Long-Term Care COVID-19 Commission Meeting

Moira Welsh, Author of Happily Ever Older
on Thursday, February 25, 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 25th day of February, 2021, 1:00 p.m. to 2:00 p.m.

BEFORE:
The Honourable Frank N. Marrocco, Commission Chair
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:
Moira Welsh, Author of Happily Ever Older and Investigative Reporter, Toronto Star

PARTICIPANTS:
Ida Bianchi, Senior Legal Counsel, Long-Term Care Commission Secretariat
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat
Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Gowling WLG

ALSO PRESENT:
Deana Santedicola, Stenographer/Transcriptionist

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

COMMISSION CHAIR FRANK MARROCCO: Well, hello, and I am Frank Marrocco. I'm one of the Commissioners. There is Commissioner Angela Coke and Commissioner Dr. Jack Kitts.

So we are the Commission, and thank you very much for agreeing to meet with us.

There is -- Deana is here. She is the court reporter, and there is a transcript, and we will post the transcript within a couple of days so that people can understand what we are doing with our time.

Anyway, if you don't mind, as you are going through, if we have questions, we'll just interrupt and ask the question rather than trying to go back.

MOIRA WELSH: Yes, that is fine.

COMMISSION CHAIR FRANK MARROCCO: Okay.

So why don't we get started. You know, why don't you go ahead.

IDA BIANCHI: Just I will give an introduction because you'll probably be more modest than I would be.

This is Moira Welsh, who is an

award-winning investigative journalist with the Toronto Star. She has won three national newspaper awards and a Missioner Award for public service journalism. She was a finalist for the Justicia Award for legal reporting, and the Canadian Hillman Prize.

She has done a lot of investigative work into the long-term care homes system and recently wrote a book, which I have been reading, but the name has just left my brain right now.

COMMISSION CHAIR FRANK MARROCCO: It's Happily Ever Older.

IDA BIANCHI: Happily Ever Older, that's it.

So she has come to talk about her investigative work in this area and the models that she describes in her book.

So, Moira.

MOIRA WELSH: Thank you very much for asking me to come and speak to you. I really appreciate that.

By way of background, I began writing about nursing homes in 2003 when the Star published a ten-day series about neglect and abuse in long-term care.

That series promoted the Health Minister of the day -- it actually prompted him to promise a revolution in nursing homes, in part leading to new legislation in 2007 and a new inspection system that was supposed to be far more rigorous.

Of course, there was no revolution in long-term care. Nobody aspires to live in a nursing home. In order to qualify for long-term care, most people need multiple health issues, all of which are serious. It is not a place you choose. Rather, admission is based more on life circumstances, often when it is too hard for caregivers to continue.

The pandemic has been a horror. It has also forced many of us to contemplate the impact of social isolation, mostly because we are all affected.

Writing for the Star, I spoke to families who watched through the nursing home window as their father or mother withered, not from COVID but from loneliness.

Research shows us that loneliness is detrimental to our physical health, with links to heart disease, strokes, or dementia. In fact, it

is so harmful to people of all ages that in the UK the government created a Ministry to combat loneliness.

In many ways, the homes and other ways of living well that I write about in my book all focus on eradicating loneliness by emphasizing the value of friendship, conversation, and a bit of fun.

Much like the way we lived before, hopefully. As they said at de Hogeweyk in the Netherlands, it is a normal life.

So moving forward, we need better options for social connections and innovative ways to live in the community, like co-owned housing or NORCs, naturally occurring retirement communities.

I have heard a group of friends who all bought new-build condos on the same floor with plans to share the costs of a personal support worker if that day ever comes.

And while we don't want to live in a nursing home, some of us, even the most powerful will one day need the kind of care it provides, so why not make it a great experience?

It is possible to operate a home that meets the medical needs of vulnerable adults while

also enabling them to flourish and reach their potential no matter what stage in life.

I started exploring these ideas in 2017. As a reporter with the Toronto Star, I spent more than a year visiting a dementia unit in the Region of Peel, in a long-term care home in the Region of Peel, to write about a pilot project called the Butterfly Model. It is now called Meaningful Care Matters. And it used something called emotion-focussed care.

