, liaisoning
6 with them, but there was never a need for us to go
7 announce to the homes. We had full right to go
8 into the homes, and we did. We would do announced
9 and unannounced visits. We would do announced and
10 unannounced compliance audits. And then we would
11 review the homes in terms of -- as you can see, in
12 terms of the buildings, the amenities, the food
13 delivery, across that whole gamut.

14 In terms of the long-term care
15 governance, the Integrated Health Authorities
16 really were that whole governance system. As I
17 said, we owned, operated, and managed. All of the
18 staff were RHA employees. On the professional
19 side, when we look at skill mix, it was similar and
20 the exact same as most provinces in terms of
21 professional and non-professional staff or
22 regulated and unregulated in terms of RNs and LPNs
23 or RPNs, which is the professional regulated side,
24 and personal care workers, which is the
25 unregulated.

1 We also had a combination of nurse
2 practitioners that would have been employees of the
3 RHAs. We had a ratio of one nurse practitioner to
4 200 residents, and they were full-time, and they
5 would have been assigned to the homes.

6 We also had a combination of fee for
7 service and salaried physicians that worked in the
8 homes as well. So I don't know if the Commission
9 would know that Newfoundland does have a model of
10 salaried physicians, both primary care and
11 specialists, and we have the combination of fee for
12 service as well.

13 So in our long-term care homes, we did
14 have that combination, but the medical staff would
15 have been hired by the RHA and would have been
16 credentialed through the medical advisory processes
17 and would have been responsible in reporting up
18 through our structures around Clinical Chiefs,
19 Division Chiefs, and then Chief of Staff.

20 And on the other side, in terms of all
21 the other staff, they would have gone through our
22 regular hiring processes.

23 The only exception is that some of our
24 homes did specialized care, and those people would
25 have been privileged through the medical processes

1 of our organization.

2 And then the other piece is that we did
3 leverage a lot, because we were an Integrated
4 Health Authority, in terms of our corporate
5 services, and those are things like finance, HR,
6 laundry, food services. So there would be a
7 funding envelope that comes with long-term care,
8 but obviously because of economies of scale within
9 an Integrated Health Authority, we were actually
10 able to keep some of the costs associated with
11 those functions relatively stable or somewhat more
12 efficient than if they were stand-alone.

13 So what I would say is that this slide
14 tells you kind of the structure and how we do it,
15 but I just wanted to give you an example.

16 So again, when I was listening in in
17 Newfoundland about what was happening in Ontario,
18 and there was lots of commentary across the country
19 about how things were unfolding and that we needed
20 to do a better job, I kept telling myself, we are
21 doing a really good job. And, you know,
22 Newfoundland was blessed. It was blessed, blessed,
23 with low COVID, both on the island and, thankfully,
24 as I touch my table, we did not have any
25 COVID-positive cases in any of our residential

1 options.

2 But I just want to describe for you, as
3 the CEO sitting at the table, what unfolded.

4 So when the World Health Organization
5 declared the pandemic on March the 11th, things
6 really started to take off. I mean, we had been
7 involved in planning. We had been talking way
8 before that. But when that happened, and the
9 person that is sitting at the table next to you is
10 responsible for long-term care, and we know that
11 what unfolded across Canada was that this was
12 probably the most vulnerable population we had in
13 our entire system, we quickly turned around to
14 address it.

15 And so we quickly talked about making
16 the staff whole. We didn't want them to be
17 floating between sites. They did. And not that we
18 had private entities where they were working. Some
19 of them had second jobs.

20 But within our integrated system, one
21 of the things that people talk about as the benefit
22 is that, as an employee, you can move around, and
23 you can work in many clinical areas and lots of
24 people like that variety. But we knew that that
25 needed to stop right away, and we stopped it, I

1 think, in week one.

