

# Long Term Care Covid-19 Commission Mtg.

Ageing Well Group  
on Tuesday, November 17, 2020



77 King Street West, Suite 2020  
Toronto, Ontario M5K 1A1

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom, with all participants attending  
remotely, on the 17th day of November, 2020,  
1:00 p.m. to 2:06 p.m.

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BEFORE:

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

1 PRESENTERS:

2

3 Don Drummond, Stauffer-Dunning Fellow and Adjunct  
4 Professor at the School of Policy Studies at  
5 Queen's University

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7 Dr. Duncan Sinclair, Co-Author of the "Ageing Well"  
8 Report

9

10 John Muscadere, Associate Professor, Department of  
11 Critical Care Medicine, Faculty of Health Sciences,  
12 and Scientific Director, Canadian Frailty Network;

13

14 Cathy Szabo, President and C.E.O., Providence Care  
15 Hospital

16

17 Catherine Donnelly, Associate Professor, School of  
18 Rehabilitation Therapy, Faculty of Health Sciences

19

20 Dr. John Puxty, Associate Professor and Chair of  
21 the Division of Geriatric Medicine in the  
22 Department of Medicine at Queen's University

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1 PARTICIPANTS:

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3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

5 Ida Bianchi, Counsel, Long-Term Care Commission

6 Secretariat

7 Dawn PalinRokosh, Director, Operations, Long-Term

8 Care Commission Secretariat

9 Sanjay Bahal, Team Lead for Operations, LTCC

10 Derek Lett, Policy Director, Long-Term Care

11 Commission Secretariat

12 Kate McGrann, Gowling LLP

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14 ALSO PRESENT:

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16 Janet Belma, Stenographer/Transcriptionist

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I N D E X

\*\*The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and no other purpose\*\*

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following pages: 36

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following pages:  
None

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following pages: None

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

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, good afternoon. Are you -- Mr. Drummond, are  
4 you waiting for anyone? I don't know who's leading  
5 the -- but are you waiting for anybody?

6 CATHY SZABO: Duncan?

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Oh, you're on mute, Mr. Drummond.

9 COMMISSIONER ANGELA COKE: You're  
10 muted.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 You're on -- or --

13 DON DRUMMOND: I don't see Duncan  
14 Sinclair's face on a box on my screen.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 Well, we're a bit early. We'll just wait for a  
17 bit. I'll go on mute, though, because the dog  
18 barking is driving me nuts.

19 COMMISSIONER ANGELA COKE: And, hello,  
20 everybody. I'm Angela Coke.

21 DON DRUMMOND: Hi. As I was to lead  
22 off on our part, I can start at any time you want.  
23 I'm aware we only got the one hour.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 All right. Well, I guess you've now met

1 Commissioner Coke, Angela Coke, and then  
2 Jack Kitts, you all -- you know, at least one of  
3 you does.

4 DON DRUMMOND: Yes.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 And I'm Frank Marrocco. So we -- we're the -- we  
7 are the three commissioners. If you've been  
8 following along, we are in the process, really, of  
9 informing ourselves about the next phase of our  
10 report. We released an interim report or a series  
11 of recommendations. We did that primarily because  
12 we felt some pressure to do it because of Wave 2  
13 rather than follow the more traditional route of  
14 reporting two years from now. So we reversed  
15 things a bit.

16 We do have a -- someone from Neesons  
17 who's going to create a transcript which we will  
18 put on our website, and we do that so that people  
19 who are interested in what we're doing can follow  
20 along with the nature of our investigation and our  
21 interviews and that sort of thing.

22 The only other thing, I guess, is we  
23 tend to ask questions as we go along, if that's  
24 okay, so we might interrupt with questions rather  
25 than wait to the end. So if that causes any

1 difficulty, let me know.

2 DON DRUMMOND: That will be taken as  
3 a -- that will be taken as an honour of a sign of  
4 interest, so...

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 Okay. All right. Well, having said that, I think  
7 we're ready when you are.

8 DON DRUMMOND: Well, fair enough. So  
9 your commission and our opportunity to speak to is  
10 a dream come true because when we thought of  
11 starting this project, we anticipated, and  
12 correctly, it turned out, that there would be  
13 commissions probably across the country.

14 And we had a fear that, given what was  
15 going on at the moment, and particular COVID  
16 hitting the long-term care facilities so hard, that  
17 that would be the focus. And in a sense, to bring  
18 it into your context, we are fearful that the end  
19 result of the commissions might be something like  
20 your interim report.

21 Obviously, that's not your intention,  
22 so that's clear. We were very concerned that any  
23 type of review of not just long-term care but more  
24 generally the well-being of seniors be put in the  
25 broader context of the tsunami that's coming of our

1 way of seniors, and, yes, we will need to increase  
2 the infrastructure and the protocols to deal with  
3 the current problems we've got, but we better put  
4 that in the context of a much bigger problem  
5 that's because it's been coming for a long time,  
6 but inevitably, there's some reason nobody's  
7 particularly planning for it.

8           So that was our context. So I'm quite  
9 often described as being a bean counter having  
10 worked at Federal Budget for 23 years, but for the  
11 moment, I'm now a bed counter. So my task in this  
12 project is to figure out, well, how many beds do we  
13 need? And I was quite intrigued by Ontario's plan  
14 to add 15,000, intrigued at first and then  
15 frustrated because I could never find any rationale  
16 for it, and I've come to the conclusion, after  
17 cranking the numbers myself, it doesn't really  
18 matter. It amounts to nothing but rounding error,  
19 and we've probably lost more than we've added under  
20 the plan, so I've kind of got over that now.

21           But we looked at some existing studies,  
22 the Conference Board, the Financial Accountability  
23 Office, B.C. Care Providers and Their Methodology,  
24 and we adopted their methodology even if it applied  
25 to a province for the national level, and we

1 concluded between now and 2041, we needed 250 to  
2 300,000 beds.

3 A key aspect of the demographics is not  
4 the normal thing that people say. Everybody seems  
5 to know we're going to go from one-sixth of the  
6 population to one-quarter being 65 plus. Some know  
7 that we're going to add 4.2 million seniors between  
8 now and 2041, so we've got 21 years to absorb 4.2  
9 million, whereas we had 38 years in the past to  
10 absorb 4.2., but that's not actually the issue.

11 The issue is the skewing of the elderly  
12 population to the higher age group, and that's just  
13 a simple math, and I say, I'm your perfect example.  
14 And, in fact, you could describe, if you want --  
15 I'll lend you my name for the purpose -- whatever  
16 you come up with as a Drummond plan because I'm  
17 your prime baby boomer born in 1953, so I turn 85  
18 in 2038. And that's a large percentage of people  
19 at 85 at the moment are in long-term care. Not  
20 that many go in 65 to 75. It kicks up 75 to 85, so  
21 that it's not just that we're going 65 to 75, but  
22 we're going into those upper years of the seniors.

23 Implicit in the methodology that others  
24 use and hence we did is that the same percentage at  
25 every age goes into long-term care as at present.

1 So we'll look at all the 75-year-olds, and whatever  
2 percentage are now in long-term care, we assume  
3 that continues the same thing for 85 years old.  
4 Implicit in that in a very rough and ready way is  
5 the degree of dementia, frailty, other challenges  
6 as remaining unchanged, not directly but, sort of,  
7 indirectly as a product of doing that.

