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**Official Report
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Wednesday 29 January 2014

**Journal
des débats
(Hansard)**

Mercredi 29 janvier 2014

**Standing Committee on
Social Policy**

Local Health System
Integration Act review

**Comité permanent de
la politique sociale**

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

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Wednesday 29 January 2014

Mercredi 29 janvier 2014

*The committee met at 0804 in the Crystal Ballroom,
Walper Hotel, Kitchener-Waterloo.*

[Failure of sound system.]

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

PEACEWORKS

Ms. Joanne Young Evans: —and demonstrates a high degree of alignment. In particular, this model is built upon all of the philosophical and policy prerequisites. It is designed to maximize system capacity to ensure a full range of services within a sustainable framework. Fundamental to its design is a shared commitment to a holistic, psychosocial, client-centred, evidence-based model of care and the decision-making process.

In promoting highly coordinated administrative and clinical structures and practices, it offers a more cohesive administrative structure, integrated information systems and significantly improved capacity to develop strong linkages with CCACs, primary care, hospitals and other social and human services.

At 8:45 a.m., you will be hearing from Dale Howatt, executive director of Community Support Connections—Meals on Wheels and More. Ms. Howatt will be demonstrating how integration and mergers do work, save money, increase capacity and provide excellent services for Ontario's seniors and people with permanent disabilities living in their own homes, living independently and with dignity as long as is safely possible, as evidenced by the following graph.

This committee must recommend that LHSIA be strengthened, resulting in a more effective and efficient health care system to serve Ontario residents now and well into the future.

Thank you for your time, energy and understanding of this critical cornerstone in putting Ontario residents first.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about eight minutes left. With that, we'll start with the official opposition: Ms. McKenna.

Mrs. Jane McKenna: Thank you so much for coming today. Excellent presentation. The purpose of this—I'm not sure if you've been following the Hansard of all the things that people are coming in with. We're getting a bit of a theme right now that has been coming in.

Your last comment here, saying to strengthen, "resulting in a more effective and efficient health care system": As an MPP, I can say that all of us chat at times, and CCACs and LHINs in our area—there doesn't seem to be a flow of consistency of the resources that each one needs. They don't seem to go hand in hand. Everyone has different experiences with each of them.

We're clearly seeing here today, and during the last meetings that we've had, that unless we all push from behind and all work together—that's going to be the key component of making things successful.

Just listening to Gordon and Martina about their strategy and plan, do you not think it would be helpful if those resources and strategies went from each LHIN and CCAC to strengthen them? How do you see the strengthening, I guess is my question to you.

0830

Ms. Joanne Young Evans: One of the things that needs to occur is that the LHINs have to be able to integrate organizations much more quickly and much more effectively and efficiently, without the potential of political fallout and threats of court action etc.

We understand the LHINs are in place in 14 areas to deal with the contextual issues in each of those areas, and they do a very good job of that, hence why it's so different in every LHIN. But what we have here is a waste of funding—at least to 30%—not only in our LHIN, but in LHINs across this province, on administration of numerous organizations that truly do not need to exist.

I think that the LHIN is doing an expert job at strategizing and policy-making. What's happening: The CCACs are directing many of the services, but only have so much control.

One of the issues that we talked about a year ago was that eventually the organization that we would create from community support services may, in fact, then become linked with the CCAC, and the CCAC then becomes bigger. I'm not suggesting regional health centres. Alberta is proof that that doesn't work very well. However, we must do a better job at not wasting the resources we have.

The wait-lists, I can tell you: up to eight years for certain services. Not only is that unacceptable; it's abysmal for a nation such as Canada and a province such as Ontario.

So you need to be able to decrease the amount that's being spent on administration and increase what's being

spent to the front line. Integration is one of the ways to do that.

The Chair (Mr. Ernie Hardeman): Thank you. Thank you very much. Third party: Ms. Fife.

Ms. Catherine Fife: Thank you very much, and, Joanne, thanks for the presentation. I think the matrix of services that you provided on page 3 is actually a good indication of the work that's in front of us. You do mention on page 2, though, that the Attorney General's office has already concluded that LHINs do have the power to force integration, and yet obviously there's a reluctance to do so. We are seeing this in various stages across the province.

Ms. Joanne Young Evans: One of those reasons would be that they don't want to waste taxpayers' dollars in court. I respect the LHINs for that, and I think that that's a good decision.

Ms. Catherine Fife: So your recommendation, though, is for this committee to go back and be supportive of a direction around forced integration, even if there's a cost?

Ms. Joanne Young Evans: But if you eliminate the court action, then the costs of actually integrating in the LHIN is eventually your return on investment; as will be proven by Ms. Howatt when she comes up, it will actually decrease your costs in the end.

Ms. Catherine Fife: And I think that a strong case could be made for integration.

