

Long Term Care Covid-19 Commission Mtg.

Meeting with Seniors for Social Action Ontario /Dr.
Patricia Spindel
on Monday, December 14, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants
attending remotely, on the 14th day of November,
2020, 11:00 a.m. to 12:11 p.m.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

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7 PRESENTERS:

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9 Dr. Patricia Spindel, Co-Founder, Seniors for
10 Social Action Ontario

11 Kay Wigle, Communications, Seniors for Social
12 Action Ontario

13 Douglas Cartan, Regional Coordinator, Seniors for
14 Social Action Ontario

15

16 PARTICIPANTS:

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18 Alison Drummond, Assistant Deputy Minister,
19 Long-Term Care Commission Secretariat

20 Ida Bianchi, Counsel, Long-Term Care Commission
21 Secretariat

22 Kate McGrann, Counsel, Long-Term Care Commission
23 Secretariat

24 John Callaghan, Counsel, Long-Term Care Commission
25 Secretariat

1 Lynn Mahoney, Counsel, Long-Term Care Commission
2 Secretariat

3 Derek Lett, Policy Director, Long-Term Care
4 Commission Secretariat

5 Dawn Palin Rokosh, Director, Operations, Long-Term
6 Care Commission Secretariat

7 Jessica Franklin, Policy Lead of the Long-Term Care
8 Commission

9 Adriana Diaz Choconta, Senior Policy Analyst,
10 Long-Term Care Commission Secretariat

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13 ALSO PRESENT:

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15 Olivia Arnaud, Stenographer/Transcriptionist

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1 -- Upon commencing at 11:00 a.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 If you don't mind, we'll ask questions as we go
5 along.

6 DR. PATRICIA SPINDEL: Absolutely.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 And we do post a transcript. Olivia, whom you've
9 met, will post that -- we'll post that within a
10 couple of days --

11 DR. PATRICIA SPINDEL: Okay.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 -- just to help people who are following along
14 understand what we're up to on a day-by-day basis.

15 As you know, we've released a couple of
16 interim reports and --

17 DR. PATRICIA SPINDEL: Mm-hm.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 -- we're not adverse to doing that again, although,
20 at present, we haven't decided one way or the
21 other.

22 So with that, we've probably all had a
23 chance to look at the presentation, the one that
24 was dedicated to Orchard Villa. So we've probably
25 all seen it and looked at it, but just tell us

1 whatever, you know, so we have a sense of where you
2 might be coming from, but just happy to proceed as
3 you see fit, and we're ready when you are.

4 DR. PATRICIA SPINDEL: Okay. That's
5 great. Then I'll begin. Do you have the
6 backgrounders that we sent?

7 COMMISSIONER FRANK MARROCCO (CHAIR): I
8 think so, yes.

9 DR. PATRICIA SPINDEL: Do you have
10 those in front of you? Okay. Because they will --

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Well, I don't know if they're in front of us, but
13 we do have them.

14 DR. PATRICIA SPINDEL: You have them,
15 okay. Because --

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Olivia, can you show them, show one of them? Or
18 which one, Doctor, do you want to start with?

19 DR. PATRICIA SPINDEL: Well, the
20 backgrounder is to our presentation, actually.
21 We've put together a document, and we put together
22 a PowerPoint presentation.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Yeah, yeah.

25 DR. PATRICIA SPINDEL: So we'll be

1 speaking to the PowerPoint.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Okay.

4 DR. PATRICIA SPINDEL: But the
5 backrounder I will sometimes refer to because it
6 provides more information than the PowerPoint.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Sure.

9 DR. PATRICIA SPINDEL: So the point I
10 was just going to make was that our personal
11 backgrounds -- and I'm joined by Kay Wigle and
12 Doug Cartan. Our personal backgrounds are outlined
13 in the backrounder on the first page, okay?

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Yes.

16 DR. PATRICIA SPINDEL: So if you need
17 to have a look at that...

18 And just very briefly, we're with
19 Seniors for Social Action Ontario. And so we have
20 members all across the entire province who have
21 significant, in other words, like, four decades of
22 experience in legislation, policy, and program
23 development, systemic advocacy on behalf of people
24 with disabilities and older adults, and some of us
25 were there for the first round of reforms of the

1 Nursing Homes Act.

2 And so I played a part as former
3 president of Concerned Friends in getting the
4 Bill of Rights into the act, getting the
5 Family Councils and Residents' Councils set up, all
6 of that sort of thing. So we were there for the
7 first round of reforms and have been dealing with
8 this sector off and on for about 40 years now, so
9 we have a historical perspective that you may not
10 have heard before.

11 So with that, Doug, I'm going to ask
12 you to please leap right in because we don't have a
13 lot of time and lots to cover.

14 DOUGLAS CARTAN: We have the PowerPoint
15 presentation. It was expected to be up on the
16 screen. Somebody was controlling that, were they?

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Yeah, I think so. Just, Olivia, can you put it on
19 the screen?

20 THE REPORTER: Yeah, I just need a
21 minute. It's not usually my job to do that, but...

22 Is there nobody on the Commission,
23 sorry, that's controlling that? Because I need to
24 write, and I can't be flipping through PowerPoints.

25 LYNN MAHONEY: Sorry, it's Lynn Mahoney

1 speaking, Commissioners. We spoke about this the
2 other day. Doug or Kay or Trish, are you able to
3 operate the PowerPoint?

4 DR. PATRICIA SPINDEL: Okay. I had
5 actually sent the PowerPoint last night, and so --

6 LYNN MAHONEY: Yes. Yeah, we have it.
7 Yeah, we have it.

8 DR. PATRICIA SPINDEL: Oh, okay.

9 LYNN MAHONEY: But that's a different
10 matter than it being displayed today. So if you're
11 not able to display it, then I'll see if I can,
12 Olivia.

13 THE REPORTER: Okay. Thanks, Lynn.

14 LYNN MAHONEY: Can you help me with
15 that?

16 THE REPORTER: So if you just open up
17 the PowerPoint somewhere on your computer and then
18 do "share screen"...

19 LYNN MAHONEY: Okay. I apologize,
20 Commissioners. It'll just take me a minute.

21 DOUGLAS CARTAN: I think the reason
22 that we did put the PowerPoint together, it is
23 really helpful to visualize and see what we want to
24 talk about here because what we're trying to do
25 initially, anyway, is not get too far down into the

1 weeds because we think we're talking about a
2 transformation of the system and that these are
3 interrelated parts which cannot really be talked
4 about separately.

5 I think anybody that's involved in
6 system reform or transformation understands that
7 one of the things that is problematic is when we
8 look at parts separately from the whole and think
9 we can improve parts and that will improve the
10 whole. And I think systems theorists will tell us
11 that actually is not true.

12 And so what we're trying to do today is
13 start off by talking about the underlying
14 principles, the underlying foundation of long-term
15 care. And so when I say long-term care, we are not
16 speaking just about nursing homes. We are speaking
17 about --

18 LYNN MAHONEY: Doug, sorry to interrupt
19 you. I'm just about to see if this works, and you
20 sent us several documents that I'm -- I don't know
21 if this is working or not.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Not yet. Not yet, Lynn.

24 LYNN MAHONEY: Sorry.

25 DEREK LETT: Hi, Lynn. This is Derek.

1 We can do it here in -- oh, there we go.

2 DR. PATRICIA SPINDEL: Oh, wonderful.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay.

5 DR. PATRICIA SPINDEL: There it is.

6 LYNN MAHONEY: All right.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Thanks, Derek. All right.

9 LYNN MAHONEY: Sorry for the delay.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 That's fine. We've got a little bit of extra time
12 on the end if we need it.