8 I will defer in all of these aspects  
9 that John Muscadere knows infinitely more than I do  
10 about it. I did a quick research check, and it  
11 seemed a reasonably valid assumption that it didn't  
12 look like those propensities had changed, but one  
13 thing that scared me was when I looked at some of  
14 the conditions, like, particular, the increase in  
15 inactivity of near seniors and particularly women,  
16 I thought to myself and, again, I'm the layperson  
17 in this, that can't be good for the future of  
18 somebody living independently. It doesn't seem to  
19 have shown up yet, but that's kind of thing, if  
20 that's a real threat, that would just increase the  
21 numbers.

22 So we took these methodologies in  
23 applying the Canadian level. We got something like  
24 250 to 300,000 beds would be needed across Canada.  
25 So if we take the Ontario population and the

1 population of seniors, and the whole population's  
2 fairly similar to the 38.3%, that suggests  
3 somewhere between 96,000 and 115,000 beds, right?  
4 And so again, that's, like, forget about the  
5 15,000. That's not even table stakes to start with  
6 this.

7 We then went back and looked more  
8 closely at the Financial Accountability Office  
9 because we anticipated there might be a particular  
10 interest on this Ontario perspective. And they  
11 said that we needed to go from 79,000 beds in 2018  
12 up to 149 by 2033, so if we just extend that  
13 149,000, that gets you up to 186 by 2041, so we're  
14 getting apples to apples.

15 But an interesting feature of the  
16 Financial Accountability Office and implicit in the  
17 others is it leaves the wait list unchanged, so  
18 there's roughly 38,000 people now on the wait list.  
19 There is at the end of the Financial Accountability  
20 Office, and so if you went up to 186,000 beds, you  
21 would still have a very big wait list.

22 If one were to build enough bed  
23 capacity to not only encompass that demographics  
24 but not so to take the zero to the wait list, you'd  
25 actually need 223,000 beds which is triple the

1 number of beds we have right now.

2 That's just, kind of, confirmed our  
3 feeling is we cannot possibly accept the status  
4 quo. The overriding reason has, of course, nothing  
5 to do with these numbers. The overriding reason is  
6 not many people stand up and put up their hand and  
7 say I want to go to long-term care; get me there as  
8 quickly as they can. Most people want to age in  
9 place, their own home, the community setting. So  
10 you should deliver sometimes what people want, but  
11 it's just the logistics, the infrastructure  
12 requirement and the expense of that.

13 So in Canada, we spend 1.3% of our  
14 Gross Domestic Product in long-term care. Our  
15 guess is if they implement the sort of things that  
16 you're talking about, the increase in the number of  
17 workers, better qualified workers, better trained  
18 workers, better compensated workers, and increased  
19 safety protocols, the 1.3, it will go up to about  
20 2.1% of GDP.

21 That would put us just slightly above  
22 what the average of all OECD countries spend. So  
23 it may look like a huge increase in our spending,  
24 but it basically just gets us in the ball game that  
25 virtually everybody else is already playing into.

1 But then if you feed in the demographics, that  
2 suggests that 2.1% of GDP will go up to 4.2% of  
3 GDP.

4 So under the status quo, and, again,  
5 this is just continue to do what we are doing right  
6 now and been doing for a long time, get the people  
7 to a certain age; put them in a long-term care. If  
8 we continue to do that, we'll go from 1.3 to 4.2%,  
9 and, again, we're thinking that just doesn't sound  
10 like a reasonable proposition. We better do  
11 something that blows up the current convention, the  
12 status quo.

13 So as Duncan and I have partnered on  
14 many things, and I don't know why we always do it,  
15 but I always seem to the get the problems; I define  
16 the problem, and then he gets to decide what we do  
17 about it.

18 So I've laid out a pretty stark  
19 problem, I think. It's an horrendous one, and now  
20 I'm going to turn it to Duncan who pays for the  
21 mess I just created.

22 DUNCAN SINCLAIR: Well, thank you, Don.  
23 As Don said, he's the archetypical baby boomer who  
24 will in future require long-term care. I'm more or  
25 less the archetypical already-there guy born in

1 1933, so I can tell you a number of things.

2 First of all, the issue of who pays was  
3 not something that we addressed in our report, as  
4 you have seen. We concentrated on what we found  
5 and believe are the necessary -- is the necessary  
6 balance among the several needs that older people  
7 need to age well better than they do now.

8 Who will pay for it? Basically, the  
9 same people will pay for it in future as do now,  
10 the taxpayers. The problem with the taxpayer, of  
11 course, is that if we borrow to meet today's needs,  
12 the future taxpayers, who are now young people,  
13 will pay for it. If we do it out of tax revenues,  
14 then the old and the young will both pay for it.

15 So we anticipate that the tax base will  
16 bear part of the cost. The users will bear part of  
17 the cost, and charitable institutions, through  
18 their donors, will pay part of the costs as they do  
19 now. But make no mistake; the people who pay now  
20 will continue to do so one way or another.

21 That being said, we do appreciate,  
22 Mr. Commissioner, the significance and the  
23 difficulty that you as a commission will have in  
24 communicating the results of your discussion.  
25 Governments will have very much on their minds who

1 does the paying this -- this, and notwithstanding  
2 that their cost is high taxes, the public perceives  
3 that Medicare's publicly insured hospital and  
4 physician services are free. The service needed --  
5 the services needed to age well, like  
6 pharmaceuticals, like dentist, dental services, and  
7 the services needed to ensure that elderly people  
8 age well, are excluded from our current publicly  
9 insured system.

10           Why so? This could well be to avoid  
11 there, too, being considered free and thus subject  
12 to the insatiable good demand for a free good.

13           What should be in and what should be  
14 out of Medicare's basket and how its contents  
15 should be funded are too long deferred discussions  
16 for governments themselves -- may I say so,  
17 independent of your commission. It's not within  
18 your remits.

19           My own view is that all health services  
20 including those of ageing well should be entirely  
21 free to those whose poverty now excludes their  
22 access to them, and there are presently of those  
23 people, while the rest of us should share in the  
24 cost of their provisions in relation to our ability  
25 to do so.

1           In the report, we did point out that  
2 the warehousing of Canadian seniors in care homes  
3 is both more expensive, and as far as the evidence  
4 indicates, it's less effective than the approaches  
5 of other countries. Don has told you already that  
6 it will be more expensive as the population ages.

7           We also point out that the cost  
8 efficiency of delivering the requisite surgeons --  
9 services for aging well through home and community  
10 care is much less overall, and that's important as  
11 we head into a less-than-robust economy in which  
12 everybody, the public and the private sector alike,  
13 will be challenged to pay their bills of all kinds,  
14 healthcare bills as well as others.

15           As for who provides the services, which  
16 clearly you will be interested in, the public, the  
17 private, or the charitable sector, our belief is  
18 that the current admixture provides a reasonable --  
19 reasonably healthy degree of competition necessary  
20 to drive efficiencies, provided, and the proviso is  
21 that governments exercise rigorously their power to  
22 regulate and hold accountable all providers for the  
23 health outcomes they achieve.

24           We assume, as is -- as with all manner  
25 of public services, regulation to ensure their

1 safety and good quality will remain the  
2 responsibilities of governments; and that  
3 regulatory power, in our view, keeps the public  
4 service hand firmly on the tiller regardless of who  
5 owns, manages, and provides the services required  
6 to age well.