2 The other part that was interesting is,
3 you know what, as a nurse I never thought I would
4 have to deal with a crisis and not know where the
5 PPE was coming from, but when we knew that there
6 were issues around PPE, the long-term care facility
7 got as much as the acute, as much as the community.
8 We were and continue to be the clearinghouse for
9 everything in terms of care.

10 So when we talked about who is the
11 vulnerable people, well, we knew it was the
12 long-term care residents. We also knew that staff
13 unfortunately were often times associated with
14 transmission, and we quickly moved our facilities
15 to long-term care, to put up the structures for
16 screening, for visitor restriction, and then all
17 the PPE flew to the long-term care homes the exact
18 same day that we instituted new guidelines for PPE,
19 without exception.

20 And then the other piece on the
21 personal care homes is that even though these homes
22 were not ours, we were still responsible for the
23 clearinghouse for PPE to them. So when we knew
24 what the shipment was going to be, we knew how many
25 staff were working in these private institutions

1 and what we needed to get to them as quickly as
2 possible.

3 And within our service, what we talked
4 about is, Look, on the acute care side, we are
5 pretty protected. We get to screen people. We get
6 to screen staff. We can screen patients. We can
7 screen everybody that comes in. We know where our
8 high touch, high impact areas were for direct care,
9 and we'll make sure that those staff are really
10 protected with our PPE. But the hospitals will not
11 be getting all the PPE. It will be going where we
12 believe the need is.

13 And so when you work within an
14 integrated system, that is just intrinsically how
15 it happens. There is no debate. It is you pull
16 staff. I mean, when I think about the infection
17 control piece, you know, we are underfunded -- or
18 were underfunded in long-term care for infection
19 control. It has been overlooked for years.

20 But when we realized infection control,
21 quality, you know, infectious diseases, they needed
22 to be in long-term care, we quickly said, You are
23 being re-deployed to long-term care. And there was
24 no debate, discussion, and people went willingly
25 because we knew where the risk was, and we knew

1 that we needed to protect those people because, by
2 protecting them, we actually protected the acute
3 care side as well.

4 And so it is different, and it is
5 successful. Is it perfect? Absolutely not. But I
6 believe that how we impacted changes to protect
7 people happened so quickly that we did everything
8 to mitigate the risk to that population.

9 Next slide, please.

10 So, again, this talks about the
11 continuum of care, and I won't spend a lot of time
12 on it. As I said before, prior to 2005, there were
13 three big groupings. After 2005, there are no
14 groupings. Everything collapsed into one, and what
15 we ended up with was four Integrated Health
16 Authorities across the continuum of care.

17 When you compare that to what is
18 happening in Ontario around, you know -- and again,
19 I won't talk about the histories of the LHIN and
20 now Ontario Health and Ontario Health Teams. I
21 think all of these initiatives are really about
22 trying to drive that integration and change a
23 system to better meet the needs of people in your
24 communities. And I get that. I mean, Durham is
25 one of the Ontario Health Teams. We have 18

1 partners in that team. We are going to do really
2 good work in that team.

3 But I can tell you that it is not bold
4 enough. If you really want to make bold, broad
5 system changes to really impact continuum of care,
6 it needs to be much bolder than that. These teams
7 will do great work. We will have great
8 partnerships, and individually, we will have better
9 lines of communication, transition, and care for
10 people, but it is small, and it will take a long
11 time if that is the strategy of integration in
12 Ontario.

13 Next slide, please.

14 And so this is the one that I think
15 about in terms of the opportunity, and particularly
16 where I am right now. And I am going to go back
17 again and say that Newfoundland is small. It is
18 small. Small. Nova Scotia is small. There is
19 about a million people in Nova Scotia. New
20 Brunswick, small. Prince Edward Island, even
21 smaller.

