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Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude da la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 9 December 2013

Lundi 9 décembre 2013

The committee met at 1404 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): We'll call the meeting to order. This is the Standing Committee on Social Policy. This is the December 9 meeting and we're here to review the Local Health System Integration Act and the regulations made under it as provided in section 39 of that act.

ASSOCIATION OF ONTARIO HEALTH CENTRES

The Chair (Mr. Ernie Hardeman): We have with us the first presentation of the day, the Association of Ontario Health Centres: Adrianna Tetley, executive director of the association. Thank you very much for being here. I think it's a half-hour presentation, but then we turn it over for 20 minutes to each party for questions and comments.

We are presently recessed, but when the party leaders get back into the House, they are going to be making some very important statements. So I expect the committee will recess for that period of time and then come back to hear the rest of our presentation, if that should happen between now and the time your presentation time is over. So we beg your indulgence.

With that, we'll turn the floor over to you.

M^me^ France Gélinas: Chair, can I interrupt for one second?

The Chair (Mr. Ernie Hardeman): Yes.

M^me^ France Gélinas: I think I did it while we were in camera; I asked the researcher if she could give us an update as to what was happening in the rest of Canada and in other jurisdictions. I don't know if I have to do this outside of camera so that it gets done.

The Chair (Mr. Ernie Hardeman): I believe that would likely have gone through the researcher to gather information. We can't make any decisions, but the researcher can be—no, the researcher wasn't here.

Ms. Carrie Hull: No, no, I was here, but she said it off the record, and I just thought the procedure was that you authorize it.

The Chair (Mr. Ernie Hardeman): Oh. Well, that's only if there was some reluctance by legislative research to produce the information, and then it would require a motion. But as long as we're all aware of that which was requested, we'll put on the record now that that which was requested by the member at the previous meeting be provided—what do they call that?—toute de suite.

Thank you very much, and the floor is yours.

Ms. Adrianna Tetley: Good afternoon, Chair and honourable members of the Standing Committee on Social Policy. My name is Adrianna Tetley, and I am the CEO of the Association of Ontario Health Centres.

As Ontario's voice for community-governed primary health care, the Association of Ontario Health Centres is really pleased to present to the Standing Committee on Social Policy as it begins its review of the Local Health System Integration Act, LHSIA.

The association represents 108 community-governed primary health care agencies across the province: 75 community health centres, 10 aboriginal health access centres, 15 community-governed family health teams and nine nurse-practitioner-led clinics. These centres are distinct from Ontario's other primary care models because they are all governed by community boards. All 75 community health centres are the only primary care model in Ontario that currently falls under the jurisdiction of the LHINs. This allows us to bring a unique perspective to this table.

CHCs are located in each of the province's 14 LHINs. This presentation is largely informed by our experience working with the LHINs over the last seven years. AOHC's submission is also shaped by our vision, a vision that unites our membership: the best possible health and well-being for everyone living in Ontario. Underneath my statement in your paper is a detailed look at what that future would look like. At different points in my presentation, I won't be reading the sub-points; they're there for your reference for later.

Our member centres are actually committed to a leadership role that achieves this vision of community health and well-being. To do so, we have also recently adopted a model of health and well-being to guide our delivery of primary health care. This is important as we go through our comments, and you will find it in the appendix of the brief that you have in front of you.

Our submission provides AOHC's perspective on how the LHINs, at a regional level, can also lead the way towards community health and well-being. First, let me start by saying that the review process offers a critical

opportunity to maximize the LHINs to full potential. Going forward, the LHINs need to play a key role in establishing community health and well-being regional systems that promote the best health and well-being for everyone. To achieve this, we actually urge the committee to consider the following directions for change.

(1) Require the LHINs to use a health equity approach as foundational to all its work.

(2) Enhance the capacity of the LHINs to serve as strong planning bodies across the full continuum of care, especially when it comes to building a more organized and effective primary health care system.

(3) Widen the LHINs' scope. The act defines the objectives of LHINs too narrowly on treating sickness and organizing health services. LHINs should be mandated to prevent more in order to treat less, with a special focus on prevention measures that address the root causes of illness and disease.

(4) Build strong community-based services.

(5) Require the LHINs to improve their processes for meaningful community engagement and responding to the needs of the communities they serve.

These are directional recommendations based on our years of experience working with the LHINs. As the committee continues its review, we're hoping that our membership and you will continue to explore these ideas further. Today I am going to present some more specifics around each of these as we go forward with our conversation.

AOHC actually stands by our 2005 submission to the standing committee when LHSIA was first introduced. At that time, we supported the establishment of the LHINs, and we continue to do so, because we believe it represents a major opportunity to press forward with a positive transformation for health and health care in Ontario.

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Ontario needs regional bodies that understand the regional perspective and unique realities of their communities and are held accountable to the regions they serve. We also need regional bodies equipped to set objectives, evaluate performance, allocate budgets and hold providers accountable for the services they deliver. However, AOHC contends that it's time for the LHINs to be retooled. In our view, the purpose of the LHINs, as currently defined in the act, doesn't capture a big enough picture.

The act opens by stating that the main purpose of the LHINs is to improve the health of people living in Ontario, but reading through the rest of the act and watching what's happening on the ground, it's clear that the LHINs' raison d'être is health services integration, especially the structural kind of integration.

Later in my remarks, we will offer our thoughts on building an optimal approach to a more integrated health system, but in our view, integration, especially structural integration, should be treated as just one means to achieve a longer goal.

In our view, the LHINs' long-term goal should be the establishment of community health and well-being systems across the region that promote the best health and well-being, and ensure equitable health outcomes for everyone. This health system must be retooled to deal with the fact that good health is not just something that you get in a medical clinic or a hospital. Promoting a sense of health and well-being requires reaching objectives that are currently not listed in the act.

We have an overall recommendation. The overall recommendation is that the act should be enhanced with the following objectives explicitly stated as purposes in the LHIN:

(1) Advance health equity and reduce health disparities.

(2) Advance upstream interventions that address the root causes of illness; in short, prevent more in order to treat less.

(3) Conduct comprehensive system planning that advances population health with equitable access to services.

(4) Develop a high-performing primary health care system with the capacity to fulfill its role in the foundation of the health system; and

(5) Develop high-performing, community-based services.

To implement this overall objective, the committee has to ask itself: If we are to achieve an integrated community health and well-being system that promotes the best possible health and well-being for everyone, ensures equitable health outcomes for all and ensures a sustainable health care system, what are the changes required in the act to enable the LHINs to achieve this vision and to transform the delivery of health services? In 10 years, what parts of the system will be the same? More importantly, what parts of the system will be different and how do we enable LHINs to have the tools to transform the system? Through my remaining remarks, we will provide principles and recommendations that we believe are essential in achieving this vision.

The first one we want to speak about is equitable health outcomes. Only in the preamble of the act do you find a commitment to equity briefly mentioned. In the main body of the act, the need to advance health equity and reduce health disparity is not explicitly mentioned, yet the provincial government currently describes health equity this way: Within the health system, equity means reducing systemic barriers in access to quality health care for all by addressing the specific health needs of people along the social gradient, including the most health-disadvantaged populations. This is a provincial policy.

In Ontario, the LHINs could just look at some of the facts that we all know. I'm not going to read them for you today, but we do know that aboriginal people, francophones, many people living in poverty, people in the north, South Asians, immigrants and LGBT people all have worse health outcomes than the general population. We believe that the province and the LHINs can do more to advance equitable health outcomes and reduce

health disparities. The ministry has developed a powerful tool called the health equity impact assessment that is specifically designed to identify and mitigate unintended impacts of any health initiative on health outcomes prior to implementation, yet in the minister's action plan, health links, or in any provincial initiative that we're aware of, HEIA is not applied.

Our recommendation in relation to this is that the objects in the act should be expanded to ensure equitable health outcomes and the reduction of health disparities for all people living in Ontario, with a particular focus on the people who are most marginalized.

Number two, the MLPA—the ministry-LHIN performance agreement—should include the requirement that HEIA be used in all regional planning and in the application of all provincial health links.

We want to focus upstream so that we can prevent more and treat less. Effective treatment of illness is critical to the health and well-being of Ontarians, and we continue to support the work that the LHINs are doing in making a more efficient and effective illness system.

But if we want to ensure the health and well-being of everyone in Ontario and sustain our health care system, the LHINs must place a stronger focus on preventing more in order to treat less. The population health and system sustainability will improve if both the province and the LHIN apply a broader, stronger focus on prevention, especially prevention that addresses the broad determinants of health.

As things now stand, Ontario currently applies a downstream as opposed to an upstream approach. We are not doing enough to build systems and supports to deal with all the factors that affect health, not just the medical ones.

When we look at the LHINs' mandate, and I've had several conversations with the LHINs, they are more focused on health care than on health. This is clearly reflected in what LHINs are measuring and not measuring, and funding and not funding.

I heard you in the different Hansards talk about the 14 of the 15 LHIN performance indicators that are currently required by the LHINs. They're all focused on the acute system. One indicator is actually focused on home care. There are no indicators that measure how well LHINs are doing keeping the populations they serve in good health or that measure health equity.

Several HSPs, health service providers, including our members, provide a wide range of upstream services, including assisting with housing, education, employment and food security. Yet the LHINs are not mandated to understand or learn how these services impact the health of the most vulnerable populations. They have not significantly funded these services and have shown little interest in measuring the health outcomes of this work. Health promotion and community development work that address systemic barriers, assist people with the root causes of their ill health and support communities to build capacity and resilience to keep people and communities well are not well funded and are seen as out of the scope of the LHINs.

Health and well-being indicators must be developed alongside the more clinical indicators. This will help the LHINs to have a more fulsome understanding of how working upstream can continue to improve health and well-being. As well, oftentimes our service providers feel invisible with the LHINs because they don't recognize this part of the work or are not held accountable for the work.

Our recommendations are that the act must be amended to expand the LHINs' purpose and objectives to encompass health promotion and illness prevention, with a strong focus on addressing the broad determinants of health. We believe that health and well-being performance indicators must be developed at the ministry, LHIN and HSP levels through their accountability agreements.

Like HSPs, the LHINs should partner with other regional partners, such as the school and justice system, to collaborate on addressing some of the upstream issues that have a direct impact on the health and well-being of the people in their regions.

Number three is population health planning. Planning needs to take a population-needs-based planning approach, yet we have public health units that have a mandate of population health. There have been significant resources, especially in epidemiology, yet in many areas, the LHINs and public health units work in silos, duplicating and not sharing information. LHINs should be mandated to work with the public health units as co-partners to develop LHIN population-needs-based plans, using a health equity lens that looks 10 years out for trends and that informs regional system plans.

LHINs must also plan specifically for the aboriginal and First Nations and francophone populations. Under the act, the minister is required to establish two councils: an aboriginal and First Nations health council and a French-language health services advisory council. Under regulation, francophone and aboriginal planning entities are also to be established.

There has been no progress on the aboriginal and First Nations health council or planning entities. The French-language health services advisory council meets very sporadically, and the French-language services planning entities are still being operationalized. The French language services planning entities actually sign accountability agreements with the LHINs, which questions their ability to make plans if they are reporting to the LHIN through an accountability agreement.

Given that the first peoples communities and the francophone population have distinct and specific histories, and legal and constitutionally protected rights, these advisory councils and planning entities need to be established to ensure respect, inclusivity and equity.

Given the poor health outcomes of these two populations, the minister, through the advisory councils, must make it a priority to develop a provincial first peoples and a provincial francophone health plan that is culturally safe, competent and appropriate. The regional planning

entities then need to be empowered to work in partnership with the LHINs to implement these plans at a regional level. As such, the accountability to report to the LHINs needs to be reviewed.

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Our recommendations are that:

(1) The act should be amended to incorporate the requirement for the LHINs and the public health units to form an equal partnership to develop LHIN-based population needs with a health equity lens.

(2) The aboriginal and First Nations health council and planning entities regulation must be implemented.

(3) The ministry needs to work with the aboriginal and First Nations council and the francophone council to establish culturally appropriate health care plans. Primary health care should be considered a priority.

(4) The reporting mechanisms of aboriginal, First Nations and the francophone planning entities reporting through the accountability agreement to the LHIN need to be reviewed in order to ensure the planning entities can fulfill their full mandate.

Principle number four is comprehensive system planning across the full continuum of care. To create integrated community health and well-being, comprehensive system planning is required. LHINs should be the planners for the full continuum of health services, equipped with the authority, accountability and resources to do an effective job.

Hospitals should not drive regional health planning. If they do, the system will continue to be focused on illness and the shift to health promotion and disease prevention will not occur.

To ensure a more seamless system, LHINs should plan for a person's journey in and out of various parts of the health system throughout their lifespan. To do this, they need to be responsible to plan and coordinate the entire continuum of care. This will ensure transitions for people moving through the health system, as well as more efficient use of resources and skills, fewer errors and improved experience for the people accessing services and their caregivers.

To enable this, all remaining direct service programs at the ministry should be transferred to the LHINs, including HIV/AIDS, the underserviced area program and hep C, among others.

If some part of the health system is not under the jurisdiction of the LHINs, they need to collaborate to ensure integrated and coordinated services are provided. A good example of this is EMS, the emergency services of the municipalities. We can't just say that they're not under the authority; they need to figure out a way to collaborate in order to plan.

There is increasing agreement that primary care is the foundation of the health care system. It should be a key door where individuals intersect with the health system through various points in their life journey, yet primary care is the most fragmented, siloed, provider-centric part of the health system.

The LHINs have stated they want primary care to be accountable to the LHINs. I would go further. The LHINs need to be responsible for planning primary care, not just holding them accountable once the providers themselves, or the ministry, have decided who goes where. Gone are the days when a solo physician or a nurse practitioner should be able to open an office where they please.

In the South East LHIN, in partnership with their public health unit, the LHIN conducted a study to measure the deprivation of a community and then mapped it against the current primary care provider supply. The results were predictable. The areas with the highest material and social deprivation—i.e., the poorest communities—had the least access to physicians, and the more well-to-do areas had an oversupply of physicians.

In another rural area, seven physicians are all over the age of 65 and several are over the age of 75, all with large numbers of enrolled patients. What is the transition plan? Who is responsible? Should they be replaced with seven physicians or with an interprofessional team of some mix of physicians, nurse practitioners, dietitians and social workers? Who will make this decision?

In addition, like everything else, primary care models need to be developed to meet the needs of the community. This means that a mix of primary care models that are designed to meet the diverse needs of the communities, and that are evidence-based, should be implemented.

Finally, primary care planning conducted by the LHINs should build towards an ultimate goal that all Ontarians have access to interprofessional teams. This would involve developing a transition strategy that is incremental and is developed taking into consideration retiring or moving physicians, new grads or, by choice, by existing physicians who want to migrate from fee-for-service into teams.

So our recommendations are that:

(1) The ministry should transfer the remaining provincial programs that provide direct services to the LHINs.

(2) The act should be amended to include interprofessional primary health care organizations as health service providers.