13 So, Mr. Cartan, you were saying? It's
14 an integrated problem...?

15 DOUGLAS CARTAN: It's an integrated
16 problem is right.

17 So if I can just go to Slide No. 3, if
18 you're able to do that, controller?

19 DR. PATRICIA SPINDEL: Perfect.

20 DOUGLAS CARTAN: Yeah. Just go to
21 slide show, start from No. 3?

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 We're on No. 3. We can see it.

24 DR. PATRICIA SPINDEL: Yeah, yeah.

25 Hopefully that...

1 DOUGLAS CARTAN: Okay. So essentially,
2 what we're talking about here is some root causes.
3 That's the beginning of our presentation is to
4 understand the root causes because a system doesn't
5 change unless the principles are understood, unless
6 the principles are modern, unless we have a good
7 foundation for what we're going to change, what we
8 want to change, and there has to be change to this
9 system. I think you and I would agree on that.

10 So when we look at the long-term care
11 system in Ontario, what we see is the
12 medicalization of age and disability. We see a
13 deficit approach being taken. In other words, it's
14 about a diagnosis. It's about classification.
15 It's about placement. It's about seeing what's
16 wrong with people.

17 And this leads to an abundance of
18 institutional placements, which basically leads to
19 disabling help that we've found in the literature
20 and in our personal experience.

21 We think if you look around the world
22 and you see 21st-Century long-term care systems,
23 you'll see that it moved from the medicalization of
24 age and disability, and think more about social and
25 structural issues as the foundation piece for this.

1 Medicalization of disability, I'll
2 speak to that. Like, age and disability are seen
3 together because anybody who has a disability is
4 going to age, and anybody who ages is going to have
5 disabling conditions that places them in long-term
6 care, quite frankly.

7 And so there's a real risk when we
8 medicalize people's age and disability, and we see
9 them only as individual issues, individual
10 treatment, patient care, and what we do is just --
11 we simply ignore the social and political
12 dimensions that affect people's experience.

13 I'll just give you one -- well, I
14 should say that physically disabled people in our
15 country have really thrown off the yoke of
16 medicalization of their situation when they
17 redefined the whole "problem" of disability, this
18 not being simply about functional limitation and
19 diminishing capacity but about the fit between
20 their functional abilities and the environment in
21 which they live.

22 The classic example for this is my
23 grandmother, who, because she needed a wheelchair,
24 because she had MS and she needed the wheelchair,
25 she needed an accessible house, an accessible

1 community, and because that wasn't possible, she
2 lived 20 years on her back in a long-term care
3 home.

4 We need to look differently than just
5 how we have been looking and see things in a
6 structural and a social context.

7 The same thing about our deficit
8 approach: We need a foundation that's based on our
9 strengths, based on a due understanding of who
10 people are, not just what's wrong with them, their
11 medical condition, their diagnosis.

12 We need to see people in terms of who
13 they are, what's their story, their strengths,
14 wishes, hopes, frustrations, boredoms. We need to
15 have a new understanding of their capacity, of
16 their assets as well as the assets of community and
17 how community can assist with what we're trying to
18 do.

19 And finally, we need a system that's
20 built on a policy priority of home- and
21 community-based support.

22 Successful countries like Denmark, who
23 have made the changes so significantly different
24 than Ontario with much less suffering and much less
25 death, base their system 30 years ago on these

1 three principles.

2 So what we're talking about this
3 morning in terms of this is to say that we think
4 the current principles underpinning the existing
5 system are incorrect, and there needs to be, in
6 order for transformation to be successful, a new
7 and different way to underpin the changes that we
8 want to see happen.

9 DR. PATRICIA SPINDEL: That's great,
10 Doug. Thank you.

11 Kay, can you discuss the lack of
12 alternatives?

13 KAY WIGLE: Yes. If you could go to
14 PowerPoint No. 4?

15 So Doug clearly outlined very nicely
16 about how we have totally relied on
17 institutionalization as a community instead of any
18 other community alternatives, and we -- because
19 when we look at medical issues, we immediately
20 reinforce the need for institutionalization.

21 I have had the privilege of being
22 involved in community development, as have Doug and
23 Trish, and I want to give an example of what Doug
24 just finished saying about looking at community.

25 25 years ago, there was a number of

1 people with disabilities, Down Syndrome in
2 particular, who had an early-onset Alzheimer's,
3 which is not an unusual situation. So they were
4 folks that were living in the community at that
5 point in a community group home. And the agency at
6 that point just looked at what are options for
7 people with early-onset Alzheimer's who could then
8 be supported, and the only option at that time was
9 long-term care.

10 And they had made a decision that that
11 was not a good option for the people, so 25 years
12 ago, they developed a group home that specifically
13 looked at aging and people with disabilities. And
14 for 25 years, this place has been very successful.

15 They didn't say they would never return
16 to long-term care as an option, but as of 25 years,
17 they've never had to use it. They've used
18 community nursing when needed, but they were also
19 able to do a lot of care that typically a long-term
20 care may or may not be able to do, such as
21 suctioning, all the medication training, working
22 with occupational therapists and physiotherapists.

23 So in the home, they were able to be
24 able to meet all the alternative needs of the
25 people who were aging. And as I said, they've been

1 in existence for 25 years. There have been people
2 who have died as a result of their medical needs,
3 but they never had to be removed from that home.

4 DR. PATRICIA SPINDEL: So, sorry, Kay.
5 Are you proceeding? Sorry.

6 KAY WIGLE: Yes. I was just going to
7 mention one more person. Doug also talked about
8 the behavioural piece. We have seen people with
9 developmental disabilities who have moved from
10 institutions into the community who have had
11 really, really high behavioural needs, and an
12 example in the paper is a man named Tom.

13 Tom was institutionalized because he
14 was considered too high-need. He had medical and
15 physical and developmental disabilities. He was
16 institutionalized until the point where that
17 particular institution closed. And in the paper,
18 it talks about the fact that the institutions
19 decided that in order to move him out, which they
20 didn't think he would be able to because his needs
21 were too high, they were going to move him out on
22 what they then called a Papoose board, which is a
23 flat board with straps on it.

24 The agency decided that's not what we
25 do here in the community. We take people out; we

1 integrate them into the community. It wasn't an
2 easy transition. Tom was not an easy person. He
3 was a person who didn't know what to do in a home.
4 So he took all the pictures down, broke the
5 windows, broke all kinds of things along with the
6 other six people.

7 But given time, he started to be
8 treated in a much more respectful way. It's been
9 years since he -- he was institutionalized at
10 age 9. He now lives in the community; he goes out;
11 he volunteers; he has his own apartment. He does
12 get 24-hour support, but this is a person that we
13 typically hear never could live in the community
14 and needs institutionalization forever.

15 We can do this with seniors too.

16 DR. PATRICIA SPINDEL: Yeah. And if I
17 might add, the small community residences operated
18 by non-profit organizations in the community have
19 been much safer during the pandemic, and we did a
20 quick survey with a whole bunch of community
21 agencies that deliver group homes in the community,
22 and not one of them reported an outbreak.

23 What's interesting is nothing like that
24 is available for seniors in this province. There
25 is nothing such as a small community residence

1 available. That's probably the best place to have
2 people with dementia who can actually get
3 individualized care.

4 In the United States -- and
5 Justice Marrocco, am I pronouncing that right, I
6 hope?

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Yes. Yes, you are.

