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Wednesday 9 October 2013

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Mercredi 9 octobre 2013

Standing Committee on Public Accounts

2012 Annual Report, Auditor General: Ministry of Health and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2012, vérificateur général : Ministère de la Santé et des Soins de longue durée

Chair: Norm Miller
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 9 October 2013

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The committee met at 1231 in room 151 following a closed session.

2012 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.08, long-term-care home placement process.

The Chair (Mr. Norm Miller): Okay. I'll call the committee to order. This afternoon, we're looking into section 3.08 of the 2012 annual report of the Auditor General, long-term-care home placement process.

We have a number of representatives here. Maybe I'll start by getting you all to introduce yourselves for Hansard, others here and the committee members, please. You have up to 20 minutes to make a presentation, and then we'll go to questions.

Mr. Saäd Rafi: Thank you very much. My name is Saäd Rafi, and I'll start with opening remarks. I'm the Deputy Minister of the Ministry of Health and Long-Term Care. Then Monsieur Joly will also make remarks, and we'll take it in the time allotted.

The Chair (Mr. Norm Miller): Sure, good. Maybe we could have the others introduce themselves.

Ms. Catherine Brown: Catherine Brown, assistant deputy minister of health system accountability and performance at the Ministry of Health and Long-Term Care.

Mr. Richard Joly: Richard Joly. I'm the CEO for the Northeast Community Care Access Centre.

Mr. Gordon Milak: Gordon Milak. I'm the CEO for the Waterloo-Wellington Community Care Access Centre.

Mr. Don Ford: Don Ford. I'm the CEO of the Central East Community Care Access Centre.

Mr. Daniel Burns: I'm Dan Burns. I'm the CEO of the Ontario Association of Community Care Access Centres.

The Chair (Mr. Norm Miller): Thank you.

Mr. Saäd Rafi: So I'll start by saying thanks for the opportunity to address the Standing Committee on Public Accounts with respect to the Auditor General's report on the long-term-care home placement process. Forgive my back; we're a little cramped at the table.

With me is Catherine Brown, who has just introduced herself and her affiliation, as well as others. Richard will be making a presentation on the long-term-care home placement process, and he, with his colleagues, will also be available to answer your questions.

I'd like to take this opportunity to thank my colleagues from the Ontario Association of Community Care Access Centres for working with the ministry to improve the long-term-care home placement process. My appreciation also goes to them for helping Ontarians access important health care services in their communities every day.

We thank the previous Auditor General, Jim McCarter, for his report and appreciate his advice to strengthen the long-term-care home placement processes in Ontario.

I'd like to perhaps just deviate from the script for a moment and recognize and welcome our new Auditor General, Bonnie Lysyk. I'm sure we're going to see a lot of each other in the near future, Bonnie, and it was good to introduce ourselves.

The ministry is fully committed to continue working closely with our key partners on improving the placement process for Ontario's long-term-care homes. Let me start by setting the legislative context. The ministry is responsible for the development of legislation, regulations, standards, policies and directives for long-term-care homes, including rules for placement into a long-term-care home. The ministry is also responsible for the licensing and inspections of those homes.

The legislation governing long-term-care homes includes several critical principles, including the principle that access to a bed is based on assessed need while also respecting the individual's preferences.

The province's 14 community care access centres are designated as placement coordinators under the legislation. Placing more than 25,000 people every year in long-term-care homes based on their needs and preferences is a complex system, and for the most part, it works well. However, as with any system, there is always room for improvement.

The auditor's report laid out four key recommendations on how to improve the system. I'm pleased to report that, working together, the ministry and the CCACs have substantially implemented all of the Auditor General's recommendations.

With respect to the first recommendation, my colleague Richard Joly will speak to the actions that the CCACs across Ontario have taken.

In response to the second recommendation, the ministry agrees fully with the auditor that in order to mitigate the growing demand for long-term-care beds and, more importantly, to reflect the preferences of seniors, the

ministry should enhance care in the community. Indeed, the ministry's strategy is to support seniors in their own homes for as long as possible. It's also why the government's Action Plan for Health Care commits to provide the right care at the right time and in the right place.

Enhanced community alternatives not only align with seniors' wishes; they are also one of the best ways to reduce the demand for long-term-care beds and thus manage growing wait-lists.

As a result, for some years now the government has been expanding home care and community support services for seniors. The 2013 Ontario budget included an additional 6% investment in home care and community services. This investment builds on previous investments that saw community funding increase by 25%, or $864 million, between the years 2008-09 and 2012-13.

These community investments are aimed at reducing wait times for nursing and personal support services. They also enhance community services for people with complex conditions that place them at risk of hospitalization, alternate levels of care or premature institutionalization.

In addition to these community initiatives, the government announced funding in January 2013 to create up to 250 new convalescent care beds in long-term-care homes to improve access to restorative care for older Ontarians; 199 of these beds are already in operation and the remaining 51 or so will come into operation by the end of the year. This expansion is expected to provide services to 1,500 more seniors annually.

We are seeing positive results from these initiatives. The total number of clients on wait-lists for long-term-care home beds has been reduced by 17% since 2010, indicating that more seniors are receiving care in their communities.

With respect to providing better information, the ministry is currently updating the health care options web portal to provide clearer information about access to and eligibility for long-term-care home placement, home care and other community services for seniors and their caregivers. The refreshed site is planned to launch in the next few months.

As for the final recommendation, the ministry is committed to greater transparency and accountability in the system's performance.

Over the past six months, the ministry and the OACCAC have been working together to enhance the collection and reporting of long-term-care home placement data. In the coming months, this work will expand to develop a reporting solution so that the ministry and its partners can better track key placement indicators, such as the time between a person's application for admission to a long-term-care home and the CCAC's completion of the appropriate assessments.

I want to assure the committee that the ministry is fully committed to strengthening the long-term-care home placement process in Ontario to support the needs of residents and their families. We're also committed to implementing the Auditor General's recommendations. The report's analysis and recommendations have helped us to improve the system to ensure that it is performing at its best at all times.

Once again, I'd like to thank the leadership at the OACCAC and the CCACs who have been our committed partners in working to improve the placement system.

Thank you for your attention, and now I'll turn to Richard for his remarks.

Mr. Richard Joly: Thank you, Saäd. I'd like to thank the committee, first of all, for having us today. Good afternoon, everyone. C'est un plaisir de vous adresser la parole aujourd'hui. No, I will not do all my remarks in French and English. It would take a bit too long, but thank you for having us.

The three CCACs represented here today participated in the Auditor General's review of long-term-care home placement in Ontario. So while I'll be delivering a few opening remarks, we are all prepared to respond to your questions here today.

The process of moving into a long-term-care home, or supporting a family member through the process, is one of the most emotional and difficult transitions a person can make in a lifetime.

As Ontario's placement coordinators, CCACs take this responsibility seriously, and our employees on the front line are well prepared for their role. Known as care coordinators, they are all regulated health care professionals—nurses, physiotherapists, occupational therapists and social workers—who have additional specialized training and expertise in health system navigation.

Our care coordinators take great care to and pride to explain the placement process to patients and their families; help them to identify their needs and preferences; explore all their care options; and ensure that they understand their rights.

So let's run through the process quickly. To determine eligibility for long-term-care home placement, our care coordinators complete comprehensive functional, cognitive and behavioural assessments to determine each person's capacity to make these types of life-changing decisions. We work with family physicians to obtain a health assessment and medical history and with other care providers to assemble all relevant health information.

We help families identify the homes they wish to apply to and provide advice on the things they might wish to consider in choosing a home, including how long they have to wait for a preferred bed. We encourage applicants and their families to visit prospective long-term-care homes in advance and speak with the staff and residents to see if that home is the right fit for them.

Once a person or a family has selected one or more long-term-care homes, the assessment information is forwarded to each of the homes on the list so that they can determine if they have the staffing and physical facilities to provide safe and appropriate care for that individual.

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If the home accepts the application, our care coordinators determine each individual's priority on the wait-list, based on the criteria outlined in the regulations under the Long-Term Care Homes Act.

It is important to note that while people wait for placement, CCACs continue to provide ongoing monitoring and home care services necessary to keep these individuals safe at home.

When a bed does become available in their selected long-term-care home, we immediate notify the family and then provide updated assessment information to the home, identifying any changes in the person's condition, to confirm that the home is still able to provide the needed care.

If a person agrees to move into a long-term-care home that wasn't their preferred choice, they also have the right to keep their other choices open and remain on the wait-list to transfer at a later date.

While guided by an extensive legislative and regulatory framework, the long-term-care home placement process is ultimately designed to ensure that people get the right care in the right place at the right time.

But it is also a complex and often very heartbreaking process. How do you fairly balance the needs of a frail senior with Alzheimer's who is at risk of wandering, with those of a couple who have spent the last 60 years together, with those of a Russian-speaking senior wishing to spend his remaining time with people of his cultural heritage? All three may be waiting for the same type of bed in the same long-term-care home, close to their family and friends.

The purpose of the Auditor General's review was to assess whether the long-term-care home placement processes at the North East, Central East and Waterloo Wellington CCACs were effective, efficient and consistent.

We were very encouraged by the Auditor General's finding that CCACs overall were managing the process well. In fact, since the report was released, we've worked closely with staff at the Ministry of Health and Long-Term Care and with our colleagues within the CCAC network in Ontario to act on the specific recommendations for improvement directed at CCACs in the province.

You do have our report summarizing the progress we've made to date, and outlining the remaining work to be done.

I'd like to take a few minutes to highlight some of what we've accomplished.

The North East CCAC was one of the first in the province to publicly release wait times for the long-term-care homes in our region. While just one tool, this level of reporting has been extremely beneficial in helping families choose the homes that they wish to apply to and understand how long they may have to wait.

Starting this month, I'm pleased to say that all 14 CCACs will publish long-term-care home wait-list reports, using the same wait-list metrics across the province. We felt it was important that the information provided should be the same across the province, as it is not unusual for people to consider homes across CCAC regions.

CCACs have universally adopted an enhanced online information referral system called thehealthline.ca, which can be used by our staff, health providers and the public at large to identify services and resources in any community across the province. The system provides in-depth information about long-term-care homes and will be one of the places where wait-time information is made publicly available.

We're also process of implementing a province-wide electronic referral system to long-term-care homes. Through the e-referral process, homes are alerted when an applicant chooses their specific home, and all of the relevant assessment information is made available to them securely online.

This new e-process is helping long-term-care homes respond to applications more quickly, and is contributing to patient safety by ensuring that all patient information is available in one place.

Finally, this November, all 14 CCACs will have common protocols in place to allow for peer audits on our placement process, to ensure that we are compliant with the regulations and are administering the placement process fairly and appropriately.

Just a couple of comments in closing that may surprise you: The overall number of people waiting for long-term-care homes in Ontario has actually decreased. One would say, "Why?" Because we can now provide enhanced levels of support at home as well as access to new models of care, like convalescent care programs and assisted living programs. The people who are moving into long-term-care homes are frailer and have more complex needs, and they're actually living in long-term-care homes for shorter periods of time. Because of our collaborative efforts with our acute care partners, there has been a significant reduction in the number of patients moving directly from hospital to long-term-care homes. These are very positive trends.

That said, we recognize that moving into a long-term-care home is one of the most difficult transitions that people make in their lives. As CCACs, we remain committed to providing compassion and support to patients and their families throughout the placement process.

I thank you for your time this afternoon. If you have any questions, I could answer or my colleagues could answer. Thank you.

The Chair (Mr. Norm Miller): Very well. Thank you for that presentation. We'll go to the opposition first. You have up to 20 minutes, and you'll have a couple of rounds of close to 20 minutes. We'll start with the opposition. Mr. Barrett?

Mr. Toby Barrett: Thank you, Chair. Thank you, everyone, for explaining some of these things for our committee—

The Chair (Mr. Norm Miller): Excuse me, Mr. Barrett, could you move your microphone?

Mr. Toby Barrett: Yes. Thanks again for coming out. We realize we're here and why an audit was conducted by our Auditor General: Since 2005, there has been an 85% increase in the number of people waiting for long-term care, and there has only been a 3% increase in long-term-care-home beds.