7           And speaking of ageing well, I'm going  
8 to turn over now to John Muscadere who leads as the  
9 scientific officer of the Frailty Network in Canada  
10 on whose Board I had the privilege of serving a  
11 while ago.

12           So, John, over to you.

13           JOHN MUSCADERE: So thank you. Thank  
14 you, Duncan, and a pleasure to present here today.  
15 I'm just going to take a few minutes.

16           First of all, just to address, we talk  
17 about frailty as one of the determinants of  
18 long-term care, so just a quick definition: So  
19 frailty is a state of increased vulnerability and  
20 loss of function and is associated with mortality,  
21 hospitalization, changes in status with minor  
22 stressors, and the requirement for long-term care.  
23 The vast majority of people in long-term care are  
24 frail.

25           And if you look at the Canadian

1 population, about 20% of people above the age of 65  
2 are frail. It rises to over the -- over 50% over  
3 the age of 85, but if you're on optimist, 50% of  
4 the people above the age of 85 are not frail.

5 And that one leads to the next  
6 important point is that frailty is not an  
7 inevitable part of ageing. It's dynamic. It can  
8 be mitigated. It can be prevented to a large  
9 extent. And we don't emphasize that mitigation,  
10 that prevention to any -- to any degree.

11 So from what Don was saying, assuming  
12 that the percentage would remain the same, I think  
13 I would argue that with a proper public health  
14 approach to ageing, we can actually change those  
15 percentages and move them back, align so that  
16 people do not require nursing home care at the same  
17 stage of life.

18 And the things that will mitigate or  
19 prevent frailty will also have been shown to  
20 mitigate or prevent dementia, the prevention of  
21 cognitive decline as in the National Dementia  
22 Strategy.

23 So -- and just to also, to go back a  
24 bit, frailty is readily measurable. There's  
25 multiple scales, but we don't actually routinely

1 measure it in the population. We don't routinely  
2 look for it, and we don't routinely put in place  
3 multidisciplinary things that can actually mitigate  
4 the declines that people would require long-term  
5 care.

6           And the measures that we're talking  
7 about from a public health approach are things like  
8 promotion of exercise, the same as what Don said,  
9 maintenance of activity, looking at -- make sure  
10 that you're on the appropriate medications, not too  
11 many, not too few; that you receive -- that you  
12 have access to appropriate diet and nutrition  
13 including vitamin supplementation, things like  
14 vitamin D, falls prevention, and importantly,  
15 social isolation is a really key component.

16           So in saying that -- all that, we know  
17 that if we adopted a public health approach, we can  
18 actually flatten the curve and make populations  
19 much more resilient than they are now. The  
20 vulnerability has been highlighted by the COVID  
21 epidemic.

22           And some -- and when we visited  
23 Denmark, some of the things that we actually --  
24 that they have put in place to actually do this is  
25 that -- is that the care for ageing seniors is much

1 more tied to the community and to the municipal  
2 level. And everybody is entitled to two visits per  
3 year once they've reached the -- they're over the  
4 age of 75 to see what the vulnerabilities are, what  
5 can actually be addressed to keep them at home.

6 There's also much more focus on  
7 reablement which is teaching people the skills to  
8 stay at home or addressing the things that wouldn't  
9 probably -- may mitigate them -- may mitigate their  
10 progression of frailty or ageing -- ageing well.

11 And also, they've integrated long-term  
12 care much better within the community with  
13 different levels of long-term care, so highest  
14 level, but also these mixed models of care where  
15 they have apartments with shared living spaces  
16 where they can tailor community and have a much  
17 more integrated approach to ageing well in the  
18 community. And I think that's what we need to do  
19 if we want to avoid the numbers that Don mentioned.

20 So maybe I'll just stop there. I'm not  
21 sure who else is going to -- who was going to come  
22 after me.

23 DUNCAN SINCLAIR: The next on our list  
24 is John Puxty. So, John.

25 JOHN PUXTY: Okay. I hope everyone can

1 hear me. I'm a practicing geriatrician. I've been  
2 practicing for over 30 years in Canada, primarily  
3 at Providence Care in Kingston, and I served under  
4 Duncan when he was the then Dean of health  
5 sciences. So I've been involved in designing  
6 models of care but more particularly, models of  
7 care around people with dementia because I run a  
8 memory disorder clinic at Providence Care, and I'm  
9 involved in designing a model around an integrated  
10 model of care involving geriatrics, drugs,  
11 psychiatry, and neurology that we're launching  
12 shortly.

13 So dementia is common in long-term  
14 care; 70 to 80% of individuals in long-term care  
15 have dementia, but that doesn't mean everyone with  
16 dementia goes into long-term care. At any one  
17 time, two-thirds, some 62% of individuals who were  
18 diagnosed with dementia are living in the  
19 community, many of them living well, some not so  
20 well. And it's helpful to understand some of the  
21 reasons why those individuals go into long-term  
22 care.

23 One of the commonest risk factors is  
24 actually being hospitalized, not being hospitalized  
25 because of dementia, but during the

1 hospitalization, the diagnosis of dementia being  
2 made. Those individuals are five to sixfold  
3 increased risk of being referred and put on a  
4 waiting list for long-term care.

5           And it may be because family caregivers  
6 were aware of some memory problems but not the  
7 diagnosis of dementia. It may be the person had an  
8 acute confusion or delirium with behavioural  
9 problems because of surgery, because of pneumonia,  
10 but it's created a social crisis. The family have  
11 a new issue. They haven't got the coping  
12 mechanisms. They haven't got the services, and  
13 quite often, they're encouraged to make a referral  
14 to long-term care just in case because of a long  
15 waiting list. And unfortunately, that becomes a  
16 prediction of almost certainty once the referral is  
17 made at that stage.

18           Individuals with greater degrees of  
19 cognitive problem, moderate or severe dementia not  
20 surprisingly have a three-fold increase risk.  
21 Individuals who have dementia who are having  
22 problems with activities of daily living, feeding,  
23 walking, dressing themselves, that's a marked  
24 increase of risk. Living alone, naturally, one can  
25 understand with cognitive problems even in a mild

1 degree, it may be difficult in the absence of  
2 community programs to support you. This has been  
3 particularly an issue during our pandemic where  
4 there's been a gap, a huge gap in community  
5 programming.

6           And some communities, if you live in  
7 the North, if you live in a rural community, those  
8 access to services are very limited. At the  
9 moment, there's a dramatic shortage of personal  
10 support workers which is a barrier to discharging  
11 people from hospital.

12           Sometimes it's the caregiver who  
13 becomes ill and is admitted to hospital who was  
14 looking after someone with dementia. Now, there's  
15 a community crisis, and suddenly, there's a  
16 requirement for long-term care which wasn't present  
17 when there was a caregiver at home who was well.

18           And if the individual has behaviour  
19 problems, particularly wandering, that's often  
20 poorly tolerated by families and others, so that  
21 will increase the risk.