9 DR. PATRICIA SPINDEL: Thank you. You
10 may be aware of the Olmstead decision in the
11 United States which said that people with
12 disabilities were being unjustifiably
13 institutionalized because of an absence of
14 community alternatives.

15 And so the Olmstead decision in the
16 United States has led to a whole range of community
17 alternatives that have kept people with very
18 significant disabilities, and I'm talking about
19 highly complex needs now, behavioural, medical, all
20 types; it's kept them out of institutions.

21 We have nothing like that in Ontario,
22 and there are no lawyers willing to take up an
23 Olmstead case in Canada. I guess there's no money
24 in it, I don't know, but basically, they seem
25 unwilling to see this as a human rights issue when

1 thousands of people are being forced to go into
2 long-term care facilities.

3 So just to add to that, that's why
4 we're concerned about the lack of alternatives.

5 But the other problem is that you
6 cannot have strict enforcement and sanctions if you
7 don't have alternatives, and that's actually what
8 I'm going to talk about. I'm going to talk about
9 the whole inspection system, which is the next
10 slide, which is Slide 5. Okay.

11 Because you can't levy the effective
12 sanctions for repeated violations unless you have
13 somewhere safe to put the people, and I believe
14 Deputy Minister Steele actually testified to that,
15 that he needed community partners.

16 Well, the community partners are out
17 there, but because of the silos we see between
18 health, community, and social services and
19 long-term care, one ministry is not aware of other
20 ministries that have enormous capacity if they were
21 funded to provide those kinds of alternatives.

22 And I believe Ms. Coke will understand
23 that, having been in government, having been a
24 deputy minister: Trying to get the ministries to
25 talk to each other and work together is extremely

1 difficult. So if we want to shift from
2 institutions, the medicalized, institutionalized
3 model to a social and community model, we might be
4 looking at a shift of ministry here or at least a
5 shift of focus inside the Ministry of Long-Term
6 Care.

7 So those two things go together. You
8 can't bring in tough sanctions -- we've found that
9 over the years -- unless you have the ability to
10 revoke licenses, cease admissions, not renew
11 licenses, and if you're going to do that, you've
12 got to deal with the wait lists, and you've got to
13 deal with the lack of other alternative places,
14 safe places for people.

15 So what we believe is that there's been
16 no prosecution policy as there was in the 1980s.
17 We had a prosecution policy in the 1980s, and a
18 Crown attorney was cross-appointed to the
19 Inspection Branch from the Ministry of the Attorney
20 General to prosecute nursing homes that were
21 repeatedly in violation of the Nursing Homes Act
22 and regulations. And I believe that was
23 Lloyd Budzinski, but I'm not absolutely certain of
24 that. My memory fails a little bit on that.

25 So that was in place at one time, and

1 it was working. As soon as licenses started to be
2 revoked, homes, they sat up and took notice.

3 There's no working relationship with
4 the police that we can see. We don't see
5 inspectors on a regular basis making referrals to
6 the police when there's been thefts, when there's
7 been assaults, when there's been criminally
8 negligent care that's resulted in harm and death.
9 There's no referrals from the Inspection Branch,
10 and there's something wrong with that.

11 There's no forensic accounting
12 capacity. So when homes regularly short staff,
13 when there are no supplies available, not even to
14 change beds or towels -- and that has significant
15 implications when it comes to infection control --
16 when that's not available, they can't just send in
17 forensic financial auditors to say, well, why is
18 this home not staffing properly? Like, is this a
19 financial matter, or is this for some other reason?

20 So they need to have some capacity to
21 do that; otherwise, they can't hold these places
22 accountable.

23 And finally, the credibility of the
24 inspectors. We've seen news reports now that some
25 inspectors were hired from long-term care. Well,

1 as a member of the public, I don't see that as
2 appropriate at all, and I think that that presents
3 a conflict of interest. So that's problematic.

4 I also have had questions over the
5 years, I must say, with the level of ability and
6 the level of competence and credentials of people
7 who are in senior positions in the Inspection
8 Branch but also are inspectors themselves. Do they
9 have Public Health backgrounds? Do they have
10 infection control backgrounds? Do they have an
11 understanding of gerontology and geriatric nursing?
12 Because I think a lot of them don't, and that's a
13 problem as well.

14 So they tend to see things sometimes
15 from the perspective of the home instead of from
16 the perspective of the people lying in the beds,
17 and that's been an issue.

18 We had to push in the 1980s to get
19 inspectors to even interview residents, to even
20 talk to their family members. It just wasn't
21 happening. They were going in, interviewing the
22 nursing director, and then saying, okay, we've done
23 an inspection. That's not good enough.

24 So that's the end of my part of it for
25 this --

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Well, just before we move on...

3 DR. PATRICIA SPINDEL: Yes.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Why do you think that this kind of, I guess,
6 neglect as you've described it, why do you think
7 that happened?

8 DR. PATRICIA SPINDEL: Why do we think
9 that the neglect of...?

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Well, why would they have an inspection system that
12 isn't really an inspection system? That's what I'm
13 trying -- you've been around so long.

14 DR. PATRICIA SPINDEL: Yes, you're
15 right.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 Don't take that the wrong way.

18 DR. PATRICIA SPINDEL: Oh, that's fine.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 I'm the last person in the world who should say.

21 But in your experience, why is it
22 neglected, as you've described it?

23 DR. PATRICIA SPINDEL: I think I can
24 tell you exactly why it's neglected.

25 It's neglected because as soon as the

1 for-profits came in, and they came in and bought up
2 those mom-and-pop operations in the late 1970s, we
3 had the big corporate interests coming in, and by
4 the early 1980s, we had huge companies starting to
5 deliver long-term care. And they began exerting
6 enormous public pressure, and they began exerting
7 enormous influence on government policy.

8 And so what you had was you had, you
9 know, an Inspection Branch that was basically
10 disempowered. We saw it again around the lobbying
11 that went on to get rid of the comprehensive annual
12 inspections. You know, that was, again, enormous
13 lobbying pressure: Get rid of them; they're just
14 red tape.

15 Well, they're not red tape. They're
16 comprehensive inspections that tell the public and
17 people in these homes and their families what's
18 actually going on, and there was lobbying to get
19 rid of those as well. Just like there's lobbying
20 now to get rid of criteria and credentials for
21 people who provide direct care.

22 You know, we've seen it. We saw
23 lobbying to get government money for renovations.
24 They got that money. So they've been very
25 successful. They can afford to hire lobbyists.

1 They have very deep pockets; they can afford to
2 hire lobbyists. Families and residents cannot, and
3 so their voices are drowned out, and the voices of
4 the industry and their lobbyists actually hold sway
5 with the government.

6 And they have had enormous influence
7 and, I believe, undue influence, which is why we've
8 had these kinds of problems. Does that answer --

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Why --

11 DR. PATRICIA SPINDEL: -- the question?

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 I'm sorry to interrupt.

14 DR. PATRICIA SPINDEL: Yeah, that's all
15 right.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Why do you think the for-profits, these large
18 interests or large pools of money are interested in
19 these investments? Obviously, they think they're
20 profitable, but do you have a sense of why they're
21 attracted to the investment?

22 DR. PATRICIA SPINDEL: Well, they're
23 basically real estate investment trusts. They're
24 basically REITs -- that's how they start out -- and
25 the residents are in the beds. So, you know,

1 they're a little bit of an afterthought. You know,
2 these are real estate holdings essentially, and
3 they're often in areas where the real estate is
4 pretty pricey. And so the residents occupying the
5 beds, I mean, we used to say in the 80s that this
6 was a license to print money.