You do mention that there's been some improvements in transportation and the services around Alzheimer's. I'm hearing that this is actually an emerging and growing issue, across the province. The finance committee just finished travelling across the province. We need to plan for this. Would you agree?

Ms. Joanne Young Evans: I would, and Alzheimer's is probably an excellent example in our area of three smaller organizations coming together as one. So they've done a very good job of doing that. It took them three to four years to finally get there, and I guess that's the speed I'm talking about. It was voluntary, which was wonderful.

The transportation piece: What's happening is that there are organizations that are giving their transportation services over to other organizations. Again, they're larger organizations, and it does make sense. You probably couldn't do any better in those areas, but some of these organizations are really quite small, and you can see basically the patchwork quilt of what exists. So you can imagine the thousands of hours, both in administration and in volunteer time, that really could be put to better use.

Ms. Catherine Fife: Thank you for coming forward, and putting forward a theme of residents over organizations. I appreciate it.

The Chair (Mr. Ernie Hardeman): Thank you very much. For the government, Mr. Colle.

Mr. Mike Colle: Thank you for all the work that you've done and your staff—they're responsible. It's obviously a very thoughtful process here. The graphs

really help. I think it's one of the few presentations we've had with this type of visual support, so it's very, very welcome.

I guess the real dilemma, though, is that what you're saying is almost counterintuitive, because everybody really treasures their local, non-profit organizations. Everybody treasures their local hospital. So when a LHIN comes around and says, "Well, listen, we can deliver better service, more effectively and efficiently, if we do some coming together"—alliances, or whatever it is, like they did with the Alzheimer's—Dementia Alliance, I think, they call themselves.

So if government then has given the LHIN the power, you can see it really is still very problematic, because the reality of trying to implement this—you know, the end of these traditional enclaves.

I'm almost saying to you that it's easy to say that. It's probably going to save a lot of money. I think my colleague Donna Cansfield said that there's the 20% cost of administration. For all these organizations, you have that 20% cost.

Ms. Joanne Young Evans: Minimum.

Mr. Mike Colle: So the question is—again, it's easy to say it—how is it ever going to be done?

Ms. Joanne Young Evans: Actually, we developed a model on the way it could be done in this LHIN, and in working with Community Support Services, we're only talking a \$30-million budget. But it is possible, and you put like services together.

I think that when we look at who is serving the resident, that front-line worker will never change. Hopefully, we'll increase the number, but that front-line worker will never change. The client doesn't need to know about the administrative piece. All they care about is that awesome person who is coming in to see them on a daily or weekly basis in order to offer services. Then what we need to do in the back end is amalgamate all of that back-office piece and save those dollars so we can do a much better job on the front line.

It's hard, because you have to take this hat off and be able to speak on behalf of your clients and not on behalf of your organization. That's the hard part, because people say, "Well, that's my job." But the people who work in this field are highly intelligent, highly motivated and they're very skilled. They'll be able to find a job somewhere else—if not in the health care system, then somewhere else.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. Thank you.

Ms. Joanne Young Evans: Thank you very much. I'm glad your system is now working.

The Chair (Mr. Ernie Hardeman): I just wanted to point out that you did make the sound come back on.

Ms. Joanne Young Evans: It's amazing, the power that women have.

The Chair (Mr. Ernie Hardeman): Thank you. And with that, before we have our next presenter, we do want

to take a short break so staff can deal with the sound system. We have to change from one to the other.

The committee recessed from 0837 to 0842.

The Chair (Mr. Ernie Hardeman): I call the meeting back to order.

She made the sound come back on and now I was able to do it on my own mike, but I can't do it on anyone else's. So we will persevere and see if it will come back on. Somebody suggested it may be the climate this morning.

UNIFOR ONTARIO HEALTHCARE COUNCIL

The Chair (Mr. Ernie Hardeman): Our next presenter is Shawn Rouse. He's representing Unifor. Shawn is from Oxford county. Welcome this morning, Shawn, to make your presentation. You have 15 minutes to make your presentation. You can use any or all of your time, as you see fit. I see your mike is on too. You can use all the time if you need, and if you don't, if it's less than four minutes, we will give it to one caucus, and I think that will be the official opposition. If there are more than four minutes, we will divide it equally to all three parties for questions and comments.

With that, the floor is yours for your presentation.

Mr. Shawn Rouse: Thank you very much for this opportunity to present today. I'd like to bring today a spotlight to a few issues involving health care delivery in Ontario through the local health systems act and its subsequent regulations.

My name is Shawn Rouse and I am the president of the Unifor Ontario Healthcare Council, which represents over 26,000 front-line health care workers across Ontario. I am a health care worker myself, with over 26 years in the hospital sector, previously as a dialysis assistant. Unifor is the largest private sector union in Canada, formed by the coming together of the CAW and CEP, representing over 300,000 members in every province and territory in Canada. We represent workers in more than 20 sectors of the economy.