In our package, we were given a news release—I think it was January of this year—from the ministry. I will just quote: "The McGuinty government has created over 9,200 new long-term beds since 2003." I don't have all the numbers. Is that the 3% that the Auditor General is referring to, the creation of 9,000-plus long-term-care beds? I think my questions are directed probably to the deputy minister or the assistant deputy minister.

I guess my second question—I have the ministry figures: 9,200 new long-term beds since 2003. The question on my mind is, how many new long-term-care beds were built before 2003, say, by the previous government? I've got the figures for the McGuinty government. I just wonder how this squares with only 3% being built, which I assume is part of the reason why we have wait times, but we know there are other reasons.

Mr. Saäd Rafi: I'll start generally by saying that I think the focus has not just been about building beds. Part of the reason behind wait times, of course, would be demand against the number of existing beds. I would note, parenthetically, that in the last few years the number of people on wait-lists—as has been referenced by myself and Richard—has come down, in the last two or three years, actually. Some of that is also due to the investments being made on the community side of things.

In the past, I think people saw long-term-care homes and those beds as a different place to go than they do now. They're coming in with more frail conditions because they're staying at home longer and longer.

I'll have to get the number of beds built pre-2003; I don't have that with me.

Mr. Toby Barrett: We're here for another hour or so, if that could come forward.

I know also that in the Auditor General's report it indicates that over the next 10 years, the older long-term-care homes—again, containing 35,000 beds—will be renovated for wheelchair access and a number of things like that. So in the next 10 years, 35,000 beds will be renovated. I guess my question is, how many have been renovated in the last 10 years? I assume these are the C beds or the B beds.

Mr. Saäd Rafi: They are the B and C beds. We targeted those beds, I think, in 2007-08—I hope that date is correct; if not, it's the year after—for redevelopment, thinking that it might be a five- to seven-year process, averaging maybe 5,000 to 7,000 beds per year. We have not had that level of success in redevelopment, so we've just conducted two extensive market soundings with the industry to get a sense of what's holding them back from some of those redevelopments. There are all manner of different reasons, with some having to decant individuals in the interim while beds are redeveloped; in other words, it's a reconstruction activity in some cases. So we're in the throes of trying to put together some strategies on how to respond and encourage that redevelopment, but we are behind target.

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Mr. Toby Barrett: Okay. So is there actual money available? As an MPP, I've certainly seen the brand new homes that have been built in my riding—about four of them, brand new. I'm not aware of any of these beds being upgraded or fewer people in a room. Has money been rolled out in the last 10 years for that?

Ms. Catherine Brown: There is a standard per diem that is provided to long-term-care homes that allows them to set aside funds for redevelopment. There was a nominal increase to that in July of this year to encourage more redevelopment, and that hadn't been increased for a number of years, so we are hoping that that will have some impact on homes' interest in redevelopment. But as the deputy indicated, we believe that it's more than just funding that is holding homes back. There are a number of issues that they have raised with us, as noted, that we're looking at how we might best address and work with them to allow them the opportunity to redevelop, knowing that they want to do that.

Mr. Toby Barrett: So we haven't really seen big capital grant announcements in the last 10 years like we saw previously for the new buildings that went up.

Mr. Saäd Rafi: Right, so—you know, you probably should never go on recollection, but to your first question on pre-2013: Yes, as you probably recall better than I do, there was a large capital project announced to build several thousand new beds, and that gets us our current stock. There is a specific construction allocation in the per diem for these bed redevelopments, but we also want to get a sense of what the gap is in what we are providing, and why developers are not prepared to redevelop these beds.

In some cases, the larger homes are sitting on some significant real estate, so that may be an issue for them; they may want to have a higher purpose for that real estate. In other cases, they may feel that the money is not sufficient, so we're trying to do a cost analysis to figure out what it is costing in today's construction market. There's not just one market in Ontario, obviously.

Mr. Toby Barrett: Okay. To change direction a bit, one of the Auditor General's recommendations: The ministry should be streamlining health assessments to avoid duplication and, again, ensure that clients are placed as soon as possible. We understand that, in the legislation, health assessment has to be done by a doctor or a nurse—I think that's the law.

I know we talk about duplication; I'm wondering if it's even triplication. There would obviously be an assessment done when, say, a patient is discharged from a hospital and perhaps on their way to a long-term-care facility. That is done, I assume, by a doctor. Then, at the CCACs, another health assessment is done there. Then, say there is a transfer of that patient to a long-term-care facility. That facility, I think, would have an intake procedure where they would also do an assessment.

Does everybody use the same forms, the same tool? In this case, leaving one institution, flowing through a CCAC and entering another long-term-care institution, is it the same tool? Is it the same forms that are filled out? Does it have to be done by a doctor in all three cases, or a nurse? That's my first question on that.

Ms. Catherine Brown: Okay. I will start, and then I will hand off to my CCAC colleagues to respond.

We have made some changes in response to the Auditor General's report. It may appear that there is some duplication, and in some areas there may be duplication, but in other areas it is because people need to be reassessed before they enter the home. Sometimes people choose to be on a list for a longer period of time, or are on a list for a longer period of time, and so we've changed the requirements and the regulations. Those changes go into effect November 1, to require—sorry; that's not accurate. But we've clarified the policy as well, to ensure that necessary assessments are done so that clients are reassessed at least three months before they are admitted to a long-term-care facility, and they are assessed as necessary according to the CCAC or their primary care physician for their care at home through that time period that they're waiting. But we no longer require a six-month assessment regardless.

Mr. Toby Barrett: I know the Auditor General recommended a "touch-base" assessment, like updating. Does that make sense?

Ms. Catherine Brown: The CCACs are working with that on the ground to ensure that that touch-base happens, but we do require that they're assessed within that three-month period before they go into a home. It's important to see what their needs are and whether or not their needs have changed.

As my colleague Richard described earlier, we want to be sure that the right bed is the bed that they are going into. So we require them to be assessed at least three—

Mr. Toby Barrett: Yes. So I guess my question is: This is done two times over or three times over, then?

Ms. Catherine Brown: We're working to streamline that. It shouldn't be done two or three times over. It should be done as necessary by those in the community. I'll—

Mr. Toby Barrett: No, I'm referring—three times, like from the source, through the CCAC and to the ultimate home.

Ms. Catherine Brown: No, it is not. I'll let Richard speak to the—

Mr. Richard Joly: I can certainly elaborate if you want. I know from our area, there is a need for a physician to do their own assessment from a medical point of view. Their lens is very different than the CCAC, for example.

Our assessment is a standardized assessment across the province. We use the same assessment regardless if you live in downtown Toronto or you live in Thunder Bay; it's the same assessment. We have the ability to even share between CCACs this particular assessment. So if it was done recently in one area, in one hospital, but the person is transferred, we share that information. We don't do that reassessment.

But it is critical that we do the reassessment within that period of time, within the three months. Conditions do change and seniors do age in place. I can give examples of seniors that are frail, are approaching the end of life, and who in a period of three months can change significantly. That update, that refresh, that reassessment is critical for the home just prior to assessment.

I know that we always—we will not now go on a standardized six-months automatically and just do a reassessment for the sake of doing a reassessment. We do it for the touch-base, making sure that it's value-added to the long-term-care home, but also value-added to the caregivers and families to say, "Are we making the right choices? Is this the right home?" And we provide that information to them.

Mr. Toby Barrett: So the sharing within the CCAC system, but again, going back to the source of the referral and the destination of the referral, is there sharing there? Is it the same assessment tool? These are my questions.

Mr. Richard Joly: We don't have the same assessment tools; for example, from source. If it's from a hospital or from a physician, we don't have the same assessment, but we do share our information. When they do their own assessment, it is not as in-depth as what we require for a long-term-care-home application. When we see the assessment done either in-hospital or by a physician, it may be a one-page or a two-page, but we need to do a more in-depth assessment. That's our practice in the North East.

I'll pass it on.

Mr. Don Ford: I would just add that every stage along the way has a different purpose for their assessment and a different depth and a different view. The one thing that we have done to try to smooth that out and to address the issue you're raising is that within the hospitals in our region, we've now embedded in every hospital care coordinators who, at a very, very early stage of an individual's contact with a hospital, are involved with them and are facilitating the assessments using our tool, so that we're reducing the amount of reassessment that may need to be done. Our care coordinators do the assessment in the hospital and pass it on to their colleagues in the placement area. That assessment has continuity, and that's the essence of the information that we then provide to the long-term-care home. They will have to do an assessment for very specific questions they ask. The hospital may do an assessment for very specific issues that they're dealing with. But within the transition block, we've tried to, through our care coordinators in hospitals transferring individuals back home or to long-term care, smooth that out using the common assessment that Richard spoke about.

Mr. Toby Barrett: So care coordinators and other supervisors or managers under the law: They're not required to be a nurse, are they?

Mr. Don Ford: Our care coordinators are nurses—are regulated health professionals.

Mr. Toby Barrett: Is that required by law?

Interjection.

Mr. Toby Barrett: It is required by law, for coordination—

Mr. Gordon Milak: Yes. By policy.

Mr. Toby Barrett: By policy. The law actually requires a nurse at a computer to fill out that assessment form? Is that required by law?

Mr. Richard Joly: Not necessarily a nurse. A regulated health care professional, as I alluded to in my comments earlier, could be a social worker, a physiotherapist, an occupational therapist, but for the most part, our care coordinators in Ontario are nurses.

Mr. Toby Barrett: Okay. Thank you.

1300

Mr. Bill Walker: A couple of follow-ups, if I could.

The Chair (Mr. Norm Miller): Mr. Walker.

Mr. Bill Walker: Thank you, Mr. Chair. Thank you again for coming—a pleasure.

A couple of follow-ups on my colleague's questions: I may be using inappropriate terminology, but with the upgrade per diem that we were talking about earlier, do you have any kind of accountability process built in? What I mean by that is, do you track the progress? So if a home says, "I will do X, Y, Z beds," and you're giving them the per diem in that allotment, do you have a timetable? Do you have a progress report? And if they're not meeting those intended goals, what's the repercussion? What's the protocol?

Ms. Catherine Brown: On redevelopment?

Mr. Bill Walker: Yes.

Mr. Saäd Rafi: I don't know the exact steps in the process, but, yes, we've actually recently re-examined that process by including all manner of financials, the ability of the home to deliver on those changes. If it's a provider we're not as familiar with, we'll have different milestones. Milestones must be met. Per diems are provided as those milestones are undertaken. So they have to qualify for the redevelopment process. I'd have to get you the steps that we undertake. So if you allow me to do that, I will.

Mr. Bill Walker: I would appreciate that. I guess the other piece of that that I'm really trying to get my head around—I'll just throw out a number. Let's say that there are 1,000 of these available, but we go through a year and a half and there has only been 20 of them developed. Are you then going to those people saying, "You're off the docket. There's another home over here that can make it happen," so that that money's being utilized and the patient, first and foremost, is always getting the service and care they require?

Mr. Saäd Rafi: I would like to say that—it's dynamic, in the sense that it isn't just, "You didn't show up this year. You're not going to be around next year." But, candidly, the demand has not outstripped what we had budgeted or pegged.

But, yes, if you couldn't get your system together for this fiscal year and you wanted to come next fiscal year, we'd want to be open to that because we want to see those beds redeveloped.

Mr. Bill Walker: The other is kind of on the placement side—and I hear this anecdotally in my riding a fair bit. Who is the final arbiter if someone needs placement? Is it the doctor or is it the CCACs?

Mr. Richard Joly: That's a good question. One, I think it's the patient themselves and the caregivers who decide this, so they make the decision and so on. In the event that that person is not able to consent, to make that decision, there is a process we can follow through regulation and so on to make that decision. So, really, it's not the doctor or the CCAC. We determine eligibility based on consent. It has to be consensual to enter into a long-term-care home. If they can't consent, that's a whole different issue.

Mr. Bill Walker: Sure.

Mr. Saäd Rafi: Can I just supplement? It depends what type of physician at what part of the process, if it's a referral from the community or if it's a referral from hospital. I think we still have circumstances in hospitals where "long-term care" or "nursing home" is a euphemism. A nurse or a physician may say, "Your mother cannot be on her own at home" or cannot be on her own for X number of hours a day, and many times, that's just become, in the sibling's or the children's mind, "Oh, she has to be in long-term care." I think that becomes a factor, and that's why assessment and the thoroughness of assessment, not just sitting beside a computer, is really critical in the steps.

