Long Term Care Covid-19 Commission Mtg.

Ageing Well Group
on Tuesday, November 17, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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

BEFORE:

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

PRESENTERS:

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

Dr. Duncan Sinclair, Co-Author of the “Ageing Well” Report

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

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

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

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

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Dawn PalinRokosh, Director, Operations, Long-Term Care Commission Secretariat
Sanjay Bahal, Team Lead for Operations, LTCC
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Kate McGrann, Gowling LLP

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, good afternoon. Are you -- Mr. Drummond, are you waiting for anyone? I don't know who's leading the -- but are you waiting for anybody?

CATHY SZABO: Duncan?

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, you're on mute, Mr. Drummond.

COMMISSIONER ANGELA COKE: You're muted.

COMMISSIONER FRANK MARROCCO (CHAIR): You're on -- or --

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we're a bit early. We'll just wait for a bit. I'll go on mute, though, because the dog barking is driving me nuts.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, I guess you've now met

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

DON DRUMMOND: Yes.

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

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

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

difficulty, let me know.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

number of beds we have right now.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, John, over to you.

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

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

And if you look at the Canadian

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JOHN PUXTY: Okay. I hope everyone can

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So it's not inevitable that people with

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

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

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

DUNCAN SINCLAIR: Sure.

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

JOHN PUXTY: M-hm.

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

So when you say another 20 to 30%,

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

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

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

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

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

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

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

JOHN PUXTY: Exactly.

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

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

COMMISSIONER KITTS: Okay. Thank you.

DON DRUMMOND: And Drummond here. I

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

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

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

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

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

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

COMMISSIONER KITTS: Thank you.

DUNCAN SINCLAIR: Thank you, John, Jack.

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

So, Cathy, you're up.

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

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

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

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

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

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

In my past, I've worked with

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

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

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

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

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

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

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

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

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

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

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

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

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

DUNCAN SINCLAIR: Thanks, Cathy.

Our final member of the team, actually, is -- I don't know which of you, Cathy or Catherine are singing alto and which one is doing soprano, but, Catherine, you're up next.

CATHERINE DONNELLY: Wonderful.

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

CATHERINE DONNELLY: Yes, we're closely --

DUNCAN SINCLAIR: Right.

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

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

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

Sort of underpinning all of this,

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

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

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

and neighbourhoods, thinking upstream.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So many of the programs and services

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

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

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

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

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

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

DUNCAN SINCLAIR: Thank you, Catherine.

Well, Commissioners, you've been very quiet apart from Jack asked one question, but we're now available to you entirely.

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

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

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

And Cathy said that if we keep people

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

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

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

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

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

they've hired a provider to do that.

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

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

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

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

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

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

COMMISSIONER KITTS: Thank you.

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): It's --

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

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

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

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

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

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

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

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

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

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

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

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

Oh, sorry, Cathy.

CATHY SZABO: And I would say that

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

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

CATHY SZABO: Yes.

DUNCAN SINCLAIR: That's true. Yes.

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

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

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

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

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

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

COMMISSIONER KITTS: Thank you.

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

Is what you're suggesting really just

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

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

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

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

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

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

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

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

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

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

other community support services.

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

DUNCAN SINCLAIR: Yeah.

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

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

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

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

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

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

DUNCAN SINCLAIR: Sure.

DON DRUMMOND: Right.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): No.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think we've exhausted our questions. I think maybe we were silent more or less because we were listening. This was something quite different than we've heard all along, and I think probably we were trying to absorb it.

And I just want to thank you for the

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

DUNCAN SINCLAIR: Thank you for the opportunity.

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

COMMISSIONER JACK KITTS: Thank you.

CATHY SZABO: Thank you so much.

COMMISSIONER ANGELA COKE: Thank you.

CATHY SZABO: Bye, everyone.

COMMISSIONER JACK KITTS: Take care, Cathy.

-- Adjourned at 2:06 p.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 18th day of November, 2020.

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