I believe there are four main principles for the reform of LHINs. The core function of our public health system is to measure and meet the population's need for health care services. To date, capacity planning has not been done, even sectorally, in almost 20 years. Health system capacity planning must be done, and it should be based on an evidence-based assessment of population need. To date, LHINs have cut, closed, and facilitated or forced offloading of needed health care services, particularly hospital services, in regions all across Ontario. Health care planning has been divorced from population need.

The guiding principle of our public health care system is equality, or equity. This is not reflected in LHIN legislation, regulation, practices and decisions. Special attention is needed for access to publicly-funded care must be given to improve equity across all regions: in rural, remote and northern Ontario, for diverse groups, marginalized and at-risk populations, and aboriginal and First Nations populations.

Cuts forced under the LHIN system of accountability agreements and service integrations have transferred services from public and non-profit entities to private and for-profit entities—for example, physiotherapy, endoscopy, cataracts, colonoscopies, chronic care and long-term care. Many of these service transfers have been made without the required LHIN integration decisions. Though the legislation prohibits the minister from transferring services from non- to for-profits, it allows the LHINs to do so. Moreover, the legislation prohibits the forced mergers, closures and dissolutions of for-profits, but gives extraordinary powers to enable the minister to force amalgamations, closures and dissolutions of non-profits. Requirements that LHINs not transfer services to entities that charge user fees have been ignored and, when publicized, they're still ignored.

The public health system belongs in the democratic arena. This means meaningful public input, public involvement in the evaluation of decisions, access to documents and information, the right to appeal and representational governance. None of these exist in the LHINs.

Health care workers and their supporters have been raising the issue of minimum staffing levels to ensure adequate levels of care for every resident in long-term care. Staffing funded to an evidence-based minimum, measurable and enforceable standard in long-term care would go a long way to improve the lives of seniors in care.

0850

The current government is implementing changes to Ontario health care delivery through support of specialty outpatient clinics. The Ontario government intends to transfer surgeries, allegedly of a lower risk, from hospitals to smaller specialty clinics elsewhere.

Regulatory amendments have been made to categorize new and existing independent health facilities—IHFs—as health service providers, thus enabling the LHINs to fund and regulate. The Ministry of Health would pay facility fees to the clinics. It is totally unclear how much these subsidies would be, and whether these subsidies would be higher than regular OHIP payments.

I urge the NDP and Progressive Conservatives to study the challenges of this new health care venture, as the Ministry of Health has had an unimpressive record when transferring services to external agencies. Also, the process is in great haste.

I advise that IHFs not be used in this way, as a huge majority of these have been, in practice, for-profit clinics. We strongly recommend that any such specialty clinics, if desirable and necessary, be registered under the Public Hospitals Act and not as an IHF. The latter have been for-profit, very weakly regulated by the ministry, and would be transferred from hospitals that are not-for-profit, well-established, very closely regulated, and with emergency services on-site.

There are serious problems with the for-profit IHFs. These are not audited regularly, if at all, and have odd billing and record-keeping as a result of loose regula-

tions. Safety would not be ensured because of poor oversight, emergency services not on-site, and quality control protocols missing. There are higher costs because of the usual costs when restructuring, IHFs needing subsidies in addition to regular OHIP payments, new business and administration costs, and the need to find ways to collect fees.

The Canada Health Act covers hospitals and doctors with medically necessary services, so when services are transferred elsewhere, the CHA coverage must not be lost. The charging of fees which can limit access, guaranteed in the CHA, would be contrary to the Ontario Commitment to the Future of Medicare Act, 2004.

There would be a danger to the sustainability of community hospitals if hospital services are dismantled. Progressive Conservatives should be most concerned about the future of smaller, rural community hospitals.

The Ontario Auditor General's annual report in 2012 found that there were 825 IHFs, and 97% of these were for-profit, despite ministry claims otherwise. There were professional fees charged, and queue-jumping on ability to pay can occur. Most IHFs had not been tracked or audited, and these facilities will now do surgeries. For-profits will not do these surgeries unless profit can be made. Will it be user fees or extra subsidies? Regulatory conditions would have to be loosened. They would do the simplest, highest-volume surgeries, leaving the most costly and complex to the hospitals, with declining funding as a result.

If not-for-profits are established, will they remain that way? In the LHIN legislation, 2006, LHINs can transfer not-for-profits into for-profits but the inverse direction is not permitted. When services are provided in the community, there is less guarantee of patients not paying out-of-pocket, whereas in hospitals, the CHA guarantees against user fees. That would suggest that hospitals providing specialty clinics off-site could perhaps work.