In its original state, the home was actually pretty good by Ministry standards, but again, Ministry inspections are focussed on tasks, cleanliness, and hourly documentation. People were safe, fed, and clean. They were also lonely, sometimes agitated, and very, very bored.

It was a typical long-term care home in Ontario.

For residents, every day was spent sitting in the TV room, usually staring at the floor. Others walked non-stop through the hallways as if they were seeking something, although they never found it.

Usually twice a day there was a scheduled activity. Sometimes somebody came in and

played catch the balloon with residents. If they weren't there to take part in any of those activities, nothing else happened for them during the day.

But as the Butterfly Program unfolded, these scripted activities became a thing of the past. So did the traditional approach to long-term care.

And I have to say that Peel Region did hire a few extra workers. As employees received training from the Administrator to the housekeeper, life began to unfold very differently. Music became a big part of the day with a man I called "the professor". He played the piano. He had fairly serious dementia, but knew all the old war tunes and church hymns, and he must have been a great conversationalist in his day because his way with words remained a significant part of his skill set.

I share this because despite of our fears in society about dementia - and I am not pretending that it is easy on anyone - people with cognitive decline still have much to offer, especially when they are stimulated by their own interests and others throughout the day.

In June 2018, when the Star published the Peel Region story and video, the response from readers of all ages was remarkable. Most were deeply moved by the possibility that long-term care could be different. No one was transfixed on one specific model of care. They were just excited about the possibility for change.

It surprised me how many were seeking new ideas that showed parents, grandparents, or themselves, could actually spend their days doing what they enjoyed which gave a sense of value and purpose.

That response inspired me to seek out other homes that are changing the way we live in our later years, and as it turned out, Jack David, publisher of ECW Press, was interested in the same idea. So in the fall of 2018, I began working on my book.

I realized from interviews with geriatricians, advocates, operators, and families, that some had heard of these programs but didn't seem to know what they looked like in action. And that made it difficult for anyone to call for change.

So I wanted to give firsthand accounts,

based on detailed journalistic reporting, of what life is like in these different homes.

For my book, I looked at individual homes with programs that had an existing track record of success but are also constantly evolving with new ideas, especially in the field of dementia care where so much of the current innovation is underway.

With the exception of the Butterfly Model, which has some qualitative studies and some data collected by individual homes that show improving health outcomes, most of these programs have independent research. Some studies looked at the impact of, for example, a philosophy called The Eden Alternative and its impact on hope. It found that residents -- a statistically significant number of residents had a positive view of their future.

Others, such as the Greenhouse Model, showed health outcomes that lessened the need for higher medical care, and it provided better social connections.

The Carol Woods Retirement Community in North Carolina has relatively new research that also shows its latest work, bringing staff into

huddles and enhancing the voices of all staff, led to happier residents and workers, although the publication has been delayed by COVID.

There are already untold studies about the value of nature in our lives alleviating anxiety and depression. We know that daily exercise, especially in fresh air, can lead to better sleep, which makes us all happier and stronger.

Good sleep can also lessen falls, which lead to a cascading downward spiral for many older people and are expensive to the health care system.

As mentioned earlier, studies on loneliness found it is as detrimental in its own way as smoking, I have heard, 14 cigarettes a day.

So starting in October 2018, I travelled across North America and into the Netherlands to meet with leaders of individual nursing homes, retirement homes, and an enriched day program which offers family respite and can also delay the entry to long-term care.

As a journalist, I used the narrative or story-telling method to describe my research, showing the deep relationships between workers and residents, personal inspiration that keeps leaders

moving forward, or even the way an artist in residence works with those with advancing dementia and how their dementia changes the way they paint.

And what was really interesting about this particular point was that some people who had never picked up a paint brush in their lives turned out to be very talented artists and their work has been shown in a number of different galleries. So you never know.

All of this merged with research that examines the value of social connections over isolation, different models of care, truth-telling to people with dementia or reminiscing about days past.

I was curious, in an industry that doesn't need to try very hard to fill beds, why are some leaders inspired to create change? One recurring theme was the fact that many had a parent with dementia. They understood how painful it was to watch a loved one decline, sinking into boredom in the traditional homes.