22 But what I would say is I am not
23 talking about size. I am talking about models of
24 care. And when we think about the Durham Region,
25 in my mind, it is absolutely the opportunity to

1 look at integration differently and to look at how
2 within a small population -- and I say small, it is
3 like almost 800,000 people and growing to over a
4 million, but it is compact. And the other piece is
5 it allows you to be really potentially successful
6 within a region that you can then try and
7 replicate, and as I -- if I went back to the other
8 slide that I talked to you about in terms of
9 Newfoundland, you know, it started with 14 boards.
10 Then it has gone to 4. Do I think it is going to
11 go to less? Yes, I think it should. But it can
12 only happen that way after you have demonstrated
13 success and done a really good job in small pieces
14 that you can carve off.

15 And lots of people talk about how you
16 tackle a big problem. You cut it off into small
17 pieces that you can figure out how to do it and do
18 it really well, and then you can make it bigger and
19 replicate it everywhere.

20 So when we talk about what could happen
21 in Durham, it really is -- you know, if we want it
22 to be bold, it is that model that I showed you that
23 really no door is the wrong door. Everywhere you
24 come, you will be cared for and transitioned. We
25 will pull every lever that we have to make your

1 care as good as we can.

2 Yesterday, actually, I was on a call
3 with the Minister of Long-Term Care, both myself
4 and the Chief of Staff, and we were talking about
5 our alternate level of care population, of which we
6 have over 200 in hospital and another 100 in the
7 community. And at the same time, we have empty
8 long-term care beds in our region, and there is all
9 kinds of reasons why they are empty, and there is
10 all kinds of reasons why we need to be really,
11 really careful about moving people back into those
12 homes.

13 But what I shared with her is that I
14 came from an integrated system, and I don't say
15 that because of anything that, you know, is
16 outstanding, other than the way I think is that I'm
17 a public servant that is responsible for caring for
18 the entire community, and if one of the things that
19 we can do in the Durham Region is make sure that
20 the homes have the confidence and the skill to
21 start accepting more people into their homes, we
22 are going to be there. We'll be there by their
23 side if they let us. We'll be there with IPAC,
24 with professional staff, with quality staff,
25 whatever they need, because their success is our

1 success.

2 But more importantly, it is about
3 making sure that people are cared for really well
4 and that they are cared for in the right
5 environment. And, you know, whether or not we have
6 an Ontario Health Team or we have directives from
7 government, we are going to partner with our
8 long-term care facilities to figure out how we
9 learned from COVID and how we manage people in our
10 communities collectively much, much better.

11 Some of that will be challenging
12 because some of the homes will welcome us with open
13 arms and some probably won't, but we are going to
14 go knocking on their door and make sure that we try
15 and help them because helping them is helping the
16 people that we are responsible for.

17 I am trying to see if I have anything
18 else.

19 So next slide, please.

20 Yes. So, you know, when we think about
21 Durham, I think that the opportunities are endless
22 here in terms of what has been achieved, and if I
23 go back, again, to even the transition of regional
24 systems in Canada, the first start actually was the
25 integration of the hospitals, and Lakeridge Health

1 actually has done that heavy lifting. They have
2 amalgamated five of the hospitals in the region.
3 That is it. There is no more.

4 We are also looking at new and upgraded
5 acute care hospitals. We have outpatient services.
6 We are looking at a brand new ambulatory care
7 service, and also, we are one of the rapid builds
8 for the new long-term care facilities, 320 beds at
9 our Ajax-Pickering site.

10 And it is interesting because, you
11 know, we are having a lot of discussion about
12 long-term care, and I said when I arrived, Well, we
13 are just going to own and operate it, right, own,
14 operate, and manage it. Well, it is not that
15 straightforward. It is really tough to figure out
16 how you maneuver this within the legislation and
17 also within the funding envelope.

18 But fundamentally, I believe we should
19 be owning and operating and managing the long-term
20 care facility. Why would we do anything different?