I would like to end this submission with a quote from a presentation made by the Canadian Auto Workers to this very committee on February 8, 2006:

"Our fundamental position of criticism of this statute rests on the two following essential themes:

"(1) the absence of any meaningful public consultation or civic engagement, let alone a governance structure allowing for democratic and equitable representation of our diversity and communities; forums in which the people of Ontario as citizens are enabled and empowered to actively engage in the policy dialogue and policy choices concerning delivery of health services; and

"(2) the absence of any labour adjustment strategy to minimize the effects of this transformation agenda on health workers and the presence of specific arbitrary distinctions and discriminatory means by which the bill proposes to treat non-professional and 'non-clinical' workers—a significant attack on employment security without the protection of Bill 136 [PSLRTA, 1997]; a proposal to 'trump' existing negotiated contract provision restrictions in the event of work transferring to contractors.

"The challenge for our province in building an integrated and comprehensive public health care system capable of delivering safe, quality services and improved outcomes will be to ensure both a collaborative and focused effort by providers of health services and a deepening civic engagement by and accountability to the people of Ontario for their investment and commitment to medicare."

Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have about six minutes left, so we'll start with the third party. Ms. Armstrong?

Ms. Teresa J. Armstrong: Thank you very much, Shawn, for coming in and presenting to the committee. One of the things I heard you talk about was public engagement. You found that a very important example of how the health care system can be successful. Can you give me some examples where you think that we can engage the public better in order to make the health care system sector work better for patients?

Mr. Shawn Rouse: One way I can see is the engagement of allowing public participation in decisions of the LHINs. Currently, it's a rare occurrence—I'll use that term—that a meeting is actually publicized so that persons can have adequate time to be able to attend the meeting. Also, meetings are normally held during the daytime, and when they are made aware, persons who have to work for a living have no ability, usually on such short notice, to make the attempt to attend. They go out of their way to limit people's ability to attend or participate—even in writing, for that matter.

In the province of Ontario, there has only been, to my knowledge, one person from a labour group ever appointed to a board of a LHIN in Ontario.

The Chair (Mr. Ernie Hardeman): Thank you very much. The government: Ms. Cansfield.

Mrs. Donna H. Cansfield: Thank you very much for coming today and for your presentation; I enjoyed your presentation. I have a couple of questions. On page 3, you identified that although the minister does not have the authority to transfer, the LHIN does, but that "service transfers have been made without the required LHIN integration decisions." What do you mean by that?

Mr. Shawn Rouse: Decisions are made by a board and just presented as, "This is what's going to happen." We've had cases that have been publicized in the newspapers where a decision has been made to transfer services away from a hospital—only to find the uproar or clamour by the local public to try to reverse a decision that has already been made.

Mrs. Donna H. Cansfield: Are you suggesting that there's no outreach to the community about the decision either before it's made or after it's made; that it's just made?

Mr. Shawn Rouse: Yes.

Mrs. Donna H. Cansfield: "Requirements that LHINs not transfer services to entities that charge user fees are being ignored"—can you give me an example?

Mr. Shawn Rouse: One that happens more times than most people would like think about is, if a patient has

been deemed to be capable of discharge from a hospital but has not yet found a place in a long-term-care facility which has been designated, a hospital has been known to notify the family or the patient that there are increased costs for staying, sometimes in the thousands of dollars per day. The minister has had to publicly be involved, in the newspaper, to ridicule that decision and have it reversed, only to find that the facility would do it again in a couple of weeks to another patient.

Mrs. Donna H. Cansfield: That's interesting.

Mr. Shawn Rouse: That's documented in the newspaper; that's not secret—

Mrs. Donna H. Cansfield: I think there is a provision, \$50 a day or something—

Mr. Shawn Rouse: It's a known fact that hospitals will present bills to patients, demanding thousands of dollars a day in overstay charges, to force patients to pick anything, to get out of the hospital, which is illegal.

Mrs. Donna H. Cansfield: Thank you very much.

The Chair (Mr. Ernie Hardeman): The official opposition: Ms. Elliott?

Mrs. Christine Elliott: Good morning, Mr. Rouse, and thank you for your presentation. It's very illustrative of a lot of the issues outstanding with respect to the LHINs.

You did indicate at the beginning of your presentation that there were four main principles for reform of the LHINs, but you've got a lot of problems with LHINs. Do you think that they can be reformed, or do you think we need to look at a different structure?

Mr. Shawn Rouse: Well, I'm not a policy wonk, to say for sure; I'm a front-line hospital worker per se. The LHINs aren't, I believe, the best way to present what's happening. It's a way of isolating the government from decisions in health care. But as a funding agency, they do have their place. I believe that reform is possible, based on the issues of accountability and involvement of your communities in the decisions that affect those communities.

