# 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

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--- 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.

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BEFORE:

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

PRESENTERS:

LAKERIDGE HEALTH:
Cynthia Davis, President & Chief Executive Officer
Susan deRyk, Executive Vice President & Chief Transformation Officer

PARTICIPANTS:

John Callaghan, Co-Lead Commission Counsel, Gowling WLG
Lynn Mahoney, Counsel, Gowling WLG
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat

ALSO PRESENT:

Deana Santedicola, Stenographer/Transcriptionist

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

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

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

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

LYNN MAHONEY: Okay.

SUSAN deRYK: Thank you.

LYNN MAHONEY: So Susan deRyk is back as well.

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

LEAD COMMISSIONER FRANK MARROCCO: Well, thank you, and go ahead. Well,

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

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

And I feel quite fortunate that I am here today.

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

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

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

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

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

Next slide, please.

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

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

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

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

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

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

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

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

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

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

of the island.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And then the RHAs would have also

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

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

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

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

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

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

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

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

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

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

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

of our organization.

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

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

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

options.

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

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

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

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

think, in week one.

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

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

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

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

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

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

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

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

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

Next slide, please.

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

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

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

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

Next slide, please.

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

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

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

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

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

care as good as we can.

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

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

success.

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

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

I am trying to see if I have anything else.

So next slide, please.

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

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

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

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

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

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

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

So more work to be done on that for sure.

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

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

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

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

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

Next slide, please.

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

Next slide.

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

And I get that Ontario is big. It is

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

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

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

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

So thank you.

LEAD COMMISSIONER FRANK MARROCCO:

Okay. Commissioner Kitts?

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

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

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

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

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

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

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

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

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

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

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

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

So that is a problem.

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

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

So I can't remember the year that it

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

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

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

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

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

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

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

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

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

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

COMMISSIONER JACK KITTS: Okay. Thank you.

LEAD COMMISSIONER FRANK MARROCCO: Commissioner Coke.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER ANGELA COKE: Thank you.

LEAD COMMISSIONER FRANK MARROCCO:

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

And I am wondering whether it really

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

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

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

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

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

The other thing that we had in Western

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

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

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

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

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

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

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

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

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

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

LEAD COMMISSIONER FRANK MARROCCO:

Dr. Kitts, you had --

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

LEAD COMMISSIONER FRANK MARROCCO:

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

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

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

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

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

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

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

LEAD COMMISSIONER FRANK MARROCCO:

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

with it.

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

COMMISSIONER JACK KITTS: Yes.

COMMISSIONER ANGELA COKE: Thank you.

LYNN MAHONEY: Thanks very much. Bye-bye.

-- Adjourned at 2:05 p.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 5th day of February, 2021.

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