22           So -- but the issue is, are these  
23 really inevitable risks, or are they mitigatable?  
24 Well, they are. So we know from existing best  
25 practices that early detection, so programs like

1 primary care memory disorder clinics; specialized  
2 clinics like I offer with others for more complex  
3 cases; help with early identification,  
4 identification of strategies to mitigate,  
5 particularly lifestyle modification; there's  
6 tremendous evidence to suggest that 40% of people  
7 with dementia, we can positively influence the  
8 outcome through relatively simple changes in  
9 lifestyle.

10 Education and training of frontline  
11 people -- that's family and frontline staff --  
12 there's a huge gap. Although in Ontario, there's  
13 been some investments in the last couple of years  
14 in this. It still doesn't meet the needs.

15 Use of technology: Tremendous advances  
16 in technology that can help mitigate some risk  
17 factors, for example, improve in-security, GPS  
18 devices that enable us to locate someone if they  
19 should wander; memory aids that can advise  
20 individual about taking medications regularly.  
21 There's a whole range of technologies that we're  
22 currently only just beginning to consider using in  
23 these situations.

24 And that leads on to the idea of what  
25 we call a dementia-friendly community and

1 dementia-friendly hospitals. So there's been work  
2 done by the Alzheimer's Society in Ontario around a  
3 program called the Blue Umbrella Program where they  
4 work with businesses and provide education and  
5 training on how to help people with cognitive  
6 impairment, so they destigmatize the cognitive  
7 problem and increase the ability of those  
8 individuals to engage in their community and remain  
9 in their community.

10 Our environments are not safe. So we  
11 know falls are a common problem for all older  
12 adults, particularly those with comorbidities, but  
13 dementia or cognitive impairment is probably one of  
14 the biggest risk factors for falls. So those  
15 things like snow not being cleared, ice not being  
16 cleared, lack of ramps, they all add to risk  
17 factors for people with dementia to be -- end up  
18 being admitted to hospital with a fall and a  
19 fracture which almost always results in decline in  
20 function and many, many ending up in long-term  
21 care.

22 Support programs: So community support  
23 programs that go out and help the individual with  
24 dressing, provide respite to the caregivers.  
25 There's a lot of evidence to show that caregivers

1 would support people for a lot longer if they had  
2 more ready access to respite, respite in the home,  
3 and also to community programs which also provide  
4 stimulation to the individual with dementia.

5           Recognizing that there are older adults  
6 with dementia who live alone: Look at some  
7 innovative models for group homes. In Australia,  
8 they have some really innovative ideas where  
9 individuals, six to ten individuals with dementia  
10 would live in a -- in a home-like situation with a  
11 live-in support person and would avoid admission to  
12 long-term care or hospital.

13           And the importance of case management:  
14 Across Ontario, most Alzheimer's Societies have a  
15 first-link program but not all. And that program's  
16 been crucial for connecting people to services once  
17 diagnosis is made by the family physician.

18           And investments in health teams like  
19 behaviour supports Ontario teams, these are teams  
20 usually through geriatric psychiatry that provide  
21 support through nursing, OT, psychology, to help  
22 with understanding behaviours, atypical behaviours,  
23 or responsive behaviours, and help families support  
24 that person in the community for much, much longer.

25           So it's not inevitable that people with

1 dementia should go into long-term care. I would be  
2 bold enough to suggest that we could probably delay  
3 20 to 30% of those individuals going into long-term  
4 care or even prevent it, if necessary. We could  
5 improve their quality of life, and it would be  
6 really cost-effective to invest in some of these  
7 strategies. I'll hand the podium back.

8 DUNCAN SINCLAIR: Well, thanks, John.  
9 That's great. Our next member --

10 COMMISSIONER KITTS: Can I just ask a  
11 question before we go on to the next one? I'm  
12 sorry.

13 DUNCAN SINCLAIR: Sure.

14 COMMISSIONER KITTS: I guess it's for  
15 Dr. Puxty. A decade ago, there was a concern  
16 around -- I think CIHI put out a report that 20 to  
17 30% of residents in long-term care homes didn't  
18 need to be in long-term care homes.

19 JOHN PUXTY: M-hm.

20 COMMISSIONER KITTS: Recently, we've  
21 heard that in Ontario, that's about 8%, and likely  
22 due to the Ageing-At-Home and Home First Strategies  
23 that the governments have been, I think, doing for  
24 the past decade.

25 So when you say another 20 to 30%,

1 could be -- could stay at home with the right  
2 investments and resources, how does that -- how  
3 does that work?

4           JOHN PUXTY: How does that work? Well,  
5 what I'm aware of as an individual who runs memory  
6 disorder clinics, I'm seeing individuals at this  
7 point in time who are being put on long-term care  
8 wait lists or prematurely admitted, in my opinion,  
9 because all their caregivers have become stressed  
10 in the last three to six months through COVID  
11 pandemic because of a lack of respite, because  
12 there's a lack of PSWs who support them in the  
13 community, because they have not been able to see a  
14 family physician because at the moment, they're  
15 doing virtual visits, not real visits.

16           So I've seen -- I follow a number of my  
17 patients for periods of time. I've seen dramatic  
18 changes in the last few months just because of a  
19 reduction in the normal level of service.

20           So if you, then, were to imagine  
21 actually we were to enhance the level of services  
22 to the real need, that's where I'm coming from  
23 saying, in my opinion, as a geriatrician, who is  
24 aware of the literature, I would suggest at least  
25 20 to 30% of people who have been admitted or are

1 being admitted at this point in time, it could be  
2 mitigated by alternative investments. And there  
3 have been studies that have shown in a number of  
4 jurisdiction that multicomponent community  
5 investments, things like first-link programs, PSWs  
6 in the home, respite, do prevent long-term care.

7 I really doubt the 8% could be  
8 prevented. I would with respect, Sir, suggest that  
9 figure is too low.

10 COMMISSIONER KITTS: And so you're  
11 suggesting that more targeted investment in  
12 different areas is required, not more money of  
13 the -- more of the same?

14 JOHN PUXTY: Exactly.

15 COMMISSIONER KITTS: And that would  
16 bend the curve that Mr. Drummond is concerned  
17 about?

18 JOHN PUXTY: It would certainly assist  
19 with it, but I think we need to move the  
20 interventions. Currently, we're downwind. We're  
21 reacting. We need to go upwind. And that's where,  
22 I think, we can still make significant gains that  
23 we haven't realized.

24 COMMISSIONER KITTS: Okay. Thank you.

25 DON DRUMMOND: And Drummond here. I

1 think we have to be a little bit careful in  
2 comparing with what Dr. Puxty is referring to and  
3 the CIHI Report because the CIHI Report basically  
4 asks the question more or less within the existing  
5 parameters of the alternative long-term care, what  
6 percentage could be at home, but they weren't  
7 envisioning a -- well, what we're calling for the  
8 report is a fairly radical change in the supports  
9 at home or in other locations. I think that offers  
10 the opportunity to blow that CIHI number up.

11 It's not just saying you've got a  
12 choice of long-term care or go back and living in  
13 your house that -- exactly the way you were before  
14 with a minimal amount of care. We're saying, well,  
15 their meals could be provided, a personal  
16 careworker could be visiting, that sort of thing,  
17 and then I think the number's quite elastic, can go  
18 up quite a bit higher.