Mrs. Christine Elliott: You also indicated that we really need greater equity in the system; that there's too much discrepancy in service levels in different parts of the province. How do you think we could achieve that equity? Do you think it's a question of the ministry becoming more involved? Is it a question of the LHINs taking a stronger role in coordinating services? Where do you think we need to make the changes in order to achieve that equity?

Mr. Shawn Rouse: I believe there are probably a lot of people better versed to speak as to how to bring about the changes of equity, but one thing that comes to my mind quickly is that the drive to efficiencies has overwhelmed the needs of the population that the health care facilities are involved in. They will remove services that are needed in communities—rural communities or otherwise—in the name of efficiencies, completely disregarding the will or the need of that community to use that service. We've seen it in physiotherapy and we've seen it in maternity care, and the list just keeps going.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for making your presentation today, Shawn. When I introduced you, I didn't say that you were representing the Unifor Ontario Healthcare Council, so we want to make sure that's on the record.

Mr. Shawn Rouse: Thank you very much.

COMMUNITY SUPPORT CONNECTIONS— MEALS ON WHEELS AND MORE

The Chair (Mr. Ernie Hardeman): Our next presenter is Community Support Connections: Dale Howatt, executive director. Thank you very much for being here this morning. We look forward to your presentation.

Mr. Mike Colle: Mr. Chair, can you turn on the heat while we're here—or is that out of order?

The Chair (Mr. Ernie Hardeman): I don't run the facilities. Thank you.

Thank you very much for being here this morning, and I too feel the cold. I just want to assure you that the issue of the temperature in this room is not because you were here.

Ms. Dale Howatt: I certainly hope not.

The Chair (Mr. Ernie Hardeman): I do want to welcome you and tell you that you have 15 minutes to make your presentation. You can use any or all of that time to do that. If there's time left over, if it's less than four minutes, it will go to one party; if it's more than four minutes, we will divide it equally among the three caucuses for questions to your presentation. With that, again, thank you very much for being here, and we look forward to your presentation.

0900

Ms. Dale Howatt: Thank you very much for the opportunity to speak to you this morning. My name is Dale Howatt, and it is my privilege to present to you today on behalf of Community Support Connections—Meals on Wheels and More. We are a community support service funded by the Waterloo Wellington LHIN, as well as an active member of both the Waterloo Wellington Community Support Services Network and the Ontario Community Support Association, a network of agencies providing home and community care to over one million Ontarians every year.

Community support services form a very small but integral, responsive and growing part of the provincial health care budget. We serve a large number of some of our most vulnerable citizens, those who are living independently in their own homes and those who are struggling to do so. As I present to you today, our organization alone is supporting 4,594 seniors and adults with disabilities in our community: 447 are over the age of 90, living independently in their own homes; and 16 are over the age of 100, living independently in their own homes.

Community Support Connections—Meals on Wheels and More provides a myriad of volunteer-driven supports and services that enable these people to live with independence and dignity, services such as Meals on

Wheels, escorted rides to and from doctor's appointments and the grocery store, gentle exercise, friendly visiting and much, much more. Last year, 600 local volunteers contributed more than 70,000 hours to direct service delivery. That's the equivalent of approximately 42 full-time jobs in our world, and at that time, we employed fewer than 23 full-time staff.

We like to think of our organization as an integration success story. On May 2, 2008, four small community support service organizations officially merged to become Community Support Connections—Meals on Wheels and More. In the subsequent five-year period, we realized a significantly increased capacity to serve by leveraging that resulting change into a client-focused, innovation-embracing culture, and by redirecting redundant administrative resources to direct service.

Merger is an increasingly common phenomenon in our world. But we're now coming up to our sixth birthday and so are able to provide information about real results in the lives of real people here in this community, results that have continued over time, results that are sustainable. During the five-year period of time between our merger and the end of this last fiscal year, the number of clients we served increased 39%; the number of rides we provided, 118%; the number of sites where our services are available to individuals in the community, 338%; and community dining and exercise units, 630%—all within a relatively stable funding context of 16% over the same period of time. That's a lot of numbers, but the resulting differentials range between 23% and 614%. That's capacity.

This capacity to serve was released from four structures that previously existed. This capacity to serve is critical as we seek to meet the needs of our aging population with very limited resources. This capacity to serve is critical as we examine the sustainability of our health care system and seek ways to improve it.

As a larger organization offering more services than its predecessors, Community Support Connections—Meals on Wheels and More is also better able to understand and meet the increasingly complex needs of the people that we serve: 46% of our clients receive more than one service. That means that with the old structures, close to 2,000 local seniors and adults with disabilities would have had to tell their story at least two times and maybe three times in order to receive the services that they now receive with a single phone call. Some may not even have been receiving the services that they need because they didn't know to ask or because the organization offering a single service was unaware of their other needs.