7 I know that they're always crying foul
8 and saying they don't have enough money, but if you
9 look at what their shareholders are being paid and
10 you look at the profits that are being made, it
11 seems like they're doing okay in the eyes of the
12 public.

13 So to answer your question, I think the
14 reason why care is secondary and why we haven't
15 seen effective sanctions or anything else is you're
16 seeing the impact of the powerful real estate
17 corporations.

18 DOUGLAS CARTAN: Trish, I could also
19 add to that, just to address Frank's question a bit
20 more in terms of what you've already said, is that
21 in terms of the Inspection Branch's effectiveness
22 and efficiency, right now in the system, the tail
23 wags the dog, right?

24 There is nowhere else for people to go.
25 Even Richard Steele, in his open testimony to you

1 said, I have nowhere to put people. So if you're
2 going to have an inspection branch that is going to
3 create orders, that's going to cease admissions or
4 take licenses away, there are no alternatives --

5 COMMISSIONER FRANK MARROCCO (CHAIR): I
6 understand.

7 DOUGLAS CARTAN: -- that can be in
8 place right now that would help make inspection any
9 more effective unless we have alternatives out
10 there for people other than the few for-profit
11 alternatives that actually exist to
12 institutionalize people.

13 If we don't have other kinds of
14 community-based alternatives, people can just
15 ignore the inspection reports. They can ignore the
16 orders, and that's what's been happening for the
17 longest period of time. There's no consequence
18 that can move the large corporations to do anything
19 different but tidy up the corners a little bit.

20 DR. PATRICIA SPINDEL: [Inaudible].

21 COMMISSIONER FRANK MARROCCO (CHAIR): I
22 found what Dr. Spindel was saying interesting in
23 the sense that these are fundamentally real
24 estate -- from your perspective --

25 DR. PATRICIA SPINDEL: Yes.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 -- these are fundamentally real estate investments.

3 DR. PATRICIA SPINDEL: Yes.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 And is the idea that the people in the beds provide
6 you with the revenue to hold on to the property
7 until you want to do something else with it? Is
8 that...?

9 DR. PATRICIA SPINDEL: I think that's
10 possible for sure. I think that's possible, but I
11 think it's also a pretty lucrative industry, the
12 long-term care industry if we look at, you know,
13 where the money is going and who is making good
14 profits and who is paying their shareholders pretty
15 well. So I think it's both.

16 I think they're holding lucrative real
17 estate investments, but I also think that they're
18 getting pretty good return on their investment, it
19 sounds like, from payments from government.

20 And, you know, we see tons of money
21 going in from government into this industry. They
22 were supposed to bring their own capital. They
23 were supposed to use resident co-payments to
24 upgrade their facilities. They haven't done any of
25 that. So where is that money going is our

1 question.

2 You know, a 200-bed facility where
3 residents are paying 1,500 at least a month in
4 co-pays, and they can't put in air conditioning?
5 They can't put in semi-private rooms? I mean, it
6 just, you know, defies logic that this shouldn't
7 have happened already.

8 Meanwhile, now the government is
9 putting millions more in, and they're putting in
10 millions to build more institutions. And the last
11 thing on earth we need is more institutions. We
12 need a moratorium on institutions. And we need
13 those small community residences and we need those
14 non-profit organizations and, frankly,
15 municipalities to step up and start delivering
16 those services.

17 Municipalities already deliver
18 supportive housing. There is tons of in-home care
19 going into those supportive housing buildings
20 already; they need to be able to build the
21 community residences.

22 And just to add, if in the first wave,
23 if in May the government had gone to the
24 municipalities and all of these non-profit
25 agencies, which we'll go into more detail about

1 later, if they had gone to them in May and said,
2 can you start renting condos, can you start renting
3 apartments, can you start renting homes in the
4 community and buying them, and can you start
5 staffing up because we're going to need to move
6 residents -- I think they call it decanting, kind
7 of like wine or something -- but we need to move
8 residents, you know, if they had done that, within
9 eight to ten weeks, those alternatives would have
10 been in place, and they would have been in place
11 forever for people. But that's not what happened.

12 Instead, the government chose to
13 announce all kinds of more long-term care
14 institutional beds, and that doesn't make any sense
15 because they take a long time to build, and they're
16 not humane. They're not working. This is an
17 unsustainable system. They need to go to the
18 community care system that the other countries
19 have.

20 So I am on No. 6, by the way.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 All right.

23 DR. PATRICIA SPINDEL: So I've moved
24 along because I did talk about the for-profit
25 involvement.

1 Just to add, we also have some concerns
2 about possible criminal involvement only because
3 we're seeing it in lots of other jurisdictions.
4 The Charbonneau Commission has seen criminal
5 involvement in nursing homes. They've seen issues
6 with fraud, money laundering, kickbacks, various
7 things. We've seen it as well in the
8 United States, and Attorneys General across the
9 United States are bringing charges against nursing
10 homes.

11 And the Attorney General, even under
12 the Trump Administration, which was surprising to
13 me, has issued -- you know, they're investigating.
14 The Department of Justice is investigating nursing
15 homes across the United States for criminal
16 negligence causing bodily harm and death.

17 So we see nothing of that in Ontario.
18 We see the police not involved at all. The people
19 from Orchard Villa asked for a police
20 investigation, and the police response was, we're
21 going to hold off till the commission reports. So
22 that's the situation as it stands right now.

23 So that's what I had to say about, you
24 know, what we've been talking about here as far as
25 for-profit corporations and inspections. So I

1 think we're going to move on.

2 Doug? Doug has some historical
3 information that I think the Commission may be
4 interested in. So, Doug?

5 DOUGLAS CARTAN: Yeah. Thanks, Trish.

6 I think what we wanted to do,
7 Commissioners, is just get a sense of an example of
8 systemic reform that was quite bold, quite
9 courageous, met with lots of opposition, but has
10 been an unbelievable success in our province.

11 50 years ago next year, we began with
12 the building of a comprehensive community-based
13 service system for people with significant
14 disabilities, those with developmental
15 disabilities, and it was built on -- it began to be
16 built on the right premises versus the wrong
17 premises of -- that institutionalization deficit,
18 medicalization approach.

19 In 1971, the government of the day
20 appointed Walter Williston, who was a well-known
21 lawyer at the time, just to investigate what was
22 happening in the institutions for people with
23 disabilities, particularly those with developmental
24 disabilities where there were 5- or 6,000 people.

25 There had been all kinds of scathing

1 indictments over the previous ten years beginning
2 in 1960 with -- you might have remembered
3 Pierre Berton wrote an article in January of 1960
4 about the conditions of Huronia Regional Centre in
5 Orillia that were absolutely just horrendous
6 conditions to live in. And at the same time, what
7 was happening is a lot of families were beginning
8 to say they didn't want to institutionalize their
9 child.

10 So in 1971, Walter Williston was
11 appointed to review the situations about people
12 with disabilities living in institutions and make
13 recommendations for the future of supports in this
14 province for people who had developmental
15 disabilities.

16 His report was groundbreaking. He said
17 that we should downsize and begin to eliminate the
18 institutions. It's not the way we want people to
19 live. He said we should develop a comprehensive
20 community-based service system, including a
21 community-based residential system, small homes,
22 supported living, that kind of thing.

23 What he did was look around at the most
24 promising practices in the world. He talked to a
25 lot of people in Europe and was really impressed

1 with the Scandinavian models that were coming out,
2 and he wrote a report that was the basis of
3 government action for the next 30 years.