19 COMMISSIONER KITTS: Right. But I  
20 think today without those targeted investments, it  
21 is what it is.

22 JOHN PUXTY: Right. Can I make just  
23 one more comment? The other issue is that  
24 individuals with dementia are vulnerable as  
25 John Muscadere was saying in terms of frailty, but

1 frailty is reversible and preventable. Individuals  
2 with dementia, when they're admitted to hospital,  
3 often go through a period of delirium. In the  
4 absence of treatment of that delirium that  
5 declining cognition, that decline in function can  
6 become ongoing. So it may be thought to be  
7 inevitable that person goes into long-term care if  
8 all you're doing is responded to the symptoms and  
9 not the disease.

10 If you avoid the delirium, if you  
11 shorten the period of delirium, and if you  
12 rehabilitate the person, then that individual may  
13 again return to the community. In the absence of  
14 that, they're in inevitable long-term care.

15 COMMISSIONER KITTS: Thank you.

16 DUNCAN SINCLAIR: Thank you, John,  
17 Jack.

18 Our next speaker is Cathy Szabo who has  
19 the responsibility at the head of an institution  
20 that deals both with community and institutional  
21 care.

22 So, Cathy, you're up.

23 CATHY SZABO: Thanks, Duncan, and  
24 thanks everyone. Jack would know and some other  
25 people on this call that I spent the better part of

1 my career in community-based healthcare service  
2 delivery either as a service provider or managing  
3 home and community care with various CCACs around  
4 the GTA. So I'm going to underscore what both John  
5 and both -- the both Johns said about recreation  
6 activation, socialization, and care.

7 I think we do a good job of medically  
8 diagnosing and treating people. We do that very  
9 well, but hospitals are illness-based care, and the  
10 medical model doesn't help people with activities  
11 of daily living.

12 My goal has been acute care hospital  
13 avoidance because as John said, as Longwoods have  
14 said, as CIHI has said, you're six times more  
15 likely to be destined for a long-term care home if  
16 the assessment is done in a hospital.

17 So the idea is to treat people where  
18 they are, care for people where they are, and avoid  
19 acute care hospitals at all costs because that's  
20 where delirium really ramps up.

21 Restorative care, decline is not  
22 inevitable. Medication management, we have to get  
23 serious about deprescribing and taking a look at  
24 what medications people should be on.

25 In my past, I've worked with

1 Paul Williams from U of T and looked at  
2 David Challis's model from the U.K. called the  
3 Balance of Care. And if you take a look at some of  
4 the financials in that, if someone's in long-term  
5 care, it costs about \$30,000 a year in 2009  
6 numbers.

7 If we activate supportive housing with  
8 some community support, that number turns into  
9 about \$21,000 a year, and if we keep people at home  
10 in the community using adult-day programs,  
11 transportation, activation, socialization, retool  
12 adult-day programs to include personal support  
13 nursing, PT, OT, whatever healthcare needs they  
14 have, that turns into about \$14,000 a year. So who  
15 pays or where we're investing, what we're investing  
16 in is really important.

17 As I said, you're six times more likely  
18 to be destined for a long-term care home if that  
19 assessment is done in the hospital. I want to  
20 underscore the same tool is used whether you're in  
21 a hospital or if you're in the community, but  
22 you're just six times more likely to be destined to  
23 long-term care if it's done there. The factors  
24 that influence entry to residential care, not only  
25 is it about the hospital assessment; if somebody

1 requires physical assistance, and that would be  
2 physical assistance versus being pretty much  
3 independent. If there's a moderate cognitive  
4 impairment versus someone being completely intact,  
5 if someone lives alone, if a caregiver is unable to  
6 continue, or if the person is wandering. But those  
7 are minimal in comparison to that hospital  
8 assessment.

9           Balance of Care works. When I was at  
10 the central CCAC, we delayed admission to long-term  
11 care by two-and-a-half years for individuals; 6% of  
12 the people that we cared for through these programs  
13 took their name off of a long-term care wait list.

14           We had more people dying at home and  
15 ending up being cared for in their home to the end.  
16 The adult-day program with nursing, physio, rehab  
17 that provided socialization, activation, and  
18 recreation worked.

19           Reducing people's medication, reduced  
20 falls, reduced trips to Emerg, increased their pain  
21 control; and guess what? The patients just told us  
22 they felt better. The families were relieved when  
23 a pharmacist and a coordinator or a care  
24 coordinator, case manager, navigator, call them  
25 whatever you want, but when the families knew that

1 someone was coming to see them and that someone was  
2 taking an interest in the medications they were  
3 taking, things just got better.

4 With Home First, hospitals were -- in  
5 our area, we work really closely with discharge  
6 planning and the -- and the medical staff at the  
7 hospital to have hospital staff stop saying to  
8 patients or their families, I'm not sure you can go  
9 home. Instead, we changed the narrative to say,  
10 the acute phase of your illness is over; we're now  
11 going to bring in the community person and the  
12 discharge planner to help you get care where you  
13 need it next.

14 And the goal was to get them home, and  
15 it was to get them home for that two-and-a-half  
16 years, and we had a LHIN that supported that with  
17 funding. So when we stop saying long-term care is  
18 a destination, when we stopped saying that you need  
19 to go to the hospital, and when we stopped saying  
20 long-term care was an end destination and looked at  
21 long-term care in a different way, we had greater  
22 success with the people we cared for.

23 So Providence has just been funded by  
24 the Ministry to develop a transitional care centre,  
25 so I'd really appreciate in about a year-and-a-half

1 if I could talk to you again because the whole goal  
2 is restorative care and acute care hospital  
3 avoidance. Long-term care should not be an end  
4 destination, and if we take the money that we're  
5 currently spending in long-term care and spend it  
6 on community-based healthcare delivery programs and  
7 services that meet the needs, we can reduce  
8 frailty; we can reduce dementia, and we can have  
9 people age in place.

10 U/T CATHY SZABO: I will send a note  
11 through Duncan about the documents that I'm  
12 quoting, but I just want to say that even  
13 Accreditation Canada recognized a Balance of Care  
14 as a best-option program for people and a best  
15 practice in our survey system. I'll stop there

16 DUNCAN SINCLAIR: Thanks, Cathy.  
17 Our final member of the team, actually,  
18 is -- I don't know which of you, Cathy or Catherine  
19 are singing alto and which one is doing soprano,  
20 but, Catherine, you're up next.

21 CATHERINE DONNELLY: Wonderful.

22 CATHY SZABO: The good thing is we work  
23 together too.

24 CATHERINE DONNELLY: Yes, we're  
25 closely --

1 DUNCAN SINCLAIR: Right.

2 CATHERINE DONNELLY: My focus now is  
3 going to be looking at alternative housing, and,  
4 really, everyone segued nicely to, sort of, end in  
5 this conversation.

6 So my name's Catherine Donnelly. I'm  
7 an occupational therapist by training and a faculty  
8 member of the School of Rehab. And I bring a  
9 primary care community care perspective to this  
10 conversation. So everyone's been alluding to, sort  
11 of, what else and this notion of, you know, how can  
12 care be provided in the community.

13 And so I'm just going to shift the  
14 conversation a little bit more upstream, and, you  
15 know, when we think about alternative housing  
16 models, you know, there's a number of common  
17 features about alternative housing models.  
18 Essentially, they're all community based and so  
19 reorienting the focus away from institutions with a  
20 focus on maintaining independence and autonomy and  
21 this idea of actively engaging older adults in  
22 decisions and in community advocacy efforts to  
23 identify their own needs and bring services to  
24 themselves.