(3) The objects in the act should be amended to mandate the LHINs to plan and implement a primary health care delivery system that is population-needs-based, is evidence-informed and ensures an appropriate mix of models to meet the diverse needs of communities.

(4) In the MLPA, a mechanism should be outlined to develop a transition strategy to enable interprofessional primary health care organizations to be the models of the future.

This leads us nicely to principle number five: high-performing primary health care. A strong primary health care system, as we have said today and in other places, must serve as the foundation of the health care system to keep people healthy and out of hospitals. We believe that there are several key elements of a high-performing

primary health care system. We will only focus on a few today that are under the jurisdiction of the LHINs.

As stated earlier in my remarks, we believe that interprofessional primary health care teams should be the model of the future. We also believe that in an efficient and effective high-performing primary health care system, all members of the team should work to their full scope of practice. This will not only ensure continuity of care with integrated and coordinated care for the people we serve, it will be more efficient and sustainable for the health care system.

As a high-performing system, we believe that all primary health care organizations should provide system navigation and care coordination for the people they serve, including as they transition in and out of other parts of the health care, community and social service systems, throughout their lifespans.

Our recommendation is that the LHINs fund and support the interprofessional primary health care teams to be appropriately resourced to enable all members to work to their full scope; and to ensure that interprofessional primary health care organizations are resourced to provide system navigation and care coordination as people navigate in and out of the health care and social service system throughout their lifespan.

Number six: Champion a culture of system navigation. The sustainability of Ontario's health system depends on the ability to keep Ontarians healthy and avoid the need for costly care. A high-performing, community-based sector is another foundational piece to achieve this goal.

AOHC envisions strong community-based services that address the determinants of health and that are integrated, coordinated and efficient, working in partnership with the long-term care and acute care systems.

More specifically, primary health care, not-for-profit home and community support services, and mental health and addictions services, the key players in the community sector, must work in partnership with other parts of the health system to create a comprehensive, fully integrated and seamless system where people can access the right services at the right time by the right provider.

The history of—the community support services have often been filled by volunteers who have grown over the years, and as a result we have many large and small organizations—many of them are underfunded—who are the life of the organization, relying on countless hours of volunteer time. Services are often front-line, community-based, consumer-driven and client-centred.

We endorse a system where every door leads to appropriate and effective services that are people-centred and coordinated at the local level. This requires a province-wide culture of service integration across health sectors and providers, championed by the ministry and the LHIN. The true test of any integration initiative is whether or not it enhances the care, improves health outcomes and results in improved quality of care for the person.

AOHC, along with the association for mental health in Ontario and the Ontario Community Support Association, supports integration initiatives that reflect well-researched best practices. There's a significant number of well-researched criteria that drive good practices and that are listed there for you for a future read.

A primary role of the LHIN is to promote the integration of the LHIN system to provide appropriate, coordinated, effective and efficient health services. As we all know, the act identifies five strategies, ranging from coordination and partnership to amalgamating services and cessation of operations. The LHINs' current work on integration seems to be focused on structural integration—back office and reducing the number of HSPs—and does not necessarily lead to better service.

In fact, recently one service provider presented a new service integration to the LHIN. There were no cost savings, but there was improved and more coordinated care. The LHIN response was: "That's fine for year one, but in year two I expect financial savings."

In another LHIN, for the past three years, there has been an attempt to merge all the mental health agencies into one LHIN-wide agency. In the end, it was going to cost more and did not improve care. The initiative was aborted.

AOHC believes that a strong community-based service sector, including community support agencies and mental health and addiction agencies, can and must work together better. We believe that if a people-centred approach is applied with a strong quality-improvement incentive and the requirements to meet high standards, agencies themselves will make decisions to transform themselves.

Health equity must also be the foundation of any integration—this is really important. We are seeing the attempt to merge culturally competent and culturally safe organizations with mainstream organizations that may not achieve equitable health outcomes. Culturally appropriate, safe and competent services must have their place in a strong, community-based service sector.

Our recommendation is that the LHINs approach service integration from a people-centred and value basis that seeks to achieve enhanced care and improved health outcomes for people, and set high standards for quality of care and accountability, rather than simply reducing the number of service providers.

Culturally appropriate, competent and safe services must be considered in any plan to integrate and coordinate community-based services. Aboriginal, First Nations and francophone services need to be protected and enhanced.

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The act needs to be amended to identify the process to establish new health service providers as needed. There's an understanding that we have many HSPs, but there are some LHINs where there are not sufficient HSPs, and the act does not actually enable the creation of new ones. The power granted to the LHINs to order, merge, amalgamate and dissolve organizations must be used sparingly and with great caution.

The Chair (Mr. Ernie Hardeman): Five minutes.

Ms. Adrianna Tetley: Five minutes.

Community engagement: To transform the health service system requires robust, bold leadership, meaningful community engagement and strong public education. The LHINs have said that this is a core value, and the act requires the LHINs to engage with the community of persons and entities involved to do this. We are mindful that this is probably the area of the most criticism that the LHINs are going to receive, and we give a number of examples of the wide variety of community engagement that has happened across the LHINs.

In 2006, AOHC commissioned a study that basically says that you need to do community engagement because it will increase the health of communities and the effectiveness of their care. We also know that less meaningful engagement involves decision-making, simply sharing information or consulting to gather information, and more meaningful means that we need to have active participation of community members in contributing to decisions that are made. AOHC contends that the LHINs engage at this level of sharing and consulting to gather information.

We're pleased that the LHIN is actually supporting community governance, and that is not being questioned, and we're happy that the LHINs are continuing to support the need for it to continue. But we do not believe that the LHINs have successfully harnessed the power of community governance. Community governance is the highest level of the hierarchy of community engagement, yet the LHINs rarely meet with board members of HSPs in meaningful engagement.

The community is also not defined in the act. As the committee begins its cross-province hearings, we urge you to ask your delegations what "community" means. We further urge you to explore this idea over the course of the year, as we go forward.

I will go through the recommendations for meaningful community engagement:

(1) "Community" must be defined, and the act must be amended accordingly.

(2) LHINs need to build their knowledge and capacity to conduct more meaningful community engagement.

(3) LHINs need to engage with the public, community and health service providers as partners to transform the health system.

(4) LHINs need to do public education on how the health system changes will improve the health and well-being of the person, their family and the communities.

(5) LHINs should be held accountable for their community engagement process, clearly outlining the process and reporting on the number of complaints per year in their MLPAs.

(6) Like HSPs are required to do client satisfaction surveys, LHINs should be required to do independent community engagement satisfaction surveys of communities and HSPs, and they should report annually.

(7) Community-governed not-for profit health care services must be maintained.

Number eight: appropriately resourced. I think what I'm going to do is go right straight to the recommendations under appropriately resourced.

(1) The act should be amended to establish a one-way valve. This is really important. We need to prohibit the flow of funding from community health organizations into acute care institutions and should include protection of community organizations from supplementing deficits incurred in other parts of the health system.

(2) As submitted by the LHINs, the regulation should be enacted that permits the LHINs and the health service providers to receive multi-year funding and carry forward surplus.

(3) The ministry needs to significantly invest in community-based services in order to increase the capacity and infrastructure of community support agencies and not just in programs.

(4) The LHINs need to strengthen the capacity of the community health sector by prioritizing investment in human resources, operations, information management systems and quality improvement.

(5) The ministry and the LHINs need to align the capital policies to support the development of integrated and coordinated community services, allowing for business plans that include co-locations, creation of community hubs and ensuring all LHIN and ministry funding is considered eligible for capital planning.

(6) HSPs need to be able to submit funding requests for urgently needed programs and services for high-needs populations that often do not align with ministry and LHIN priorities. This is essential to achieve equitable health outcomes.

Number nine: LHIN and HSP recommendations. We'll go straight over to the recommendations. This is my last set.

(1) The MLPA should measure the health and well-being outcomes of the people they serve through a health equity lens, and these measures should reflect the full continuum of care; and it should require that the LHINs conduct community engagement satisfaction and HSP satisfaction surveys.

(2) The act should be amended to include an appeal or resolution process that requires the ministry to take action if community feedback indicates dissatisfaction with the extent and the quality of community engagement undertaken by the LHINs.

(3) The act should identify an appeal process for HSPs if the LHIN has been alleged to breach their role.

(4) While recognizing the fiduciary, oversight and planning responsibilities of the LHIN, the HSP accountability agreements need to be more collaborative and engage HSPs more as partners.

These are our initial thoughts, and we certainly look forward to questions on many of these various areas. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. I believe, with the committee's consent, this would be the time we recess until the statements in the House are made. We hope that you

will be here for the rest of the presentation, and any part of the presentation you had to go over a little lightly, hopefully that will come out in the questions and answers. Thank you very much.

With that, we're recessed until the statements in the House are finished.

The committee recessed from 1436 to 1524.

The Chair (Mr. Ernie Hardeman): I call the committee back to order. We thank you, first of all, and apologize for making you wait, but I'm sure that you—well, no, you didn't know the questions so you weren't able to formulate all the answers while we were away, but I'm sure that they will be fine. I think we'll start the questioning with the government side this time. Ms. Jaczek?

Ms. Helena Jaczek: Thank you very much, Chair, and thank you, Ms. Tetley, for your presentation with a lot of suggestions and ideas. Obviously, you have given this a lot of thought.

I think perhaps I will start off with one of your suggestions, which I was very interested in and certainly agreed with. This was in relation to population health planning. I'm looking at page 8 at this point. Your recommendation: "The act should be amended to incorporate the requirement for the LHINs and the public health unit(s) to form an equal partnership to develop LHIN-based population-needs-based plans with a health equity lens." I guess I would like to point out a practical difficulty in that boundaries of LHINs do not follow public health unit boundaries. Have you given any thought as to how this could work? As an example, my constituents live in the Central LHIN, and the Central LHIN would include parts of three health units. How do you see that becoming a reality, then?

Ms. Adrianna Tetley: I think there are two points I'd like to speak to: One is the boundaries, and one is the role and relationship. I think when I was looking at the Hansards up until now, it's impossible to put the public health units under the LHINs because of the municipal relationship. My sense upon reflecting on this is that it's not about "under the LHINs"; I think that they need to figure out how to work in partnership.

Health service providers are asked to work in partnership, so in many ways, the LHIN CEO could be working with the medical officers of health from the three LHINs to figure out how to do this. We do know that the LHINs are divided by sub-LHIN regions. Without even touching the boundary issues, the sub-LHIN regions could probably align with the public health unit boundaries and figure out how to do this. Once you've figured out the parts of each region, the epidemiologists should be able to figure out the data to develop a plan. So I think it's possible to do it.

The question around the boundary question: I do think that either the LHIN boundaries or the public health boundaries should be determined to be the same, whether you have three that are totally aligned, or whether you slightly adjust the LHIN boundaries so that they align. It makes sense to align them. But the lack of alignment should not prohibit this from happening. These epidemiologists can break it down to postal codes. So once you've figured it out once, then you should be able to say, "Get the three epidemiologists from the three public health units to work with the LHINs," and you should be able to figure out a set that belongs to that LHIN.

Ms. Helena Jaczek: Okay, I take your point. The preferred option is clearly to ensure that they work together, and that's the essence of it. But since boundaries are something very dear to my heart, especially as we also have heard about—and you allude to this as well: that there should be much more on the upstream side. So looking at the social determinants of health is absolutely crucial, and again, whether you're looking at supportive housing or whether you're looking at the justice system—and we heard some testimony last week in relation to the Toronto Central LHIN doing a lot of work in relation to the justice system. Of course, police forces are municipally based; again, those boundaries do not coincide simply to the LHIN boundaries, so it does complicate the situation. In theory, as you say, down to postal codes, though, it becomes very, very problematic.

I guess what has become apparent is that within the 14 LHINs, some LHINs have subdivided into areas where there might potentially be some sort of community of interest. But certainly, given the geography in the Central LHIN and the very diverse populations that exist within the Central LHIN, there certainly is no one community of interest; there are multiple. And I'm sure with your experience with CHCs—when you're dealing with your specific population within a CHC, you presumably are able to work very well in terms of looking at determinants of health and making sure that the partners work together.

Can you give us some examples, perhaps, of where CHCs are working effectively with LHINs and perhaps point to what makes those successes, and if you have some examples where things may not be working so well? What sort of criteria make it work? Can you just sort of give us some concrete examples like that?

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Ms. Adrianna Tetley: Sure. I think I'll look at the South East LHIN. The South East LHIN is the LHIN that actually also works well with public health. They know their CHCs well. They understand the breadth of them. One valuable thing about the South East LHIN is that there are five CHCs sporadically spread across the entire LHIN, so there's sort of a CHC in each community that needs to be done. The LHINs understand their role. The CHCs work well together. They work well with public health. Together they're able to figure out what it is that needs to be done and how they can move forward.

The LHINs in that particular area understand and recognize their role. The Kingston community health centre has, as its partners, immigrant services, early years programs and Pathways to Education, so it has the full breadth of the determinants of health within the community health centre, and that LHIN recognizes it and supports that work. I think that they have a very much

community approach and they invest in the CHCs to continue to explore and meet the needs of a people-centred system. They are an example of where it's worked really well together.

Ms. Helena Jaczek: Do you have some examples where things are not working as well?

Ms. Adrianna Tetley: In another LHIN, which won't be named—LHINs have been around for seven years, and they went to an AGM of a community health centre and were surprised at the breadth of services that a CHC provides. In some LHINs, the CHCs are viewed as primary care in the very narrow sense of the word. LHINs are not interested in the breadth of the work that they do. The LHINs are interested in how many people they're seeing—doctors and nurse practitioners. They're not interested in oral health, because that's public health units. They're not interested in what they might be doing in the breadth of their services. So in essence, they may be interested in about a third of what the CHC actually does. In that case, the CHC does not feel like they're part of the LHIN's agenda. They're not being invested in as part of the solution, and the relationship is a relationship of accountability, to do what you have to do to report back to keep your funding. But it's not a partnership and it's not collaborative.

Ms. Helena Jaczek: So there's some variability, then.

Ms. Adrianna Tetley: There's huge variability across the 14 LHINs.

Ms. Helena Jaczek: Do you, as the ED of the association of community health centres, get together with the LHIN leads, the CEOs? Is there some sort of coming-together on a provincial basis to discuss these issues?

Ms. Adrianna Tetley: No. We have actually—there are a couple of answers to that. The LHIN has now set up a LHIN strategic council. In that, it has representatives of LHIN CEOs and it has all of the provincial associations who are there, and we're starting to meet quarterly—this has happened in the last couple of years—where we can raise these kinds of issues.

When we're raising sector-specific issues, it varies. The tables are not always available, and there's a sense that they need to speak to their HSPs directly and not necessarily hear the association voices. So we've constantly, from the beginning, felt that there is a provincial role to ensure provincial standards, to ensure a provincial voice, and to sort of ensure that there is equitable support for the CHCs, regardless of which LHINs they're in. The LHIN strategic council is a place where it's starting to happen, but at that table, it's about strategic issues and you're not to bring sector-specific issues to that table. To bring sector-specific issues to the table has very limited opportunities.