21 We are not there yet, and we are going
22 to continue to work on that internally and with our
23 partners. But it is interesting, because I went to
24 an advisory group where there were people
25 sitting -- it was a patient experience advisory

1 group, and people are really excited about this
2 long-term care facility being built at the
3 Ajax-Pickering site. And I walked away thinking it
4 doesn't matter who owns and operates this. At the
5 end of the day, people associate that with us,
6 Lakeridge Health, and so we are going to make sure
7 we do the best job. And honestly, I think the best
8 job we can do is to be managing it ourselves.

9 So more work to be done on that for
10 sure.

11 But one of the other things that I
12 hear, I have heard it, we are in the midst of the
13 final transition of Durham Mental Health. I have
14 been to an Ontario Health Team. I have been to
15 another forum. And what people continually talk
16 about is, Well, this is not about a hospital
17 takeover. This is not about the hospital getting
18 bigger. And I say, This has nothing to do with the
19 hospital. This has to do about systems and system
20 integrations. But I recognize the hospitals are a
21 big player in that system. But you don't have to
22 fear us. We are here to help. We are here to
23 support it. And we are here to leverage every
24 single thing we have to provide care better
25 wherever it needs to be done.

1 And fundamentally, in 14 years of
2 working in an integrated authority, your mindset
3 just changes that way. But I have to tell you, I
4 have a lot of work to do here, because when I talk
5 about it, all it is is hospitals trying to take us
6 over.

7 Next slide, please.

8 Yes. So the other thing I would say
9 is, in terms of what has happened with the
10 pandemic, in terms of how we have come together
11 through better partnerships -- and I spoke to one
12 around the vaccine, both the screening vaccine
13 distribution. You know what? When you are in a
14 crisis, the silos get broken down instantly, and so
15 that is really good stuff that we can't lose.

16 The other piece of it is that the
17 strategic plan for Lakeridge Health already talks
18 about this vision of integration and trying to
19 actually break down the silos of care for people.
20 And one of the objectives that the board gave me
21 when I was hired to this organization is whether
22 they are real, perceived, possible, impossible, we
23 want you to forge every single connection you can
24 so that we can be leaders in health, and we can
25 support the continuum of care, whether it is owned

1 and managed by us or managed by other people, and
2 that will certainly be what I do over my time at
3 Lakeridge.

4 Next slide, please.

5 So I am not going to spend a lot of
6 time on this. I have talked about the Ontario
7 Health Teams. I think as individual teams, as
8 quality improvement, as specific lines of care or
9 populations, they will be successful. Just by the
10 nature of bringing the providers around the table
11 and having discussion, you will be successful, but
12 they are hard to manage. The governance is
13 unclear. And they won't be bold enough to
14 institute broad change.

15 Next slide.

16 And so this is my last slide. So when
17 we talk about the vision for integration both for
18 what it means for the Province of Ontario, what it
19 means for Durham Region, Lakeridge Health, and
20 really for the system as a whole, I think we are
21 all saying the same thing. Like when you read the
22 reports, when you read, you know, the priorities
23 for government, we are all talking the same thing.
24 But we are trying to figure out how to get there.

25 And I get that Ontario is big. It is

1 big. It is very different. But we know that there
2 are success stories across Canada. And what we
3 have to really do is figure out how we can carve
4 off local solutions that contribute to this greater
5 system of integration. I believe it is possible.
6 I believe where I am sitting today in the Durham
7 Region is absolutely ripe for making this happen,
8 if people are bold enough to come along with us.

9 And again, what I have heard and what I
10 continue to hear, is that it is a hospital
11 takeover, and it is the complete opposite, but it
12 requires vision, and it requires leaders in the
13 system who know that things can be done
14 differently.

15 So I think I talked way too long, but I
16 am going to turn it over if there is any questions.

17 And it has been my pleasure. Honestly,
18 if I thought that I was ever going to be here and
19 be able to tell you that there is a world different
20 and just imagine what the different world could
21 look like, I feel privileged that I had the
22 opportunity today.