These long-term care leaders used their position to make a difference. An Atlanta owner spoke at length about his mother's struggle to find a good home years earlier. After she died, he

aspired to create something better. On the pragmatic side, he said it was good business to give good care, so I hope the private operators read his chapter.

I have heard Ontario long-term care leaders say that people who run homes haven't expressed a widespread interest in change because they are busy trying to meet the current government regulations, or they don't know what is happening out there.

The point of my book, to operators, governments, and families, is this isn't magical thinking. It is already happening, and it can be done.

These ideas have a shared DNA, mostly focussed on kindness, which is unique -- what is unique and very interesting is the way that each home does it differently, and what is telling is the need to stay on it with focus. The leaders I met are constantly working to uphold their philosophies so the home doesn't slip back into old ways.

It takes work. Some, like the Carol Woods Retirement Community in a North Carolina forest, are focussed on the inclusion of people

with dementia into daily life, providing freedom of movement to those who might otherwise be stuck inside for the remainder of their days.

Most of us have now heard of the studies that show the value of remaining connected to nature for our emotional and physical health. A doctor in Vancouver even prescribes a walk in the forest to her patients.

The CEO of Carol Woods, which is built within 120 acres of oak trees, told me the story of a resident, a man who was once in the CIA. He had dementia and, as we know, people with cognitive decline sometimes relive very vivid periods of life, as if those events are happening in realtime.

Every morning he got up early and went for a walk through the forest and, in his mind, the CEO said, he was patrolling a dangerous area. Carol Woods has a big volunteer community among its residents, so several people always walked nearby giving him his space but making sure he didn't get lost.

I was told he marched through that forest for at least an hour every morning, and when finished, he would stop at the CEO's office to report back on his findings, telling her about

snipers and determining that she was now safe to leave the room.

When re-telling this story, the CEO made a powerful point. Can you imagine what he would have been like if he was inside a locked unit? In a traditional home, he would have spent his days sitting in a chair, probably staring at the floor. He would have been bored, frustrated, and quite possibly full of anxiety or anger, just like so many others who can't meet their individual interests during the day.

I think it is fair to say that any of us would feel the same way.

In Saskatoon, the Sherbrooke Community Centre, which uses a philosophy called The Eden Alternative, was among the first to build small households, providing inspiration for the widely known Greenhouse Project.

These homes also focussed on the unique culture of their community, with a home for indigenous people, veterans, or those of Ukrainian descent.

Greenhouse was created by American geriatrician Dr. Bill Thomas, who also started The Eden Alternative. Greenhouse has small homes of

roughly ten people with private rooms and washrooms. Over the years, studies supported by the Robert Wood Johnson Foundation in the U.S. have examined Greenhouse.

One of the studies found some implementation inconsistencies among different Greenhouse locations, but the study also found elders were less likely to be bedridden, need catheters, or suffer from pressure ulcers, and it found more shared time between elders and workers. Other operators are now starting to embrace the small home designs that are meant to offer a sense of calm and familiarity, even if they exist within a larger building.

Sherbrooke Community Centre's CEO Suellen Beatty built these small households in the late 1990s. She now has plans to build a community for seniors and people of all ages on the same nursing home property. Seniors will literally age in place, she said.

Other operators are starting to do something similar; planning for a mix of generations through libraries, cafes, classrooms, restaurants, and housing for people of all ages.

It is a new approach. Many now believe

we should stop separating people with dementia, leaving them unable to interact with others of different abilities or see the natural world unfolding around them.

During my book research, I met with many residents, some of whom have dementia and some do not. Obviously, their lives were different than in their earlier days but many were still engaged in their world. In an Atlanta nursing home, there was a closeness between workers and residents. At lunch, a woman who had been an English professor at a Georgia university, sat with a worker while everyone ate. They laughed and chatted across the table, lowering their heads together while plotting how to tease the in-house chef about his new girlfriend and at the same time get his recipe for chocolate cookies.

And the point of this detail is there was a natural ease, a closeness between these two women. That is the goal of relationship-based care.

I talked to workers who appreciated the ability to have autonomy in decisions around the emotional well-being of the people in their care and felt like they were respected as an important

part of the team.

As the CEO of Carol Woods in North Carolina said, If workers aren't happy, residents won't be happy.