Ms. Helena Jaczek: Each LHIN has a primary care lead, as I understand it. Of course, in your presentation, you've argued throughout, really, that there should be far more emphasis on the primary care piece, on the prevention piece. How do you feel the primary care leads are working within—

Ms. Adrianna Tetley: Again, it varies across the 14 LHINs. I would say that the primary care leads, generally and not individually, are mostly not focused on CHCs. Oftentimes, the CHCs are forgotten as part of primary care in different policy discussions, and we often have to remind that CHCs are also primary care. But mostly the leads are focused on how to organize the unorganized primary care system. They're more focused on the fee-for-service docs, the family health groups and the groups that are what we call unorganized. Only 25% of primary care is in an organized model—an organized model being community health centres, aboriginal health access centres, nurse-practitioner-led clinics and the family health teams. The rest are out there on their own and not even in any network. Oftentimes, the primary care providers are focused on that 75%: How do we get those primary care providers engaged in moving forward and transforming the system?

Ms. Helena Jaczek: That's surprising to me. I would have thought that the easier way of engaging primary care would be with the established CHCs, especially when there are successes like the Kingston one that you told us about. So that is very interesting.

If primary care becomes more the responsibility of the LHIN, you suggest developing a transition strategy. Could you give us some of your ideas on what that might look like?

Ms. Adrianna Tetley: Yes. We have quite a few thoughts about how to do this. I'll just use concrete examples. We have a community health centre in a community where there is a solo fee-for-service doctor working in an adjoining community. He actually wants to work with the community health centre in the community because he's by himself as a fee-for-service doctor. I think he has a nurse who works with him. He's got complex clients for whom he wants access to the interprofessional team model that's at the CHC. So we have submitted a proposal to move the fee-for-service physician to the CHC model. The issue becomes the OHIP pool and where the dollars are sitting. The OHIP pool for that physician pays for not just the physician, it also pays for rent and it pays for the nurse that they have there. What the ministry is currently doing is looking at what it would cost to put that person on salary. But the salary is only a piece of it. If you're going to take people over, they will be accessing the interprofessional team. The issue is, how do you transition that fee-for-service doctor, who wants to go, into the local community health centre?

Another example that we have is the one that I alluded to in the report, where I had to go quickly, where there actually are seven primary care physicians who have been working by themselves in rural Ontario for years, so they have very large rosters. They're all over 65, some over 75. In that particular region, there are no family health teams; there's just a CHC. They would like to engage, the physicians would like a transition strategy to start moving over now. They would love to go into semi-retirement, start moving their positions over so that if

something happens to them, or they can plan retirement—they can start to transition the people. The question becomes, and in the historical decision, if there are seven physicians in that community, who do you replace them with? Do you need a mix of interprofessional teams that includes nurse practitioners, dietitians and social workers? Maybe you don't need as many physicians, and we know the physicians are the most expensive part of the system. If you can use that money that equates it and transfer it over, my sense is you can really develop a strong interprofessional team that can meet the needs of the people with probably less money than finding seven individual physicians to run seven individual practices in their own sites with their own space. But one is in an OHIP pool, one is the funding, and one is in the LHIN-funded role. So how you transition between those pools is very important.

There's another rural example, in another part of Ontario, where the physician gave lots of notice and said, "I'm leaving town. Let's transition to the CHC." He was leaving. Nothing happened. Everybody was saying, "Who's on first?" "Who's on second?" Nothing happened. The person has now left, and there are 3,000 orphan patients.

Ms. Helena Jaczek: So was there any role for the LHINs at this point in time in sort of facilitating these discussions with the ministry?

Ms. Adrianna Tetley: I think they're starting to have these conversations. It's a result of us; we've brought these three cases to the ministry and to the LHINs, and we're starting to engage with both the LHINs and the ministry.

Everybody is sort of saying that the minister's action plan says that the LHINs shall plan primary care, but no one has done any thinking beyond that. What would that look like? How would it be done? They're initially starting to think about it. The LHINs are sort of going, "Oh. Okay. How do I do this? How do I even begin to think about a mix of models?"

A mix of models is also very important. We did a study in Ontario that says about 22% of the population needs the kinds of services that are provided by community health centres. They need more complex, coordinated, comprehensive care that also deals with determinants of health. Some communities might need them, others not, but generally 22%.

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The LHIN needs to plan. That's why the population-needs plan is so important. They need to do what South East LHIN did, and do a deprivation index and say, "Okay, this community needs a community health centre; in that community a family health team will work." So the whole issue of population planning, plus having to be responsible to plan for primary care, is essential in coming together. I just think that at the moment, it has not been the mandate of the LHINs and they're trying to figure out how to do it, but they haven't been given a mandate to require them to do it.

Ms. Helena Jaczek: In other words, that might be an area where the act should be amended to really push that kind of planning.

Ms. Adrianna Tetley: Planning from a person's perspective, not the provider perspective. That's fundamentally a key change in primary care.

Ms. Helena Jaczek: Yes, and looking at all the appropriate models that might exist. As you know very well, I represent an area of York region and we do not have a single community health centre in York region.

The Chair (Mr. Ernie Hardeman): Say it ain't so.

Interjection.

Ms. Helena Jaczek: You have one in Vaughan?

Mr. Steven Del Duca: I do.

Ms. Helena Jaczek: Oh, my goodness.

Ms. Adrianna Tetley: In Vaughan, yes. Vaughan has got a new one.

Ms. Helena Jaczek: Okay. A new one? That's excellent.

Ms. Adrianna Tetley: Vaughan got it in 2007, so it's running.

Ms. Helena Jaczek: In terms of future planning—

The Chair (Mr. Ernie Hardeman): Four minutes.

Mr. Mike Colle: Vaughan's got everything.

Ms. Helena Jaczek: One last word, because as you know, I'm a great proponent of a potential new CHC in Markham and Richmond Hill. How are you finding your conversations with the LHIN? Is there any movement going on—

Ms. Adrianna Tetley: No.

Ms. Helena Jaczek: —now that I know that Vaughan has one?

Ms. Adrianna Tetley: Vaughan has one, so the particular agency that is there is trying to become a health service provider, as a starting point. No one knows how to create new health service providers. There doesn't seem to be enabling legislation to create new health service providers, so that's step one.

Step two is that there's a sense that they're not taking a population-needs-based approach. They're saying, "Well, we have family health teams. We don't need CHCs"—the lack, again, of understanding what the community health centre is and what its unique role is. We know that the population in that particular area has gotten huge with new immigrants, and it's growing every year, so the current family health teams (a) aren't designed to meet their needs, and (b) we need new CHCs in that community to meet these needs. We will see a big difference in terms of their health outcomes if we have community health centres. There is an agency there willing and ready to go. There's no place to have this conversation currently.

Ms. Helena Jaczek: So that's this piece where you're saying that the legislation needs to be amended to include the opportunity for new health service providers?

Ms. Adrianna Tetley: Absolutely.

Ms. Helena Jaczek: Okay. That really helps.

You have a recommendation on page 15 about a "'one-way valve' prohibiting the flow of funding from

community health organizations into acute care institutions." When you're saying community health organizations, you would obviously include the CCACs?

Ms. Adrianna Tetley: Yes.

Ms. Helena Jaczek: Yes, you would, because I think that is absolutely crucial. I would definitely agree with you. Are you aware of situations where, in fact, funding has been shifted?

Ms. Adrianna Tetley: Oh, absolutely. Surplus dollars from community health centres have, over the years, been used to pay deficits of hospitals. Absolutely.

Ms. Helena Jaczek: Okay. I'll reserve whatever we've got, a minute or so.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much. I think you have a minute to spare. The official opposition: Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Chair, and good afternoon, Ms. Tetley. It's great to see you again, and thank you very much for your very comprehensive report and number of recommendations.

I'd like to just get some further thoughts, if I might, from you on the issue of equitable health outcomes. On page 5, you're talking about how the objective in the act would be expanded to ensure equitable health outcomes in a variety of communities. I wonder if you could tell us a bit more about what some of the barriers are and some of the solutions that you would propose.

Ms. Adrianna Tetley: I think that I'm going to use Fred as an example. Do people know who Fred is? Fred is the poster person for health links. He's described as 50-some years old, living alone. He has 26 different illnesses and he costs the system a lot of money because he's going from specialist to specialist, and no one cares for him.

There are two different kinds of Fred. You can have a Fred who lives at home alone, as I said, but he has a sufficient amount of money to buy extra care. His two daughters have a university education, and they're helping him navigate the system.

Then there's Fred number 2, who doesn't speak any English, has no family in town, is living on old age pension and has no ability to buy any extra services, and doesn't eat properly, because he doesn't have enough food.

The health system looks at them generically, as if they're one person. The kind of need that Fred 1 has and the kind of need Fred 2 has are very different. Unless we're very, very deliberate in trying to figure out the needs for Fred 2, he's not going to having as equitable health outcomes as Fred 1.

Seniors are another question. We look at the health outcomes for seniors, but what about aboriginal seniors versus francophone seniors versus seniors living in poverty? Generically, we might say, "Okay. We've reached 60%." But maybe it's because we've reached 40% for aboriginal seniors and 80% for seniors who live in Forest Hill.

The health equity impact assessment tool actually outlines all the various things that you need to take into consideration to actually measure and break down populations into different kinds of population in order to measure their equitable health outcomes. Seniors with mental health issues versus seniors who don't have mental health issues: unless we start looking at that, we're not going to design—another really good example I just heard is with health links. They were going to look at 37 people who were identified as higher users of the health system. They did phone surveys. Of the 37 people, 17 they reached on the phone, and those 17 had a physician. The 20, they said, "Well, we've discovered they don't have phones, and they actually are unattached to a physician, so we're just going to go with the results of the 17." Just imagine the different story they'd have if they actually reached out and got the 20 who don't have phones, who don't have a physician. A very different care plan would need to be designed for those 20 they didn't reach instead of planning the whole system on the 17 they did reach.

I'm not sure if I'm answering your question, but that's why we need to have a very deliberate health equity lens, or we are not going to get the same outcomes for people, whether they live in the north, whether they're francophone, aboriginal, live in poverty, new immigrants in Helena's riding, where they're looking for a new community health centre. It's pivotal to making sure we have equitable health outcomes.

Mrs. Christine Elliott: Thank you very much. I also had a question on page 10. Please forgive me; I forgot my glasses today, so I'm having a little trouble. It has to do with the system navigation, and I'm wondering just what that would look like in your view.

Ms. Adrianna Tetley: We really differentiate between care coordination and system navigation—just to make sure we have the words. For us, system navigation is when a person who needs care would be needing to navigate the system, and navigating the system might be as much about going to the food bank, getting to an employment office, helping them write a resumé—navigating the system to get the kind of care that they need. It's much broader and has a much greater breadth in the scope of what they do. It might be helping them get their OHIP card. It might be helping them get into school.

Care coordination for us is when a person is sick and needs intensive care. They need intensive care coordination going into the system. But, for us, that care coordination could start as a young mom who has a baby, and helping them figure out how to provide good care to that baby. The baby may be sick, or may not, but they may need to understand how to keep breastfeeding. They might need to make sure that the baby is hitting all of those different milestones. Maybe they've got a speech impediment, and so they may need to get help for that speech impediment.

That child grows up, and they become early years—they have issues that arise. They become a teenager, and that teenager child might need to access mental health services. They might need sexual reproduction classes.

They might need those kinds of services. Later in life, that person might develop cancer and need very intensive cancer support, and then later in life, again, palliative care.

So for us, why it's so important is that if you live in the same community, your primary care provider is the person who will stay with you from when you have that baby to when that baby needs palliative care. In our world, you're connected to the same primary health care system that planned that place, that will ensure that you go into the system and back out of the system as required, when needed, and you will ensure that your care is done in and out.

In community health centres, they've been doing system navigation and care coordination from its model. In some cases, depending on what it is, the system navigator may be a peer support worker, and that might be the best way to work with them. In other cases, when they get into care coordination that gets complicated, they may have an RN.

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The bottom line is, it's the community health centre that is responsible to ensure that they come in and they come back because, hopefully, when they're intersecting with the rest of the system—even with cancer, it's episodic, it's for a period of their life, but eventually we want them back at the community health centre, which knows their story as they go from birth to death. The Kingston model that we talked about talks from cradle to grave. So for us, it needs to be firmly—the resources need to be located in there, and then accessing the resources as they're required.

Mrs. Christine Elliott: I guess I would take from what you're saying that there isn't a specific health care professional that would be doing the system navigation. It would just depend on what the issue is at hand that would dictate who the appropriate person would be.

Ms. Adrianna Tetley: Absolutely.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Ms. McKenna.

Mrs. Jane McKenna: Hi. Thank you so much again for coming. My first question is that you had said to Ms. Jaczek that you made a key change so now it's a person provider. When did that change—

Ms. Adrianna Tetley: Sorry? When it went from person—

Mrs. Jane McKenna: Now that it's patient-centred and that you've made that key change—when was that?

Ms. Adrianna Tetley: Right. CHCs have always used the word "client" in the past; we've never used "patient." Patient, in our mind, meant that you were sick and that's partly—when you take the model of somebody is sick, you enter the hospital, you're their patient. Oftentimes, if you have a teenager who needs sexual education as part of staying healthy, they're not sick; they need education about good sexual health behaviour. We have used the word "client." There is a lot of pushback on the word "client" and now we're using "person-centred care." It's a definition that's used by the WHO; it defines "people" and "person-centred care."

What's also really important in the word "person" is the responsibility to take care of your own health and to work in partnership with your provider as opposed to the provider being the expert telling you what to do. It's a dynamic on many fronts, and starts with you as the person.

Mrs. Jane McKenna: And how has your relationship evolved over the last seven years with the LHINs?

Ms. Adrianna Tetley: I think over time, it's maturing. In some areas, as I think I said earlier, the relationship has been very productive and is working well together. In other areas—why we're recommending the expansion to the LHIN act, as we're talking about it, is because there are many parts of the health system that we feel are not—the LHIN is responsible to plan and oversee the whole health system, and yet the LHIN act itself is focused on a small part of the health system. So where the frustration comes with the LHINs is when they do not see the entire spectrum of what we believe is health and well-being and the responsibility of the LHIN.

We also fundamentally believe that we need to keep people healthy in order to sustain our health care system in the long run. The longer we, in our rooms, stay healthy and don't need the system, the more it will be there when we need it. But we want to make sure that people who don't need it stay healthy in order to prevent them from having to use the system. So we need a robust, healthy, acute system. We need long-term-care facilities. We need each part of the system. But we're saying now, if we're going to have a sustainable system, we need to focus on developing mental health services, community support services and primary care. They need to be equally supported and robust in order to have a full continuum of care that will impact the sustainability of our system in the long run.

Mrs. Jane McKenna: So why do you think that they stay so close in their silos? I'm sorry, I can't see what page that was on either, but you do mention that everyone very much stays in their silos in that area.