This year, with the support of the Waterloo Wellington LHIN, we're growing even faster. In April, we incorporated another local stand-alone CSS program into our offerings, further simplifying access for local residents. Strategic, targeted investments will also enable us to leverage community goodwill and innovative thinking to deliver more services to more seniors and adults with disabilities in our community.

Our message, however, is not about our organization. It's about capacity, collaboration, system thinking and integration. It's about putting the client at the centre of care. We know that integrated health systems provide better outcomes. Integrated health services do likewise, and can sometimes yield enhanced capacity in the magnitude that I've just mentioned.

In addition to structural integration, we've participated in other integration activities focused on putting the client at the centre of care. Our network developed a process called Easy Coordinated Access, a way of simplifying access to the many programs and services that comprise our sector. This process is now being replicated across disciplines and in other jurisdictions.

With the LHIN's encouragement, our local network also utilized the introduction of a provincial common assessment tool to develop a community team of assessors rather than an organization-by-organization set of assessors and processes. Communication is now simplified. Service is now simplified. Duplication has been minimized.

Recent discussions have touched on the possibility of shared care coordination between community support services and CCAC. Imagine the improved client service possibilities. We've developed shared front-door and home-visit protocols with partner organizations to ensure that the often-used phrase "every door is the right door" is in fact a reality for the people we serve.

These are all examples of integration initiatives that are moving our system forward. They are improvements that put the client at the centre of care. This happens most effectively at the local level. Is there more work to do? Without a doubt.

A progressive, modern health care system keeps people healthy and connected in their homes and communities, not sick and alone in institutions. Home and community support works because it offers local, flexible, community-based solutions with and around the people we serve. We know that keeping people living independently in the community and out of hospital is a more cost-effective means of health care delivery. Investing in home and community care frees up hospital beds. It unclogs emergency wait rooms and decreases long-term-care placements and long-stay hospitalizations, all at a lower cost to the health care system.

Effective transition of services to the community, however, requires transitioning resources as well. To meet current and future need, we must ensure that there is sufficient funding and sufficient funding flexibility afforded to community agencies in order to attract and retain qualified workers; in order to appropriately recruit, screen, train and support those volunteers whose time, expertise and considerable goodwill tell our most vulnerable citizens that people do still care; to continuously improve quality and manage risk well; and to actively participate in system solutions.

As we continue to transition care from hospital to community, we need an understanding of community capacity and community resiliency. This is an understanding that comes best at the local level. As we invest

taxpayer dollars in home and community care, we need an understanding of where we get the greatest return on our investment, an understanding that, again, comes best at the local level.

In our current state, Community Support Connections—Meals on Wheels and More and other community support services are active participants at every health links table. We're also active participants at many other system tables, contributing to cross-sectoral system solutions. This was not always the case. It is a result of local system management and is critical to ensuring that community support services are fully utilized and leveraged to meet system goals.

There are many challenges ahead of us. LHSIA provides the framework within which we've begun the journey. Now is the time to build on momentum, to fully leverage the existing legislation, to build upon existing strengths, relationships and opportunities, and to push the integration agenda forward so that we can continue to find new ways to release capacity that already exists in our system and meet the needs of our community as it grows and changes. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have two minutes for each caucus. This time, it starts with the government. Ms. Jaczek?

0910

Ms. Helena Jaczek: Thank you, Ms. Howatt, for coming. Looking at this very useful description of services that we were provided with by Joanne Young Evans, I certainly see Community Support Connections in a number of areas, both in terms of service provision and geographic areas, but I do notice that, apparently, you're not involved in Guelph-Wellington and north and west South Grey.

Given your track record of successful mergers and, obviously, all of the positive things that you've been able to do over the last few years, are you looking to be able to service the whole LHIN in the future, to ensure some consistency for residents and so on?

Ms. Dale Howatt: We're looking to ensure that every resident has equitable access to service. Sometimes that comes through structural integration through merger, and sometimes it comes through active and proactive partnerships. Right now, we are currently actively working with our partners in Guelph-Wellington to ensure that the service offerings are indeed equitable across the system. I think there are many ways of getting there.

Ms. Helena Jaczek: What role does the LHIN play in that? I mean, it sounds like you, as an organization, are very conscious of these needs, but would this not be happening if we perhaps didn't even have a LHIN?

Ms. Dale Howatt: I'm not so sure that it would. Moving the system is very difficult. Implementing change is very difficult.

I'll give you a very recent, concrete example. One of the investments of new funds that I alluded to in my presentation was to provide gentle exercise and falls prevention classes across the Waterloo Wellington LHIN.

We did so in active partnership with VON Canada, to ensure that those services were equitably offered across the region, and that was a condition of the funding. In our case it was not necessary, but I think it's important that it be a condition of the funding.

The Chair (Mr. Ernie Hardeman): Okay. The official opposition: Ms. Elliott?