Mr. Bill Walker: I'll provide a bit of an anecdotal. The reality that I'm hearing from operators is that in past times, the doctor would call—directly, in some cases, because they knew the operators very well. They've been established in the community for many, many years. They've got a good rapport and a good relationship. They've dealt with this patient for 20, 30 years. They know where they're at, and they're saying that that person absolutely needs a bed today, and virtually it was done seamlessly and overnight. Now what we're hearing in many cases is that they can't even call directly. They have to go through the CCAC.

I'm not necessarily arguing that there shouldn't be a protocol, but the reality is, I'm hearing from these operators that they have empty beds—significant empty beds. I'm hearing from the other side of the coin, from the parents or the children of parents, saying, "Grandma or Mom can't get into a home, and yet we see these empty beds sitting there," and that referral process seems to have been the dynamic change and the cog in the system.

Again, I'm just trying to get a bit more clarity, because I hear from all different aspects. I have the experts in the room, so it'd be great to hear.

Mr. Richard Joly: I can start. I'm not sure it's factual that there's a whole lot of empty beds. I speak for the North East; there are not a lot. But there are some empty

beds in older homes, that's for sure. Usually, those are not the beds that people will advocate for. So they want to go in the newer homes and so on, which take longer.

I'm sure we wouldn't want a system where it's who you are and who you know that you enter in a long-term-care home. We're the neutral broker. We assess everyone the same way, and then, based on your needs, based on the categories that we have—and they are regulated categories—that person, based on their assessment, has that category attached to their priority. So it's a priority system based on needs, and that's how we determine who gets the next available bed.

Certainly, we do a lot of counselling, so the role of that care coordinator saying, "We do assessments and so on," is critical, all the counselling that occurs between the care coordinator and the physician and the family to make sure that they're making the right choice. For example, that whole publicly available information on our homes and available wait times—when you say "idle beds," they're usually in the older homes. We say to the family, "Look, it takes this much time on average to go into that home, so you may want to put that as your choice. But ultimately, you have the right to choose where you want to live, which is that you can keep one first choice." The downside of that is that, "Look, your first choice is the most popular home, which averages a wait of 300 days, for example, versus 30 days." So putting that publicly and educating our families and patients really has helped that process, so they can make the right choices for them.

The Chair (Mr. Norm Miller): Thank you. We'll move on to the NDP. Ms. Gélinas?

Mme France Gélinas: Thank you. My first series of questions will be for Deputy Rafi. Picking up on some of the comments that my colleagues have made, you've talked about the redevelopment strategy that has not rolled out the way you wanted. We certainly did not see the 5,000- to 7,000-bed pickup. You're talking about what could be done for the future. Can you put a bit of a timeline as to when we can expect a new strategy for older homes' redevelopment, and will that be made public?

Mr. Saäd Rafi: No, I can't give you a time frame, but I can tell you some of the steps we're undertaking. We're trying to match wait-lists against A-, B- and C-type beds across the province. There are 630-some homes, and there are people on the wait-list—some 20,000. First, we're trying to match that up to see where the greatest need and greatest problems are. Then, we're trying to understand what the construction environment is in those communities—the availability of construction, what are the current costs—so that we can determine how big that gap is. Because maybe there are other models in which we can do this redevelopment.

The other thing we have to look at is that there are many different types of home providers: large, publicly traded, municipally run and owned, and small, private, not-for-profit as well. So they have all manner of differing abilities to finance, differing abilities to take on additional debt etc. So I don't think we can assume any longer that we have a one-size-fits-all, and that is through a per diem model.

This is not government policy. I'm giving you what my understanding of infrastructure is and why I think we have some challenges, and what I've been asking our team to figure out.

That's why we did market soundings with the sector, to try to get the sector's view back. They gave us some really good feedback on some things that could be helpful to them. For example, CMHC has made a decision that they are no longer going to insure these types of mortgages across the country, apparently—they're trying to run that to ground. Is that truly the case? If it is, what can we do in Ontario to help with giving a 25-year licence some sort of confidence to CMHC so they can help those operators, because for some operators, having that ability to have that mortgage insurance backing makes a big deal for their investment, by way of example.

There are maybe some regulatory or procedural or architectural elements that we don't need to have anymore. Maybe things have advanced. Have we advanced to keep pace with those? That's the nature of what we're trying to do.

Mme France Gélinas: So I guess my question, coming from Nickel Belt and the situations we have, where the fact that we have so many beds that are in older homes that are very few people's first choice—when I hear you talk about everything that needs to be done before a new model is put forward, it kind of puts redevelopment, in my mind, almost a decade down the road.

Mr. Saäd Rafi: Well, I would certainly hope not. We're not working towards that goal.

Mme France Gélinas: Can you try and narrow that down for me?

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Mr. Saäd Rafi: No, I can't. I can't give you a number, because no doubt whatever number I choose will not be sufficient, so that's a bit of a risk not worth taking.

Look, it's complex. I think government has to be conscious of not just picking a number in a per diem and saying, "Well, that's on offer, if you don't want to take it up." If that's not working, then we also don't want to give too much, because, candidly, we have some companies that are for-profit companies here, and you don't want them to make—I have no qualm about the need for profit—an unnecessary gain. So I think it needs to be carefully studied.

Mme France Gélinas: I would agree with this, but what I would also add is that since 2007, we've had on the books this per diem. The pickup has been abysmal, not only in the North East but throughout. We're now in 2013, and we're now just looking at consulting with the sector to see how we move things forward.

If you get anything from our little exchange here, it's that if you can hurry this on, it makes a whole lot of difference for families that are going through a really tough time right now because they can't get their loved one into the home that they want.

Mr. Saäd Rafi: I agree that this is of some urgency; there's no question about it. Not to split hairs, but I misspoke; it was 2009. Nevertheless, that was 2009. It's been four years, and we have not seen the type of response we hoped for.

But we didn't just start the consultation. We've had our second round of it. We're drilling down on it. We did one over a year ago, and we just concluded one now.

Mme France Gélinas: All right. I would like to talk about financing of CCACs. The auditor made it clear that there was substantial variation in the amount of services that CCACs can provide, basically because in the past, funding for CCACs was based on what they received historically. What has the ministry done to make sure that this historical disparity between CCACs has been addressed?

Mr. Saäd Rafi: I'm not sure I would say historically that—well, I'm speaking now provincially, not by each CCAC—that it was just simply that what you got last year is a function of what you get next year. In some years there was a 6% increase; in another year, there was 12%; then 9%; and then 6%. But in the last few years, we've held spending from a historical 6% to 8% growth and brought that down to 3.5% and are now trying to hold it at 2% growth.

However, for the community sector—CCACs, community supports, assisted living and that nature of funding—three years ago we provided three-and-a-little-bit per cent; last year was 4%; this year is 6%. So we've tried to smooth out—

Mme France Gélinas: But your answer kind of says that we will continue to fund historically, so you get 3% of what you had before.

Mr. Saäd Rafi: No, no. What I was trying to illustrate was that where others in the health sector were held to zero, such as hospitals, we were providing 3%, then 4%, then 6% increases, in a time of fiscal restraint. In other times, they received the same amount as, or more than, other sectors within the health sector. So I think as of late, there has been a real recognition, in the last three years especially, that the community sector needs a great deal more investment.

Now, not all that money has gone to CCACs. It has gone to other investments within the community—assisted living, supportive housing. The CCACs themselves don't benefit from that, but that's not the point. The individual patients and Ontarians do.

Mme France Gélinas: So—

Ms. Catherine Brown: May I supplement? To your point on the distribution of those funds: The overall base remains the same, and it is 4% or 6% on that. But then the distribution across the LHINs is not just based on 4% of what you got last year—

Mme France Gélinas: No, but I was not interested in within the LHINs. I'm interested in the Champlain CCAC having way more resources than the North East CCAC. Every time you add the 3% to the Champlain LHIN and the North East LHIN, then you are just continuing to multiply this regional disparity. One CCAC—sorry about picking you—starts off way better off than the others, and then every time you add—I don't care if it's 3%, 10% or 20%—you add it on historical disparity, where they did not start out as equal.

Mr. Saäd Rafi: Again, if I play out your theory or your approach, then we would make everybody equal to Toronto Central, right? Because every CCAC should be equal. That doesn't make any sense to me whatsoever, given the population base, the density of those individuals, the acuity needs in that area. So we use a population-based model called HBM and we allocate funds to hospitals, and now we've moving to CCACs and then eventually long-term-care homes. But if you're suggesting that the northeast and the northwest in all areas of government funding should be the exact same as the southwest—because that's what you're saying. So I don't—

Mme France Gélinas: I'm talking about equity, not equality.

Mr. Saäd Rafi: But I'm not sure the case is made for inequities just because they have a different base funding level. That's the only thing I would take a little bit of exception to.

Mme France Gélinas: I disagree with you.

Mr. Jagmeet Singh: Just to build on that same point, the Peel region has seen a remarkable growth over recent years, and their funding models in many areas are being criticized because they are not balanced based on the population. Could you comment on that with respect to Peel region?

Mr. Saäd Rafi: Well, as I said, we have moved in the last two fiscal years to something called a health-based allocation model, which is a population- and acuity-based model. With the help of the CCAC members on our implementation committee and the steering and advisory committees, along with hospitals and representatives from other community services, we are now taking that model that we applied to hospitals and we're adapting it to CCAC funding.

Is it perfect and has it caught up with every area's growth? Probably not. We rely on municipal official plans, Statistics Canada growth projections and Ministry of Finance data as well, and that's our objective. I don't for a second sit here and say that it is perfect and 100%, at this point, efficient.

Mme France Gélinas: The auditor's report also contained a number of recommendations that would potentially require amendments to the long-term-care act. When you talk about discontinuing health assessments or moving on to a check-in, has any consideration been done to modifying the long-term-care act?

Mr. Saäd Rafi: If you're referring to the discussion that we were just having about the period of reassessment prior to placement—is that one of the examples you were thinking of?

Mme France Gélinas: Sure. We can use that.

Mr. Saäd Rafi: We thought that that required a legislative change. In fact, Catherine has written to all the CEOs of the CCACs on an interpretation that says that

you don't have to have a set schedule of assessment and reassessment, but reassess where you think it's necessary and definitely reassess three months prior to admittance into a home, because the home will want that information. That's the most recent assessment of the care needs, and we haven't yet come to ground of what other legislative changes may be needed to the Long-Term Care Homes Act.

Mme France Gélinas: Okay. Richard, c'est à ton tour. T'avais-tu hâte?

Interjection: I found it.

Mme France Gélinas: Thank you for coming to Queen's Park. My first series of questions will have to do with first-available bed. This is something that other jurisdictions have been using. This is something that, unfortunately, in your particular CCAC, you've been forced to use because of a hospital-designated crisis. I just wanted to have your lived experience as to what it means when a client is forced into the first bed.

Mr. Richard Joly: I can tell you that since 2010, nobody is forced into a long-term-care home that they don't want to be in. In fact, before that also, I would say they weren't forced.

The challenge that we had in your specific area: That particular hospital had been under crisis, if you use that term, for five-plus years, on and off, but almost all the time in crisis, which required the hospital to do some counselling with family and encourage them to pick all seven available homes and any bed at any time.

Certainly that practice has not gone on in your area or any area in the northeast since July 2010, but there are consequences to that. People wait longer in hospital, they wait longer for their first choice, and that's why publicly we release the wait times, so that they can make informed choices.

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But yes, there is that consequence of people waiting in their second, third, fourth choice. They don't want to be there; they want to be in the home that is definitely newer. Unfortunately, they are there, and there are other people in front of them with a higher priority based on the priority system we use, because then they become a priority for A, as we call it in our category—and those categories are available on the website also. But all the ones need to be placed first, all the twos and so on, and unfortunately, they stay there for a long time, and we all know that seniors don't have the time when they're in-home. They don't have the luxury of time. It is an unfortunate situation, but I can tell you that people are going into their first choice now. They wait longer, but at least they're going into their first choice since July 2010.

Mme France Gélinas: How many people would you say you still have who are waiting to transfer into their home of choice?

Mr. Richard Joly: I don't have the exact number today, but I can get that number for you.