4 In 1971, there was 232 people living in
5 small group homes in Ontario. Today, there are
6 15,000 people with developmental disabilities, many
7 who have the need for maximum support for a range
8 of disabling conditions, including physical,
9 medical, cognitive, and behavioural conditions.
10 They are delivered by over 300 non-profit agencies
11 scattered across this province in towns, villages,
12 and cities, so people with the most significant
13 disabilities could live in neighbourhoods and on
14 streets and in communities next to you and I.

15 This was the Williston Report, but it
16 wasn't implemented in '71. He had to wait -- can
17 you go to the next slide, please? He had to really
18 submit this to government, and then government, his
19 compatriot -- Walter Williston's compatriot in this
20 change was Robert Welch. Some of you might
21 remember Bob Welch. He was the minister for the --

22 DR. PATRICIA SPINDEL: Social policy.

23 DOUGLAS CARTAN: -- social policy
24 secretariat, which included policy development in
25 health, education, social service development; that

1 was Bob Welch's domain. He was appointed that by
2 Bill Davis.

3 And so what he did was he took the
4 Williston Report, and in the midst of tons of
5 opposition from the Ministry of Health, who wanted
6 to rebuild more new institutions for people with
7 disabilities, he simply said no; what we're going
8 to do is adopt the Williston Report, build a
9 comprehensive community-based service system, and
10 flip what we're doing on its head. He had the
11 courage and the boldness to see the vision for
12 people with disabilities and how they should live.

13 So that instituted a series of
14 five-year plans to downsize the institutions, close
15 the institutions, and repatriate initially over
16 5,000 people and the money that was attached to
17 those 5,000 people. He came into the community to
18 build this comprehensive community service system.

19 This was incredibly bold of both
20 Williston and Bob Welch in the government; of
21 course, it took somebody inside the government to
22 make it happen.

23 Parenthetically, I want to say to the
24 Commission, it's really sad for us, who have been
25 in the field of disability for 40 years and more,

1 to see that 3,000 people with developmental
2 disabilities are now placed back in long-term care
3 facilities when they don't need to be there. It's
4 because --

5 DR. PATRICIA SPINDEL: Yeah, and that's
6 because the Ministry of Health budget is bloated,
7 and the Ministry of Community and Social Services'
8 budget is anemic. You know, the money has not been
9 invested into the community again, so we're seeing
10 the people follow the money.

11 DOUGLAS CARTAN: So we wanted just to
12 give you an example of where two people -- a
13 commission in '71 headed by Walter Williston and a
14 compatriot in government, Bob Welch -- transformed
15 an entire system from an institutionally based
16 system to a community-based system affecting now
17 tens of thousands of people.

18 DR. PATRICIA SPINDEL: Right. Could we
19 go to Slide 9, please? And Kay will speak to this.

20 KAY WIGLE: To follow up with what Doug
21 said, both Doug, myself, and Trish have seen for
22 the past 40 years the movement of people to the
23 community and the community able to step up.

24 Because initially when people moved
25 out, it definitely was a challenge, but at this

1 point, we have seen some amazing services that are
2 available to all people, including people with high
3 acuity. People with high acuity typically would
4 only be seen as folks who needed hospital or
5 intensive nursing home care.

6 There is a home that I'm aware of --
7 I'm from the London area, so it's in London -- and
8 it has funding both from the Ministry of Health and
9 the Ministry of Child -- sorry, Children and
10 Social --

11 DR. PATRICIA SPINDEL: Community and
12 Social Services.

13 KAY WIGLE: Social Services, thank you.
14 They change the name so often, I can hardly keep up
15 with it. I still call it MCSS.

16 So that particular home is taking in
17 people that would traditionally be considered very
18 high in terms of their medical needs. And in the
19 community, in group homes -- so all of these folks
20 live in group homes of two, three people; some live
21 in apartment settings; some actually live in
22 duplexes where they have a movement of staff in
23 between.

24 To give you an idea of the kind of
25 healthcare needs that are met by these places in

1 their own homes: They provide care for feeding
2 tubes, they provide care for tracheotomy, they
3 provide care for ostomies, and they provide care
4 for mechanical ventilation programs. They work
5 closely with one of the hospitals here for OT and
6 PT, and they actually follow through with the
7 support programs in the homes of the people.

8 So we know that this can happen for
9 seniors because we've seen it happen very
10 successfully for people with disabilities with very
11 high medical needs.

12 DR. PATRICIA SPINDEL: And if I can
13 just add, we have members in our organization who
14 have brought their parents home from long-term care
15 facilities because of their concern, and they were
16 considered very high acuity in those facilities,
17 but they're being cared for at home now with not
18 very good home care. So even at that rate, they've
19 been able to care for them at home, and home care
20 is a whole other thing we'll talk about later, but
21 that's been true.

22 Others have been able to move people to
23 non-profit facilities so that they didn't have to
24 go into homes like Orchard Villa, which were
25 extremely dangerous, and they have flourished.

1 They almost died in Orchard Villa. The hospital
2 where they were admitted said that their organs
3 were failing. The hospital revived them,
4 essentially, and then they were sent to a
5 non-profit where they received much better care
6 where, in spite of everything, they are now again
7 flourishing.

8 So the high acuity argument, from what
9 we've seen, has basically been an argument for more
10 money to be thrown at the institutions, but the
11 fact is that if there's going to be more money
12 invested, it should be invested in community
13 options, like Kay is describing, but for older
14 adults as well as just people with disabilities.

15 So, Kay, carry on, please.

16 KAY WIGLE: Yeah. And just to add,
17 there was a man that I know quite well named Mike,
18 and he was considered so medically fragile, he also
19 was put in an institution. And he was considered
20 so medically fragile that, even at age 9, decisions
21 were made about him either going into a further
22 institution or a long-term care home because of his
23 high medical needs. Aside from his disability and
24 behavioural, he had a significant kidney disease.

25 His family advocated and decided that

1 this was not what they wanted for Mike, and, in
2 fact, they found a community home that would be
3 willing to take him in a community that also had
4 good medical care. And the institution said he
5 wouldn't last two years in the community, and he
6 died last year at age 42 after living a very long
7 and very good life in the community. So we know it
8 can be done.

9 DR. PATRICIA SPINDEL: Okay. So the
10 community partners exist. I think the ones that
11 Deputy Steele was looking for, they do exist.
12 They're out there. There are places like
13 Woodgreen. There are places like
14 Neighbourhood Link, places like Senior Link, all of
15 those sorts of places. Plus municipalities, if
16 they could be funded properly, would, I'm certain,
17 step up to the plate. The Town of Ajax is wanting
18 to step up to the plate right now where I live.

19 The same level of funding would often
20 help maintain people in the communities, not even
21 extra money. For some people with extremely high
22 needs, you know, if they have very high medical
23 needs, they would probably need auxiliary services
24 from hospital or maybe a bit more funding to
25 maintain them.

1 But if we look at the U.S.
2 money-follows-the-person initiative, people with
3 very high needs have been moved out of institutions
4 into the community and just used the institutional
5 dollars to fund them in the community.

6 And that's, by the way, on Slide 10.
7 So we have moved to Slide 10.

8 Kay, did you have anything else you
9 wanted to say about Slide 10? I'm looking at the
10 clock, which is why I'm moving things a little...

11 KAY WIGLE: Yeah.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 There's a question from Commissioner Coke.

14 COMMISSIONER ANGELA COKE: Sorry. Just
15 on the previous slide, on Slide 9 where you have
16 "case mixes are wrong," can you just elaborate a
17 bit on that?