25 Sort of underpinning all of this,

1     though, is a sense of developing social networks,  
2     older adults developing social networks that they  
3     can ultimately help support themselves.

4             And so I'm just going to just turn my  
5     lens to current community supports. So this focus  
6     on community supports is crucial, and so if we  
7     think about home and community care right now, and  
8     this is stats right from Home Care Ontario, 80% of  
9     families are asked to provide care in addition to  
10    current home and community care services. So  
11    thinking about alternative models where older  
12    adults can support each other in addition to some  
13    publicly funded services is crucial; 150,000  
14    Ontarians pay for 20 million additional visits, so  
15    that is quite remarkable.

16            And so again, needing new housing  
17    models that can also supplement home and community  
18    care supports is crucial. And just to build on  
19    Cathy's point, 60% of home care referrals actually  
20    come from communities and reiterating this reactive  
21    lens versus thinking about upstream  
22    community-oriented thinking and why not community  
23    supports coming from communities first to prevent  
24    those hospitalizations. So again, changing our  
25    orientation to building communities and networks

1 and neighbourhoods, thinking upstream.

2           So I'm just going to talk about three  
3 models of housing that are seen internationally and  
4 one most that I'm involved in locally. So there's  
5 something called the Village Model. And these -- a  
6 Village Model is from the U.S., so they're not  
7 currently found in Canada, but I think it's worthy  
8 to note.

9           So what it is is older adults that are  
10 living in single-dwelling homes, and they come  
11 together around in a town, or it could be a  
12 neighbourhood or a city themselves coming together  
13 and identifying themselves as being part of this  
14 village. And so it's a member-driven,  
15 not-for-profit organization that's operated by the  
16 older adults themselves who identify what services  
17 they need. And it's a whole cadre of volunteers,  
18 both member volunteers as well as community  
19 volunteers that help orient services to themselves  
20 and what they need, so anything from home --  
21 personal supports, PSWs, handyman, driving,  
22 shopping, and as well as social activities.

23           So how these are funded is interesting,  
24 is that it's actually members pay a fee, so they  
25 join these villages. They pay a fee, but they're

1 also some sort of -- there's fundraisers, and there  
2 can be some philanthropic or government support as  
3 well. So those are villages, and they're expanding  
4 in the U.S. There's approximately 250 of them and  
5 growing, and there's a whole network.

6 Another model is something call  
7 Cohousing, and you might be familiar with this.  
8 This very much comes from the Scandinavian  
9 countries, and like John, I was able to visit a  
10 number of different Cohousing models in Denmark,  
11 the Netherlands, and Sweden. And again, what it is  
12 is older adults. This is interesting because it's  
13 also -- they intentionally come together. And  
14 rather than live in their own homes, they live in  
15 more high-density arrangements. So it's typically  
16 townhomes or apartments, so everyone has their own  
17 apartment. They're completely independent, and  
18 they share common spaces, so, for instance, common  
19 kitchens, a common lounge or living room, and come  
20 together and support each other, sort of, in  
21 naturally supportive ways through their networks  
22 that they develop.

23 It's not just for older adults,  
24 Cohousing, but there's specific Cohousing units for  
25 older adults, and again, there's some very

1 interesting examples and some examples of where  
2 Cohousing units have worked with regional  
3 governments to actually integrate services within  
4 their buildings as well.

5 And the one I'm going to end on is  
6 something that's quite interesting, and it's  
7 thinking about naturally occurring retirement  
8 communities.

9 And so in contrast to Cohousing and  
10 villages that are intentional, naturally occurring  
11 retirement communities are just that. They're  
12 naturally occurring, and so they're unplanned  
13 communities that have higher proportion of older  
14 adults, and so, for example, in older -- a  
15 neighbourhood might have aged together as a  
16 community and suddenly found themselves as a NORC  
17 is what they're called. Or it might be an  
18 apartment building that's beside, say, a mall or  
19 some other amenities that older adults naturally,  
20 sort of, move to. And so again, it might just be  
21 simply a NORC and these are just high-proportion  
22 neighbourhoods.

23 And it's interesting. I've done some  
24 work with some colleagues, and we identified in  
25 Ontario using census data that there's 20% of small

1 geographic geographies in Ontario are actually  
2 NORCs, and so they're easily leveraged and built on  
3 to think upstream.

4           And so, there can be just NORCs, but  
5 then there's something called NORCs with -- that  
6 integrates supports and services called NORCS with  
7 Supported Service Programs, and we've seen a lot of  
8 this development particularly in the northern part  
9 of the U.S.

10           I've been working closely with  
11 something called Oasis here in Kingston, and it's a  
12 NORC with a social supports service program. And  
13 essentially, older adults in one Kingston building  
14 came together, and they lobbied our regional  
15 government, and they actually received funds,  
16 yearly funds, to support an onsite coordinator, and  
17 they run three pillars of activities in their  
18 building.

19           And what's important to note with these  
20 social supportive programs with NORCs is they're a  
21 partnership with private organizations, so they're  
22 in apartment buildings; and apartment buildings  
23 actually donate space, and they can help run the  
24 program.

25           So many of the programs and services

1 are just leveraged, already prepaid funded  
2 programs, so -- that actually the older adults  
3 themselves identify and are actually brought into  
4 the NORC service themselves. And I won't -- I  
5 could talk for a long time about this, but I'll  
6 just end on our stats to show how promising these  
7 really could be.

8           And so we were able to compare older  
9 adults living in the NORC in Kingston to a match  
10 building that didn't have a NORC. And  
11 interestingly enough -- and it was actually  
12 opposite of what we might have thought, but there  
13 was a 50% reduction in home care use, which is  
14 remarkable and really speaks to how older adults  
15 become supports for themselves.

16           And there was a median delay in  
17 long-term care for one year compared to the older  
18 adults living in another -- a non-Oasis building.

19           So again, it wasn't that it prevented  
20 long-term care, but most importantly, it delayed  
21 the onset of long-term care, so there's lots of  
22 ways that we can consider supporting older adults.

23           So, you know, thinking upstream,  
24 thinking differently, it's an investment, and it  
25 takes a little bit of time to evaluate, and we

1 don't have rigorous -- we haven't rigorously  
2 evaluated upstream alternative housing, but it's  
3 time to do so. And I'll leave it at that.

4 DUNCAN SINCLAIR: Thank you, Catherine.  
5 Well, Commissioners, you've been very  
6 quiet apart from Jack asked one question, but we're  
7 now available to you entirely.

8 COMMISSIONER KITTS: Can I -- can I try  
9 and summarize, I think, what I've just heard? So  
10 Mr. Drummond said we'd need about 300,000, plus or  
11 minus, beds by 2041, which is literally 20 years  
12 away if we don't change what the status quo is now.

13 And we would be spending instead of  
14 1.3% of the GDP on long-term care, it would be  
15 2.1%, would just bring us to the average of the  
16 OECD countries, so we have -- we have room there.

17 So then Dr. Muscadere and Dr. Puxty,  
18 I'm going to paraphrase, but basically said that if  
19 we have better prevention of chronic disease,  
20 better -- earlier diagnosis of disease, and much  
21 better treatment to prevent exacerbations and  
22 progression of the disease, we can -- we can bend  
23 the admissions to long-term care significantly,  
24 maybe, I think you said, about 20%.