Mme France Gélinas: Just two or three, 20 or 30, 200 or 300?

Mr. Richard Joly: There's likely hundreds.

Mme France Gélinas: In the hundreds?

Mr. Richard Joly: Yes.

Mme France Gélinas: And how long have some of those hundreds of people been waiting to go into their first choice?

Mr. Richard Joly: For the most part, on average, two years, two-plus years, but there are some that have been three-plus years in homes.

Mme France Gélinas: So if Ontario was to bring a policy forward that forces first bed, would you see that kind of scenario rolling out in other parts of the province, the same things that has happened—you have hundreds of people that are not in their first home, that have to wait for years and years before they get into their first choice?

Mr. Richard Joly: I won't speculate. That's not a good thing to do. Certainly, I can tell you that people will not be forced; they need to consent to be in their home. That's where the critical role of the care coordinator comes into play, and a lot of counselling and being very transparent, that the caregiver and the family are making informed choices that if you're waiting for the home that's the most popular, you'll wait X amount of days on average, but you can go in this home and it's much, much shorter. So the counselling will be critical moving forward. Because people shouldn't be staying in acute care either, so it's a balance and making sure that we're assessing, counselling and making sure the care is given at the right care, right time, right place.

Mme France Gélinas: Can you give me an idea of some of the complaints you have received from families that have been from clients themselves that are not in the homes that they wanted to go?

Mr. Richard Joly: The type of complaint?

Mme France Gélinas: Yes. Give me examples.

Mr. Richard Joly: Well, you know them, for sure. They are seniors that are in homes that they don't want to be in. They are much older seniors, and like I said, this process is heartbreaking at times, and we do have to work within the framework that we're given. I don't have all the examples today, but they are heartbreaking stories, that's for sure.

Mme France Gélinas: We will all remember the story of a husband calling his wife every day for years because she was in a home at one end of the city and he was in a home at the other end of the city. He called your office every day to see when his wife would be moved. Do you want to finish the story?

Mr. Richard Joly: Go ahead.

Mme France Gélinas: The story is that she died the day that she was finally transferred, and they never got to be together for the last two and a half years of their lives, and they had been married over 60 years.

We have hundreds of cases like this in Sudbury because of the five years that our hospital was in crisis 1A. I have two complete filing cabinets in my office of over 200 people—those are the people that live in Nickel Belt. I'm sure Mr. Bartolucci has just as many that live in Sudbury that are in this. So it was just a forewarning that this policy of trying to discharge people into the first bed

available comes with great hardship on a lot of people. I've shared one of the stories. There are many, and as Richard has said, all of them are heartbreaking.

My colleague wanted to pipe in.

Mr. Jagmeet Singh: I'll use it for the next round.

The Chair (Mr. Norm Miller): Very well. We'll move on to the government. Mr. Mauro?

Mr. Bill Mauro: Thank you, Mr. Chair. Welcome, everybody, and thank you for being here today.

My first question is for the deputy. One of the numbers that I use when I speak in my community of Thunder Bay–Atikokan about health care costs is that when we were first elected in 2003, we spent about $30 billion on health care and today we're spending about $50 billion. Am I close? Am I in the ballpark?

Mr. Saäd Rafi: Yes.

Mr. Bill Mauro: Okay. So it has gone from $30 billion to $50 billion since 2003, and I think we approached that $50 billion one or two years ago. So within the first eight or 10 years, there was a significant increase in total health care spending.

Somebody mentioned about the care coordinators. I think they're embedded in hospitals. Some hospitals? All hospitals? Do all hospitals within each CCAC area or LHIN area have a care coordinator, and who is paying for the care coordinators?

Mr. Richard Joly: I'll speak for my area, but for the most part in Ontario, in the larger hospitals, we have care coordinators. In fact, at Health Sciences North in Sudbury, we have over 30 care coordinators who are on site every single day doing discharges, and they're paid by the CCAC.

Mr. Bill Mauro: And they come through your budget?

Mr. Richard Joly: They come through our budget. We work very, very closely with our hospitals and acute care partners for integrated—

Mr. Bill Mauro: Thirty care coordinators in one hospital? That's remarkable. Not to understate their work, but their focus and only focus is the discharge and getting—30 of them in one hospital?

Mr. Richard Joly: Correct.

Mr. Bill Mauro: How many beds are in a hospital?

Mr. Richard Joly: But the small hospital—I just want to clarify. The smaller hospital doesn't necessarily need a care coordinator on site all the time. So the strategy that we're working with small hospitals on is—we have care coordinators in those communities, so their home office would be the hospital, so they would be coming in and out, doing assessments in the community but also working in the hospital.

Mr. Bill Mauro: I see. Okay. I wanted to talk about wait-lists, and I think it was you, Mr. Joly, who said something about wait-lists in your CCAC. Through your LHIN, I believe you said—it was the first, I think you said, community care access centre to publish your wait-lists, your wait times. I think you said that. From that, I'm concluding that it's not legislated, that you all have to do it. But then I thought I heard the deputy say that we are going in that direction. Can somebody, first of all, clarify for me whether we are required legislatively to post these, and if not, if we're moving in that direction, just as quickly as possible? Or is it up to the individual CCAC right now?

Mr. Richard Joly: I can tell you that now all 14 this month will actually publish their wait times in a very standardized format, the same way across the province.

Mr. Bill Mauro: Okay, so it's coming.

Mr. Richard Joly: It's here.

Mr. Bill Mauro: It's here. All 14 are going to publish their wait times. Is it through regulation, legislation, through a policy? You all got together—

Mr. Richard Joly: It's through the Auditor General's report's recommendation—

Mr. Bill Mauro: —through the gentleman over here, the Ontario association? You all said that we're going to do this, more or less?

Mr. Richard Joly: We voluntarily said—

Mr. Bill Mauro: Understood.

Mr. Richard Joly: —we're going to do this.

Mr. Bill Mauro: Okay. Because here's my question on the wait-lists. We learned something very interesting this morning. We had a briefing in this committee this morning, and in one of the reports that we received—and I want to drill down to the numbers that are actually on those wait-lists a little bit. There was a number provided to committee this morning that showed the total number of people on wait-lists for long-term care in the province of Ontario. It's approaching 32,000. Then a little further along in the deck that we were provided, there was a bullet point that would have been easy to miss, but it said that 40% of that number are actually people who are in a long-term-care home but who haven't received their preferred choice. So for me and for others, I'm sure, that was very significant to learn that. So the 32,000—I'm doing rounding here—less 40% is the actual number of people who do not have and who are still waiting for a home.

My question is, when you post your numbers as an individual community care access centre within your LHIN boundary, do you post your number minus that 40%, by your individual piece, or do you put the global number up, where people may be in a bed in your CCAC but don't have their first choice?

Mr. Richard Joly: I can speak for the North East. Our fact sheet, and I have it in front of me, actually posts that number.

Mr. Bill Mauro: Which number?

Mr. Richard Joly: The number that you just referred to: 40% are already in their first choice. Because if you look at—

Mr. Bill Mauro: Just so I'm clear, your CCAC will post a number 40% lower than—

Mr. Richard Joly: So it's a bit confusing—

Mr. Bill Mauro: Yes.

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Mr. Richard Joly: —and that's why it took some time to actually publish this, because people will go

straight to the wait-list and count them, and will say, "There are 800 people on your wait-list, so we need 800 new beds." Some 40% of them are already placed, so we put that on a fact sheet to say, "Be careful with that large number, because they're already there."

Mr. Bill Mauro: So your website will still show the global, larger number, but it would also clarify it by saying "less 40%, more or less, depending on your individual circumstances"?

Mr. Richard Joly: I will take that back to the provincial group that is looking at the fact sheet, because—

Mr. Bill Mauro: But you are doing it already—

Mr. Richard Joly: We are.

Mr. Bill Mauro: —so what are you showing?

Mr. Richard Joly: It's around that 40%.

Mr. Bill Mauro: Okay. So you're showing the larger number, and then, somewhere on your website, you are saying, "less this number of people who already have a bed; it's not their first choice."

Mr. Richard Joly: Correct. Yes.

Mr. Bill Mauro: Okay. On a go-forward basis—we're doing this in a voluntary way. I'm wondering: Is this what everybody is going to do? Are you all going to follow that same pattern, or is it going to be up to the individual community care access centre?

Mr. Don Ford: I would suggest, in preparing this, to try to be as common as we can be, so that it is in the best interests of the citizens. We will take this back and we'll make sure that, whatever adjustments we make, we all make the same adjustments, so that people are always comparing, to the highest degree possible, apples to apples.

Mr. Bill Mauro: It's the kind of thing that's really easy and jumps off the page, and can drive policy. I'll tell you, if I would have walked away from here and not been at the briefing this morning, and somebody had told me "32,000," I would have believed that that was the number. That's a number that would drive policy-making, should people not know any better; obviously, the deputy would know differently, but I think it's important for us as individual members to know that.

I'm from Thunder Bay. My North West LHIN is not here today, but I'm hoping that they're listening, or that I am going to remember to talk to them about this, so that when Laura Kokocinski goes to post her numbers—voluntarily, along with the rest of you—her global number will reflect the actual number of people who already have a bed that wasn't their first choice.

Mr. Barrett, in his earlier questions, raised issues related to capital funding. I lived this very personally when I was on city council in Thunder Bay. The previous government brought in their category system—A, B, C, D—and there were some questions raised by Mr. Barrett about any capital funding announcements. When the categorization came in, the D beds were left with no choice; you had to rebuild, and you were given a time frame within which to do that. When I was on council, it's my remembrance that there was no money that came along with the D-category beds. In Thunder Bay, we had two homes of 150 beds each that were D-category homes, for a total of 300 beds. No money came along with us having to rebuild those beds. I was part of a council that debentured $44 million to rebuild those 300 beds. A subsequent council changed their position; I'm not sure where the money went, but they decided that they were not going to rebuild.

To get to the point of Mr. Barrett and capital funding announcements: We now, as a province, have stepped up to the plate, and we—just in the last several months—began a groundbreaking where 416 newer beds will be built to replace those D beds. That's a $100-million project, along with 132 supportive beds. It's called CEISS in Thunder Bay, the Centre of Excellence for Integrated Seniors Services. That will be administered by St. Joseph's Care Group. That's $100 million that may not be reflected anywhere in a large capital announcement and you may not see if you're looking for something. Maybe it's being done on a project-by project basis.

Here's my point for the deputy: We've talked a fair bit today about managing the wait-list by driving more money into community care. In the remarks, there is some language of about $800 million or $900 million that has gone into home care over the last period of years.

I'm looking for you to talk a bit more about that, because while there may be some who would say that there have not been enough capital funding announcements to create more beds, the home care/community care piece is a significant component of the approach we've taken to deal with the aging population and keeping people where they would prefer to be: quite frankly, in their own homes, where it's cheaper to be.

That $800 million or $900 million that has gone into community-based care is part of, maybe, a long-term-care-bed announcement that others might prefer to see where we're just building more homes. Deputy, I'm wondering if you could remark on that quantum, what it has accomplished, and how long we have been doing it.

Mr. Saäd Rafi: I believe we started this investment in 2008-09. That number takes us from 2008-09 to 2012-13. It doesn't include the investments in 2013-14. That would bring it to well over $1 billion; it would be about $1.1 billion. What is behind that investment is a clear preference by Ontarians to age in place, that place being at home or in their community. We've heard examples of the need for that community care. That has really changed the focus of long-term-care homes and the nature of the resident who finds herself or himself in long-term care.

Mr. Bill Mauro: So while we may determine, at some point, that there is a need for more long-term-care beds, it's important to remember that $1 billion-plus has been invested already in home care and has significantly relieved the need for more long-term-care beds to this point, even though we still may need more long-term-care beds.

Mr. Saäd Rafi: I think, with the demographics Ontario is facing, along with other jurisdictions, we're going to need more of everything to deal with this very significant issue that is upon us.

Just one clarification: We have very, very few D beds left. They have been redeveloped, so we're really now focusing on Bs and Cs.

Mr. Bill Mauro: Okay. I wanted to go to a point that was raised by Ms. Gélinas, and I think it's a good point. Where she went with it is a little bit different than what I want to talk to you about. It's the policy of first choice. I don't know this, but I don't think any of the parties are interested in necessarily changing that policy where a senior can tell the community care access centre what their first choice of a bed would be. Although, as we learned this morning, there are, I think, five other provinces where they tell you where you're going, more or less; you don't necessarily get a first choice. It's interesting.