18 DR. PATRICIA SPINDEL: I can if you
19 like, Kay?

20 KAY WIGLE: Okay.

21 DR. PATRICIA SPINDEL: Basically what's
22 happened, Ms. Coke, is that nursing homes and
23 long-term care homes became dumping grounds. A
24 number of years ago, they basically became dumping
25 grounds for people from psychiatric facilities, for

1 people with developmental disabilities, for people
2 who had high-level or Stage 4 Alzheimer's, and they
3 were all housed together with people who also had
4 physical disabilities, and that was absolutely the
5 wrong thing to do.

6 We have community mental health
7 services where people with psychosis who are
8 currently in long-term care facilities, those
9 people should be being looked after in high-support
10 group homes in the community.

11 People with developmental disabilities,
12 especially younger people, should not be in
13 long-term care facilities at all. They should be
14 being looked after in residential programs
15 delivered by associations for community living and
16 other developmental service providers in the
17 community.

18 People with physical disabilities could
19 be being looked after by places, smaller places in
20 the community that are set up for people with
21 physical disabilities, and we could tell you which
22 agencies some of those are.

23 And finally, people with dementia
24 should absolutely not be in an institution. I have
25 some background in applied psychology, and I can

1 tell you that dementia is not amenable to large
2 institutions. In fact, that will aggravate
3 symptoms. You'll get more responsive behaviours,
4 and they're all triggers. They're all
5 environmental triggers or internal triggers due to
6 trauma that are not being treated in institutions
7 and, in fact, are being reinforced when they're
8 being subjected to dangerous conditions or aversive
9 types of care.

10 So when we hear this high-acuity label,
11 there are reasons why there's high acuity in
12 institutions, and a lot of those reasons could be
13 changed completely if people were in more humane
14 environments. So I hope that answers your
15 question.

16 COMMISSIONER ANGELA COKE: Yes, thank
17 you.

18 DR. PATRICIA SPINDEL: Thank you.

19 Okay. So I think we're moving on to
20 Slide 11, are we, Kay?

21 KAY WIGLE: So one of the things, it
22 came up the other day, was about the alternatives
23 in home but also the fact that they're most --
24 they're all non-profit. They're in-care homes.
25 There are a lot of options that people don't think

1 about, such as -- one of the communities that
2 supports people with disabilities, people with
3 mental health is called the L'Arche community. And
4 the L'Arche community actually has staff live-in.

5 So one of the things in terms of
6 alternatives is that it takes a lot of creativity,
7 but the creativity is already there in terms of
8 group homes, in terms of supported, independent
9 living where people can live on their own, and we
10 have paid caregivers going into the home, both from
11 Ministry of Health and Ministry of -- I call it
12 MCSS.

13 So there are lots of options in terms
14 of having seniors live in that type of environment.
15 They are also -- and the really important part is
16 what do they do during the day. So there's also
17 day programs for adults so that people don't have
18 to deal with isolation.

19 So the alternatives are in place, if we
20 can get out of the institutional thinking and start
21 thinking about seniors living in the type of
22 environments that people with disabilities do.

23 DR. PATRICIA SPINDEL: Right.

24 DOUGLAS CARTAN: Yeah. So I'll add to
25 that, what Kay said on the alternatives. I mean,

1 by now you know -- you probably realize that we
2 think institutions are anathema to good health and
3 that we think we need alternatives both to the
4 current institutional practices that exist, but
5 alternatives, such as really enhanced, robust,
6 in-home support, will stop the high institutional
7 rate that Ontario now has.

8 One of the incentives that we think are
9 important is to review and look at and remove some
10 of the caps that are on home support, exactly what
11 the Ministry of Health and Long-Term Care are doing
12 right now in their high-intensity support
13 initiative that the LHINS announced about three
14 weeks ago, which is to keep people out of nursing
15 homes by removing the caps on home support,
16 particularly the waiting-at-home program.

17 By doing that, because of the current
18 prices, right, high waiting lists, second wave of
19 COVID, and the de-bedding -- I hate that word --
20 anyway, de-bedding because it's going to occur
21 through death, mostly. The de-bedding initiative
22 in the institutions, if you remove the cap on home
23 support and have identified the people who need
24 alternate levels of care in each of the LHIN
25 regions -- and they believe that by removing the

1 caps, they'll be able to keep people at home.

2 Well, why does this have to be a
3 temporary measure? Why can't we build in a more
4 robust at-home support system that keeps people out
5 of institutions? We know from studies right now
6 that between 17 and 22 percent require moderate or
7 mild amounts of support to be able to live at home,
8 so we could do that right away if we just remove
9 the caps as the high-intensity program is doing.

10 But we can also do more than that. We
11 can also incentivize people in the community to
12 care for their family member. Newfoundland and
13 Labrador has a program where they've introduced
14 family-paid caregiving, and that has proven to be
15 really effective in many situations.

16 We also have individual direct funding;
17 there's a little bit of that going on in a small
18 niche office of the Ministry of Health here in
19 Ontario. It's much bigger in New York State, and
20 it's much bigger, quite frankly, for people with
21 physical disabilities where funding is given
22 directly to the person/family in order to implement
23 their own support system: Hire, train, monitor
24 people that come in. People with physical
25 disabilities have been tremendous advocates for

1 direct funding.

2 So we're just talking about a range of
3 alternatives that we can put in place to decrease
4 the high rates of institutionalization and to
5 decrease all the new beds that people say are
6 needed that are probably not needed if we had a
7 robust system of alternatives, including increased
8 in-home support.

9 DR. PATRICIA SPINDEL: And that would
10 turn off the spigot from hospitals if we had that.

11 Kay, can you talk about accountability?
12 I know the Commission was very interested in
13 accountability for care in the long-term care
14 homes. Could you explain how that would work in
15 the community?

16 KAY WIGLE: Absolutely. So under the
17 legislation that funds the community homes, which
18 are all non-profit, each agency -- so, for example,
19 I'm vice president of the board of Community Living
20 London. That agency and all the agencies that are
21 non-profit have an elected board of directors, and
22 typically also on that board is a person with a
23 disability, family members, and, of course, the
24 rest are a mix of financial people, et cetera.

25 The boards of directors, they are

1 responsible for fiscal responsibility as well as
2 the overall direction of the agency.

3 One of the things that is really
4 important to community agencies and are done
5 yearly -- and they are done yearly -- are the
6 yearly compliance reviews, and they're a very
7 comprehensive review.

8 So every single year, a compliance
9 committee comes and meets with an agency. Now, the
10 amount of days, it depends on the size of the
11 agency. The one that I went through last year with
12 Community Living, the reviewers were there for four
13 days. They go over everything from policies and
14 procedures, board records, records of the agency,
15 individual records -- so they actually go and look
16 at whether or not they're meeting the needs of the
17 individual people that are supported -- staff
18 volunteer records, and they actually do onsite
19 visits into people's homes to ensure that what the
20 agency is saying is actually following through.

21 So there are a number of really
22 important accountability efforts that are done in
23 non-profit organizations, starting with the board
24 of directors to the ministry, and I can tell you
25 from experience that they do uncover some things.

1 There was an agency in the London Area
2 not that long ago that, as a result of the
3 inspections that were done, they actually lost
4 their funding, some of their funding. The
5 executive director and some managers were removed
6 from that agency, and the agency was taken over by
7 another agency because they didn't feel that the
8 money that the government was giving was actually
9 spent in a proper way for what their purpose was,
10 which was supporting people in the community.