One of the main themes that emerged through most innovation is -- that is currently happening around people with cognitive decline, even though these new ideas would improve the well-being of all.

And ideas do change. Not so long ago it was considered perfectly acceptable to limit the movement of people with dementia to their beds or chairs with what homes called restraints. Some still use these. But there has long been a push to stop the use of restraints on residents just because they have cognitive decline.

That belief is now expanding in a different way. There is growing talk about the rights of people with dementia to be included in the natural flow of their long-term care home. After all, the vast majority of people living in a nursing home have some type of cognitive decline.

In Ontario, most homes keep people with dementia in closed units. Some of them get very good care. Others are kept safe, but also left

bored, and boredom leads to frustration and anxiety and often aggression.

I would be bored too if I had to spend years sitting in a chair doing next to nothing.

Many of the geriatricians and academics I spoke with firmly believe that the so-called behaviours of people with dementia in long-term care are mostly caused by boredom, loneliness, or the fear created by the unfamiliarity of a big institutional setting that places too many people in one living space.

Architecture also plays an important role, and there is a growing awareness that a home's design has an emotional impact. Smaller households, with workers dedicated to that specific group, often offer a more comfortable space with feelings of safety and calm. There is a kitchen in each little household, so meals are cooked throughout the day. Staff and residents can bake bread or cookies if the mood strikes. They sit at a table together and pass around bowls of food family style. Some of this changed during COVID, of course, but the smaller households with the same staff naturally provide better infection control and prevention.

I'm not suggesting that any or all of these models create a late life utopia, because even in the earlier days of independent living, families have squabbles, and in long-term care, there is no guarantee that everyone gets along perfectly with their neighbour.

But it is vastly superior to the traditional system that forces 32 residents to get up and out of bed every morning within an average of six minutes, with wheelchairs lined up outside the dining room, and plates whisked away on schedule.

In Ontario, a few operators are applying for funding to build smaller household models but most are still going with the old 32-bed units, and the government is doing nothing to change that.

Some homes, like Primacare Living, say they can afford to build smaller households in part because of extra government funding, and also by creating a campus of care style that takes money from the privately-operated retirement home and spends some of that on smaller nursing home designs.

All of these new homes that are being

built now will have 30-year licences, so whatever is built will be the nursing homes for the boomers and Gen-X'ers.

These big units are built for efficiencies, not for the people who live there. Not many of us ever spent our adult lives in homes with 30 other people. So why do we think it is a good idea to take people who are at their most vulnerable, fearful of the changes they are experiencing with dementia, and stick them in a unit with a few dozen residents who all share the frustration of a life with little purpose?

How did we ever think that would end well?

When I was in the Netherlands, I visited two homes. The leaders I spoke with kept using the word "normal". Eventually, at de Hogeweyk, I asked, What's up with being normal? A normal life is what we want to provide, I was told.

At de Hogeweyk, which uses an enclosed village design, the manager said a normal life with small households, freedom to step outdoors or sit at a cafe, gives people comfort because it is similar to the way they always lived.

The homes I visited across North

America didn't repeat the word "normal", but it is essentially what they were offering. Nobody wants to live in long-term care, but with effort, those who need it can still live a very good life.

Looking back at the numerous investigations that I and other journalists have written over the years, it took my book research to understand why real change didn't unfold. It couldn't, not the way Ontario envisions and regulates long-term care.

Despite language that talks about long-term care as the home of the residents, most still look and act like institutions. Tougher inspections, for example, can absolutely hold homes accountable for existing regulations, but they won't necessarily lead to a better culture or a more interesting life for residents. That is because the system doesn't require homes to provide opportunities to pursue individual interests by offering spontaneity, freedom, and that sense of purpose.

Inspections can hold homes accountable for the right temperature of food and the documentation of fluid intake, but there is nothing written in legislation or regulations that will ask

inspectors to measure a home on the importance of friendships or the right to go outside for fresh air.

To be fair, the nursing homes and retirement communities that I visited for my book exist because they made individual decisions to improve, not because of any sweeping regulations in their jurisdiction. They had motivated leaders, and without that personal motivation, change is unlikely to succeed.