Ms. Adrianna Tetley: The silos I spoke to were related to primary care and the silos I spoke to were related to public health. I think if you look at the LHINs' mandate again, if you go back and look at the objects, it's very much about managing the current health service providers. Even though it says "equity," it's about managing the current system. All of the indicators, all of the work, the 14 of the 15, are acute-focused. You're going to measure what matters, and if you say only emergency room and use of hospitals is what we're going to measure, then for us that's sending a signal that that's what matters. If you're going to start really being part of the system and feeling part of the system, you've got to measure what community support and primary care actually do, because that's what tells the story and that's what begins to challenge health service providers as well to improve and to do better.

But, you know, the whole thing is, you measure what matters, and if we're just measuring acute, then the system and the focus will only be on the acute.

Mrs. Jane McKenna: That's it for me, thank you.

The Chair (Mr. Ernie Hardeman): Ms. Forster?

Ms. Cindy Forster: Sure. Good afternoon. Just a couple of question, and then I'm going to give the rest of the time to France. You talked about the fact that primary health care organizations should provide the system navigation. Currently the CCAC does some of that navigation. So are you suggesting that there wouldn't be any role for the CCAC, that primary health organizations should take over the whole system or forge a closer relationship where they're actually working together to navigate the system?

Ms. Adrianna Tetley: So let's start by saying that CCACs do a narrow part of what I believe care coordination is, because care coordination can happen from birth until death. Their focus, predominantly, is on seniors and complex children. First of all, when I talk about care coordination, I'm talking about care coordination through a life, right? So that's first.

The second piece is that whatever the role of the CCACs is in the future, we are not there yet. We need to build a robust primary health care system in order to do care coordination. I believe currently the CCACs have the capacity to do that now. Many of our CCACs do it and do not work in partnership with the CHCs to do their care coordination because it would be seen as a duplication; it's something they already do. However, there are certain times when even the CHCs have to interact with how the CCACs are currently structured, because if you're going to do care at home or palliative care, you're going to need to do it for that time where you may need to have to connect with CCACs to do that service.

So I don't want to get into the argument or the discussion about what's the future role of CCACs. What I'm saying is a high-performing primary health system should do care coordination for the people that they serve. There may be times where they need to connect depending on how the system evolves—to connect with the CCACs for that period of their life when they need services that CCAC is the doorway to accessing those services. They may need to actually partner with CCACs to get that service.

Ms. Cindy Forster: And then you talked more about the fact that we're not really spending enough energy on health promotion and health prevention. Public health is dedicated to doing some of that work, but they only get a very small percentage of the health care budget to do that work. So do you see public health getting more dollars to move their mandates along, or do you see these as dual roles?

Ms. Adrianna Tetley: There's a very interesting debate happening in public health between public health and population planning and direct service. I know in Nova Scotia, public health has decided that they will no longer do direct service. They will no longer provide flu shots, for example—flu shots or breastfeeding clinics, that should be done by primary care.

We need a healthy debate about the role of public health in direct service. Having said that, we do need public health to have a robust conversation about population health. That's their mandate. We need clean water, clean air and many things. They need to be working in partnership with LHINs to determine how that can be done together. I think the question is, who does direct service and what kind of programs and services should those be? Absolutely, on health prevention and promotion, when it's around clear water and clean air, that is the role, and the public health units need to be invested to ensure that we have a healthy space and environment to live in. The question that I think is important is the direct service piece and who should do it.

Ms. Cindy Forster: Okay. My last question is, you also talked about the CHCs and primary care assisting people with housing issues, social service, education and all those things that directly impact people's health, but you didn't speak to the transportation piece, which I think is huge, particularly for rural, northern communities or even where I come from in Niagara, where there isn't a reliable inter-regional bus system. What are your comments around that?

Ms. Adrianna Tetley: Transportation is a key determinant of health—getting to a specialist and anywhere for appointments. CHCs play a role in mitigating transportation issues. How they do that is, if it's an urban area, they often provide TTC tickets or taxi chits to get to the specialist appointments. In rural areas, they do mobile health clinics. They go to where the people are. They organize transportation. One CHC, I think, told me that they did over 10,000 transportation trips, mostly with volunteers that they organized. So transportation is a key determinant, both in rural and urban areas.

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Ms. Cindy Forster: So you'd agree that we need to turn our minds to that piece as well if we're going to be moving into this new era.

Ms. Adrianna Tetley: What's really important—I think I said this; I'm not sure. The LHINs have worked, as far as I can tell, anyway, in silos from their counterparts in their region. Have the LHINs sat down with the boards of education and said, "What are the health issues facing your kids and how can we work together to help to do that?" Have they sat down with the municipality and said, "What are some common issues that we need to do around transportation? Maybe we need to provide better TransCare. How do we work together to actually be developing these system solutions?" It's just like a CHC. The CHCs partner with people. They don't necessarily do it themselves, but they ensure that their clients have access to the services that they need.

It's the same thing with the LHINs. Maybe in partnership with school boards, with the municipalities, with other large organizations, they could figure out what is the plan to keep our communities healthy. The LHINs don't see their role in the community. They see their role,

at the moment, as treating people when they're sick and the patients who are in the system. That's one of the frustrations with the community health centres, because their role is community resilience and that's not valued or seen as important currently within the act, and if it's not in the act, it's not going to be in their mandate.

Ms. Cindy Forster: Thank you.

The Chair (Mr. Ernie Hardeman): Yes, Ms. Gélinas.

M^me^ France Gélinas: Thank you for coming again. My first question has to do with—you talk about the aboriginal and First Nation Health Council and planning entities, as well as the francophone population, and the fact that the way the system is set up right now where francophones, where the entities exist, have to sign an accountability agreement, which makes it awkward. Would you have any recommendations as to what should change?

Ms. Adrianna Tetley: Yes. I think, first of all, the councils—one has met; one hasn't met frequently. The importance of having an aboriginal and a francophone health strategy in this province is paramount, and it hasn't happened to date in a serious way.

Around the planning entities themselves, I actually believe that the planning entities should be treated—just like I believe in public health units being equal partners with the LHINs, the planning entities need to be equal partners with the LHINs. Because there's money flowed to them, some kind of accountability over the money needs to be developed, but fundamentally I do not believe that they should have an accountability agreement with their LHIN under the direction of the LHIN. If they're going to provide advice to the LHIN in planning, there needs to be a parallel partnership.

We talk a lot about the ministry's role and stewardship and the LHINs' role in planning and accountability, but I think the planning entities have to have a distinct and separate role. They can't be treated as health service providers. They are not providing direct service. They are planners, and they need to have a step removed from an HSP relationship.

M^me^ France Gélinas: You made the parallel to the equal role with public health units. Would the same train of thought apply where the health units continue to be funded directly by the province but work more collaboratively?

Ms. Adrianna Tetley: Yes. I think that's the direction that we need to go. I do know, from the previous questions, that there's always a thorny issue with the relationships with the public health units with the LHINs, and I think it's the wrong question. We need to say that form follows function. What's the role of the public health unit and how can they work with the LHINs to achieve that role? There's always this issue that the only way that something can happen is if they're under the LHIN.

I put the planning entities in the same boat. They're planners. They're population planning bodies. Public health is a population planning body. We need to look at—maybe it's a council with the LHIN, the planning entities and the public health units working collaboratively to figure out how to plan for the best health and well-being of the individuals, the families and communities. So I think it needs to be a relationship that is at a higher level, as opposed to a relationship that is hierarchal.

M^me^ France Gélinas: You also talked a lot about primary care planning. Basically, the act mentions it in the opening statement, and then it's not there anymore. What would you recommend we do to change this, and what is the outcome you hope to get?

Ms. Adrianna Tetley: I think the act does not actually name primary care. It names health equity, but I don't think the words "primary care" are in there, actually—

M^me^ France Gélinas: You're right.

Ms. Adrianna Tetley: —so I think the objects need to be changed to mandate primary care. We believe that we need a system of primary care where every Ontarian has access to interprofessional primary health care working to full scope that provides a continuum of care that's integrated and coordinated.

To do that, we believe the LHINs have to have a role, a responsibility and the ability to actually develop those plans and implement them. We need it to be named, because if it's not named in the act, they will focus on what's named in the act. We know this because, for two years ago now, the minister in her action plan said that LHINs should plan primary care, and yet the conversation is only starting.

Often it was interesting for me when I read the Hansards that the comments were focused on "Well, we've got health links now," as if that equates to primary care planning. For me, health links does not equate to primary care planning. I support health links, and I think they're an important way of bringing people together, but that's not planning for when the doctors are going to retire, what's going to happen and what kind of system we need.

All the research shows that if people have care and they feel connected to a primary health care place, they will save the system money, and they will be healthier. We really do need to focus on that.

M^me^ France Gélinas: On a dollars-and-cents track, do you see the LHINs being responsible for funding primary care?

Ms. Adrianna Tetley: Determining what the salary is for a physician or the OMA agreement is one thing, and I think that belongs in the ministry. There's no way you're going to get a provincial agreement on that, but when we talk about primary health care, they're way more than physicians. It's about nurse practitioners, social workers, dietitians, health promoters and community workers.

Yes, of course they need to fund that, and they need to figure out how to work together. They do need to have an ability to transfer money from physician fees. If the LHINs decide that they need interprofessional teams, maybe the money needs to transfer over. But what you actually pay and how you're going to negotiate, which is typically the OMA agreement—you'll bog the LHINs down. I don't see that transferring. But that doesn't mean it can continue as it is.

Historically, the OMA have dictated the policy about how primary care develops over the years. I was at a meeting earlier today, and they know what I was going to say here today. There are new people who help to shape primary health care; it's more than the OMA now, and they need to share the stage.

How you're going to pay them and what they get paid, I don't think the LHINs should get into that. But needing to transfer some of the money—if it's an example where seven doctors are leaving and need to be replaced by a team, there needs to be the ability to make sure that the people get the right care they need. That may mean moving money from one pot to another and enabling that to happen, or you leave the pot and create a new pot of money to provide interprofessional teams. The mechanism for funding is not as important as that it get funded, that it's people-centred and that the people get the care they need.

M^me^ France Gélinas: How much time do I have left, Chair?

The Chair (Mr. Ernie Hardeman): About six and a half or seven minutes.

M^me^ France Gélinas: Okay. At the end of your presentation, you started to be quite rushed. I was wondering if there were elements of those recommendations that you wanted to make sure that we include when we look at how we change the system.

Ms. Adrianna Tetley: I do want to speak about two points. I'll talk about community engagement and accountability together. First of all, I know that the system needs a serious health system transformation. It is very hard for the LHINs, or anybody else, to do their job. Before the LHINs, it was health system restructuring; it was the ministry.

We need to have meaningful community engagement, where people feel that they're part of the system, so that when tough decisions have to be made, like a hospital service being moved into the community, the community is part of that decision so that they're with the tough decision as opposed to opposing it. I fundamentally believe that the LHINs have not yet figured out how to do meaningful community engagement. It's been very much, "Come meet with me. Tell me your ideas," and then they go away. The HSP—a lot of the board-to-board meetings are very much one-way. They're not real engagement.

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The other point is the definition of "community." We talked a little bit about community being the soul. It can be geographic; it can be cultural. There can be many different ways of defining community, and I think the act doesn't define "community." You can say a community board is the size of a LHIN. I don't believe a community board is the size of a LHIN. That's not a community. It might have a not-for-profit board, but that doesn't mean it's community.

I think you do need to grapple with what community means, and how do we do this and how do we engage community in a meaningful way in order to do the tough changes that we believe need to happen to make the system more informed.

Having said that, I think there's also a mandate—

M^me^ France Gélinas: Sorry, Adrianna. Do you see this definition being put in the act?

Ms. Adrianna Tetley: I think we need to grapple with it as part of this review and to determine what might be the best. I don't know whether it should actually be in it. I absolutely think it is a question that should be explored, to figure out what we mean by community, and then what that means.

The second is the accountability of the LHINs. There's lots of one-way accountability between the HSPs and the LHINs, but there's not a lot of accountability for the LHINs. As we've alluded to, not everybody's perfect. Sometimes some LHINs are better than others, and there are some great LHINs. But sometimes there's a bad apple in the box. There's nothing to do by an HSP or the community. There's no appeal process in the act. There's no ability to hold that LHIN accountable in any way.

I had really strong ideas about—as you're an employer, you're required to do employee satisfaction surveys. You're required to do client satisfaction surveys. Why not require the LHINs to report on their complaint process, report on their community engagement process, do third party independent HSP reviews, in order to measure how well they're doing community engagement, in order to measure how well they're doing with their providers? I think that's a very, very important part of moving forward on accountability.

My final point is about appropriately resourcing. Right now—and people better than me know the percentage of the fund that the community-based services have—it's a very, very small part of the budget. We're being kept at 0%, the same way as the hospitals, yet we're being asked to take on more and more and more.

If we fundamentally believe in a health system that is illness prevention and health promotion, we need to invest in the community sector; that means, at an operational level, infrastructure, HR or human resources, in order to make sure that it can do the role that we're asking it to do. We're asking it to stand up and do more and more. Yet when it's time to take on something—when it's time to do health links, for example—they're going, "Well, the community sector doesn't have the ability because they don't have a project manager. We'll turn to the hospital, which has a project manager. We'll use the hospital's project manager office to develop health links."

It's not because the community sector can't do that role; it's because they don't have the infrastructure to do that role. As long as we turn to the hospitals for all of those kinds of services, you'll not fundamentally create the capacity in the community sector.

We need a serious look, and that's why the one-way valve is so really important, to start building the capacity in a serious way. And a dollar goes a lot further in the community-based sector than it does in the acute sector.

M^me^ France Gélinas: What's the difference between what you're talking about, building capacity—we often hear the LHINs saying, "Oh, the community agencies should share their back office. All of the community agencies should have one HR, one finance, one etc., etc." Are you saying the same thing?

Ms. Adrianna Tetley: No, not necessarily, but what I'm saying is, as part of my remarks, we need strong community-based services. That may mean fewer in some communities; it may be more in other communities. It may mean bringing the community support agencies together, with very high standards, so that they're strong and robust. In that case, it may not be just sharing back office.

If you just look at back office in isolation of everything else, it actually—some of our CHCs have been required to do back office. It's costing them more to do back office by sending it out than it was for them to do it in the first place. The argument was that it will provide better high-quality care—high-quality services is the argument—because the costing isn't the reason to do back office. All the research has shown that back office alone, in and of itself, does not save money.

I do think, though, that we need to build the infrastructure around—and I'm not talking about HR directors; I'm saying that if you want to move from the hospital to the community, you need to have pension plans so that the people who are working in the hospital will want to work in the community and take their pensions with them. You need to have compensation that is relatively—not equal; we never say equal to the acute sector, but at least attractive enough and equitable enough that people will want to work in the community and put their careers in the community. We need to build the capacity for larger organizations, even community health centres, community support agencies and mental health agencies that are larger, to do some of this system planning and this work.

We know, and OCSA will be the first to say it, that a lot of the smaller agencies need to figure out their future. By setting high standards around quality and by having high standards in terms of what they need to do, many of the smaller agencies will come together, but it will be done because they'll take a person-centred approach and it will be the best way to go, going forward. Over time, they will come together, doing more.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. Did the government wish to use their last minute and a half? Yes?