23 So thank you.

24 LEAD COMMISSIONER FRANK MARROCCO:

25 Okay. Commissioner Kitts?

1 COMMISSIONER JACK KITTS: Yes, I love
2 your enthusiasm, your passion, positivity. It is
3 fantastic.

4 I just want to go back. I don't know
5 if you can put the slides back up, but on slide 8,
6 you compared an integrated system in Newfoundland
7 versus Ontario, and the only difference was that
8 Newfoundland has something called personal care
9 homes and Ontario doesn't.

10 Now, I want to go from that slide
11 then -- yes. So you see there that is the only
12 difference in the two integrated system building.

13 But if you go back then to slide 5, you
14 define what a personal care home -- or at least
15 what the -- I guess, residents of a personal care
16 home and then a long-term care home, and you can
17 see that they have actually -- I think Level I, II,
18 III, IV, V is -- or III, IV is the acuity level of
19 the resident.

20 So we have had a lot of discussions and
21 different opinions about whether a long-term care
22 home is a home and residence, or is it more
23 institutional and requires more health care.

24 Does it mean in your -- in the personal
25 care homes -- and I would like to hear what they

1 are -- are really treating people who need help
2 with activities of daily living and whatnot, and
3 when they progress to a point where they need care,
4 is a long-term care home more about health care
5 than being a home?

6 And one last thing is your staff --
7 what you are trying to do, I think, here is match
8 the needs of the resident or patient to the skills
9 of the staff, and given -- I don't know about
10 Newfoundland, but in Ontario, 85 percent of people
11 in a long-term care home have a cognitive
12 dysfunction and 70 percent have dementia. And I am
13 wondering what your thoughts are on the training
14 for skills with elder care, particularly focussed
15 on cognitive dysfunction.

16 Now, I don't know if you can remember
17 all that, but --

18 CYNTHIA DAVIS: I can remember some of
19 it. I'll see what I can do.

20 So the other thing I would say to you
21 is that, against my better judgment, I actually
22 started in a Ph.D. program, and I am four years
23 into it at the University of New Brunswick, and my
24 whole focus is about how we leverage the systems we
25 have to better care for people.

1 So there is this sense that when you
2 come to acute care, somehow you are protected. It
3 is the complete opposite. Within three days, you
4 are on a trajectory of care that puts you in a
5 wheelchair or a bed, potentially for the rest of
6 your life.

7 So that is a problem.

8 But when you talk about that level of
9 care -- so traditionally long-term care homes --
10 and again, this has been a big evolution. I mean,
11 people are living longer. They are living longer
12 with chronic diseases. I mean, gone are the days
13 where people drove up to a long-term care home in
14 their car and parked it and walked in and basically
15 lived with some support and then, you know, went
16 about their business. That is gone.

17 So I can tell you, though, within the
18 14 years in Newfoundland that I was there, there
19 was a complete evolution of that. I mean, we had
20 people in long-term care homes that were living
21 there for 15 years. That was the wrong level of
22 care for them, absolutely. If you are living that
23 long in long-term care, you were inappropriately
24 placed to begin with.

25 So I can't remember the year that it

1 happened, but the government made a conscious
2 effort that we needed to leverage everything in the
3 system, so home with home supports, personal care
4 homes, and long-term care differently.

5 So the only way you get entry into
6 long-term care now is that you are Level III.

7 So you are absolutely right, Dr. Kitts,
8 Level III and Level IV is the complexion continuing
9 one. Those are the people that really require way
10 more care and care by professional staff.

11 So the ratios in Newfoundland of
12 professional staff to unregulated is about 50:50.
13 On some of the units, it actually might be higher
14 than that. Like if we have a couple of ventilated
15 patients or people like -- you know, dementia, like
16 some of the really aggressive dementias and
17 Alzheimer's, I mean, we staff those differently.
18 Those are staffed -- people here are talking about
19 four hours of resident care per day. Those would
20 be the four hours. We are staffing that. But when
21 you look broadly across what the average is, it is
22 somewhere about 3.4 or 3.5.