My question is this: It seems to be a wonderful piece and a good thing to do to allow people their first choice, and it's generally the family members who are really driving that as much as or more than the individual themselves who is going to need the placement—and we've all met them in our constituency offices. My concern about it is if a senior languishes on the wait-list for a significant period of time because their first choice is not available to them, and they end up in the hospital taking up an acute care bed—maybe their needs are acute care. I would have to believe that in some instances, they're not, and that it's only that they've progressed between home care and long-term care; maybe a supportive piece would be best that isn't offered in a community. I guess I'm looking, maybe again at you, Deputy, for a comment on what that first-choice policy can do in terms of our acute care capacity in Ontario.

Mr. Saäd Rafi: I don't want to just make that direct nexus with that policy and that it is affecting all of acute care; I know that's not what you said. By the way, we're hearing of other jurisdictions moving away from first available bed, actually, most recently Alberta, which is interesting. This notion of first choice, and Richard said it really well, is that this is the difficult balance between the desires of the family—and many times, they're different from the desires of the individual. The family, with all due respect, wants to put pressure because, in some cases, they're not prepared to take on the challenges of dealing with the parent. I'm not criticizing them for it, because it's a very difficult time for everybody.

So yes, that has caused some—not that specific issue, but there has been some impact on acute care, and we refer to that as alternative levels of care. We work really hard to get those numbers down, and we're starting to see that that has been cracked in the sense that we've consistently seen every LHIN and CCAC bring those numbers down because of a home-first philosophy, aging at home, supports in the community for housing, assisted living and this over $1 billion in spending.

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Mr. Bill Mauro: Sorry. Before I go on, you said that other provinces are moving away from first choice?

Mr. Saäd Rafi: First available bed, which is distinct from, "You get your first choice." I think the auditor or her staff may have referenced that there are five jurisdictions, you said, that say, "The first bed that becomes available, you will take it." We've heard that Alberta has moved away from that and is looking to do what we do, which is, "You get your first choice."

Mr. Bill Mauro: They're coming towards—

Mr. Saäd Rafi: That's what we understand.

Mr. Bill Mauro: One of the things—

The Chair (Mr. Norm Miller): Excuse me; the auditor was just clarifying something.

Ms. Bonnie Lysyk: I could be wrong, but I think what we had is BC, Saskatchewan, Manitoba, Newfoundland and PEI in the five that you're referring to. Alberta has had a policy of 60 kilometres, and Nova Scotia, 100 kilometres.

Mr. Bill Mauro: The five you listed are the same as us or different than us?

Ms. Bonnie Lysyk: They are different.

Mr. Bill Mauro: Where they don't allow you the first choice.

Ms. Helena Jaczek: You go to the first vacancy.

Ms. Bonnie Lysyk: That's correct.

Mr. Bill Mauro: Yes, you're told where—

Ms. Bonnie Lysyk: Yes.

Mr. Bill Mauro: Okay. One of the things that I find interesting in the process—we talked a bit about this this morning; I asked a couple of questions about it—is that a long-term-care home can refuse a referral. At first blush, you think, "How could that be?" Then you realize that not all long-term-care homes necessarily provide the same services. The example used this morning was maybe dementia wards, where not all long-term-care homes would have the capacity to care for everybody who was referred to them. I guess, then, it begins to make a bit of sense.

But I would expect that the community care access centres, and if not them, the LHIN within which you reside, would have a good inventory and a sense of what each home is able to do. I don't know that, but I think it would be fairly safe to assume that; and if they can't do it now, I don't imagine it should be too hard for them to figure it out if they wanted to.

The reason I raise that is that it concerns me a little bit—and maybe the auditor said it this morning when I raised it—that this happens only about 1% of the time, where a long-term-care home will refuse to take somebody who has been referred, or maybe that was their choice. Understanding that from time to time, there might be a good reason for a long-term-care home to refuse a referral, I have to ask myself: Given that the community care access centres would know about the home already and the LHIN would know about the home already, why would the referral happen in the first place? Because I don't mind saying it concerns me a little bit that a home

gets to say no. I'm not going to necessarily go into the reasons why that would concern me, but I'm just wondering if, as providers, you think that that authority might be best vested with you.

Mr. Richard Joly: I can certainly answer that. They can only refuse—and it happens very rarely, as I identified. It can only happen for two reasons: They don't have the facilities to provide the care, or they don't have the nursing services to provide the care—only for those two reasons. If they give us other reasons, then we say, "That's not a valid reason." Very rarely—

Mr. Bill Mauro: So you can kind of go back and—

Mr. Richard Joly: Absolutely, and we go back and forth. As soon as a home says no, we say, "Why? Why, why, why?" Then really, till the end, and they've exhausted—and sometimes it gets right to my desk, saying, "Here's a home that refused one of these patients," and the reason why and so on. Then we can go back to the LHIN to say that they need more resources, the facilities are not meeting the needs and so on. We know the inventory of our homes and beds; we know exactly what they can provide or not provide. But the reason we send the referral, saying, "Maybe this one's not so right, but we'll send it anyway"—they may have changed their staffing model and so on, which we're not aware of.

The other big piece is, seniors age in place. The senior we sent through years ago may be very different than they are today. Their population changes all the time. We wouldn't know that, but they would know that, and they would know to say, "No, we can't, because we have 10 new dementia clients in this unit. If we add an 11th one, it's not safe for anybody."

There are reasons for the process. I think the process works fairly well, actually.

The Chair (Mr. Norm Miller): Thank you. We'll move on to the opposition now. Mr. Barrett.

The Chair (Mr. Norm Miller): Thank you, and we'll move on to the opposition now. Mr. Barrett.

Mr. Toby Barrett: Thank you again, Chair. Actually, I'd like to take maybe five or six minutes and then defer some of the time until later. Our health critic and former health critic have left the room.

The Chair (Mr. Norm Miller): Fine. Go ahead.

Mr. Toby Barrett: I'm just looking at a briefing from our Auditor General on wait times. I see the categories "Religious, ethnic, linguistic home (higher needs)" and regular, and I see very long wait times: 14 years for these homes, and three and a half years for the higher-needs people who wish to go to these homes.

I guess a couple of questions. Why is there the demand on these homes? I'm assuming much of it may be loyalty to one's community, for example, or church. How many of them are there, and is it also a higher quality of care or the reputation they have? That's the first part of that question.

Mr. Don Ford: I can address that. We have some of those homes in our CCAC. They're not a higher level of care. The care that's provided in the majority of the homes is of an equal value. What it is—

Mr. Toby Barrett: Equal value, did you say?

Mr. Don Ford: Of equal quality for the client and the patient. What it is—it's often linguistic. So we have homes where people want to go because it's the only home where they have Russian-speaking staff and Russian-speaking residents. There's only one, so if that's what you're waiting for, there's a long wait. Homes where they speak Mandarin or Tamil—it's a case of the numbers of individuals in those populations that are being referred to those homes where there are specific linguistic, religious or language issues that they are trying to have addressed in the interests of the individual, because some of these elders speak nothing but that native tongue. It's a case of wanting them, obviously, cared for in an environment that respects their religion, their language, their dietary habits. So those homes can be very long wait-lists because there are very few of them that have those very specific, targeted population requirements.

Mr. Toby Barrett: And what can we do to deal with these very long wait-lists? Do some of these communities wish to expand their homes or to build a home?

Mr. Don Ford: In those cases, it would most likely be a capacity issue, and that would have to fall into the hands of the overall planning in the province as to the refresh and renewal and the addition of stock.

Mr. Saäd Rafi: I would just hasten to add that our data says that for that category of home, the average wait is 500 days: still long, but I think that has to be considered in perspective if you want that kind of a specific type of home, as Don has indicated.

Mr. Toby Barrett: Five hundred days. Okay. Now, I have some information here: three and a half years and 14 years. That was why I asked the question.

Mr. Don Ford: Again, when you're looking at the admissions to long-term-care homes, there are so many variables that go into it. It may be private, semi-private, basic, male, female, special-needs. So by the time you match all of those up, there may be some cohorts for whom there's a very long wait because there are very few of those beds. But on average, as the deputy says, it works out to about 500-plus days for those homes.

Mr. Toby Barrett: Five hundred days—

Mr. Don Ford: But you have to really parse out each specific subset of individuals to look at. Some of them are in very quickly because they're looking for a basic bed. Some only want a private room, and if they're dementia and they are female and there is no female dementia bed in that—so it's matching the stock against the individual's specific requirements, needs and—

Mr. Toby Barrett: And they're all open to the general public, too?

Mr. Don Ford: Oh, yes.

Mr. Saäd Rafi: Sorry, I misspoke. Five hundred is the number of individuals who are currently, in 2012—well, we're in 2012-13—looking for that type of home. Our average—I think the auditor's team would disagree; we have a disagreement on data, I think, but our average is 291 days for that type of home.

Ms. Catherine Brown: That doesn't mean there aren't specific examples outside of that that may be as described, some number of years, but that's the average number that we—

Mr. Toby Barrett: That's the average? Okay. I just wanted to go back—

The Chair (Mr. Norm Miller): Excuse me. I think Susan, who did some of the work, would like to clarify this a little bit. Go ahead, Susan.

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Ms. Susan Klein: Thank you. There are two different wait times. One is the wait time of the people who were placed during the time period. Then there's the wait times of the people who were on the wait-list at March 31. I think that was the time that Mr. Barrett was referring to. We looked at the number of people on the wait-list at March 31, we looked at the number of people who had been placed in the prior fiscal year, and, based on that, determined an expected time to placement. Those were the times that were being referred to.

Mr. Saäd Rafi: Did you have data on how many people at March 31 were waiting for how long, by individual?

Ms. Susan Klein: Yes.

Mr. Saäd Rafi: So 13 years, 14 years? How many?

Ms. Susan Klein: That would be the number of people who were waiting at March 31, and if you divide by the number of people who were placed in the prior fiscal year, you would have come up with 14 years.

Mr. Saäd Rafi: Oh, it's a derived calculation for placing? I see. Not a witnessed event, but a derived calculation.

Ms. Susan Klein: It's the people on the wait-list as of March 31. Some of those can be your more difficult-to-place people, as well as your people who are taking longer to place. Your people actually placed during the year would maybe have a larger crisis component that would reduce your median wait time.

Ms. Catherine Brown: It's in Figure 7 of the 2012 report.

The Chair (Mr. Norm Miller): Please go ahead.

Mr. Toby Barrett: Yes, I'd like to go ahead. Actually, I'd like to bounce back to some previous discussion on assessment. We know that the act requires a physician or a registered nurse to complete a health assessment as part of the eligibility process. During the Auditor General's work, staff were told that these assessments add little value as they are often not fully completed or are duplicate information, and they make reference to the Resident Assessment Instrument—Home Care.

There's a provincial working group—maybe some here are members of the provincial working group—that recommended that these assessments be discontinued and recommended that the act be amended, which is something that, I guess, would lie in our bailiwick. Advice on that? Has any consideration been given to either streamlining this assessment process, which I assume takes up a lot of the work of people in the assessment referral centres? Secondly, any advice? Should we be looking at amending the legislation?

Mr. Richard Joly: I don't have the total answer in regard to the working group and the advice and so on because I'm not part of the working group. But we need to differentiate between the health assessment, which you're referring to, that the physician/nurse has to do. It's kind of a medical update, and it's a very brief, brief assessment.

The RAI tool that you just referred to is the comprehensive assessment that's done throughout Ontario the same way, and that is the comprehensive assessment that takes—

Mr. Toby Barrett: Is that the eligibility assessment?

Mr. Richard Joly: Which is part of the RAI. The medical update is not the eligibility. It's not a comprehensive behavioural, functional, risk assessment. It's just a medical update, very brief, although the question is: Is there value now? We question, in Ontario, since we've standardized the assessment tool that we do, the RAI tool, which is a very comprehensive assessment: Perhaps, because now we're going to send it electronically to all the homes, is there a need for that additional medical update when you have to go to a physician or a nurse practitioner and use their time for that particular tool?