Mrs. Christine Elliott: Thank you, Ms. Howatt, for a great presentation, and for the great work that you're doing in building capacity significantly while still keeping the client at the centre of all of your plans.

I'm just wondering if you would be able to point us in the direction of any material that you might have about how you were able to do this, and the process that you went through. I think that would be really helpful for us as a committee as we consider options going forward. I was also wondering if we could get a copy of your written presentation from today, if you'd be kind enough to share that with us.

Ms. Dale Howatt: Absolutely. I'm happy to forward that. I was trying to save a tree or two. All of the information about our merger is publicly available on our website, and I will forward that link as well. Our most recent annual report speaks to the capacity numbers—all of those percentages that I reeled off for you. There's quite a visual graph in our most recent annual report documenting that.

Mrs. Christine Elliott: Thank you. That would be very helpful.

Ms. Dale Howatt: You're most welcome.

The Chair (Mr. Ernie Hardeman): Thank you. The third party: Ms. Fife?

Ms. Catherine Fife: Thank you very much, Ms. Howatt, for the presentation. Just to sort of piggyback on Ms. Jaczek's question around the role of the LHIN in the four agencies coming together: Did the LHIN inspire, at least, the sitting down and having a conversation, the facilitation of the agencies coming together for a more coordinated approach? I'd like to pick up on that a little bit more.

Ms. Dale Howatt: The LHIN was very supportive of our merger. It did happen in the very early days of the LHIN itself. The legislation was 2006; our organizations began discussing a potential merger in 2007. I think that the environment created by LHSIA actually encouraged health service providers to think differently about how we're constructed and how we deliver services, and that, in fact, was an impetus to the merger.

Ms. Catherine Fife: Okay. That is good for us to know. The other issue: Home care, of course, was in the last budget, so there is some new funding flowing out to the province; it's long overdue. But there is a conversation afoot about minimum levels of care for home care. I know I've heard from personal support workers, in particular, who feel that they would like to spend more quality time, because home care on the surface sounds great, but it also is tied to quality. Can you comment on that at all? Because it is a human resources issue, and it is a funding issue.

Ms. Dale Howatt: I think that ensuring quality in everything that we do is an important aspect. You'll notice that in my presentation, I talked about capacity, not efficiency, because I think that effectiveness is an important metric. As we look at community care, we need to ensure that the interventions that we're offering are not only efficient but effective.

We see that every day with very simple supports in terms of volunteer interaction. Sometimes, for some of our more well clients, it's as simple as a daily social contact.

Ms. Catherine Fife: Absolutely.

Ms. Dale Howatt: So, ensuring that people get the right services at the right time needs to be an element of every individualized care plan.

Ms. Catherine Fife: Okay, and just one quick final—we've heard on the finance committee that not-for-profits across the province would like to see some greater support, because, as you pointed out, 600 volunteer hours equals 42 FTE. Is there a role, or can you comment how government policy could be more supportive of the not-for-profits within the health care model?

Ms. Dale Howatt: I think it's important that policy-makers understand that there is a cost associated with leveraging volunteer resources in the community and doing that well, particularly with vulnerable populations. Sometimes not-for-profit organizations are challenged by what looks like administrative costs in coordinating the efforts of all of those volunteers.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. We thank you very much for your presentation. Sorry for the climate.

Ms. Dale Howatt: Not a problem. Thank you.

WATERLOO WELLINGTON
LOCAL HEALTH
INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presentation is the Waterloo Wellington Local Health Integration Network: Joan Fisk, chair, and Bruce Lauckner, chief executive officer. Welcome.

Thank you very much for being here this morning. As with previous presenters, you'll have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's time left over, less than four minutes, it will go to the opposition caucus. If it's more than four minutes, it will be divided equally among all three. With that, thank you very much, again, for being here. The floor is yours.

Ms. Joan Fisk: Thank you very much as well. Good morning. My name is Joan Fisk and I'm the chair of the board for the Waterloo Wellington LHIN. I want to start by thanking the standing committee for taking the time to visit Kitchener today. The work you're doing is critical, and we welcome the opportunity to appear before you in our own community.

I also want to explain the format of our presentation. I'll speak for a couple of minutes, and then I'll pass the

microphone to our chief executive officer, Bruce Lauckner, who'll speak for roughly 10. We appreciate that the committee may want to ask questions, so we've saved some time at the end for that.

I became chair of the Waterloo Wellington LHIN almost three years ago. My background is primarily in business at the CEO level. I have extensive governance and community service experience. I've served on boards of two different post-secondary institutions, and I'm currently on the board of an insurance company and a public-private partnership. I'm also a member of various advisory groups, and I volunteer extensively.