Ms. Helena Jaczek: Mr. Colle.

Mr. Mike Colle: One minute?

The Chair (Mr. Ernie Hardeman): Yes.

Mr. Mike Colle: It's okay. It's just a minute?

The Chair (Mr. Ernie Hardeman): Yes, a minute and a half.

Mr. Mike Colle: I've got too many questions. I can't.

The Chair (Mr. Ernie Hardeman): Nobody wants to use it?

Ms. Helena Jaczek: No.

The Chair (Mr. Ernie Hardeman): Okay. And the opposition? If not, that concludes the presentation and the questions. Thank you very much for coming in and putting up with the delay in the middle of the presentation. We commend you for coming back, full force and invigorated.

Ms. Adrianna Tetley: Thank you.

ADDICTIONS AND MENTAL HEALTH ONTARIO

The Chair (Mr. Ernie Hardeman): Next is Addictions and Mental Health Ontario: David Kelly, chief executive officer. If you will have a seat, Mr. Kelly. We thank you very much for coming in. Again, on behalf of the committee, we apologize for the hold-up. Obviously, because the first one was delayed, the second one is just as much delayed.

As with the previous one, we will ask you to make your presentation, up to a half an hour, and then we will divide another hour, with 20 minutes for each caucus. This time, the questioning will start with the official opposition.

With that, the floor is yours.

Mr. David Kelly: First, I just want to let you know who Addictions and Mental Health Ontario is. I'm going to be brief because we're actually kind of the result of some of the transformation, integration, look and understanding of health. We've come together to form a new association from two founding organizations, the Ontario Federation of Community Mental Health and Addiction Programs and Addictions Ontario. We came together to make sure that Ontarians have access to the services and supports they need to address substance misuse and mental health issues. We want to foster dignity and accountability to all clients within the system, and we're here to give hope to and transform lives for those living with mental health and addiction issues.

In a sense, we are part of the result of what's been happening in the health care system for the last few years. I'm very pleased to say that we've come together and worked with over 280 mental health and addiction programs across the province. That's the full continuum of care, from hospital-based acute programs right down to drop-in centres, front-line housing etc.

The other thing I really want to do to start off this presentation is to extend thanks to each and every one of you. We know that your leadership and support have made a difference in local health providers, particularly in mental health and addictions. We want to thank all the MPPs and all of the political parties who are addressing these complex issues through the select committee, the 10-year strategy for mental health and addictions, and for their support of funding for these services. So thank you. You may not hear that enough, but I really wanted to make sure that that got on the record.

Also, when you start looking at mental health and addictions, to understand where we are today, you actually have to look at the past. We are in a system that is dra-

matically transforming through better understanding of what's going on, but in the 1990s, we actually had reductions in the base budgets of mental health and addictions services in the province of Ontario. Zero per cent base budget increases between the years of 1992 and 2003 resulted in a drop of capacity of these services to provide and meet the needs of their communities by about 25%. That's through inflationary pressures.

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We also, in the 1990s, had policy decisions on who would be—and how to access services. That often meant that individuals needed specific diagnoses to be able to get access to community-based services. All that did, with the best of intents, was actually to create longer lines.

So you have a perfect storm brewing, where you've actually had base budgeting reductions. You've had 0% increases, so your capacity continues to diminish. You've had policy decisions about who can access the services, which meant fewer people could access those services, and they would end up showing up to family physicians and emergency rooms—all kinds of different places, except for the place where they could actually get the help that they needed.

Into that system, we were instigated. We had regional offices come through that couldn't address the issues of mental health and addictions, and we went into the LHIN process going forward. So we're in a place where we actually work at a system that was teetering. I don't want to say "turmoil," because I can only support—you cannot imagine the dedication of individuals, staff and organizations, and their boards, to keep their organizations functioning through that time period. It wasn't that the system was teetering; it was just that the system had not been worked with to actually meet the evolving needs of mental health and addiction issues.

We're here today to talk about the Local Health System Integration Act: what's working, what's not working and if we were supporting the Drummond report. In my presentation, you're going to see two slides; I'm just going to quickly hold them up so you understand which two I'm talking about.

I think I heard an earlier presenter touching on these, but the objects of this Local Health System Integration Act actually speak exactly to the heart of mental health and addictions services in many different ways: the need to collaborate, the need to integrate your approach, the need to work on these system issues to better build the health care system.

When we get to our performance agreement and our indicators, none of this is actually relevant to community-based services in the short run, but also in the sense that these are not indicators of a high-performing health care system, but are indicators of an acute system. Until we actually get out of the box of thinking of health within these acute boundaries, or family physician boundaries, and start looking at the broad determinants of health, we will continue to have to go through a continuous change in the health care system. We will not address the core issues of maintaining and lowering our costs or making sure that people have the right access.

In mental health and addictions, if you're not talking about the broad determinants of health, if you only focus on treatment, you're only doing part of the job. People need safe places to live. They need help to find work again. They need a friend. They need social environments. They need a lot of things that are all supported in some ways, but many are outside of the health care system. We have to get to a better integration and understanding. I'm sorry; you can have as many physicians available as you want, but if you do not have safe and affordable housing, that physician is not going to be able to help you. It's very important when we talk about mental health and addictions that we understand and look at the broad determinants and not the narrow confines of legislation and the health care system.

One of the best things that I've seen happen in the last 10 years for mental health and addictions was actual increases in the ODSP rates. That meant that individuals had that much more, a little bit of money to be able to spend at their direction to improve their lives. What happens with ODSP funding envelopes and what happens in the justice system dramatically impact people with mental health and addictions, and we need to start thinking and taking those approaches into consideration to successfully address these issues.

So as I said, the objects are very desirable. They're inclusive of provincial and local needs, they seek the engagement of the community and it's about achieving higher performance through best practices and continuous improvement. But again, these are hospital sector, hospital focused, and health is much more than what happens in the hospital. We need to incorporate systems that reflect broader determinants of health. One of our key recommendations is to develop indicators and policies and implement strategies to reflect community health services and the needs of Ontarians in their local areas.

Included also for you is what is probably the leading thought piece on quality. It's about quality by design and what we know that works. Some 80% of first mergers and amalgamations fail within the first three years, but by taking some of these sort of bullets, these high-level thoughts, and applying them to your processes, you can actually achieve higher success rates.

The importance of leadership and policy: Policy without tools doesn't work, and that's one of the biggest challenges we face. We talk, but we don't implement in the right way to get the results that we want. We have to change that.

Transformation is ongoing. It doesn't stop tomorrow or at the end of this review. It will be ongoing the next day.

Fostering a culture of co-operation and participation: I'm sorry, but it takes time and a lot of strategies to be able to go forward on that.

Be wary of narrow targets. Narrow targets will not work in health care. In mental health and addictions, narrow targets actually defeat a lot of the services.

Just as an aside, in an acute setting, we talk about the contact with the family physician. In a mental health or addictions service, you could have 10 contacts a day with an individual, that are completely necessary for that person to feel safe, to function in their home and to not have to go to an emergency room.

Remember, we always say, "Let's fix this problem. We'll get that hip replaced." In mental health and addictions services, it's about the relationship you have with clients that supports their independence and their dignity and allows them to be full, functioning partners of our community.

One of the things we know is we've had some real successes, but we're not necessarily always building on them. I just want to flag, when we talk about changing and implementing quality and looking at transformation, some of our great examples in mental health and addiction. For example, the system enhancement evaluation initiative, the SEEI, was one of the first comprehensive pieces of research tied to new investments that were issued by the government of Ontario around specific mental health services. That evaluation showed that those resources worked, for what they were, but they were nowhere nearly comprehensive enough to actually dramatically change the situation with Ontarians' mental health and addictions. The comprehensive assessment project was another good example.

The MIS compliance project: I cite that because it was a good example of collaboration. We wanted to go to a new management information system for reporting to the ministry and the LHINs. The organizations tried to reach that. Out of the initial pilot, which included about 15% of organizations, only 4% were able to make their first submission. But through a strategic partnership with Addictions and Mental Health Ontario, we were able, within a year and a half, to get that up to about 95% compliance. Again, it's about the collaboration, the integration, and utilizing the expertise to get those.

As we go further along in today's presentation, there are a few priority areas that I'm going to be focusing on: accountability, collaboration, system transformation, governance, the Ministry of Health and Long-Term Care and LHINs' collaboration, and funding.

Let me talk about some of the growth and success in accountability. The three-year multi-sectoral accountability agreement cycle is a success. It's part of the growth we needed to have so that we could look at targets and start to actually get out of the planning from, often, month to month and year to year in mental health and addictions. We now have a process that lays out, for three years, our accountability and expectations with the LHINs.

Increased emphasis on performance measurement and quality indicators: I've heard this criticism many times, that we're not sure what mental health and addiction agencies are doing. We want to see more improvement in that area. I think the discussions that we've been having are getting us to that place. We have a long way to go, but we are making progress.

Some of our attempts at standardized software—for example, what's happening with the newly announced health links—have been successful. It gives us some consistency from LHIN to LHIN and across the province.

We think there has been a lot of success with consulting on the sector. Our most recent MSAA process has seen a lot of consultation between associations, sector organizations and the LHINs, to get this agreement right.

Back office model—somebody was asking questions on that earlier: Again, you're going to see as we go through this that sometimes I'm going to highlight successes, but the same problem will exist in other areas.

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Back office has been very successful in areas where we have gone back to what is a high-performing quality system, how you actually integrate services. When you're using the best practices, you will have much more success in those types of processes. We think because there are too many organizations, and we can save money by bringing our back offices together, we'd get a different reaction and you'd get different results.

For accountability, some of the challenges—I'm just going to start citing a lot of these. Within our MSAA agreements, the variability in definitions, the variability in data collection, the variability in data measurements and on and on and on continue to distort what is actually happening, our understanding of mental health and addictions services, and the results of that. We're actually in a position where it is very difficult to compare for you, say, for someone in Simcoe-Grey, what's happening with their mental health services to what may be happening in any other area of the province. We need to get a better understanding of data, the definitions and the data collection systems.

We really need to understand the systems, and this alludes to what I had been discussing earlier about not utilizing the broad determinants of health. The importance of housing in the outcomes of mental health and addictions services is crucial. Without housing, there will not be the success that we all know we need to achieve. But that understanding has been very difficult to build. We have a long way to go so that organizations like the LHINs and, I'd say, the ministry and many other decision-makers actually understand what community health is all about.

Smaller agencies are often struggling to meet the same accountability requirements as large institutions and hospitals. All of us in mental health and addiction want accountability. We want to be able to demonstrate our success. But setting the bar at one level right across the system actually goes to the heart of the matter, because many of these small community organizations and service providers are actually the linchpins in ensuring the success of mental health and addiction treatments. We need to make sure that those organizations are nurtured within this system until we can get to a place where we are a truly integrated health care system. Issues like governance, back office—all of that will start dissipating, but

until we actually value those organizations, I don't think we're doing them any justice within the system.

A really good example of that: I've worked with this family, and 20 years ago, before anyone was really talking about supportive housing in the mental health sector, they bought a house for their son with schizophrenia. Then they opened that house to 10 other individuals. They supported that for many years. Finally, the ministry has stepped up, and obviously, there's funding that's going in, but there's not a lot of value placed on that governance that that family—with a board, not for profit—not a lot of value has been placed on their efforts within the health care system, and that, to me, is really a very big problem.

Often, with our MSAAs, our outcome indicators do not line up with our new projects, so we have discussions about indicators and targets, but we don't necessarily have that embedded in our accountability agreements, much like I identified earlier in the legislation. A good example is ALC, alternate level of care. Right now, I know there are 450 people identified with mental illnesses who should be in supportive housing. There is no capacity for that supportive housing in the province.

These people have been languishing in hospital beds. Of that 450, the minimum is six months' time. We have a lot of work and discussion about addressing ALC beds, but because we do not have the political will to go forward with a housing strategy and to expand the availability of supportive housing in the province, we let people languish in a hospital bed.

Sector consultations around accountability: LHIN processes are often rushed, and there's very little opportunity for local providers to have input into those processes, let alone on a provincial basis. Consultations also tend to occur with larger mainstream organizations, not acknowledging the realities of those services working with some of our most vulnerable populations. Communication and rollout plans following public consultations require much more involvement from stakeholders, and also much more communication to our communities.

Further challenges around accountability, on integration: Efforts are often focused on reducing the administrative burden for LHINs. Collaboration and willingness for that integration is often forced. These are where we fail when we go forward. Some 90% of community-based service providers—mental health, addictions, community support, developmental disabilities, autism services—were started by community members, people like me and you, to actually address issues that were not being addressed by our health care system. We have to start actually understanding why that commitment came forward and why people fought for these services and built them and make sure that, as we go forward with our transformation—accepting that this is right; housing is the right way to go—we don't discard that effort and initiative. There's more on that when I get to governance.

Back office and administrative overload: Many of the temps have actually required more training for staff, and trained temporary staff more often. An increased workload on fewer people: Even with the back office, your material has to be prepared and presented to be fed into the back office, fed into accountability agreements. The savings haven't been that great. Increased costs onto contracted-out services: Again, we go back to the size of the investment not being equal to our accountability agreements. These back office initiatives can actually be overbearing on smaller organizations.

I wanted to touch on the administration rate. There has been a big push to have a 10% administration rate. Who could argue with that? I think that we can clearly say in mental health and addictions service that we have probably some of the lowest administration rates. The problem is, we continue to compare apples to oranges. I can tell you that, in an acute setting or on a hospital budget, you have a physical plant line, to maintain your building. There is a funding line for that. In most mental health and addictions facilities, that's considered part of administration. The cost of food is a similar type of process. An executive director who may be running a small organization spends 40% of their time on administration and 60% of their time on clinical or support services, their entire time is considered administration. Our system continues to look at what happens in one part of the health care system and try to overlay that on other organizations who really have never had that flexibility within their budget lines and whose data, quality and information systems are not reflecting what services they are providing. It's a beautiful, noble goal to get to 10% administration, one I think we could all embrace or try to get to, but let's actually get to the place where we're truly comparing what our administrative costs are in different parts of the sector.

Accountability challenges on LHIN boundaries: LHINs try to work through saying boundaries are not going to be a barrier to service, but they continue to do that. We know organizations that are serving two to three LHINs. Their funding comes from one LHIN; that's the only LHIN that they are relating to. Despite the fact that they may be providing services across that boundary, there's no interaction.

There's also the tension between local needs and best practices and standards. We will have evolution happening where a LHIN, with the best of intentions, tries to improve access to a service in their community, but through that process, they ignore the fact that that resource may actually be a provincial resource. So they put in blocks for people accessing it from different LHINs.

A good example of that is residential treatment facilities in the addictions sector. Sometimes, people do not want treatment in their local community; they want to go somewhere else where they will have better outcomes. They need to get out of that environment, but as we go forward and see that evolution, we don't necessarily treat that residential setting in a LHIN as a provincial resource. It must conform to the LHIN requirements, putting a block to somebody from Thunder Bay or another part of the province getting access to that service.