I would imagine the working group—which I'm not aware of where they're at with their progress, but there are two different assessments. The one you're talking about is very small in nature.

Mr. Toby Barrett: Okay. Thank you. Christine, did you want to—

Mrs. Christine Elliott: I'm just wondering—

The Chair (Mr. Norm Miller): Welcome back. Go ahead.

Mrs. Christine Elliott: Oh, thank you, Chair. I had a question regarding some of the placements of people into long-term-care homes, specifically people with intellectual disabilities. I'm trying to understand whether that's considered a problem, what the plan is for that, and how many people are now being housed in long-term-care facilities.

Ms. Catherine Brown: It is a challenge that we face across the system around aging adults with intellectual disabilities. Some of our long-term-care homes have individuals in their homes who are not necessarily the right fit for the client group, but that is the best care that is available for them.

We are working with our colleagues across other ministries who have those populations in their care, like the Ministry of Community and Social Services. We also have the Ministry of Children and Youth Services, who have aging children who have severe disabilities and are looking for the right place of care for them. It is not necessarily long-term care. It may be some other form of care. So that's an issue that we're trying to address alongside the issues that we face in the long-term-care system.

Mrs. Christine Elliott: Are there any parts of the province that are impacted by this more than others?

Ms. Catherine Brown: I don't think we have a good sense of where in the province there might be bigger problems. The Ministry of Community and Social Services probably has a better handle on that information than we would.

Mrs. Christine Elliott: When you consider the waitlists—I guess it's about a 40% discount from the amount that we heard this morning, so it's about 18,000 people, give or take, who are waiting for long-term-care placements. Are they all seniors or are some of them people with intellectual difficulties?

Ms. Catherine Brown: They should be predominantly seniors, but there may be some who are under the age of 65 who have been designated—

Mr. Richard Joly: Very few.

Ms. Catherine Brown: —but it would be a very small number.

Mrs. Christine Elliott: Okay. Thank you. Those are all my questions for now.

The Chair (Mr. Norm Miller): Okay. We'll move on to the NDP. Who would like to go? Mr. Singh.

Mr. Jagmeet Singh: Thank you. My questions are just—first off, with regard to cost, is there a way you can just give me an estimated cost per day in a long-term care? If there's a range, what would that cost? And very briefly, if you could break down what the total cost is, provincial-municipal, if there's a formula that you have?

Mr. Saäd Rafi: Approximately $155.

Mr. Jagmeet Singh: One hundred fifty-five dollars per day? How is that often broken down—for example, any of the CCACs—in terms of how much the province pays, the municipalities pay and—

Mr. Saäd Rafi: The province pays a per diem, and it's broken into four categories. They are nursing and personal care, programming and support services, raw food, and other accommodation.

Mr. Jagmeet Singh: Okay. And is that—

Mr. Saäd Rafi: A hundred and fifty-eight; pardon me.

Mr. Jagmeet Singh: And is that the provincial average or is it higher or lower, depending on what region you're from?

Ms. Catherine Brown: That's the average, but it wouldn't vary by region. It would vary by your care level.

Mr. Jagmeet Singh: Your care level. Okay. We were talking before about the desire to keep more people in their homes, and that's a strategy also to reduce the burden on long-term-care homes and the beds there. What does it cost to keep someone at home, and at what threshold—where they're at a point where they might need long-term-care facilities and services, but if we provide them with the care at home, they could stay at home. What is that threshold and what's the cost associated with the difference between—the long-term-care cost is $155 per day. What would it cost to keep someone at home?

Mr. Saäd Rafi: I actually don't think we do this on a financial calculus, in the sense that we're not trying to keep people at home in order to alleviate pressure on long-term care as the practice but, rather, trying to respond to what people are actually wanting for their parents and themselves.

Mr. Jagmeet Singh: That's fine.

Mr. Saäd Rafi: So I think the cost at home varies by your acuity level, just as the number I gave you is the average for the resident who has the lowest need.

Mr. Jagmeet Singh: Is there an average cost, and is there an average cost from lowest to highest need at home that you have?

Ms. Catherine Brown: Cost for home care: I don't think—

Mr. Saäd Rafi: It's very difficult to calculate that.

Mr. Jagmeet Singh: Okay. We all know that—is there actually a number?

Mr. Richard Joly: The average, if you want to use the same methodology, is about $42 a day, but again, the complexity of client—your very complex client is much higher than $42, but the average home care patient in the province of Ontario is about $42, and that's in our quality report that we released last year.

Mr. Jagmeet Singh: Okay. The report that we received indicated about 85% of the people who are in long-term care right now are aged 75. That's 85% of the folks there. Roughly, that's—of course—

Ms. Catherine Brown: Seventy-five or older.

Mr. Jagmeet Singh: Seventy-five or older. Yes, exactly. So the prediction is that, in the year 2021, the baby boomers are going to hit 75—

Interruption.

Mr. Jagmeet Singh: We can just disregard that. It's okay.

Mr. Saäd Rafi: Are you sure?

Mr. Jagmeet Singh: Yeah, I'm sure. There's going to be a significant increase in terms of the demands on long-term-care beds and the need for them. Is there any strategic planning? Is there any "where we need to be" at that point in terms of how many beds or how many facilities need to be built? I guess if anyone can respond to that, or everyone.

1400

Mr. Saäd Rafi: I would say that the strategic plan starts with a community-based model. The supports in the community, I guess, at the far end of the spectrum are institutional, which is long-term-care homes, nursing homes and private retirement homes right through to other types of home supports, predominantly, to try to get that cycle of hospital readmission broken for many of those individuals who are in the 5% of Ontario patients driving the highest needs for the system. So that's part of the strategic planning that's taking place—

Mr. Jagmeet Singh: I think we are all aware of that. I'm talking more concretely, in terms of how many beds you think you need to have, or what types of services you think need to be in place by that point. If you can kind of look ahead, predicting how many beds we need now and the waiting list that we're at right now, where do you think we'll be at that point, and where do you think we need to be in terms of actual numbers of beds or numbers of services?

Mr. Saäd Rafi: I can't tell you that because, for me, that presumes that that's the only solution: long-term care. If I did a demographic analysis and then looked at long-term-care bed needs against wait-list, plus, plus, plus, I could generate a formulaic answer. But I don't think that's the utility or the model that the current government nor Ontarians want to see.

So it's difficult for us to say that in 20 years, we'll need X number of beds. Who knows how we will proceed with such things as community health links as the community programs that we have in place? Maybe they will properly help to elongate or prolong people's ability to stay at home. It's a very difficult thing that you're asking us to predict.

Mr. Jagmeet Singh: Sure. I presented the question in terms of just beds, but you're absolutely right. There needs to be some sort of planning in terms of the need to promote this type of health care, this type of prevention plan. We need this many people to be this—I guess this level of health needs to be achieved.

Mr. Saäd Rafi: Yes.

Mr. Jagmeet Singh: So there has to be some level of metrics, whether it's not just simplistically looking at beds, but there has to be some planning in terms of where we need to be as a society so that we can accommodate and take care of our elders with the dignity they deserve. But there has to be some sort of visioning that's in place now beyond just loosely saying that, of course, we need to have certain models in place. Is there that planning, and is there some sort of concrete visioning—

Mr. Saäd Rafi: Yes.

Mr. Jagmeet Singh: —that is being done—

Mr. Saäd Rafi: Yes.

Mr. Jagmeet Singh: —and what are those?

Mr. Saäd Rafi: Yes. Okay. If you would allow me, I'd like to explain that. We have established a model called community health links. We're looking at the 5% of Ontarians who have the highest health needs, the poorest outcomes and drive the highest amount of costs. We have very sophisticated data from the Institute of Clinical and Evaluative Sciences, the only organization of its kind in the country, that suggest that that 5% cohort drives 66% of the costs. They have many multiple, chronic comorbid conditions.

We have established now some 46 health links representing about five million Ontarians overall, and 5% of those individuals will get a coordinated care plan amongst primary care, specialists, hospital, community care, long-term care and social supports: housing and food banks. Other social agencies are all participating in these models across the province. We will likely end up having about 80 or 90 of these community health links. Right now, we're tracking, by calendar year-end, easily 51 or 52. The idea is that they will then also have a care coordinator.

So when they run into challenges—let's say it's from a knee replacement, and they have congestive heart failure, diabetes and COPD—their immediate place to respond for care is not the hospital because that creates a cycle of challenges for them that many times they don't break out of, and they end up being the most challenging clients for my colleagues to have to place. So that is a very distinct strategy that is being deployed at the sub-LHIN level on a community-based approach where 65% of primary care physicians must participate, and it has been voluntary thus far.

Mr. Jagmeet Singh: One last question about complaints, and I know my colleague has lots of questions. Is there a mechanism in place now for residents who want to complain anonymously, for friends and family and perhaps even employees who want to complain about certain practices that are going on that they don't think are proper? Is that in place, a whistle-blower type of protection, and what is that, if it is in place?

Ms. Catherine Brown: We have a program in place; we work with the CCACs. You can complain to the CCAC. There is also a third party that we collectively put in place that allows for that anonymous, no-reprisal whistle-blowing, to use that expression. Where people feel that they do not get the response they would like from the CCAC, they can also go to the health systems appeal board to seek direction from them on service complaints and complaints of that nature.

Mr. Richard Joly: It's called the Long-Term Care Action Line. They can go there, and that's a third party and so on. But then the issue that Catherine just referred to—they go through and exhaust the complaint process that we each have within our organizations, but then the last resort is, we always refer them to the Health Services Appeal and Review Board, which is independent and so on, and they can bring their complaints forward.

Mme France Gélinas: I want to come back to the big picture. It's not very often that we have capable and knowledgeable people like you at Queen's Park, so I want to take full advantage of your visit here. You're talking to legislators. Is there something that you're thinking about that you would like us to do that would make the system better? And when I talk about the system, don't think solely long-term-care homes, but a little bit of what the deputy was saying as to what are some of those models—not necessarily focusing on the 5%. I would say, focus on the 95% of us who will age. What are some of those models? What is some of the talk, the buzz within your part of the health care sector?

Interjection: Do you want to do that one?

Mme France Gélinas: Mr. Burns, I think they're turning—no?

Mr. Richard Joly: Well, I'm wondering, because Dan has had a lot of discussion with us—just last year, our budget submission and so on—talking about the system itself. It's not all about just long-term care or home care. I'm wondering, Dan, if I can put you on the spot.

Mr. Daniel Burns: Just to say a few things, and partly in response, also, to the way it was phrased by the previous questioner, looking out a little further—some elements of things we need to pay a lot more attention to and, I think, do better at as a large community of people interested in the health of our citizens.

First, we are rapidly increasing the number of people with complicated problems living at home. That means we are creating a tougher environment for family members and friends and small community organizations to support those folks. The good news is that we've got more sophisticated professional support, and we've got more sophisticated technology. But if the world unfolds in the way we're all describing, the need to be effective at supporting the folks who are the supporters is going to rise. I don't think there's any doubt about that. So in the longer term, I think that's one issue that we all have to think a lot about.

Mme France Gélinas: And in your thinking, what does the future look like?

Mr. Daniel Burns: On that particular question? I think it's going to need more access to advice. It's going to need better monitoring support technology. It's going to need a more sophisticated respite strategy, both for the individual being cared for and for the people who are doing the caring. There are people doing quite interesting things experimentally in western Europe and North America around these things, people whose populations are already a lot older than ours is already today. I think those are some of the ingredients on that one.

Mme France Gélinas: We hear a lot about the northern European countries that made decisions not to build any more long-term-care homes. Their population is as old as ours, if not older. Does that hold any possibilities for Ontario?

Mr. Daniel Burns: On that front, the Ontario Long Term Care Association published a paper two years ago arguing that, as long-term-care providers, they didn't think that we needed to have a dramatic increase in long-term-care supply We did need to more carefully organize it geographically and by special needs if we were capable of supporting a much larger population of people who need support in community settings.

The European jurisdictions you've referred to are the ones that have actually gone a little further down the road that I just described, although I would say that when it comes to populations of people with quite difficult care needs, in the province we've actually already experienced levels of individuals getting that kind of support that are comparable to the most aggressive approaches that you'll see in western Europe already.