11 So there is a lot of accountability to
12 the non-profits.

13 DR. PATRICIA SPINDEL: Yeah, and
14 non-profits also can't unduly influence government
15 policy because they're not allowed to give campaign
16 contributions, and they certainly don't have money
17 to hire lobbyists.

18 So perhaps we can move on. Kay, did
19 you have anything else to add there?

20 KAY WIGLE: No. I meant to say that
21 the audit that was done for that particular agency
22 was a forensic audit.

23 DR. PATRICIA SPINDEL: Yes.

24 KAY WIGLE: And it was an important
25 statement that we are very accountable.

1 DR. PATRICIA SPINDEL: Yes, exactly.
2 Doug, I'm going to ask you to race
3 through the information about Denmark because we're
4 at about 15 minutes left.

5 DOUGLAS CARTAN: So let me just
6 highlight the second example, Commissioners, that
7 we wanted to give to you besides the issue of the
8 institutionalization of people with disabilities,
9 and that was a broad system change.

10 We wanted just to point you towards
11 Denmark. So Denmark, a small country, 6 million
12 people; when we looked at that, Denmark came the
13 closest to the kind of system that would make us
14 feel a little better. And by the way, I don't want
15 to go into a nursing home. My friends and family
16 don't want to go into a nursing home. Roughly
17 98 percent of Ontarians don't want to go into a
18 nursing home.

19 So 35 years ago, Denmark began to look
20 seriously at the kind of system that they wanted,
21 and I just want to start off by saying that in June
22 of this past year when Ontario had 80 percent of
23 deaths due to people living in long-term care, in
24 Denmark, 33 percent of deaths were due to long-term
25 care. And so the changes they initiated 35 years

1 ago did have some effect.

2 The first thing is that Denmark had a
3 policy priority that they put in place which
4 Ontario does not have. Ontario's statements of
5 policy priorities are good experience for people,
6 words, phrases like that, whereas Denmark said
7 we're going to initiate a deinstitutionalization,
8 and we're going to emphasize community-based health
9 and home care over institutional care. That is
10 what we mean by a policy priority.

11 And so what they began to do was
12 develop residential alternatives to
13 institutionalization called close accommodation:
14 Small, subsidized homes where people had their
15 individual apartments and might share a common
16 room. They haven't built a nursing home or a
17 nursing home bed added to their system for
18 20 years.

19 They created a robust home and
20 healthcare system. They focused on the activation
21 and re-ablement of all their seniors so that they
22 would be able to live longer, more independently at
23 home, and they created a local governance, a
24 municipal governance, if you will, of their system.

25 So absolutely the opposite of what

1 Ontario has been doing, which has been increasing
2 the institutional rate of people.

3 Can you go to the next slide?

4 So what we also saw here in Denmark in
5 terms of, I guess, a commitment -- we always talk
6 of Ontario being, and Canada in particular, having
7 low investment. Well, I would agree with them on
8 that fact. And the [indecipherable] at the OECD,
9 right, the Organization of Economic Cooperation and
10 Development -- basically 33 countries, or sometimes
11 they talk about 17 countries -- are analyzing
12 things.

13 So Canada has 1.3 in terms of
14 expenditure versus GDP of 1.3 percent; Denmark,
15 2.5 percent; and the average in the OECD, 17
16 countries, 1.7 percent. So you can see that in
17 order to make this happen, there does have to be
18 investment in this, and Denmark sort of puts their
19 money where their mouth is in trying to make
20 something happen here.

21 Could you go to the next slide? Yeah,
22 thanks.

23 So here's another slide that I find
24 very instructive in terms of their commitment to
25 change their system. So if you look at long-term

1 care beds per 1,000 population over age 65?

2 So about 15 years ago, Canada has 58
3 and Denmark 5 percent less at about 54, 55 percent
4 per 1,000 population long-term care beds.

5 Fast-forward that about 15 years later
6 or, in this case, it was about 12, 13 years later:
7 Denmark, 42 percent less than Canada in terms of
8 its institutional beds. Less infection. Less
9 death. Greater acceptance from the public. The
10 public is very supportive of Denmark's long-term
11 care system now because they've funded it. They
12 have re-oriented to a community-based system and a
13 strength-based model.

14 So I just wanted to put those up as an
15 example of a country that took a bold change in
16 what they wanted to do.

17 DR. PATRICIA SPINDEL: Thank you, Doug.

18 So I'm going to race through the next
19 few slides because we've already covered a lot of
20 these things.

21 So on Slide 16, we do have a good
22 Long-Term Care Act, and we made sure of that in
23 1984 and 1985.

24 We note that the Health Facilities
25 Special Orders Act, which Larry Grossman wrote,

1 helped write when he was Health Minister in order
2 to take over the Ark Eden Nursing Home which was
3 endangering its residents, has not been used, and
4 it could be used. It could be beefed up and used
5 to take over facilities that are endangering
6 residents.

7 I've already mentioned the
8 Crown attorney and the forensic auditors and making
9 criminal referrals.

10 Dr. Kitts, you could be particularly
11 helpful here: One of the things we have seen, and
12 I think Dr. Stall testified to it, was that people
13 have not been transferred to hospital when they
14 should have been, that many doctors didn't make
15 onsite visits anymore, so didn't know, actually,
16 what was happening with their patients -- and I
17 think you refer to that in the medical profession
18 as abandoning a patient -- and also, the whole
19 issue around the horrible, horrendously bad levels
20 of substandard care.

21 What we're saying is that there's been
22 systemic issues like this involving physicians who
23 may be employed by four or five homes, and the
24 College of Physicians and Surgeons looks at
25 individual situations. So there's nothing

1 systemic.

2 And I'm hoping, Dr. Kitts, because I
3 know you have a real patient orientation, that you
4 can give this some thought and think about what
5 kind of body might be available or how there could
6 be some oversight of physicians in long-term care
7 and physician services in long-term care. I think
8 that would be enormously helpful.

9 COMMISSIONER JACK KITTS: Thank you.
10 We will.

11 DR. PATRICIA SPINDEL: Well, I'm
12 looking at No. 17, and again, I'm going to skip
13 through this because we've pretty much covered
14 everything about lobbyists and...

15 Residents' voices are drowned out, and
16 that's got to stop. I mean, residents and families
17 should be the ones who are providing input into
18 what kind of care is provided, and they should be
19 being empowered, not disempowered because the
20 industry is so powerful.

21 The last point on this slide I think is
22 interesting and important. We sent you a document
23 from the Central East LHIN, which shows that
24 November 30th, they issued a request for capacity
25 assessment to agencies around the Intensive Home

1 Support Program. They gave them a week to respond.
2 That's it.

3 And if you consider that non-profits
4 have to put things through boards and
5 municipalities have to go through councils, what
6 they've done in that is they have maybe
7 inadvertently, completely disempowered the
8 non-profit sector from being able to be partners in
9 delivering community care of this nature.

10 They also said that it was only people
11 who had dealt with them before who could come and
12 submit these proposals. Well, there are a great
13 many people who have never dealt with them before
14 who should be able to help, to submit these
15 proposals. So they're eliminating huge sectors
16 from being able to be helpful in this regard. So I
17 just wanted to draw your attention to that.

18 We can go to the next slide. I said I
19 would race.

20 Ms. Coke, I think, can be particularly
21 helpful because we're now talking about our
22 recommendations.

23 On the first one, you have a great deal
24 more experience than we do when it comes to the
25 civil services and how ministries deal with each

1 other. I guess, historically, we saw Assistant
2 Deputy Minister George Thomson and the Ministry of
3 Community and Social Services take over in I think
4 it was in the 1980s, 1990s, and he was extremely
5 instrumental in bringing in the Special Services at
6 Home Program, which ultimately led to the
7 Passport Program for adults, which is
8 individualized funding.