Consistency across LHINs: When LHINs were first initiated, I went to every consultation on that front, and I talked to every community service provider who would give me a moment. I talked about this as an opportunity to transform the system and actually get to true community health.

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I believe in meeting local needs and the requirements to do that, but it can't be done in isolation. We need some consistency as to how they operate, how funding decisions are rolled out, what the system priorities are and how we will evolve the system. You can make changes for local needs, but I know that if you go into a withdrawal management or supportive housing project, whether it's in Windsor or in Wawa, you should have expectations of similar outcomes. I think we're seeing too much of a disjointed approach.

We need to look at population health research, and we need long-term solutions, not band-aid solutions. That's part of our challenge. We will get increasing pressure from news and all kinds of other things, and we turn on a dime to address that issue.

Again, I talked about those 450 people in ALC beds. We have all this work going on about trying to divert people out of ER and ALC beds, when really the solution is about getting more supportive housing within the system. It's not going to get you an immediate response; those 450 beds will be filled immediately by somebody else with the same sorts of issues, but we need that concerted strategy to start changing the dynamics, to go from band-aid solutions to actual health solutions.

For accountability, we want to see the three-year cycle of accountability continue. We'd also like to see three-year commitments to funding, including base budget increases so that we can plan as we go forward and that, when we see other opportunities, we know we have a steady base.

We want to see continued consultations and collaboration. I think we've set a tone for this round of the MSAAs, and we need to continue to build on it.

We need meaningful measurements of successes and failures of current services. Again, we go back to the minister's action plan, what was given there and what's happening in the 10-year strategy. But by the time we get down to our MSAAs, what we may be measuring is not really reflective of our services, but is meeting the other needs of other components within the health care system.

I'm going to move into collaboration and integration. I want to talk about some of the successes—

The Chair (Mr. Ernie Hardeman): Five minutes.

Mr. David Kelly: Five minutes? Okey-doke. I'm going to go really fast now.

Shared agreements and relationships—these are our successes—have been enhanced, and better networking opportunities. Expanded coordination of service delivery with provider-led coalitions has been successful.

I think there's actually a much better understanding about the requirements of the ministry and the requirements between the LHINs. I think there's a much better understanding of service providers and how they need to support and integrate that. There have been more education and training funds available, and LHINs have acted as a conduit to bring providers together.

Challenges around collaboration: Recognition of the value of best-practice models in integration and collaboration are required. We keep trying 13 different approaches—there's actually a lot more than that—and we know that 80% of forced mergers fail, so let's go to the best practices on integration and collaboration, adopt that and support that through the system.

Relationship development between providers is needed, and incorporation of change management strategies. We have not actually talked to these community organizations about the need to transform in a meaningful way. It's just, "Here are your marching orders. Go and do that," when there are a whole bunch of strategies that we know will be able to make that a success.

I'm going to skip over the rest of the collaboration recommendations. You can get to some of that in your questioning, I hope. But on recommendations, we need a concerted effort to become actively involved in service- and system-level projects.

Constantly, we're doing all kinds of work on a provincial basis to improve the outcomes of the health care system. LHINs are either under-resourced or focused on other components, so they can't always participate, which means that when we find out the best practice and we want to instill that, not only do we have to go through the ministry, but we have to go through LHINs to get to a place where we actually get buy-in for those types of changes. In a system like mental health and addictions that has been underfunded and underserviced for a long time, that is a recipe for disjointed service delivery across the province.

We need better collaboration with provincial partners. We need implementation of evidence-based solutions, standards and best practices, but beyond treatment. We often always just get focused on whether we have access to a psychiatrist. Do we have access to that? We have to start thinking about other solutions.

Do I just keep going here on system transformation?

The Chair (Mr. Ernie Hardeman): Yes, you've got a few minutes yet.

Mr. David Kelly: Growth and successes: We have seen resources, direction and support to encourage utilization of best practices. We need a lot more. We think the development of health links is actually a positive step. It's early days still, but we do see some good coming out of that. We've seen some excellent collaboration on software, and some encouraging of true partnerships that really enhance client-centred care.

Challenges: Some of our partnerships have felt coerced. We need more substantiation of the active use of evidence-based research and best practices. Policy support is lacking in the implementation phase across the system; we have a policy shop and we have an implementation shop, but there's a lot that has to happen in between to get the success on the ground, and we've

seemed to really fall down on that. A lot of that, I think, has to come from our ministry partners.

Often, back offices cost more, and often our transformations have been focused on structures instead of people. I'd like to really recommend that we reverse that and focus on what people need, and not on the structure that's required to meet those needs.

Some recommendations on system transformation: We need clear definitions of the roles of the ministry and the LHINs, and stronger collaboration between all the ministries. Mental health and addictions are impacted by about nine ministries. We actually need stronger collaboration, and stronger collaboration with the LHINs. If we don't understand what's happening in our justice collaboratives and the diversion of people in our court system with serious mental illnesses and addictions, that will negatively impact planning for our health services. We need to get a holistic approach to mental health and addictions.

We need better provincial policy and change management strategies, and we need to better understand the utilization of best practices within that system. We know best practices, but we're not sure if any of the decision-making processes are utilizing those best practices.

Governance—I need to touch on this, because I think it's really important. I think it's been positive; the board-to-board meetings between LHINs and local service providers have never happened in the province before, and that is a very positive thing, but we need governance that allows communities to participate in the shape of the delivery of health care. I think those are positive.

But, on the negative side, where we need improvement is that there's often a view that these community sectors are viewed very negatively by the LHINs and decision-makers. I know; I work with all of them all of the time, and they can be problematic at times, but usually it's problematic because they are unable to address the needs of people accessing their services. We just have to get our heads around how, yes, we have these voluntary boards. We should be unleashing the potential of all of these volunteers—their time, their fundraised dollars—into building a better health care system, and through consultation.

We feel that there's a lack of understanding of the broader health system at the LHINs. The governance model of the boards is not clear, and I think that we need a process to establish representation of the community and broader health sector on LHIN boards. This will lead to better social, economic and cultural aspirations.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. I'm sure the rest of it will come out in the questions.

With that, we'll start with the official opposition.

Mrs. Christine Elliott: Mr. Kelly, thank you very much for appearing for us today and for the work that you've done. I remember you appeared before the Select Committee on Mental Health and Addictions as well, so we really appreciate your input.

Mr. David Kelly: Yes, I did. Thanks for your leadership there, Christine.

Mrs. Christine Elliott: Thank you. You've raised a lot of issues here. Let's start with some of the governance issues. It's rather concerning that some of the LHINs aren't taking seriously the views of local boards. Is that happening, in your experience, across the province?

Mr. David Kelly: Again, nothing is blanket across the province. Ontario is a very diverse place, so there are many different initiatives and approaches. I would say, though, that it has been challenging within that governance in the sense that it's not an equal partnership. Oftentimes a LHIN will end up having to focus on, say, these five large providers within their boundaries. Often, with a larger swath of those community organizations, their voice cannot be heard.

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I understand it in some ways. Look where the money is flowing, how those dollars are held in those systems. So, the LHINs naturally, with their outcomes and indicators, turn to address those funding dollars, even though we know that that community governance is the strength of that system and why all of those community organizations were developed in the first place.

So, is it everywhere? I would say no. Does it depend on the organizations or their service sectors? I would say yes, it does.

Mrs. Christine Elliott: Okay. Thank you. The other issue that's of some concern is the consultation piece. That, of course, was the subject of an Ombudsman's report, that there were many LHINs that weren't engaging in that community consultation. Would you say that that's improved in the last while? Is it something that still needs a little bit of work, or is it still a major problem?

Mr. David Kelly: I think that there have been improvements in that, but I think that we could actually be doing a lot of different things. To my thinking, every organization that is funded by a LHIN, not-for-profit, actually consults continuously with their clients and with their community in a whole bunch of areas.

Again, LHINs, I think, have an opportunity there to utilize that consultation to better demonstrate how they're building the health care system. Actually listening to people with serious mental illness and their feedback on the services or what they need would actually go a long way in strengthening the governance models of both the local providers and of the LHINs.

A simple thing might be, what are the five questions each LHIN would like answered from every annual general meeting from every funded organization that they support?

Mrs. Christine Elliott: Thank you. You talked a little bit about the priorities for the LHINs. Of course, they were set up to reflect local concerns and local priorities, but there seems to be some concern that's been expressed that there isn't a central direction for the LHINs, that many of them are going off in different directions, not necessarily in adherence with what the general priorities of government or health policy are. Are you seeing that in the mental health and addictions side of things?

Mr. David Kelly: Yes, we do, despite, I think, the best efforts of all parties to actually get this right. We didn't come at this from a very strong base. Essentially, I go back to what I had flagged: Our data quality and our functional centres are not necessarily there to start with and are not necessarily reflective of what's going on in the system.

But also, the data are being inputted from different directions, in different ways, because of different historical directions from each of the LHINs. Again, what ends up happening is that when we look at it, a LHIN may talk about its outcomes in one area of health care, but we cannot necessarily compare that to other LHINs, because, again, the quality of that data and how it's been inputted into the system could vary from place to place to place.

A good example of that is often case management. Some LHINs have been moving to a place where you can only have one contact with a client in a day collecting that data, but in reality what we know is that, with some clients, you have multiple contacts on any given day for that individual. People who are showing up in an emergency room on a daily or weekly basis are often there not for health reasons, but because it's a safe, warm place for them to go.

We don't have a handle on how to actually address some of those issues. When you see things being implemented on a provincial basis—a good example would be addiction supportive housing. The government laid out about 12 principles. The LHINs went forward, and we were doing an evaluation of addiction supportive housing.

When the LHINs implemented that, they implemented it in 14 different ways. Some were for very, very valid reasons, to be able to meet their local community needs, but in reality, when we start looking at that, and analyzing and evaluating the services, we cannot tell, because each of these have been implemented differently. The data had been collected differently, so we had all these barriers to jump over to get a picture of what was actually happening.

That distorts all of our planning. If the bad data is being utilized to do our planning, the bad data duplicated will get us different resulting bad decisions across the system.

Mrs. Christine Elliott: Just specifically with mental health and addictions, you talked about the fact that there was a need for greater coordination, given that about nine ministries deal with mental health and addictions—justice, housing and so many others. As I understand it, the implementation of the mental health strategy provincially is now resting as a standing agenda item with deputy ministers. Do you think that's sufficient?

Mr. David Kelly: Bearing on the results, the first year of the three years of the strategy was focused on children and youth—which I think was a good strategy, because we can start downstream and hopefully prevent people from having to access those services in 10 years.

But I don't think that is adequate enough, because I don't think we still have—ministries, like LHINs, all feel rivalries between each other. With how they go forward and plan, health is the behemoth in the room, so often it's looked to as a resource-rich ministry. I don't think that's actually the best way to run the system, but I think we need more of that all-government approach and actually understanding what's going across.

When we make an investment in human justice and the diversion of people from, say, the court system, then we actually have to look at what that impact is on health services, because individuals who've come out of a court system are going to have different housing needs than individuals who may have had emerging schizophrenia or another mental illness. I think we need more and stronger coordination between the ministries and the LHINs as they make their decisions.

Mrs. Christine Elliott: I would suppose that the lack of coordination among the various industries would have an impact on the decisions that are being made by the LHINs, because they would get somewhat confusing signals about what the priorities should be. Is that fair to say?

Mr. David Kelly: I think that there has definitely been some of that happening within the system. We spent two years developing what we thought would be the top, or an accepted, assessment tool for mental health services in the province, then we had to spend another two years because it wasn't recommended for community health services, but not used in hospitals. We had to get past that barrier.

Everyone wants to rush to the one holy grail of answers. I think that's a mistake. We actually need different tools in the community setting, as you do in a doctor's office, as you do in a hospital setting.

We spent a lot of time on that process to get to one assessment. I was on that committee. We reviewed 127 different assessment tools. We made a specific recommendation to go forward with that. We had to get the ministry buy-in across a whole bunch of different places to have that happen, then we had to go LHIN by LHIN by LHIN to get that implementation to happen.

Eventually, we got that. We're at about 85% implementation now, but, again, you would think that if you're going forward to develop assessment tools on a provincial basis—and we have some really good ones coming out for the addictions sector, which I hope to see implemented soon—if you have to do that work and you have it on a provincial basis, and you've had the experts come in, then that tool needs to be implemented, and it takes all the LHINs and the different ministries to implement that tool. That, I think, is where we could do a much better job.

Mrs. Christine Elliott: Thank you very much. Those are all my questions for now. I think my colleague has some questions.

The Chair (Mr. Ernie Hardeman): Ms. McKenna?

Mrs. Jane McKenna: Thank you so much. There's lots of information here, and I appreciate you being here. In all the time that you've been dealing with the LHINs—how long, actually, have you been dealing with them yourself?

Mr. David Kelly: Myself?

Mrs. Jane McKenna: Yes.

Mr. David Kelly: Okay. As a provincial organization, we were initially funded by three different LHINs. We were bounced around, and are now funded through the Ministry of Health. But I am very pleased and proud to say that I am able to work with the LHINs on many different projects and strategy tables, so I have a lot of interaction with the LHINs on a provincial basis.

Mrs. Jane McKenna: And how long?

Mr. David Kelly: Sorry. Well, I started before they even had the name of LHINs.

Mrs. Jane McKenna: Okay, so seven years ago.

Mr. David Kelly: For their entire lifetime.

Mrs. Jane McKenna: Okay. And how has your relationship evolved with them over that time?

Mr. David Kelly: Again, I think it's been up and down. There have been many challenges in working with the LHINs. We've seen huge, incredible amounts of turnover on staffing and leadership within the LHIN envelope. When you lose that leadership, you often end up starting at base one. It takes them a little while to actually even understand what is happening within their health system.

I would say we have seen a steady improvement. I go to the most recent MSAA negotiations, and the provincial MSAA table that we've just gone through. Whereas the first round was actually consulted through in July, and we had to provide final answers to the LHINs by September, we've had a much more successful process now: greater interaction and more willingness to look at changing these to make it more reflective of the sector; it's not been as rushed. I think with the maturing of the LHINs, we should be able to see the maturing of that relationship.

1700

Mrs. Jane McKenna: I didn't realize there was a big turnover and then a leadership change, so that's news to me today.

You being the constant there, I think one thing that we have noticed, being in here, is that it's the performance of what one person is doing to the next, the silos and giving the information from one to the next, and actually not doing that. What would you say the biggest challenge is, besides the leadership and the turnover?

Mr. David Kelly: One of the biggest challenges is the disjointed approach of the many ministries involved in mental health and addictions, and the LHINs as their processes.

Understand that it's just in the last few years we've had the recognition that we need to start addressing our mental health and addictions concerns in the community. You have organizations in a system that has been over on the side of health care—and no offence to any of my colleagues in the acute sector. Any of that—heart attacks, babies and cancers—drives and has driven health care, not necessarily the need to build the community resilience to address individuals' mental health and addiction needs.