1410

Mme France Gélinas: Another thing that the auditor talked about in her report was that there are a range of wait-lists, from 300 days in Central West to 1,100 days in Champlain. I realize the numbers have changed since then. Is there an active strategy to bring equity of access throughout Ontario, no matter where you live, no matter which CCAC you happen to be part of?

Mr. Daniel Burns: As we experience it, within the framework of a LHIN area, there are discussions going on about evolving the service configuration in a community. On the other side, that interacts with the ministry's strategy, so I'd just rely on what the deputy said earlier with respect to that.

Mme France Gélinas: Coming back to this, the deputy seems to say that there was no historical pattern of inequity in the funding of the 14 LHINs. Would you agree?

Mr. Saäd Rafi: Could I just correct that? I don't recall saying that at all, actually.

Mme France Gélinas: All right. Go ahead; what did you say?

Mr. Saäd Rafi: Well, I responded to a very different phrase that you put in place. What I heard you say was, "Why are the North East and North West CCACs not funded at the same level as the Champlain CCAC?" My musings were that if that was the case, then we would likely go to the highest-cost or highest-funded organization or community, and why would you need to necessarily bring that up to that level?

Some of the other interactions we are trying to undertake to have the North East, Central East or Waterloo Wellington areas—just to randomly pick three—have lower wait times are to work with a home-first philosophy, work with aging-at-home strategies, work with assisted housing to try to make sure that either the care coordinators in the hospitals, the community providers or the contractors they work with are equipped to take on those individuals.

I don't know about the analysis with respect to inequities that may or may not exist. I'm not so naive as to think that there are no inequities; of course there would be, but I don't think that normalizing funding to someone else's level is the solution.

Mme France Gélinas: Okay, so let's try the question again. Funding for CCACs was based on the financial support they received historically. Historically, there were disparities. Have those been addressed?

Mr. Saäd Rafi: In some cases, I would say they have. Have they all been addressed? No. I think some of that has to do with how the LHINs allocate the monies they are given. We do provide the funding at a province-wide level, and we have augmented individual CCAC or LHIN funding on a case-by-case basis. To say that that has solved the problem—no, I'm not saying that, but I don't know that the problem is at a magnitude of trying to level funding.

Mr. Jagmeet Singh: But you would agree that part of the solution, in addition to creative solutions and looking at other models for delivering health care, is that certain LHINs in certain areas need to be augmented to offset, perhaps, historical inequities. That would be one of the ways of addressing the fact that some areas have been historically underfunded based on their needs, their geography and their population.

Mr. Saäd Rafi: I'm not qualified or prepared to say that there are historical inequities or underfunding from one LHIN to the next. I don't know that. I have not done that analysis.

I would agree at a prima facie level that inequities exist, and we try to grapple with those as they arise, in some cases prior to allocating funding.

Mme France Gélinas: The auditor also talked about a pilot project that the association has been doing to trans-

mit client-related documents electronically. Did it work? Are we making progress?

Mr. Daniel Burns: In the places where it has been put in place, it has reduced the amount of transaction time between ourselves and long-term-care homes dramatically. In Champlain, it has been in place for a while. This is another element of change in the system, where we are working towards the universal application of this particular methodology. We're not quite there yet, but where we have had it in place, it has made a very significant difference in the time it takes to sort out all the pieces that Richard described earlier, that need attention between ourselves, the families and long-term-care homes.

Mme France Gélinas: Is this something that you intend to pursue, and what are some of the obstacles in order to get there?

Mr. Daniel Burns: We're on our way to universal implementation. The only impediments are making the technical changes at our end and in the homes and sorting out the agreements between ourselves on how to appropriately protect the data. There is no significant impediment other than the need to just accomplish the work over a period of time.

Mr. Saäd Rafi: But the RAI tool is probably the most connected e-assessment anywhere in the health sector. That follows individual residents. If they have a hospital admission from long-term care, then when they come back, there's an RAI update for those individuals. It actually is the most connected sector within health care, electronically and otherwise.

Mme France Gélinas: The Auditor General's fourth recommendation—I suppose you guys all know this by heart—talks about performance measures. I was wondering how this process is improving and moving forward from the CCAC point of view, or their association.

Mr. Gordon Milak: I'll respond to that. We have been working collectively with Health Quality Ontario, the LHINs and the ministry in developing those metrics. We have been following preliminary metrics for some time, but that group has been brought forward and we're ready to start monitoring those with targets to be developed in the next fiscal period. We do anticipate that those will assist in identifying barriers, where there are anomalies across the system. But the consultation is under way at this point just to confirm what those are.

The Chair (Mr. Norm Miller): Thank you, and we'll move on to the government. Ms. Jaczek.

Ms. Helena Jaczek: Thank you all for being here. I'm going to pick up a little bit on where my colleague Mr. Mauro left off, which is in relation to that small number, the 1%, that do get rejected by long-term-care homes. I appreciate these conversations backwards and forwards.

I have a long-term-care facility in my riding which has 125 beds, all Alzheimer's. It's really becoming kind of a centre of excellence. They've explained to me that they phone an organization, Behavioural Supports Ontario, if they need some extra assistance in terms of very difficult behaviours. I'm wondering if, either from the CCAC side or from the ministry side, you could describe how that works and how, hopefully, that helps.

Ms. Catherine Brown: Certainly. The ministry invested in working with Behavioural Supports Ontario to help support both CCACs and long-term-care homes in providing the services to clients that are harder to serve. As we know, the acuity of clients going into long-term-care homes, as you point out, is more challenging. Behavioural Supports Ontario provides the training and education for individuals in long-term-care homes to help support them in the work they are doing. They've had great success, both associations, the Ontario Long Term Care Association—both the non-for-profit and the for-profit associations are very supportive of the work that has been done and how it has helped them to do their jobs on the ground and to serve those more complex clients.

We also provided funding for the homes to allow staff to be trained. One of the difficulties, particularly for smaller homes, is that they don't have the funds for replacement workers. So you take someone out of service for a day for training and they lose that staff person. We provided them funding this year to allow them to be able to participate in this kind of training and other types of training to support them in the work they are doing with those populations.

Ms. Helena Jaczek: And the CCACs would concur that this has been useful?

Mr. Don Ford: We've been doing the training on behalf of our LHIN, and the results and the feedback from long-term-care homes have been that it has been tremendously helpful because what they're learning are the skills that are necessary to intervene before an individual reaches a stage of escalation where they then become a major behavioural challenge. They're learning the intervention skills, the ability to observe, the ability to know the techniques to use, and the result is that the entire population is stabilizing. We're not seeing the acting-out behaviours to the same degree, not seeing the risk to other patients and, obviously, to staff. The results that we have seen on the follow-ups that we have done have been very, very positive.

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There's obviously an intention to try to move that now into communities so that the individuals who are dealing with people in their homes can learn those same skill sets so that they can help manage those individuals in their homes and help with family members who can manage individuals. So we're beginning to tier it out. The success, I think, has been recognized as very, very important and a good investment.

Ms. Helena Jaczek: Thank you. Just looking at that first recommendation from the Auditor General related to a consistency in terms of ranking applicants, especially the crisis category, I'm wondering if you could just tell us about the progress you're making in terms of ensuring consistency, and also comment a little bit on the spousal reunification issue. Certainly we've heard in the Legislature some very heart-rending stories related to spousal

reunification. So maybe if you could just explain how we are now moving toward consistency across CCACs and how spousal reunification is being handled.

Mr. Don Ford: Well, with respect to the first question, the strategy that we have in place is that we will have rolled out a full implementation of a standardized ranking tool by November 2013 across all CCACs, so that issue will have been dealt with, and we will then monitor it to see whether or not it needs to be modified based on our experience as we have rolled it out consistently across the province. So that's—

Ms. Helena Jaczek: That's going well.

Mr. Don Ford: —how we've addressed the first recommendation.

Mr. Gordon Milak: I'll answer the reunification process. Certainly, reunifying spouses is the second-most-important priority, right behind crisis placement. Obviously, there's a very human impact in this.

What we find is that there is still choice in terms of which home that couple choose to reside in. So, again, the wait time for that reunification is tied very much to the homes that are selected. In many cases, that's also going to be very much driven by proximity to their family, to their friends, to the community that they have been in. So there is wide variability.

However, our care coordinators do more than just the assessment. The assessment is very much the science, but there's a great deal of art in terms of helping individuals and their families really understand all the care options that are available to them so that they can truly make informed decisions. That's taking into consideration those subjective components, but also all of the other life changes, all of the other dynamics that are involved in that family's life.

Ms. Helena Jaczek: Okay. Thank you.

Again, in I guess it was the Auditor General's second recommendation related to wait-list management, we understand that there are some ministry initiatives that have commenced since January 2013. I see a reference to expansion of short-stay convalescent care programs. Could you just expand—I suppose it's a ministry question—as to what exactly that comprises, what it looks like, how many people are being served?

Ms. Catherine Brown: Certainly. The ministry provided funding to enhance or expand the number of convalescent care beds. These are beds that are for a shorter stay, say up to about 90 days. Also, to the questions that were raised earlier, there are a small number of underutilized beds in homes that may be less desirable for people, and it allows those beds to be put into use.

So we announced funding for 250 beds, and 150 of those are up and running. The remaining 100 will be up and available by the end of this calendar year, so over the next couple of months.

In addition to that, we changed the way in which people get referred to those beds, so much of the conversation that has been had today on long-term-care beds around choice and first choice—for the convalescent care beds, we have changed the regulation, and that goes into effect November 1, to allow those individuals to be referred to the first available bed. It doesn't completely eliminate choice. They can refuse that bed. But it takes away from the administrative process that was required for those very short stays to find out and assess and determine which preference an individual had and gives them the option to go into the first available bed to get the care they need for that very short stay. That allows them to then return home, their health restored, and to go back into the community or their home where supports can be provided.

Mr. Saäd Rafi: Sorry to interrupt. There's a large intangible component to this as well. Although it's already serving 1,500 seniors annually, the confidence that family members get from knowing that there's this transition out of hospital into the home, as opposed to going directly from hospital to the home—I think there's sort of a bias that we all have that, "If you're coming out of a hospital, I don't know how to care for"—it could be all manner of things; I don't need to tell you. That's going to be hard to quantify, but I think it's a very important feature.

Ms. Helena Jaczek: Yes. Since we know people prefer to stay in their own homes and we're moving towards more and more community-based care, has there been any attempt to actually de-institutionalize individuals from long-term-care homes? Again, the Auditor General referred to, I think, Health Quality Ontario looking at care needs of people currently in long-term-care homes, or who were in 2012, saying that perhaps they could have been cared for in the community. Is there any program to actually review who is currently in long-term-care homes with a view to perhaps talking to the family, talking to the patient and saying, "Could we try it outside?"

Mr. Saäd Rafi: I'm not aware that the government is pursuing a program in that regard, but of course if an individual feels that they don't need long-term care and they would like to reunite with a family member, would like to live with a child, they're able to do so. I think that these folks could be better judges, but they would say that with of the acuity level, the challenges that people are facing today, that is becoming exceedingly unlikely.

Mr. Richard Joly: There's less and less every day. Back in 2012 and even before, yes, it was a larger number because there were no other options. With the increase in investment in assisted living, enhanced home care and so on, there are more options, and that's why we see the higher acuity level in long-term-care homes. The likelihood of them being discharged is likely not. But I know we've had some success. As an example, when there was investment in additional assisted living, we went through the homes and said, "Could you identify people that could go in assisted living?" And we have successfully transitioned some.

Ms. Helena Jaczek: Into assisted—

Mr. Richard Joly: Not large numbers, but some numbers.

Ms. Helena Jaczek: I was intrigued by the difficulty in projecting. Mr. Singh was sort of, "Can't we plan for maybe 2021?" and so on. But I guess what is actually happening is that we are looking at other models. I've had some constituents make a suggestion to me, which is, "Okay, home is best—in your own home." A long-term-care facility is kind of daunting. Is there any possibility of something in between, sort of group assisted living within more of a home-like setting where CCAC would be visiting etc? I'm wondering to what extent you're considering completely different models.

Mr. Richard Joly: We hear that all the time, various options and so on, and I would say there's probably all kinds of examples across Ontario. Is there a provincial strategy to say we must do that? No, but the indication on investments in home and community care, which is broader than CCAC, indicates to us there is a strategy to actually invest in those areas. Therefore, as a result, these innovative models are coming into play and allowing seniors to congregate, essentially, and support themselves from a social point of view, from a health one, and so on. But then we provide the additional support that they require prior to going into a long-term-care home, or even delay the long-term-care admission forever.