23 The other thing is the average length
24 of stay now in our long-term care homes is about
25 three years, and because these are the sickest of

1 the sickest in terms of the people that need care,
2 and they need professional care. On the personal
3 care home side, Level I is, like, people that
4 have -- you know, they need some assistance. They
5 might need reminders around their ADLs, so their
6 activities of daily living, so they need -- oh, I'm
7 explaining it to a doctor. You know.

8 But they might need help with
9 reminders, with bathing, with dressing. They would
10 be independent and ambulatory and be able to feed
11 themselves.

12 Level II is the kind of mild to
13 moderate dementia. They may actually need more
14 assistance.

15 And Level II Enhanced is really what
16 traditionally would have gone to long-term care
17 home, which is what I see is in a lot of the
18 long-term care homes here.

19 And so because the personal care homes
20 are private, you can actually go into a personal
21 care home if you have a Level I care need, but you
22 won't be subsidized by the government. The only
23 way you get a subsidy for personal care home is if
24 your need is II or II-plus. So then those people
25 are private pay.

1 COMMISSIONER JACK KITTS: Okay. Thank
2 you.

3 LEAD COMMISSIONER FRANK MARROCCO:
4 Commissioner Coke.

5 COMMISSIONER ANGELA COKE: I was just
6 interested in terms of what was your biggest sort
7 of challenge in terms of moving to this model in
8 Newfoundland, and just in terms of how the
9 long-term care part of your system, how they felt
10 about the broader integration. How difficult was
11 it or challenging to get them into part of this
12 total integration model?

13 CYNTHIA DAVIS: So, you know, it is
14 hard for me to talk about that because I came in
15 2005 when the final piece of integration was done,
16 and honestly, I would say the biggest challenge was
17 on the acute care side. It was never on the
18 long-term care side. And I am trying to think if
19 it was on the community side. Maybe, maybe not.

20 The biggest challenge was the hospitals
21 because they are the beast who think they are
22 special and that they are the powerhouse of
23 communities.

24 And, you know, I go -- it is
25 interesting because -- you know, I say to people,

1 we integrated in 2005, but you can't take your
2 finger off the pulse of this ever. And we do -- we
3 go to communities and they were like, Well, you are
4 laying off people in our hospital and our hospital
5 needs a CAT scanner and we need this and we need
6 that. And we are like, No, what your hospital
7 needs actually is more ambulatory care service.
8 Everybody needs to have a primary care provider,
9 and we need to make sure that we have lots of
10 virtual care and that you are well looked after in
11 the place you reside.

12 So what I would say is my personal
13 experience has been -- the biggest challenge was
14 the hospitals and less so the long-term care
15 facilities. But again, it was probably because
16 some of them were already integrated. Lots were
17 not-for-profit. Some were organized by religious
18 denominations. And the transition was really easy.

19 What I would say, again, is that there
20 was also a conscious effort -- when these
21 integration and collapsing happened, the CEO of
22 Western Health came from the community. The CEO
23 from Central Health came from the community.

24 So they really tried to say this is not
25 about a hospital. This is about an integration

1 and, look, we are putting leaders into these
2 integrated systems that for the most part have
3 never worked within the acute care walls, and they
4 will help foster what needs to be done.

5 The other part in -- if you look at
6 what is happening in terms of the structure for
7 Ontario Health, is that we were responsible for
8 making sure that at the senior executive table
9 those lines of service had dedicated senior
10 executives. So there would have been a CEO; there
11 would have been a Vice President responsible for
12 community; there would have been one responsible
13 for acute care, one responsible for long-term care
14 and residential options; and then we would have had
15 the traditional medical structures in terms of VP
16 Medicine, Chief of Staff.