25 And Cathy said that if we keep people

1 out of the hospitals, they're six times more likely  
2 to be admitted to a long-term care.

3 And then the last was the naturally  
4 occurring retirement communities which -- also.

5 So do we know how much investment and  
6 how long it would take to see the fruits of those  
7 activities? Because 20 years is not -- is not very  
8 far away.

9 CATHY SZABO: Can I -- I'll start by  
10 saying that every one of the people that we cared  
11 for was eligible for a long-term care home, and  
12 when we implemented Balance of Care, and it was  
13 done in Central CCAC and many other ones across  
14 Ontario; and that's where the research was from  
15 through this Balance of Care model, those programs  
16 didn't take long to get up and running because it  
17 was redesigning what already was there.

18 But the effects that it had over the  
19 four years that I was there were extremely  
20 positive, but with change in leadership, change in  
21 government, change in a lot of things, they've  
22 dwindled away to nothing, and the new -- I would  
23 say the new flavour of the day is hospital hubs  
24 with hospitals at -- in-the-home program, so in my  
25 neck of the woods, it's called KHSC-at-home where

1 they've hired a provider to do that.

2 They're pretty much -- some of the  
3 money is already there and can be used better in  
4 the short run.

5 There is a labour shortage, though,  
6 right now, and we have to keep our eye on health  
7 human resources and start looking for people that  
8 want to do this kind of work and provide a stable  
9 workforce to support this because at the time we  
10 implemented it, there were more providers than  
11 there was work to do. And now we're in the  
12 opposite part of the cycle. There's more work and  
13 not enough providers.

14 COMMISSIONER KITTS: But I think it's  
15 also got to be different to work. I think early on  
16 in the Ageing-At-Home and Home-First strategy, that  
17 probably explained a lot of the decrease in the  
18 number of residents that were deemed not to  
19 necessarily have to be there based on their acuity.

20 But I think what the doctor, the  
21 Doctors John are talking about is something  
22 different now because more of what we did over the  
23 last ten years, I don't think, is going to make as  
24 big a difference, and it has to be something  
25 different.

1                   CATHY SZABO: Well, I also think it was  
2 a little bit sporadic, what we were doing. I don't  
3 know that it was consistent or a consistent  
4 approach, and we haven't consistently approached  
5 this population from a staying-healthy, aging-well,  
6 looking-after-yourself. As Catherine said,  
7 we've -- we have medicalized somewhat, and there  
8 needs to be medical support. Don't get me wrong.

9                   But having patients or people and their  
10 families as partners and saying, our goal is to  
11 keep you healthy; what is it you need? We might  
12 come up with some alternative ways than long-term  
13 care at the end.

14                   COMMISSIONER KITTS: Thank you.

15                   DUNCAN SINCLAIR: One of the examples  
16 that we brought draw -- drew on, and Catherine and  
17 John can speak to it, Denmark is a good example of  
18 having been consistent over many years, that they  
19 are allowing people, helping people in every way  
20 possible to stay in the community. And the  
21 evidence is very plain there.

22                   Now, Canada and Denmark are different,  
23 but they are also similar in many ways.

24                   CATHERINE DONNELLY: I'm just going  
25 to -- I'm just going to --

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 It's --

3 CATHERINE DONNELLY: Sorry. I was just  
4 going to respond by saying, and I think John had  
5 mentioned that as well, this, you know, focusing on  
6 upstream prevention services, so it's not just home  
7 and community, sort of, after the fact when you  
8 need it. They actually do preventative visits, and  
9 this whole notion of reablement is even separate  
10 than prevention, so it's even up -- upstream than  
11 preventative visits.

12 So I think that it's hard to measure  
13 what doesn't happen, and, you know, that is  
14 upstream medicine, but that is what we need to  
15 think about. And so start to investing in  
16 alternatives rather than reacting, and, you know, I  
17 think that's crucial and really having a robust  
18 evaluation so we can actually measure it rather  
19 than having multiple pilots that we really don't --  
20 ended up having good data from to have a bigger  
21 conversation.

22 JOHN MUSCADERE: Maybe just to add to  
23 that, I think that -- so the long-term approach, I  
24 think, is the most important. A committed  
25 public-health approach for enabling healthy aging

1 which includes medical components but also  
2 addresses some of the social determinants plus  
3 sustained long-term approach is key.

4           Some of them will have immediate  
5 benefits, some intermediate benefits, and some  
6 long-term -- and some long-term benefits, but we  
7 can't just go from a program that ends in a few  
8 years, and we need the long-term approach, and I  
9 think that's probably the key; and that's what  
10 Denmark is able to do for whatever reason.

11           COMMISSIONER FRANK MARROCCO (CHAIR):  
12 Commissioner Coke. Just a sec. Commissioner  
13 Coke's trying to get a question in here.

14           COMMISSIONER ANGELA COKE: And I'm  
15 sorry if it's something that you've covered. I've  
16 been having trouble with my connection throughout  
17 our chat.

18           But I was just -- we'd heard this week  
19 from the Ontario Health Teams, and I'm interested  
20 in your thoughts about, as they mature, the role  
21 that they can play in advancing or sustaining the  
22 agenda that you've put forward today.

23           DUNCAN SINCLAIR: Well, if I may speak  
24 to that, I think that they have great potential in  
25 this because they will, of necessity, understand

1 their communities -- or the communities they serve  
2 better than anybody else. And, in fact, I can't  
3 see the upstream focus that we're recommending  
4 being done any other way. Frankly, it won't happen  
5 out of the Hepburn Block. It's got to happen  
6 over -- from the ground up, more or less, community  
7 by community.

8           And in Denmark, their -- the success,  
9 as I understand it -- now, I have not been there  
10 personally, but John could speak to that and so  
11 could Catherine -- part of that success is that  
12 it's primarily municipally based, that the cities  
13 themselves have a big stake not only in managing  
14 the resource but also paying for it.

15           You know, I'm in no way suggesting that  
16 yet more gets loaded on the municipal tax base here  
17 in Ontario or in Canada generally, but through  
18 Ontario Health Teams, we're doing -- we could do --  
19 we could provide that local knowledge so that the  
20 system that applies to a particular area needs to  
21 be focused on that particular area. What works in  
22 downtown Toronto will not work here in Northern  
23 Ontario or Northeastern Ontario.

24           Oh, sorry, Cathy.

25           CATHY SZABO: And I would say that

1 local geography or the OHT knows what resources are  
2 there and knows the ones that they don't have and  
3 should shift their focus to developing what they  
4 don't have to keep people healthy, so that has to  
5 happen locally as Duncan and everyone has said.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 But the impression I had -- correct me if I'm  
8 wrong, though, was that these Ontario Health Teams  
9 are in their infancy.

10 CATHY SZABO: Yes.

11 DUNCAN SINCLAIR: That's true. Yes.

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 And we only have 20 years.

14 DUNCAN SINCLAIR: Yeah. Commissioner  
15 Coke said when they mature; they're just being  
16 born, so, yeah, we -- it's not going to happen  
17 fast. Well, one would like to think it could  
18 happen a lot faster than it is.