No one wants relationship-focussed care to become an exercise in branding instead of real transformation. But people keep asking how to scale up these ideas. So one way, in part, through regulations and language written into, for example, national standards, is a way that it could be accomplished.

In the States, some states provide extra funding for homes that use culture change models, and while we absolutely need to hire more staff to provide at least four hours of daily care, the way staff work and interact in a home won't significantly change until they are trained in relationship-based philosophies, and none of that will happen unless operators and administrators are

on-side.

So we are in a time of reckoning. We know what needs to be done to fix long-term care, and so do the decision-makers. If we don't do it now, it is likely that we never will.

Thank you.

COMMISSION CHAIR FRANK MARROCCO: Thank you. One of the things that has bothered me is that long-term care seems to have been neglected, and yet everybody faces the prospect of going there. Almost everybody either has a direct connection because they have someone directly related to them in a long-term care facility or they are on a waiting list or someone is ill and you are not sure they'll be able to look after them.

Did you get any insight into why it is almost orphaned off?

MOIRA WELSH: There are a couple of reasons why.

First of all, I think long-term care started at a time when people were not as compromised medically when they went into the home, and that has obviously evolved over the years as we all live longer. And you have probably heard

people discuss that.

Long-term care has just been set aside. It is like dental care in a sense for people. There is no coverage for it other than limited amounts that we get from the government, and it is no longer -- it is not viewed as part of the medical system. It has been hived off.

Another piece to it is -- quite honestly is ageism in society. We don't want to look at what it is like to get older and vulnerable, and people -- homes are set aside. We don't see them as part of the community, which is one of the reasons why people are calling for greater inclusion, is to not isolate them. Dr. Bill Thomas in the States calls nursing homes the house on the hill where nobody wants to go.

So we have not kept up with the medical needs and the emotional needs of people living in homes. We have neglected that. And we have this natural built-in ageism, so in many ways we don't want to look at people, we don't want to see it, and we want to ignore it.

COMMISSION CHAIR FRANK MARROCCO: It is interesting to contemplate ignoring something that is inevitable. There is absolutely no way of

avoiding it. It is one of the few things I guess in life that really there is no possibility of avoiding it, unless you die prematurely, I guess.

Dr. Kitts?

COMMISSIONER JACK KITTS: Just on your culture change models, we have heard, and we agree, that there needs to be a change in the culture in long-term care homes, but I want to ask you a question because you mentioned -- you were very clear all through that cognitive dysfunction and dementia are dominant in today's long-term care homes.

And long-term care is in the health care service industry, and I think the first principle of understanding success in the service industry is to understand what your customers need or, in this case, what the residents need.

And I think long-term care has suffered from being taken as a whole from someone who is in there just for some help with the activities of daily living all the way down to an extreme complex medical care required.

And so I don't know that there is one size fits all for long-term care, and we have talked about the fact that -- and I think we got

this from interviewing the Butterfly Model leaders, that 85 percent of people in long-term care -- I mean, it varies, but have some level of cognitive dysfunction and 70 percent or thereabouts have either dementia or Alzheimer's.

So the question to you is, if you are going to change the culture, would it be a culture of continuous improvement based on the residents' needs and focussed on the cognitive dysfunction and dementia and create that culture around the best care for them? And I don't know what that would do to the other 15 to 20 percent, but I have got to believe that it would also be helpful.

So it is a long-winded introduction to do you think that the staff -- the leadership and the owners and the staff should start looking at staffing and infrastructure and other ways to meet the needs of that type of elderly population?

MOIRA WELSH: Yes. And so a lot of programs that I look at - there are other programs as well out there or models or philosophies - can do all of that.

So I'll give you an example with The Eden Alternative. It talks about giving people the opportunity to be cared for and care for others.

So there is one example where there was a woman who was very cognitively astute, but she used a wheelchair, and another example of a resident with cognitive decline, but they became friends, and the resident with cognitive decline would push the wheelchair, and they would go for walks and, you know, visit the art gallery or whatever they did during their day. So that is an interaction between two people with very different needs but a relationship still evolves from that.