17 So it doesn't happen without a
18 strategy, without structure, that really says to
19 people we are going to behave different, but we are
20 also going to manage different, and our commitment
21 back is look who the people are around the table.
22 They are with the lines of business around that
23 integration. And you can't do it any other way. I
24 mean, to think that you could merge long-term care
25 into Lakeridge Health, for lack of a better

1 example, and think that I could do that and do that
2 successfully without saying that I am going to
3 dedicate resources to really ensure that this is
4 integrated and managed well would be naive.

5 What I say to people is the bricks and
6 mortars and the merger of systems in terms of, you
7 know, hospitals is tough work, but the culture and
8 the integration of the care is hard, and you
9 absolutely need to have dedicated people that
10 understand philosophically you are changing the
11 landscape on what you are delivering.

12 And it is not about the hospitals
13 adjusting to long-term care. It is the complete
14 opposite.

15 And I could just give you a quick
16 example. So I had a discussion since I have been
17 here, and somebody said to me, I am a
18 community-based service, and I find it offensive
19 that the place I go to talk about my experience is
20 called Patient Experience. And I said, I get it.
21 I understand it. Because you are not a patient.
22 You are a client. You are out in the community.

23 And particularly around the mental
24 health side, people that are, like, homeless, going
25 to shelters, availing of our mental health

1 services, they don't want to be called "patients".
2 They are not patients. They are consumers of care.
3 They are clients.

4 And so our systems have to start
5 responding different. So when think about the
6 long-term care piece, I would never refer to a
7 person in long-term care as a "patient". It is
8 their home. They need to be treated as a resident
9 within a home. And the whole philosophy of care is
10 very different than what we do in the walls of
11 acute care.

12 So long answer, but what I would say is
13 we need to have lots of support in order to do it,
14 and you need to be very methodical and make sure
15 that you don't just try and put a round peg in a
16 square hole. It doesn't work.

17 COMMISSIONER ANGELA COKE: Thank you.

18 LEAD COMMISSIONER FRANK MARROCCO:

19 I have heard this repeatedly that a
20 long-term care resident is living in their home,
21 but they are a specific kind of person. I mean,
22 they have certain deficits. So their home is going
23 to be different than the conventional understanding
24 of what the word "home" means.

25 And I am wondering whether it really

1 isn't a form of institutional care -- or
2 institutionalized care that ultimately is what they
3 are getting.

4 CYNTHIA DAVIS: So I would say that you
5 are right on that. I mean, it is institutionalized
6 care. There is no way about it.

7 And so in Canada, do we have all of it
8 right? Absolutely not. And so what we are trying
9 to do is figure out how you can provide the best
10 level of care that economically you can afford.

11 And so I think about some of the other
12 models that existed within Western Health that I
13 would say were absolutely more home-like. One was
14 a congregate living house that -- I can't remember.
15 It might have had 20 small apartments with a
16 communal area for food preparation and
17 socialization.

18 And so would I think that that was a
19 great model? Absolutely. When I saw it for the
20 first time, I thought, Well, why aren't we doing
21 that everywhere? Like this model works. We had a
22 full-time social worker. We had a housekeeper. We
23 had somebody who did meal preparation. They were
24 all case-managed. But it was too expensive.

25 The other thing that we had in Western

1 Health was bungalows, and they were more home-like.
2 They were called Protective Care Residents, and
3 they were clusters of ten people in what looked
4 like a traditional house, and again, it had the
5 central areas for eating and food production and
6 socialization. And these were for people with mild
7 to moderate dementia. So they may have been a
8 little more than II-plus, so they would have
9 exhausted what they could in a personal care home,
10 weren't quite ready for long-term care, but they
11 came to these residence.

12 So it is interesting because Susan and
13 I were today talking about long-term care, and we
14 are planning for the building in Corner Brook. And
15 so how do you get around the institutional nature
16 of these long-term care buildings when you really
17 do need to have large numbers in buildings that you
18 can care for?