9 He also did a lot of other things that
10 really strengthened community-based services for
11 people with developmental disabilities.

12 And I guess our thinking because of
13 that is maybe giving an assistant deputy minister
14 in that ministry responsibility for seniors and
15 building the community care network would make more
16 sense, provided that the money gets moved from the
17 long-term care institutional sector to that sector
18 because we don't want to help create another anemic
19 ministry I guess is what we're saying. So that
20 needs to happen. So the money needs to be
21 redirected.

22 Also, we're suggesting doubling funding
23 to the home care program and making it much more
24 flexible so the people aren't told, you have only
25 five minutes to do this particular service. You

1 can't deliver service that way, and it
2 unnecessarily bureaucratizes things.

3 So if we're going to have home care, I
4 think what we have to have is we have to have the
5 caps off, first of all, so that money is tied to
6 the actual needs of the person and so they can be
7 more effective in preventing institutionalization.

8 And Slide 19.

9 And, Doug, if you'll bear with me, I'm
10 going to deal with both of these because we have
11 very little time.

12 DOUGLAS CARTAN: Yeah.

13 DR. PATRICIA SPINDEL: The Commission,
14 as I mentioned, needs to recommend that the LHINS
15 give sufficient time for non-profits to actually
16 submit proposals and also recommend the
17 money-follows-the-person initiative that we've seen
18 in New York State. That direct funding approach
19 that is in the Ministry of Health needs to be
20 greatly expanded. It already exists; it just needs
21 to be expanded.

22 If we go to Slide 19, we're asking that
23 the Commission recommend that the inspectors have
24 much better investigative and public health
25 experience and that they come from sectors other

1 than the long-term care sector, which I think is
2 extremely important.

3 And finally, that the Commission
4 recommend that the Inspection Branch work much more
5 closely with the OPP. And here, I just want to
6 mention another historical note.

7 In the 1980s, the Attorney General,
8 Ian Scott, asked the OPP to investigate criminal
9 acts in nursing homes after Dr. Birthe Jorgensen
10 did her report on criminal acts, and there were
11 very serious charges that were levied against
12 nursing home operators at that time. It was led by
13 Inspector Ted Rowe, who I remember very well, and
14 we have not had a similar police investigation
15 since then. And one needs to be called again,
16 especially around what has happened, what's
17 transpired during the pandemic.

18 So I'm moving just --

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Can I just stop? I know you're going quickly, and
21 I appreciate --

22 DR. PATRICIA SPINDEL: I am, yes. I'm
23 trying to save the time.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 No, no, I understand why. But is there any reason

1 why they can't work with the OPP? The OPP is a law
2 enforcement organization. If an inspector sees
3 something, they should be able to report it to the
4 appropriate organization.

5 Do you have any sense of why there's
6 this kind of disconnect between a violation and
7 enforcement?

8 DR. PATRICIA SPINDEL: I think what
9 happens is that right now, the way it's set up,
10 local police forces are the first line, and so what
11 happens is there's little to-ing and fro-ing
12 between local police forces and the Inspection
13 Branch. And when families go to the local police
14 forces, they're told that that's a matter for the
15 Inspection Branch.

16 So they seem not to want to deal with
17 criminal acts that are going on in nursing homes
18 because they think that's the Inspection Branch's
19 jurisdiction. It's not. Older people should have
20 the same rights to protection under the
21 Criminal Code in nursing homes, irrespective of
22 where they live.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Well, criminal negligence is criminal negligence.

25 DR. PATRICIA SPINDEL: Exactly.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 It can happen anywhere.

3 DR. PATRICIA SPINDEL: Exactly. And
4 theft and assault can happen anywhere, and they
5 should be being investigated by police forces, but
6 they're not, I can tell you. They're absolutely
7 not. Police forces punt to the Inspection Branch,
8 and they treat it differently. So it's as if older
9 people in these nursing homes don't have protection
10 under the Criminal Code, so it's a huge, huge
11 problem.

12 What I'm going to do is I'm going to
13 skip a little bit here and just go straight to --
14 oh, and we've mentioned the forensic audits. I
15 think I just want to mention that briefly as I
16 finish up that these calls for more funding that go
17 on all the time, government has no way of knowing
18 whether they're justified or not.

19 There really need to be forensic audits
20 to tell government whether or not those calls for
21 more funding are justified, so just to reiterate
22 that.

23 And also, there's a phenomenon that
24 we're seeing -- we saw it in Orchard Villa, and it
25 was very bad, where we had Southbridge own the

1 home, and we had Extendicare Assist managing it.
2 So two companies are taking profit out of the same
3 home. We think that that process should end, that
4 if a company is being given beds, they should have
5 to manage them.

6 So last slide. We're finishing.

7 Basically, what we want to see is this:
8 We want to see people empowered and not devalued,
9 okay? So we're all a stroke or we're an accident
10 away from ending up in a nursing home ourselves,
11 and I think most people don't want to think about
12 it, but it's true.

13 I was friends with Dorothea Crittenden.
14 I don't know, Ms. Coke, whether you knew her, but
15 she was the first female deputy minister of a major
16 ministry in Ontario, the Ministry of Community and
17 Social Services. We used to call her Crit, and
18 Crit was very hot to trot about reform for older
19 adults. And sadly, she ended up with Alzheimer's
20 disease, and she ended up dying in an institution,
21 which was absolutely tragic and should never have
22 happened.

23 Essentially, what I want to say is that
24 residents are parking their rights at the door
25 right now. Their constitution does them no good if

1 it's not enforced. The Resident Bill of Rights
2 does them no good if it's not enforced. Same with
3 criminal law not applying. Human Rights Code
4 doesn't seem to apply, either.

5 So we're very concerned about this. I
6 mean, as soon as you enter a nursing home, it's as
7 if you're going into the Twilight Zone, and all of
8 a sudden, all of the rights that other citizens
9 have no longer apply to you. So that should not be
10 the case.

11 We believe that you have the expertise
12 because we have looked at your backgrounds, and you
13 have the authority to make recommendations to
14 change all of that, and we sincerely hope that you
15 do because we think a lot of people are depending
16 on you.

17 So I want to thank you for hearing from
18 us today. We very much appreciate it.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Well, thank you very much for the presentation, and
21 thank you very much for reminding us of the fact
22 that very many people are depending on us. That
23 will give us a further reminder that we have to
24 keep at this.

25 And thank you very much for the

1 perspective because so much of what we've received
2 has been naturally and sensibly grounded in the
3 present, but there's a perspective and a history
4 that's important to understand, if nothing else,
5 for no other purpose than to avoid making the same
6 mistakes again and again.

7 DR. PATRICIA SPINDEL: That's right.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 So thank you very much for that.

10 DR. PATRICIA SPINDEL: Well, thank all
11 of you. Yes.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 We will continue our work, and thank you for the
14 recommendations. We'll consider them very
15 carefully.

16 DR. PATRICIA SPINDEL: Thank you for
17 having us.

18 KAY WIGLE: Thank you.

19 COMMISSIONER ANGELA COKE: Yes, thank
20 you. Very helpful.

21 KAY WIGLE: Thank you.

22 COMMISSIONER JACK KITTS: Yeah. Very
23 helpful. Thank you.

24

25 -- Adjourned at 12:11 p.m.

1 REPORTER'S CERTIFICATE

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

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

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

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

16
17
18 Dated this 14th day of December, 2020.

19 

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