And what I have seen in others is -- for example, there are people, yes, who do not have cognitive decline or lower levels of cognitive decline right up to people who are in the very advanced stages, and so they are not necessarily speaking. The same model or program can meet those needs just in different ways. That life is slower as time advances. People just spend more time sitting with someone.

There is another example of a man in the Butterfly home that I covered for the Star who did not speak. He sat in his chair. He did not move. He did not speak. And then one day I came in, and they had on -- these white headphones on, and I guess he loved disco music in his day, and

they were playing ABBA, and he was shaking a maraca and dancing and, in his own way, singing. And I just thought, Wow. You know, you would not have thought that that was possible, but it was possible. He later died, and I know the worker stayed with him and just held his hand and sat with him.

So same program, just different ways to apply it.

Does that answer your question?

COMMISSIONER JACK KITTS: Yes, I think that the point is that you have to pick -- a culture can mean, you know, so many things, but I think, you know, like you said, that in Ontario there is a lot of dementia patients in lockdown or locked up. So I think your culture will demand on who your customer is and how you are going to meet their needs.

And culture does involve the infrastructure, the staff mix, the staff skill set, the training, and other things.

But, you know, as Commissioner Marrocco said, we struggle with the notion that these are people, these are residents, coming to a home, and there is so much concern about, you know,

institutionalizing it, but I still think that, you know, if the predominant patient -- or sorry, resident has needs that a geriatric person would -- a skill set that you would need for geriatrics and dementia, and it is 80 percent of the group, at least it is starting with the 80/20 rule.

MOIRA WELSH: Yes, yes. And I think another piece of that also is -- and I am not sure if this was the point you were making, but that the medical piece of it is still there. Obviously they need clinical care, but it doesn't have to be the star of the show, so to speak. It can operate beautifully, but it doesn't have to be sort of overpowering the other part of their lives.

COMMISSIONER JACK KITTS: Right, and I think the star of the show needs to be what the resident needs, and if it becomes more medical, the hospital partnership would become the star for that brief period.

MOIRA WELSH: Exactly.

COMMISSION CHAIR FRANK MARROCCO: Commissioner Coke.

COMMISSIONER ANGELA COKE: Yes, just following up on that, I think it is, you know, not just the quality of the care, but the quality of

life that people can enjoy.

But my question was more around, when you were travelling around to different places, any observations about HR matters in terms of the education, the training, how are people recruiting or developing or rewarding staff differently to drive this kind of change in behaviour?

MOIRA WELSH: That is an important question. The homes that I visited felt fundamentally that staff -- their frontline workers especially, but all staff, are almost on an equal level as the residents in terms of the need for enjoyment in life and work.

And so I would give you an example of Carol Woods in North Carolina. The CEO, as I walked with her through the home and through this community, she knew everybody by name, and that is fine. That doesn't necessarily mean anything. But she was, like, really adamant with people. We were stopping to speak with some new gardeners on staff because gardening is huge there, and she asked this new guy that was recently hired, like, What do you know about elder care and what we are doing here? And what is your understanding of our philosophy? And he didn't know. And she was adamant that he

had to, you know, get training in the work that they are doing.

They also did a recent study called Quest Upstream with an academic from the University of Reno in Nevada, and her name is Jennifer Carson, and she has done some really interesting work around dementia care.

And that got workers even more involved. So they had these daily or even, like, shift huddles to discuss what was needed. And what happens is the frontline workers who know the residents so well are given a greater voice. And I have talked to some people from the Butterfly home in Peel Region, and one of them, he is a team leader and an RPN, and that is what he found as this program is slowly unfolding. Because of COVID, there have been delays, but he found that the frontline workers, PSWs, who often are sort of treated at the bottom of the hierarchy, he said there has been a flattening of the hierarchy and that, because they know the residents so well, their voices are heard and they have these discussions with a lot more give and take.

And one of the PSWs I spoke with said that when she leaves at the end of the day she

feels like she has actually made a difference, and that is what she is seeking, is a job with value. She loves caring for people. She has been in the business for 11 years. But she wanted to feel like she was making a difference, and that means something to her. And that is why a lot of these homes are able to attract people and retain people, because it is a hard job. Nobody is pretending that it is not. But when you actually feel like you are making a difference in the world, and your voice is valued, then you have a lot more loyalty to your employer, and you are better connected with the people that you care for.