19 So on the design side, what we know now
20 is that the most successful models are that you try
21 and form neighbourhoods or smaller clusters within
22 the floors of long-term care. So if you were to
23 look at best practice -- and again, you have
24 probably heard from loads of people. I don't need
25 to tell you guys this.

1 But what you would do is you try and
2 carve off smaller clusters so that you can make it
3 more home-like. So rather than a 30-bed unit, you
4 had 15-bed units. Within those 15-bed units, you
5 would have had dining for 15 people. When you go
6 into the washrooms and the shower rooms, you put
7 them like spas. The colours are different. The
8 feel is different. And you try and make it as
9 home-like as possible.

10 But you are absolutely right, their
11 care needs do not allow them to be at home unless
12 they have potentially 24-hour care, and in
13 Newfoundland, you know, the funding system didn't
14 support that and most people financially could not
15 do that on their own.

16 But there is ways to make it more
17 home-like.

18 And so, you know, for me personally,
19 even as I walk through Lakeridge, some of the
20 people have been in these buildings for years
21 waiting for placement, and I look, and they are in
22 a hospital bed. There is a corridor. There is no
23 dining room. There is no communal area they can go
24 to. And some of these people will die in our
25 building, and they will die having never had the

1 wind on their face or been in an area where they
2 have shared a meal.

3 And so is the long-term care model we
4 have in Canada, you know, perfect? Absolutely not.
5 But it is certainly better than what we are doing
6 right now with some of our complex continuing care
7 and alternate level of care people that are being
8 housed in our hospital systems.

9 There is more that we can do, but the
10 models of care for long-term care are really trying
11 to figure out how you make it more home-like for
12 sure.

13 LEAD COMMISSIONER FRANK MARROCCO:

14 Dr. Kitts, you had --

15 COMMISSIONER JACK KITTS: No, I think
16 that has covered it. Thanks.

17 LEAD COMMISSIONER FRANK MARROCCO:

18 Okay. Well, I think we have run out of
19 questions. Thank you very much for giving us a
20 broader perspective in terms of Canadian options
21 than we might have otherwise appreciated.

22 One of the things we are wrestling with
23 is how do you transform, how do you move. We are
24 all conscious of the fact that there is a waiting
25 list, and there is no reasonable prospect going

1 forward of eliminating that waiting list if we
2 continue as we have in the past.

3 So we have been wrestling with that,
4 and this is quite helpful to -- well,
5 thought-provoking, I guess. Helpful would have
6 been a solution and told us where to sign on,
7 but --

8 CYNTHIA DAVIS: I can give you a
9 solution. In Durham, integration is the solution.
10 We can start with the build we are doing at
11 Ajax-Pickering. We can move to all the non-profits
12 and ask them to join our structure. And we can
13 commit to every single new home being built as part
14 of our system.

15 And so, you know what? Your work is so
16 important. You are going to change what happens in
17 this province, and I wish you, wish you, the best
18 success that you can have.

19 And what I would say is you have a
20 willing partner in Lakeridge Health to implement
21 and operationalize whatever boldness you are able
22 to put towards us.

23 LEAD COMMISSIONER FRANK MARROCCO:

24 We will write the best report we can,
25 and then it will fall to others to do something

1 with it.

2 But thank you both actually.

3 Ms. deRyk, you were here too, and I didn't mean to
4 ignore you. Thank you both for your presentation.

5 COMMISSIONER JACK KITTS: Yes.

6 COMMISSIONER ANGELA COKE: Thank you.

7 LYNN MAHONEY: Thanks very much.

8 Bye-bye.

9

10 -- Adjourned at 2:05 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, DEANA SANTEDICOLA, RPR, CRR,
4 CSR, Certified Shorthand Reporter, certify:

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

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

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

13
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16 Dated this 5th day of February, 2021.

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18 

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23 PER: DEANA SANTEDICOLA, RPR, CRR, CSR
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25

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