Ms. Helena Jaczek: Right.

Mr. Saäd Rafi: If I could just add, we are looking at—we put out an RFP for providers of care in the community. We competitively chose three pilot sites where we're looking at a campus of care. Those happen to be the Schlegel site, Bruyère in Ottawa, and Baycrest. What we're looking at there is independent living right through to palliative care and every type of care need in what I'll call a home environment that they have put forward, so that one can really be in the community and see how you can go from having a great deal of independence to where maybe you would need a great deal of assistance throughout those years. We have not yet received the evaluation of that pilot, but we're very hopeful that that will start to address the types of things that these folks hear every day.

Ms. Helena Jaczek: Yes. Thank you.

Mr. Don Ford: The other thing that we've done is we are looking in our region and trying to look at the construct of clustered care, where you've got a number of individuals who may live in an apartment building or a complex area. So we're working with our service providers to try to make sure we've got a consistent service provider doing the nursing and the personal support so that they can then go in and manage that population in a different way, which is a bit more responsive, a bit more immediate, and a different way of thinking about it.

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As the deputy says, as this funding has come into the system, we've had a capacity to be a bit more creative about the way we think about the populations that we're serving and move to a congregate where we're not moving them into another environment—they're in their environment already—but we're allowing them to be more successful in providing congregate supports in those fashions.

So I think there are different models, as Richard says, that we're testing throughout the province by virtue of people's willingness to be creative.

Ms. Helena Jaczek: How much time do I have left, Chair?

The Chair (Mr. Norm Miller): You have six minutes.

Ms. Helena Jaczek: Okay. I'll just go back to Madame Gélinas's talk about historical inequities and so on. Obviously, I come from a very high-growth area, so I would just like to say to the deputy that I'm a great fan of HBAM. I certainly get from my CCAC in the Central LHIN a real desire to move to address our population growth. We know you are addressing it. There's simply a comment that I get all the time: that we need to move to, at least, that needs-based allocation method in as timely a fashion as possible. So I just put in a plug right there.

I think we'll save our time for the—will we get any?

The Chair (Mr. Norm Miller): If you want to save it, you can save four minutes.

Ms. Helena Jaczek: Yes. Thank you.

The Chair (Mr. Norm Miller): We'll go to the opposition then. You have seven minutes left.

Mr. Bill Walker: I want to go back a little bit to the plan for the renovations. Do you have any stats? Have you done anything comprehensive in regard to—particularly in a rural area—if there are homes that people may be deeming to not be satisfactory, and that's one of the reasons they're not choosing? If that's the case and you have some definitive information on what the plan is to actually enhance those—because in many of the areas that I serve in Bruce–Grey–Owen Sound, that would be the case: where many times it's a very old home; it maybe hasn't had the upkeep that it could have over the years, and people start saying, "Oh, I don't want to go there. I want to go to the brand new one somewhere else." To me, every time you take someone out of that community—and again, we get into geography, we get into winter conditions, we get into the lack of transportation—that becomes very problematic for the families. Are there any plans there to really put a focus on those homes that may be sitting partially empty, as opposed to maybe where the plan has been going? You referenced earlier that it hasn't been rolled out as well as you would have liked. Is there any plan at all to focus on those areas?

Mr. Saäd Rafi: Yes. On average, we have 98% occupancy, but since that's an average, of course we would have some homes that have several beds available to them for some of those reasons perhaps. That creates the types of fractures that Madame Gélinas and yourself have already pointed out, in that people may have to go across town to see their loved one, and they may not have the ability to do so themselves—as a spouse, for example—and that gets more and more difficult. In some cases, the children don't want to travel to see Mum, and they want Mum wherever they want Mum.

What we're working on currently is looking at the breakdown of the wait-list—not the transfers that are already in a spot, waiting; so net of the 40%—and the homes that are B and C beds, and first off, just doing the mapping of those. Then, what we want to do—what I'd like us to do, anyway—is approach the individual owners of those homes and ask, "What are your true impediments for not developing these beds?" and find a way that we might be able to make that redevelopment happen. My suspicion is that there's probably one easy answer: more money. That's going to be difficult for us in times of restraint, but maybe there are other things—and a couple that have come up are a longer licence period to help the redevelopment be financeable. So if your licence has 10 years remaining, we would say, for the redevelopment, "We'll give you another 25-year licence." That makes it financeable with a mortgage lender or a financier.

So we are looking at various things. We've got great feedback from the sector, and we need to address those issues.

Mr. Bill Walker: Very good. In our case, it isn't across town; it's 30, 40, 50 miles in the dead of winter, so it's a much more pragmatic reality.

So I'm glad to hear that, because, again, some of the homeowners I've been talking about—for the most part, I find them very entrepreneurial, and they want to expand. They want to be there, and yet they're getting caught in a no-person's land. They're saying, "For me to invest the type of money that's being expected of me, with only a two- or a five-year licence, then why would I do that?" No one is actually going to do that. What they were sharing with me was that there wasn't a lot of flexibility to look at that long-term licensing. I think it's like anything. If you've got the business plan—they don't even necessarily need government financing; they'll go and get their own financing in any case. Why wouldn't we do that, particularly in times of extreme fiscal restraint that we find ourselves in? So it's good to hear that.

A different area but similar are culturally appropriate homes. What again are you hearing as far as—what are you trending and what are you tracking? I guess where I'm really going with this is, there's an increasing demographic, particularly in many of our urban centres but in some rural areas as well, and that's only going to continue to expand. So what are the plans? We can't be waiting until five years into the problem to be addressing it. Are you ahead of the curve there? Is that something that you're anticipating and is a priority?

Mr. Saäd Rafi: To have, for example, homes where people who are preferring—you know, since maybe their mother tongue is Mandarin, that they would have the ability to have a facility like that. I don't know that we—have we done any prioritization? I suspect we have not.

Ms. Catherine Brown: We have not done a provincial mapping of those populations to determine where that would be, but through the market sounding that the deputy referred to earlier, we have heard there is a need for that. That being said, when we look at some of our underutilized homes, they are sometimes—there is a home in northern Ontario that is a francophone home that is under-bedded because of the distance of where it is. So it's designated for that population. It doesn't take non-francophone, which is appropriate, but it is left under-bedded because the distance it is relative to the northern landscape is problematic. So how do you map that and not have it be so specific that you can't fill the beds and yet accessible enough that you can serve populations in the language and the culture of their choice?

Mr. Bill Walker: The key, I think, to many—and I'm still a newbie. I've only been here for two years and a couple of days, so I'm still learning lots and have lots to still climb. But I think one of the things that I'm unfortunately consistently hearing in many areas of our jurisdiction is that it's the planning that's what's lacking, the foresight to be ahead of the game plan.

I met with some medical students about six months after I arrived, and they shared with me the story that there's really nobody mapping how many docs of a specific area we need. So everybody goes in and becomes very specialized, but there are three placements for them, and yet over here there are 500 needs for general practitioners. We all keep screaming about it, but why weren't we doing the planning?

I made the assumption, to be honest, before becoming a politician that that would be a key component of the ministry, to say, "How many docs in this area do we need, how many in this stream, how many in this stream?" and we would gear our schools to actually produce those, as opposed to just, "Everybody take whatever you want," and then we find that we've got 60 doctors who can't practise and we have need.

So this is a similar type of thing that I think we obviously see in the urban centres—specifically, growing trends—and we need to be there. I think the consultation with the stakeholder community, to say, "What do you"—you know, they have the answers to the secret. We should be working and dialoguing very much ahead of them and looking out beyond to ensure that those are there when we need them.

Mr. Saäd Rafi: Maybe a couple of things on that. I think that individual communities have responded for the needs of their ethnic community and have done just a remarkable job, and, yes, that's on their own philanthropic activities. I'm not suggesting that that should be the sole reliance. I'm just saying that that has been one response. Other matters that come up are, will we have the capacity in that community for that type of home? That's difficult to plan for, but I don't discount the need to do the planning.

If I could, just on the physician piece, actually, Ontario has led the country with having the only 25-year model for physicians and nurses going out in terms of supply needs. We have talked with deans of medicine about this. We have identified what we know demographically and what we're not seeing in terms of medical education—how much time is spent in a general practitioner model, on gerontology? How much is spent

on orthopedics etc.? So those things are slow shifts, but they are shifts that are taking place.

Now this is happening at the national level, but students themselves also make choices about what specialties they want to go into, and since it's 10 years to build a physician—it's a 10-year exercise—that's a dial you have to work. Change is slow, but we are currently examining that based on research that was sponsored prior to my arrival, so I won't take credit for it, obviously. But it's something the other jurisdictions are looking to Ontario for.

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Mr. Bill Walker: I'm pleased to hear that—

The Chair (Mr. Norm Miller): Thank you. We'll move back to the government.

Ms. Helena Jaczek: Have they used up their time?

The Chair (Mr. Norm Miller): Yes. Go ahead, Ms. Jaczek.

Ms. Helena Jaczek: We've covered a lot of ground and, in essence, have even gone beyond what the Auditor General talked about.

I'm sort of echoing what Madame Gélinas said. From your point of view, can you see further improvements that are on the horizon in terms of the actual operations of the CCAC? Maybe you would like to talk to us about your relationship with the LHIN, the ministry.

It's interesting that you're here and we don't have the LHIN here, because presumably the LHIN is involved in what we've heard is the crisis situation when a hospital absolutely has no more beds and ALC patients are blocking beds and so on and so on.

Can you talk a little bit about the relationship: the ministry, the LHIN, you? How does it work? Is there any room for improvement?

Mr. Daniel Burns: There's obviously no part of public service that isn't capable of being improved, so let me just touch on one theme, and that is the positive benefits that come from better real integration of professional practice. We've touched on a few today, but they're only part of what we're doing.

We touched on the positive consequences of electronic exchange of materials with long-term-care facilities but that our other partners, which include primary care hospitals and other community agencies—we're all progressively working on exactly the same format with all of them.

Mr. Barrett asked a number of questions earlier about understanding the way in which assessments and reassessments work. There are now a large number of hospital settings in the province where discharge planning and our assessment are not separate processes. Actually, in smaller settings, there are a number of cases where one professional is actually doing both of those pieces of work. As we've said before, a discharge document from a hospital is largely a medical document. It's not a broad-based community assessment, but there is a connection.

I think what you're finding progressively are more and more benefits from integration that come from technology, but also from the development and use of common professional practice.

The Health Links initiatives that the deputy alluded to earlier—I'm actually going to tell one of Don's stories. One of the most interesting things about it in the early going was that, in collecting a bunch of health sector practitioners in a community, looking at a very particular population, they'd spent two or three meetings actually understanding what the other ones really did and what they meant when they said they do this. "When you say you do assessments, what is it you're actually doing? Because I do assessments." Now we have a much better knowledge of all that.

That's a series of snapshots of a flow of benefits to patients that are coming from real integration.

Now, what is the LHIN piece of all this?

Ms. Helena Jaczek: Yes.

Mr. Daniel Burns: Well, they are charged, in part—what do they do? Regional planning, administration of annual funding arrangements and reporting thereon, and change management.

What I just described is a group of snapshots of changes that are improving the system, and the LHINs have an important role in fostering that, in funding it and in convening it.

But I would say at the end that it's only going to work when we all own it. Just speaking on behalf of my colleagues, we own this one. We are completely and totally committed to making integration—those interfaces—work better.

Several of you have raised questions about how those transitions work for patients: Mr. Barrett, when it came to assessments, family reunification. They're all on our agenda, and they will all benefit from professional practice and technology allowing better integration.

Ms. Helena Jaczek: And the structure of the LHIN facilitates that, would you say?

Mr. Daniel Burns: The regional structure, which they have a responsibility for, with respect to planning and change management—most of them, I'd say, have a good scale for allowing these conversations to take place. I think, in fairness, a couple of them are pretty big.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Norm Miller): Thank you very much. We are out of time, so thank you very much for coming before the committee this afternoon. We appreciate it.

We are now recessed and going into closed session.

The committee continued in closed session at 1445.

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