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.

BEFORE:

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

PRESENTERS:

Dr. Patricia Spindel, Co-Founder, Seniors for Social Action Ontario
Kay Wigle, Communications, Seniors for Social Action Ontario
Douglas Cartan, Regional Coordinator, Seniors for Social Action Ontario

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat

Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead of the Long-Term Care Commission
Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

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

COMMISSIONER FRANK MARROCCO (CHAIR): If you don't mind, we'll ask questions as we go along.

DR. PATRICIA SPINDEL: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): And we do post a transcript. Olivia, whom you've met, will post that -- we'll post that within a couple of days --

DR. PATRICIA SPINDEL: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): -- just to help people who are following along understand what we're up to on a day-by-day basis.

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

DR. PATRICIA SPINDEL: Mm-hm.

COMMISSIONER FRANK MARROCCO (CHAIR): -- we're not adverse to doing that again, although, at present, we haven't decided one way or the other.

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, yeah.

DR. PATRICIA SPINDEL: So we'll be

speaking to the PowerPoint.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. PATRICIA SPINDEL: But the backgrounder I will sometimes refer to because it provides more information than the PowerPoint.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

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

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

Nursing Homes Act.

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

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

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

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

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

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

LYNN MAHONEY: Sorry, it's Lynn Mahoney

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

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

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

DR. PATRICIA SPINDEL: Oh, okay.

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

THE REPORTER: Okay. Thanks, Lynn.

LYNN MAHONEY: Can you help me with that?

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

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

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

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

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

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

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

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

LYNN MAHONEY: Sorry.

DEREK LETT: Hi, Lynn. This is Derek.

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

DR. PATRICIA SPINDEL: Oh, wonderful.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DR. PATRICIA SPINDEL: There it is.

LYNN MAHONEY: All right.

COMMISSIONER FRANK MARROCCO (CHAIR): Thanks, Derek. All right.

LYNN MAHONEY: Sorry for the delay.

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine. We've got a little bit of extra time on the end if we need it.

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

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

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

DR. PATRICIA SPINDEL: Perfect.

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

COMMISSIONER FRANK MARROCCO (CHAIR): We're on No. 3. We can see it.

DR. PATRICIA SPINDEL: Yeah, yeah. Hopefully that...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

three principles.

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

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

Kay, can you discuss the lack of alternatives?

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

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

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

25 years ago, there was a number of

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

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

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

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

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

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

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

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

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

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

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

We can do this with seniors too.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So that was in place at one time, and

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, just before we move on...

DR. PATRICIA SPINDEL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Why do you think that this kind of, I guess, neglect as you've described it, why do you think that happened?

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, why would they have an inspection system that isn't really an inspection system? That's what I'm trying -- you've been around so long.

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

COMMISSIONER FRANK MARROCCO (CHAIR): Don't take that the wrong way.

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

COMMISSIONER FRANK MARROCCO (CHAIR): I'm the last person in the world who should say.

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

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

It's neglected because as soon as the

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Why --

DR. PATRICIA SPINDEL: -- the question?

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): I understand.

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

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

DR. PATRICIA SPINDEL: [Inaudible].

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

DR. PATRICIA SPINDEL: Yes.

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

DR. PATRICIA SPINDEL: Yes.

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

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

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

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

question.

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

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

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

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

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

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

think we're going to move on.

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

DOUGLAS CARTAN: Yeah. Thanks, Trish.

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

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

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

There had been all kinds of scathing

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

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

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

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

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

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

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

DR. PATRICIA SPINDEL: Social policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. PATRICIA SPINDEL: Community and Social Services.

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

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

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

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

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

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

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

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

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

So, Kay, carry on, please.

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

His family advocated and decided that

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

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

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

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

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

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

KAY WIGLE: Yeah.

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

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

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

KAY WIGLE: Okay.

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

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

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

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

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

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

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

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

COMMISSIONER ANGELA COKE: Yes, thank you.

DR. PATRICIA SPINDEL: Thank you.

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

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

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

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

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

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

DR. PATRICIA SPINDEL: Right.

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

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

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

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

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

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

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

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

direct funding.

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

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

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

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

The boards of directors, they are

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

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

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

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

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

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

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

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

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

DR. PATRICIA SPINDEL: Yes.

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

DR. PATRICIA SPINDEL: Yes, exactly.

Doug, I'm going to ask you to race through the information about Denmark because we're at about 15 minutes left.

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

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

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

ago did have some effect.

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

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

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

So absolutely the opposite of what

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

Can you go to the next slide?

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

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

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

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

care beds per 1,000 population over age 65?

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

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

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

DR. PATRICIA SPINDEL: Thank you, Doug.

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

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

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

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

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

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

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

systemic.

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

COMMISSIONER JACK KITTS: Thank you. We will.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And Slide 19.

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

DOUGLAS CARTAN: Yeah.

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

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

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

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

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

So I'm moving just --

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

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

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

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

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

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

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

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

DR. PATRICIA SPINDEL: Exactly.

COMMISSIONER FRANK MARROCCO (CHAIR): It can happen anywhere.

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

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

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

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

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

So last slide. We're finishing.

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

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

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

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

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

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

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

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

And thank you very much for the

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

DR. PATRICIA SPINDEL: That's right.

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

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

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

DR. PATRICIA SPINDEL: Thank you for having us.

KAY WIGLE: Thank you.

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

KAY WIGLE: Thank you.

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

-- Adjourned at 12:11 p.m.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, 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 14th day of December, 2020.

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