What I'd say is, we are just showing the approach with the best of intents to address multiple issues, but not actually getting a focus to have a direct impact across the province. We have the meeting of local needs or we have pots of investment that come out that then are not necessarily utilized in a similar fashion from LHIN to LHIN.

If you look at any high-performing health system or any high-performing regional system, the basis of that system needs to be the standards, the best practices and the funding mechanisms to actually build that system. What we had is a process that came and overlaid LHINs to replace regional offices which were doing similar work beforehand, but not as in-depth—had them overlaid without the base of standards, best practices etc. in the community mental health and addiction system, I'd say, almost in all community service provision. We have those for the health system so we can actually start getting to measure in the acute systems, so we can go to those measurements—or within community care access centres, where they've spent lots of money to get to those types of data collection systems and measurements of those systems. But when we come down to mental health and addictions, those investments have never been made.

So what is a standard—again, I'll go to case management. We have different variations in the standard of case management, anywhere from a 1 to 8 ratio to a 1 to 12, 1 to 20, 1 to 100, because organizations have picked up the slack and have addressed every need that's coming to their door. Without actually having a clear understanding of what it takes for intensive case management and what the number of clients should be or the severity of those clients in a case mix, we don't necessarily have all of those in place.

I'd also say that the ones that we've had have never been able to be kept up. So as you see the release of funding—I'll use case management again. An existing case management position was funded at a much lower level than new case managers added to the system. All that means, then, is you're robbing Peter to pay Paul: You can't hire staff and pay them at this higher salary with the same qualifications; you have to water down that money to keep all of your staff at a similar type of level. But when you go into the community sector, you can have people doing the same job—and I know of places where they're sharing offices and desks—and an acute or a hospital provider staff is being paid 30% to 40% more than that community setting service provider.

Mrs. Jane McKenna: Do you think too, though—you made a very valid point there that having a baby, a heart attack—I can't remember the other one you said—

Interjection: Cancer.

Mrs. Jane McKenna: Cancer, sorry.

Mr. David Kelly: I don't mean to be derogatory, believe me.

Mrs. Jane McKenna: No, no. I'm just saying that those things are immediate things that you see right then and there. I did my white paper on children and youth, and it is a systemic problem and it is one band-aid after another. When you look at one person going through

their lifetime—I could be incorrect with the actual data right now, but I think it's $1.4 million from beginning to end, in and out of hospitals, doctors, jails, whatever those situations are. Do you think it is because it's a situation where we don't—right at that immediate second, there was some result that you could have taken?

Mr. David Kelly: It's two things, and it absolutely is because we don't see immediate results from the services that we provide. As I said, working with that client, say, 10 phone contacts or 10 visits from them in a day actually may be exactly what that person needs to keep them out of the emergency room that evening, but it takes special relationships and to be able to utilize those relationships to get those results.

But a broken hip, for somebody without a serious mental illness or addiction or without isolation problems, we can then say, "Okay, we'll fix that broken hip. Six weeks later, you're going to be fine, and we can know we can discharge you."

In mental health and addictions, and I say this—because I don't like to be self-serving; I want to be able to think about building better and healthier communities. I think that is crucial. So if we don't link, say, children's aid societies, where we know that 60% of those kids will have a serious mental illness or addiction in their lifetime, if we're not building resiliency with those kids, we are just creating future customers for mental health and addiction services. We need to actually link those systems with health care and vice versa to be able to get to those better results. This is not easy work.

Any of us all know we've been impacted by mental health and addictions. It sometimes takes four or five times in a withdrawal management program before you can actually get to the core issue, and trauma—we're just getting to understand that.

We spend all this time and effort on trying to get homeless people off the street or addressing these issues, and in reality, most of that is the result of childhood traumatic experiences. So we will move heaven and earth to get that kid into a safe place, yet we will go to a model of ignoring or punishment for the adults who are the result of not being saved from that childhood traumatic experience.

Our understanding is changing daily in mental health and addictions, and we need a system that can help transform in that type of way.

Mrs. Jane McKenna: I'd like to just also say a couple more things. In the kids that are awarded to the crown, 70% of those children go out into the streets. It's a massive—it was heartbreaking and saddening when I got all that information myself.

I want to thank you very much for coming in and for continuing to put us in a place where we definitely need to go. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much, and that concludes your time.

The third party: Ms. Gélinas.

M^me^ France Gélinas: Hi, David, and thank you for coming. I always admire your in-depth knowledge of the mental health and addictions system and how you can share this passion when you speak.

I want to bring you back to the reason why we're here. We're here because we're looking at a review of the LHINs, and I will put my question to you in a minute, but I fully understand that if we are to help people who have addictions and mental health problems—we now have a system that deals with nine different ministries. That system is disjointed. I fully understand that Housing First is there. If you don't have a safe home, nothing else matters. You're not going to be able to work on your addiction or your mental health. You need a place. And incomes matter and isolations and stigma and the justice system, and all of this.

So help me understand how adding a layer of bureaucracy called the LHINs actually helps your system, and let me finish before you start answering. If I was to be serious about wanting to integrate and do the work of the LHINs for the mental health system, I wouldn't put that under the Ministry of Health; I would put this in a place within the government that has access to all nine ministries.

I know that the funding some of the members of your associations get from their LHINs is actually a pretty small part of what they do. They get funding from six, seven, eight different sources to do the great work that they do, and the part they get from the LHIN, frankly, sometimes is considerable, and sometimes not so much.

1710

We are here right now, looking at the act. Mental health was put into the act, which is why the agencies that get financing from the Ministry of Health now get it from the LHINs, with their accountability agreement and their MSAA and all of this. I fail to see how this could help the addiction and mental health system.

Mr. David Kelly: I think the first thing is that all of us, as part of our submissions to the select committee—the 10-year strategy actually called for a focus on mental health and addictions that could cross all of those different ministries. We cited the example of Cancer Care Ontario, that has transformed cancer services in the province.

What we do actually need is that type of specific focus that can go across all of those components of the government of Ontario, and then translate that through good policy and implementation to the local health integration networks. What we end up getting with the disconnect is, we talk about the need to reduce emergency room visits, and that is implemented, but it doesn't necessarily implement in a way that addresses some of the core issues, because we go back to our indicators and our outcomes and that type of discussion.

No matter what, within the health care system, we do need administration. I firmly believe in accountability, and I think that the LHINs have actually demonstrated that they are trying to work that through. The LHINs are essentially in a box themselves, because they are boxed in around health care and those services that are funded by the Ministry of Health. That's where I think the failing

is, because it does not take housing into consideration. It does not take into consideration those other actions or services of the ministry, because that's outside of health.

When you look at these organizations, I'm really proud, honestly, to say, "Look at all these community-based services that get this much funding, literally this much funding, from the Ministry of Health." But that little bit of funding actually sets the base for the organization and it starts leveraging other dollars, because they're legitimate and they receive Ministry of Health funding. That leverages United Way dollars. It leverages other funding dollars. It may leverage federal dollars. Those organizations piece that together to provide quality services in their community. It's not the way a system should be functioning.

M^me^ France Gélinas: I fully believe in regional planning, and I, with you, support more accountability and more robust transparency. But you have not convinced me that having mental health services under the LHINs is the way for the mental health services to meet the needs of Ontarians.

I was on the Select Committee on Mental Health and Addictions. Our number one recommendation was to create what we called, at the time, Mental Health and Addictions Ontario, which would basically—

Mr. David Kelly: The name is taken now. Sorry.

M^me^ France Gélinas: Yes. You put it in alphabetical order; we didn't.

But the idea is really, to me, you would be so much better served in a regional model that is not under health but that is under the government, that is able to connect with all nine ministries provincially, and that funds and that has a direct impact on services, the first one being housing, the second one being ODSP payment, the third one being—but health would certainly not be the top one. It would be kind of seventh or eighth on my list. But health is the one that has the bucks, and I get that—$48 billion; it stands out. If you get 2% of $48 billion, it's way better—I get that. But that doesn't bring us to a highly performing mental health system that actually achieves goals of supporting people.

Mr. David Kelly: France, when you're thinking of this in some ways, it's about how you want to define individuals. Are individuals actually their illness? I understand why we are with the LHINs and that, because the barriers to people with serious mental illnesses and serious addiction issues have been so great in them accessing any ancillary—any of the other health services.

Some people call it stigma; I usually call it discrimination. People, because they have a mental illness, will be sidelined in an emergency room where the health protocols are that they should wait and they will decompress, and then they'll either go or we might be able to do some services. Right? I like to think of people much more beyond what their immediate health issue is. I think that's why we need to be connected through all of the health systems so that we can actually facilitate the access for individuals and for other vulnerable populations to get to those services.

I always get concerned, because we've been hived over on ourselves before. We've been marginalized and ignored within that. Not being linked to the full health care system would make me a bit nervous in the fact that it's much easier to ignore mental health and addiction issues when it's not right front and centre in the room. That's where mental health and addictions need to be. They need to be front and centre in every room in the province so individuals who are accessing can connect to all of those other services and supports that they need.

M^me^ France Gélinas: Do you really have hope that the LHINs, at some point, will care in a meaningful way about income, housing and social determinants of health specific to the population you're trying to help?

Mr. David Kelly: I thrive on hope, France. We have to be able to do that to function in mental health and addiction services and, I'd say, in community services. You have to understand that you're working with some of the most marginalized and hard-to-serve people. What gives you hope is seeing the success of those individuals when they get access to stable housing, when they get the right health care, when they get connected and when they have a living income. You can see the results and you can see functioning people. We've had members of Parliament who have been able to get there because they had their total health, their total experience as a person, addressed.

Just to answer you a little bit further, I was a member of the minister's 10-year strategy. The most important facet of that strategy is building community resilience. If we are not addressing and building that community resilience—it's from everywhere, from a local sports team and arenas and hockey—we will not have a good health care system. Part of the challenge here has always been that the health system has been focused on those acute needs and the band-aid solutions, the operation, and not on building the resilience within their community. What I hope to be able to do is help build that resiliency. So, yes, I still have that hope.

M^me^ France Gélinas: But that will happen beyond the LHINs. So what you're saying is that being under the LHINs means that you are not forgotten by the health care system, which is very easy for your sector to be—the poor cousin of the poor cousin doesn't get invited to the wedding too often—but at the same time, in order for the system to thrive, most of the work will be done outside of the LHINs.

Mr. David Kelly: Again, I go back to building that community resilience. We need to tie those pieces together, and so many—

M^me^ France Gélinas: But the LHINs are not tasked with building community resilience.

Mr. David Kelly: I hope that some of the result of this LHSIA review is that we either task the LHINs with going forward with that or we strengthen the ministry implementation role in setting those provincial directions and we task the LHINs to be able to do that. But understand that no one organization is going to address that.

We used to have other mechanisms like social planning councils etc. around the province that could help

support that. I think that we need to connect all of those pieces to be able to do that. My fear is that by taking it, say, out of health—because we've had this discussion. Many of our services were in Comsoc, community and social services, before that. We wanted out of there to be able to make sure that mental health and addictions were addressed right through the health care system.

M^me^ France Gélinas: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Okay. Ms. Forster?

Ms. Cindy Forster: How much time do we have left?

The Chair (Mr. Ernie Hardeman): Eight minutes.

Ms. Cindy Forster: I'm actually going to give you my time so you can finish your presentation.

Mr. David Kelly: That's very nice of you. I'm not sure where I left off.

Ms. Cindy Forster: I think that's much more insightful for us.

Mr. David Kelly: Okay. Thank you. I'm going to just sort of go back—

The Chair (Mr. Ernie Hardeman): She should have given you that notice ahead of time.

Mr. David Kelly: Yes, and then I could have actually found my spot. I was ready for another hard question.

1720

I'm going to go back to some of the—I really started rushing when I started getting into collaboration and integration, so I'm going to go back there and start. Just let me know when my time is up.

I flagged some of the growth and successes: the shared agreements and relationships between providers; enhanced networking opportunities; expanded coordination of service delivery with provider-led coalitions.

The reason I said "provider-led coalitions" is because wherever you have seen failures has often been the overlay of new ones. LHINs that have utilized those provider-led coalitions and existing infrastructures within their local communities have had more success in getting collaboration.

I said that one of the positives that has come out of it is that there has been a lot more understanding of LHIN responsibilities, requirements and reporting relationships with the ministry and local service providers. This is more than has ever existed before, whether it was in a regional office or—so now I think there's a broader understanding, even by these smaller community organizations, of what pressures may be on the health system and how they need to better support that work.

When we get into the challenges, it's again—a bit of a theme in my presentation, I guess, is the recognition and the value of best-practice models and integration and collaboration. We need to go into that area to actually get to a place where we can understand how to bring community services together.

Even the relationship development between providers needs to be strengthened because, again, we often are going to those larger provider systems, or providers within them, and many of the smaller ancillary groups.

For example, France was saying that if we had LHINs bringing together, as they do on governance with health service providers, and actually having those discussions with those other organizations within their communities—but right now, LHINs are hesitant to go in that direction, because it falls outside of their purview in health.

Even making sure that they take into consideration that we have stronger, more robust consultation processes, so that it's not just focused on, "Here's a meeting; I'll meet with five hospitals and 10 community providers, and that will be our consultation"—it may be that perhaps the minister needs to be much broader, including children's aid societies, social planning councils etc., that that's a possible way to get to some of the issues.

Engagement of service and system-level projects to facilitate learning and aid in knowledge translation: Again, often, I can tell you we've had several projects where we've gone ahead and done massive amounts of work but have not been able to engage LHINs within that process. The mental health leads and addiction leads of the local health integration networks, I presented to them probably four times, three times, over the course of the existence of LHINs, and I think that those types of discussions need to be strengthened. We can't have every CEO on every phone call, but at least getting the LHINs and their mental health leads to have much more interaction and much more involvement on provincial partners would be viewed as a success by our organization.

I don't want to be self-serving in any of this, but there are resources on the provincial base level that need to be utilized in a more cohesive way by LHINs. There's a lot of strength, energy and work that happens on a provincial basis with an organization like Addictions and Mental Health Ontario that actually is speaking to LHIN agendas, speaking to ministry agendas and actually could be utilized to support resources.

For example, we just had a very interesting Trillium grant and created a tool with CMHA Ontario and our other partners, the Association of Ontario Health Centres and the Ontario Community Support Association, on integration. It's a comprehensive tool, a website, all available. It tells you all types of integration. It gives you where LHINs are going, where the federal government is going, where provincial governments are going. It's a fantastic tool. But actually trying to get LHINs to recognize or even take the time to look at that type of tool or participate in the discussion or the development is always challenging.

On collaboration, we want to see more implementation of evidence-based solutions and standards and best practices, and this is beyond treatment. Housing can have as much of an impact on ER usage or be a successful conduit for diverting that, but we need the best practice standards.

I'm going to go to system transformation and growth, and I'm going to go to the challenges there, because I think I really ran through that quickly. You can see the

successes on the slide before. I touched on the coerced partnerships. Often what we've seen is, "Oh, this is a good idea if you form a new organization." So when your funder tells you this is a good idea, whether it is or not, or whether your community organization, which could be two hours from the other community organization—whether or not you should have the same governance structure or whether or not you should be actually as one organization—it's not always the best process.