COMMISSIONER ANGELA COKE: I just had one follow-up, and it was around the -- you mentioned the issue of inspections, and I am just wondering, in any of your travels, did you see any inspection regimes that were in fact reinforcing of more this type of quality of care rather than the traditional sort of inspection routine?

MOIRA WELSH: What I found was all of these homes operated around the inspection regimes. They had figured out how to do that and -- because I was looking for a way -- like I was looking for an example of jurisdictions that might actually

have some of these examples in there, and even in the Netherlands, it is my understanding that they have some good general principles, but it is still the individual homes that are operating.

So they still have to follow all the rules. For example, de Hogeweyk is a village model that is enclosed, and they would love -- dearly love now, they said, to open it up and make it much more inclusive allowing people to come and go from the community, but they still have to follow the safety rules and not allow people to disappear from the site.

So they still have to follow all the same safety regulations, but they manage in spite of it.

And in another example in Saskatoon, Sherbrooke Community Centre, when Suellen Beatty was creating those small households back in the late 1990s, there were no roles for her around the care of the people in those specific homes. And what I mean by that is the job description for the caregivers because they were now going to be -- you know, they would bathe people, but they would also be cooking the meals, and they would also be the community friends, so to speak. So she had to

write up a completely different job description to make it work with the union, but it worked. She did it.

And so I think a lot of people just move forward.

And one other answer to you is around something called "pay for performance", and that is found in a couple of states. And what they do is they provide extra funding for homes that use culture change. And so those are not regulations, but it is another way of getting at that.

COMMISSIONER ANGELA COKE: Okay. Thank you.

COMMISSION CHAIR FRANK MARROCCO: In terms of the work you did, did you come to a view about public versus private ownership? You know, that has been very much -- very topical here given the relative performance of private, not-for-profit, and charitable homes.

Did you form any observations about that?

MOIRA WELSH: I didn't form specific observations about that. I can tell you that I met with people. For example, in San Diego at the day program, the man who is the CEO of that program was

in the private long-term care system for decades, and we had a really interesting conversation about that, and he had just grown fed up with that industry. He said, you know, how many -- like how many profits do you need? Like he just kept seeing care cut and cut and cut, is what he said to me. So I would believe that there would be a lot of people who would agree with him.

On the other hand, when I went to Atlanta, this was not necessarily a traditional long-term care home the way we know it. It was a beautiful retirement community with an additional home that provided nursing care on the same site. So that home, that operator worked very hard at -- if I want to break it down, at customer service, so to speak, for the very able people who were living in the retirement home but also in the long-term care home. They did some really interesting work there, and he said that he feels that the good care that is provided in the nursing home helps his business because people see a continuum of care that is worthy, and so they are willing to move there because they feel like they'll be well cared for in their later days, if they need it.

So that was an interesting approach.

And I am not saying that all private homes feel that way or private operators feel that way, but he certainly felt that it was good for his business.

COMMISSION CHAIR FRANK MARROCCO: Okay. Well, thank you for that.

I don't know if -- are there any other questions?

Well, thanks for a very interesting -- it is helpful to get views that are based on observation coming from someone who doesn't really have a stake in the outcome or skin in the game I guess is the slang expression.

But it is very interesting to be able to ask you some of the questions we have been asking ourselves and get your answers.

So, Ms. Welsh, thank you very much for coming.

MOIRA WELSH: Thank you very much.

-- Adjourned at 1:40 p.m.

REPORTER'S CERTIFICATE

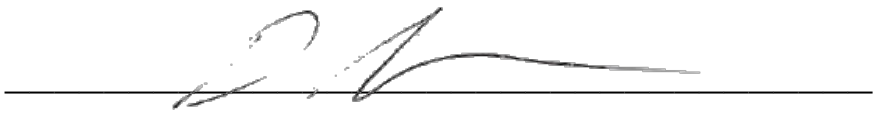
I, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, certify:

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 25th day of February, 2021.



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PER: DEANA SANTEDICOLA, RPR, CRR, CSR

C L A R I F I C A T I O N S

Page 32, lines 4-5: "University of Nevada, Reno" not "University of Reno in Nevada"

WORD INDEX