19 DON DRUMMOND: One aspect of the  
20 Ontario Health Teams I always look for when I see  
21 them applying is how broad their inclusiveness is,  
22 and what I particularly look at, do they include  
23 things like physiotherapy and do they include  
24 caregivers -- care coordinators, I mean. Somebody  
25 would say that this person doesn't need to go to

1 long-term care; there's an alternative, and the  
2 ones I'm seeing have that.

3 So that's adding a dimension, I think,  
4 that we don't have. So I think that's a -- there's  
5 some promise.

6 Back to Dr. Kitts question on how soon  
7 you might see some results, one of the things that  
8 gives me encouragement in that is the average  
9 duration in long-term care is about two-and-a-half  
10 years, so John Muscadere and Dr. Puxty say you  
11 could actually permanently push it off for  
12 somebody, but suppose you push it off six months.  
13 That's 20% of the demand right there, and I -- and  
14 I think in many cases, well, that should be able to  
15 happen.

16 COMMISSIONER KITTS: Thank you.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 And how is that -- there was this movement towards  
19 people being -- ageing at home and being cared for  
20 at home, and this -- as I have been listening to  
21 this, is something that began years ago in the --  
22 maybe ten years ago, and it's resulted in a change  
23 in the -- in the average age of the person going  
24 into a long-term care home.

25 Is what you're suggesting really just

1 an extension of that, to pursue that further, or is  
2 it different?

3 DUNCAN SINCLAIR: Well, if I may speak  
4 to that, it is -- I don't know anywhere in Canada  
5 where we really put our back into helping people  
6 stay at home.

7 But for those examples that do apply in  
8 other countries, yes, the deferral of the need, of  
9 the total need, prevention of the total need to go  
10 into a home care and even the deferral of when it's  
11 necessary has been proven -- again, I'm thinking of  
12 Denmark as the cardinal example, but there are  
13 others -- of the success of that environment.

14 And what we were proposing out of our  
15 study is, yes, we should, as John Puxty said, put  
16 more of our energies, resources upstream, and the  
17 consequence will be better and cheaper care down  
18 stream.

19 DON DRUMMOND: There's this question of  
20 what we're saying is a continuation or a marginal  
21 change. I would say it's much more radical in  
22 that -- oh, the smoke alarm keeps going off in this  
23 house. We spend six -- I'll have to come back.

24 COMMISSIONER FRANK MARROCCO (CHAIR):  
25 I don't feel so bad about the dog barking.

1                   COMMISSIONER KITTS: Yeah. I hope he's  
2 checking for fire.

3                   CATHERINE DONNELLY: Well, I'm just  
4 going to pick up also the OHTs. You know, I think,  
5 and as people have mentioned, it's this  
6 reorientation to geography and, you know, we -- you  
7 know, through the OHT, really identifying pockets  
8 of high need, whether that's by age or by social  
9 determinant or an overlay of both.

10                   And so, you know, I think, for the  
11 first time, this notion of looking at social  
12 determinants and the other influences are [sic]  
13 health are coming out strongly in the OHCs, and,  
14 you know, we've been talking about it for so long,  
15 and it will be nice to see if that actually comes  
16 to fruition.

17                   And I think the other thing about the  
18 OHTs, it's shifting away from, sort of,  
19 institutional focus not only to primary care as  
20 being a leader, but these community support  
21 programs which, really, are, sort of, on the  
22 peripheral of care, but that's where many, many  
23 people are receiving their supports, and we have a  
24 hard time tracking that level of care, so thinking  
25 about the Alzheimer's Society is just one of many

1 other community support services.

2 DON DRUMMOND: Maybe I could try again,  
3 get a respite from the alarm here. I was just  
4 saying that we spend \$6 on long-term care for every  
5 dollar we spend on home care in Canada. The  
6 Northern European economy is pretty much dollar for  
7 dollar, and Denmark spends more on home care than  
8 they do on long-term care, so I think, given, going  
9 back to my roots as a bean counter, that suggests  
10 to me that this is radical. It's not a marginal  
11 change, and the scope for doing it along the lines  
12 of what other countries do is -- is great, and it's  
13 still cheaper. I mean, you could do an awful lot  
14 of home care for 50 to \$100 a day which is a lot  
15 cheaper than the long-term care.

16 DUNCAN SINCLAIR: Yeah.

17 JOHN MUSCADERE: To add to that, I  
18 think it is -- it is a radical change in that when  
19 we talk about keeping people at home, we're, a lot  
20 of times, thinking about reacting to problems that  
21 have already developed; whereas we want to be much  
22 more upstream and actually prevent them from  
23 needing that type of -- that type of care.

24 And at the -- at the end of the day,  
25 it's going to improve quality of life and actually

1 enable people ageing and maybe cost the same, but  
2 people's quality of life is going to be much  
3 better.

4 And I think that, ultimately, that will  
5 be -- the ageing baby boomers will really think  
6 that that's a very key component of ageing.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 But it does seem that there's no reason to believe  
9 that they will build the 200,000 beds or 250,000  
10 beds that they need, so it's almost inevitable that  
11 you need some other solution because look what's  
12 happened.

13 And why would -- why would it change?  
14 Why would the outcome be -- what's the reason for  
15 thinking the outcome would be any different 20  
16 years from now than the one we're in except it  
17 would be even worse because if Mr. Drummond's  
18 numbers are right instead of what -- you're at  
19 250,000 beds across the country, so 100,000 beds in  
20 Ontario.

21 DUNCAN SINCLAIR: Sure.

22 DON DRUMMOND: Right.

23 DUNCAN SINCLAIR: And that's compounded  
24 by the future -- the future nature of our economy,  
25 which as Don can deal with better -- much better

1 than I. We're not going into an abundant time.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 No.

4 DON DRUMMOND: I absolutely agree with  
5 you. I think there's no way that that number of  
6 beds will get built, and I actually hope that they  
7 don't. But my great fear is we will not build and  
8 plan for the alternatives, the better alternatives;  
9 and we'll just end up with even worse care of the  
10 elderly. That's my -- that's my great fear.

11 And then keep in mind, I'm looking to  
12 2038 when I'm 85, and I'm not -- I'm not sure  
13 there's going to be a model there that's going to  
14 be satisfactory.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 M-hm.

17 DUNCAN SINCLAIR: Don, I'll write  
18 careful notes and leave them for you.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 Well, I think we've exhausted our questions. I  
21 think maybe we were silent more or less because we  
22 were listening. This was something quite different  
23 than we've heard all along, and I think probably we  
24 were trying to absorb it.

25 And I just want to thank you for the

1 presentation, and with your permission, we may be  
2 back asking for further assistance.

3 DUNCAN SINCLAIR: Thank you for the  
4 opportunity.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 All right. Well, in that case, good afternoon.

7 COMMISSIONER JACK KITTS: Thank you.

8 CATHY SZABO: Thank you so much.

9 COMMISSIONER ANGELA COKE: Thank you.

10 CATHY SZABO: Bye, everyone.

11 COMMISSIONER JACK KITTS: Take care,  
12 Cathy.

13 -- Adjourned at 2:06 p.m.

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1 REPORTER'S CERTIFICATE

2  
3 I, JANET BELMA, CSR, Certified  
4 Shorthand Reporter, certify:

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

9  
10 That all remarks made at the time  
11 were recorded stenographically by me and were  
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14 That the foregoing is a true and  
15 correct transcript of my shorthand notes so taken.

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