I want to touch on back-office efficiencies. One LHIN, I know, went through and did a study, looked at their 60 MSAAs and determined they could save approximately $200,000 by going to back-office efficiencies, which sounds like a lot. I'm telling you that's like probably eight staff in the community sector, so it sounds like a lot. But what they didn't go on further to explain was actually that that $200,000 came from 54 organizations, to the tune of about $3,000 to $4,000 savings for each individual organization.

Now, you could have a process where you pay your staff less, I guess. That's not usually very successful. You then have to find that money or that process within your organization, and the lessening of work is not that great, because, again, you have to prepare all of your submissions, everything, for even the back-office efficiency.

Now, it does work for HR, human resource recruitment, but again, this is one of the biggest challenges in our sector, because what we've seen is the installation of family health teams, and family health teams were able to get access to mental health workers—all very good and positive, but what it did is take resources that were desperately needed in the mental health sector and put them on a family health team where they paid their staff more and essentially recruited the staff from the existing mental health agency.

A more comprehensive approach would be to actually say, "Great. This family health team or these health links"—which we're doing with health links—"need mental health support. They need to contract with their local mental health provider to be able to do that work." That provides a stronger base for that organization. It links them with primary care, and you don't have a mental health employee or staff person working alone in isolation; they're actually working within a broader system, and you leverage all the good things that come out of that type of collaboration.

The Chair (Mr. Ernie Hardeman): Okay. Now, unless the government side wants to do the same, we'll go to the questions.

Ms. Helena Jaczek: Yes. I would prefer to ask questions. Thank you, Mr. Kelly, for coming.

Just to start off and to be really clear, and I know you put it literally on page 2 of your presentation, Addictions and Mental Health Ontario: You represent 280 mental health and addiction service and support agencies across Ontario. Do you represent also the four psychiatric hospitals? Are they members?

Mr. David Kelly: Two are members of the association.

Ms. Helena Jaczek: Interesting. Which two?

Mr. David Kelly: Sorry. Let me be clear on that. CAMH is a member, Whitby—

Ms. Helena Jaczek: Ontario Shores.

Mr. David Kelly: —Ontario Shores is also a full member; Waypoint has programs that are members of the organization, and the Royal Ottawa, for example, is becoming a full-blown member.

Ms. Helena Jaczek: So, in other words, you represent the community sector as well as the acute care side?

Mr. David Kelly: I'd say we represent the full continuum of care within the mental health and addictions system, and I would say we're also a bit of an anomaly in the sense that we have many hospital-based programs within the association. But it's always been clear, even within an acute or hospital-based setting, that mental health and addictions have been always marginalized services. Throughout the 1990s and early 2000s, when there were any cuts in hospital services, the first place they would often land is with those mental health and addiction services.

So essentially, we know that there is no health without a full continuum of care, and our organizations have always found and felt that by collaborating right across that full continuum, we will have better results for people with mental health and addictions.

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Ms. Helena Jaczek: Okay. That's useful to know, because then I assume that all your wisdom that you've imparted to us does reflect that continuum of care and the concerns across the continuum.

I know at the very end of your presentation, on page 32, you talked about the strategic partnership with the Association of Ontario Health Centres, who of course we've just heard from, and the Community Support Association, which seems like an excellent idea as you're trying to obviously influence so many different aspects of care, as you've alluded to, and supportive housing and everything we know that's so important.

You know that Adrianna was here and presented the findings—

Interjection.

Ms. Helena Jaczek: And is still here. It will be easier for the traffic later, Adrianna. You heard her recommendations. Would you say that your association is, in general, supportive therefor?

Mr. David Kelly: I think we do collaborate and we are very similar. Understand why we came together as Community Health Ontario: It's very important because our voices would never be heard in the health care system. It's actually about strengthening that community voice on a whole bunch of different levels. In general, yes, I would say—I haven't gone through their presentation and I did not hear her actual presentation, but in general what we want to be able to do is, knowing that in all of the communities across Ontario we have community support service agencies. We have mental health and addictions agencies. Some places we have health centres, and we can only strengthen our health care system through our

collaboration and through working together. We're going to have better outcomes for all of those vulnerable populations, whether they're accessing a health centre or a mental health agency or community support through our provincial leadership and communication and dedication.

Secondly, what's also very important is, the health care system is full of very large voices and many, many small ones. Some of our issues actually cross all of those boundaries. The one example I used about family health teams hiring mental health providers is a perfect example. HR is an issue that *[inaudible]*. So we need to amplify our voice to get this to happen, or else we will be back here in 20 years talking about how to fix this system again.

Ms. Helena Jaczek: Well, this is the first I've heard of Community Health Ontario, and I would urge you to consider approaching the public health sector because a lot of what you're talking about, in terms of determinants of health, is very much what public health has always said.

As a former medical officer of health, obviously I think you're absolutely right. The community health sector needs to have that strength, and the more voices you have in a combined fashion I think would be very helpful.

A lot of what you had said is in fact very similar to what we heard from the Association of Ontario Health Centres, and one of the areas was the issue of the indicators, that 14 out of 15 are acute care focus. Have you had the opportunity to consider some indicators that you would like to see as part of this?

Mr. David Kelly: Yes.

Ms. Helena Jaczek: Like some concrete examples—

Mr. David Kelly: I would say to you, I'd like to actually think on that a little bit more on time because this is a legislative level, and I know we've been in a lot of negotiations and LHINs are listening and trying to hear what we are saying about that. I'll tell you, an example I always go to is housing. If somebody is presenting in a homeless shelter because of the lack of housing, and that was public housing in some fashion, then we have an indicator of a failure of a housing project. It's the same as an individual showing up at emergency rooms. If they are attached to a case management program, then some real questions should be asked about that case management program and how it is functioning.

So when we're looking at these and thinking on that, just starting to talk about—I'd have to actually really think about what sort of indicators there are, and I'd be happy to do that, to give you some.

Ms. Helena Jaczek: I think it would be well worth it. I'm thinking of wait-lists for supportive housing, wait-lists for addictions programs, you know, this kind—

Mr. David Kelly: You see wait-lists in—thank you for giving me that because that is actually a perfect example. But I will flag to you, though, as we have transformed—and mental health and addictions agencies are embracing this transformation and integration—we've been developing all kinds of coordinated access programs. For example, in the city of Toronto there's CASH.

Ms. Helena Jaczek: We heard.

Mr. David Kelly: Now unfortunately that started about four years ago with 1,200 people on the wait-list; it just hit 6,900 three days ago. It would be great to have those types of indicators, but we actually need a concerted effort to understand the capacity of existing mental health and addictions services, which I don't think anyone has ever looked at—"What is our ability to respond in our community?"—and then look at where we need to go, because it is only going to be up, and that gets to, like, population-based health planning. But we have to actually start at what our capacity is to begin with.

Ms. Helena Jaczek: That was exactly what I was going to ask you: What would be the capacity to populate those indicators? Because actually, I've been trying to find out what the addictions and mental health services in York region are—the agencies, the addresses, their funding from the Ministry of Health, the patients served and the wait-lists—and I am still waiting.

Mr. David Kelly: Just so you know, we were doing an evaluation of addiction supportive housing. We had to go to three different places to find out who those providers were. One was the Ministry of Health; one was each LHIN; the other was ConnexOntario, which is our information referral system. Then, eight months later, we still actually found programs that were just coming online or that were providing the services and did not report to LHINs. Again, nobody has that comprehensive understanding.

Ms. Helena Jaczek: So it's a bit of a dilemma. I understand why you want those indicators, but I'm really worried they're not going to be able to actually operationalize that.

I guess there are four of us here who were signatories to the Select Committee on Mental Health and Addictions's recommendations. I guess what we're being urged by you and by the Association of Ontario Health Centres to look at is an expanded mandate for LHINs—in other words, bringing primary care within the purview, and certainly some of the human resource planning; we heard about that earlier today. I guess I have a little bit of a concern. In our deliberations as a select committee, we did all endorse the concept of Mental Health and Addictions Ontario because of the multi-ministry involvement, and the way to actualize a successful plan would be to have all those components together: the justice piece, the supportive housing etc.

So I guess we're potentially looking at a choice, here: Do we build on this regional model that we've created, which is the LHINs, or are there some areas which might not necessarily be appropriate to go into?

I would say we know that the LHINs to date are still struggling with the mandate that they have, even the long-term care and the acute hospital piece. To me, they haven't fulfilled that whole piece of it. I suppose the immediate instinct is to say, well, should we really move forward? I think we've heard good arguments and good rationale, but there's sort of a practicality. If they're struggling with the pieces that have already been given to

them, and especially in terms of consistency, community engagement and all the good things that should be a part of that, I guess it's hard to suggest expanding the mandate at this point in time. How do you react to that?

Mr. David Kelly: What I would say is you're absolutely right that there is a lot of work that needs to happen within the acute settings and within long-term care before we're actually—and this is, I think, part of the challenge and why I would say that, often, community services are set over to the side, or, "We'll get there as soon as we fix over here." I think that has been one of the biggest challenges for the LHINs going forward.

Again, you alluded to the select committee. Some of our recommendations and our advice to you at that time were about creating that provincial body, but I think that body—again, it's to balance that local need. I think there is real success in some local planning, but that organization should be supporting the LHINs and making sure, as they go forward with local implementation, that they are meeting what we know are best practices and provincial standards and the data quality that we need. I think you can actually have that mechanism and provide the support to the LHINs to be able to then better focus on some of the other challenges that they may be facing around primary care. I don't like to talk about primary care because primary care is actually primary health care, and it's about a lot more. But when we have discussions on primary care, it often focusses on physicians and physician services.

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I know, for example, we have lots of sessional fees that return every year to the LHIN, then to the ministry, because we cannot get access to psychiatric care. Last time we looked—this is a couple of years out of date—92 of the psychiatric programs in acute settings had barriers for people to access them: whether they lived in the community, whether they were referred by one of the residency psychiatrists. Those are issues that have to be fixed up.

We see millions of dollars returned on sessional fees and not used for other components of primary health care, like an RPN clinic or other services. We need more flexibility from either the ministry, OHIP funding envelopes or the OMA agreement to better allow LHINs to apply those dollars that will have an impact in their community.

Ms. Helena Jaczek: Okay. Then you see that there is still a potential for a Mental Health Ontario that would potentially coordinate activities, give advice to individual LHINs, have some sort of oversight of the whole system locally. So you could have both.

Mr. David Kelly: Exactly, yes. In reality, again, the issues in mental health and addictions and in other components of any vulnerable population are very complex. It's not just the health silo that will fix that; it requires those other components. That could be the strength of a Cancer Care model for Addictions and Mental Health Ontario.

Ms. Helena Jaczek: Okay. Well, that's useful. Thank you.

Now, you did talk about your three-year multisectorial accountability agreements. I guess this gets back a little bit to the funding side. We did hear some recommendations in the last couple of weeks from some of the deputants that there should be the ability to hold over funds from one year to the next. Would you also see that as being an advantage? If funds are not used in one fiscal year, as you say—perhaps you're developing something and the next year, you want to put in a nurse practitioner-led clinic or whatever new initiative that might come out—that that be a possibility within—since you have the three-year agreements, it would seem that you might be able to have funds over three years.

Mr. David Kelly: Yes, and that would absolutely be the flexibility from all kinds of different levels, right from your planning level at the LHIN down to the local community organization. You'll often have the implementation of a program midway, "Here's your funding," and obviously, organizations—and this is right across the health care system—rush to spend that money as opposed to looking at where they could get the best bang for their buck—also, to look at where the collaboration is to help expand that program, to make it more inclusive and involve those other components that you know need to be there.

So I would say, yes, LHINs should have that ability. But I would also say to you, community-based service providers should also have that ability within an accountability framework so that they can actually utilize the dollars in the best fashion for their community.

Ms. Helena Jaczek: And to do a little bit longer-range planning, presumably.

Mr. David Kelly: We were very pleased to see a three-year accountability agreement because it does help us start setting the course. Again, mental health and addictions and the transformation of the 10-year strategy came in the worst economic crisis. What we've seen is a lot of initiatives to contain and control costs.

If this was the best of times, I would probably be here recommending to you that you need a concerted effort to contain your costs, but to expand investments, sort of a two-way track: Build a community sector so it can take on the role that we all know it needs to have before you start reducing costs in other parts of the sector—which almost requires the government to have an investment strategy in those community-based health services, and I want to acknowledge that we've seen that commitment from the Ministry of Health, saying that the sectors would continue to see an increase in funding—addictions and mental health, community support services; health centres, I believe, were also a part of that.

That's the kind of process we actually need to get to so we can build those organizations. Too many times, I've heard LHINs say, "We need to do this, but we need to do it fast," and we don't have the infrastructure or the knowledge within the community sector. This has been ongoing for 30 years. The investment is taken; it's given

to the same players that have always been funded. It has not allowed that sector to grow in a way to support the health care system and actually be the health care system.

Ms. Helena Jaczek: How much time, Mr. Chair?

The Chair (Mr. Ernie Hardeman): You have about three minutes left.

Ms. Helena Jaczek: Do you have any final words of wisdom for us?

Mr. David Kelly: I think what I would say to you is that with this rollout coming of years four to 10 of the mental health and addictions strategy, we need to really make sure that we're getting this right. It's about the full continuum of care. It's about all of the services outside of health funding. We need to get better coordination to have the best impact on individuals.

Ms. Helena Jaczek: I think that's all. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. If there are no further questions from the government side, then that concludes the presentation. We thank you very much for your indulgence in being here this afternoon and helping us out with a lot of the issues.

Mr. David Kelly: Thank you very much.

The Chair (Mr. Ernie Hardeman): To the committee, that also concludes our hearings. We do have a few minutes in camera so that we can deal with scheduling for the other meetings for tomorrow's committee.

Ms. Helena Jaczek: Mr. Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Helena Jaczek: Could I ask—perhaps it's the Clerk—who else is scheduled to appear before us? We had long list of associations, and I'm wondering when we're going to hear from the Ontario Hospital Association, the Ontario Medical Association and the other organizations.

The Chair (Mr. Ernie Hardeman): That will be part of the next meeting.

M^me^ France Gélinas: I guess they want to do it in camera.

Ms. Helena Jaczek: You want to do that in camera?

The Chair (Mr. Ernie Hardeman): Yes.

Ms. Helena Jaczek: Oh.

The Chair (Mr. Ernie Hardeman): We have a list here, but it would part of how the committee wishes to set up the hearings.

Ms. Helena Jaczek: Okay.

Interjection.

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Cindy Forster: Could I suggest that we be provided with a copy of the select committee's report on mental health services to read in conjunction with all of the other materials—from 2010, I believe, right?

Ms. Helena Jaczek: Yes, August.

The Chair (Mr. Ernie Hardeman): Okay. That note is taken and you will get that.

Ms. Cindy Forster: Thank you.

The Chair (Mr. Ernie Hardeman): Okay.

The committee continued in closed session at 1747.

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