I believe deeply in the challenging work we're doing at the Waterloo Wellington LHIN, and I feel that the model of local, community-based boards is crucial. Because we live here, we have first-hand knowledge of the system. We hear about our residents' experiences regularly through the course of our everyday lives, and through our activities in the broader community, we also hear. We have a personal stake in ensuring the decisions we make are the best possible ones; they will affect us directly.

Openness and interaction with the community is also fundamental. We hold our board meetings approximately once a month, and at each meeting we welcome at least 50, and often more than 100, visitors. Our approach at the meeting is intended to both inform the broader audience and ensure the board is able to make good decisions.

We receive regular feedback about the health system when we're in conversation with community members who attend our meetings. After the meetings, we frequently reach out to them, or they reach out to us, to continue the interaction.

We see health service provider board-to-board and governor-to-governor engagement as a key aspect of our role. For this reason, we host meetings and events that bring people from different boards together so they can learn from one another, better understand their role within the system and provide ongoing input to the LHIN.

I suspect you've listened to presentations over the past week and heard a wide range of views of whether or not the LHINs are effective, whether targets are being reached, whether there's enough local input into decisions, whether the LHINs should have more authority or less, and much more.

Some comments we'd agree with; others we likely would not. But we're not here today to respond to what others have said, and we're not here today to tell you everything is perfect. We believe great progress has been made within Waterloo Wellington, and the information Bruce is about to share will illustrate that. However, there is still much to do.

Over to you, Bruce.

Mr. Bruce Lauckner: For the record, my name is Bruce Lauckner. Thank you, Joan, and thank you, committee members, for your commitment to this sector and this important task.

0920

As I've read the Hansard transcripts from the hearings to date, I've been impressed with the questions being

asked and the depth of the discussion. Your knowledge of the system comes through very clearly, as does your strong commitment to your constituents and the well-being of the people of Ontario.

In terms of my background, I've been at the Waterloo Wellington LHIN for just over eight years, and in the role of CEO since 2010. Prior to that, I led high-performance teams in the public and private sectors, including at Sun Life Financial, Clarica, KPMG and in municipal government. I've been involved in or led major changes, mergers or amalgamations for over 100 organizations.

Recognizing that you've already received the LHINs' four recommendations about the legislation, my plan today is to focus on our local story: our performance and the importance of the local model in achieving results.

When the topic of LHIN performance is raised, the focus is usually on targets. Currently on the Waterloo Wellington LHIN website, there are two charts that we call dashboards. These deal with local areas for improvement, which are tied directly to the objectives in our Integrated Health Services Plan and our annual business plan commitments. They reflect the targets that our hospitals and other health service providers have agreed to meet.

One dashboard gives a monthly snapshot; the other focuses on the change from the time the factor was first measured. If you look at the monthly snapshot version, you'll see a number of factors that are labelled green, yellow or red. These show you where things stand at a particular moment in time. They don't tell you what happened the month before or what will happen the following month. And for any number of health-care- and non-health-care-related reasons, some of these indicators can change from red to green, or vice versa, in the space of a single day, let alone a single month. So the month-to-month indicators tell only part of the performance story.

We pay close attention to this dashboard to ensure our health service providers are on track to achieve the necessary system improvement for our residents. But we don't just check off a box when we see green and say, "Great; that's done." Our core value at the Waterloo Wellington LHIN is to act always in the best interest of our residents' health and well-being. The first question we therefore ask is whether or not the improvement is sustainable. If the answer is no, we work with the appropriate health service provider to figure out how to make it so. If the answer is yes, our next step is to look at the target and ask if we, as a system, can do even better.

Another part of the performance story is told by the second dashboard, and that looks at trends. This is particularly helpful because it shows the kind of progress that has occurred in the system since our LHIN came into existence.

In terms of measuring impact, it's crucial to look at the overall changes over time, to really see what's happening and where significant work still needs to be done to improve the health care available to our residents. In Waterloo Wellington, there have been a number of substantial improvements.

When the LHINs were created, this region had some of the longest wait times for non-urgent CT and MRI exams, for cataract surgeries and for hip replacements. These wait times have decreased substantially.

But the performance of the system is not just about wait times; it's about quality of care. As an example, when the LHINs started, there was limited local access to quality care in a number of areas in this region, such as cancer and cardiac. Many people had to drive out of this area for treatment. Now, in addition to the improved wait times, this region has one of the best overall cancer programs in the province and arguably one of the best cardiac centres in the entire country.

When the LHINs started, there was insufficient physician coverage in several of our local emergency departments. Now we have a full complement, and the departments are functioning much better.

Let me give you just a few examples from the trend dashboard that I mentioned a few minutes ago. The percentages that follow show the improvement from that starting point, which is either when the LHINs started or when the factor was first measured:

- improvement in emergency department stay for admitted patients: 49.7%;

- improvement in wait times for non-urgent MRIs: over 73%;

- for non-urgent CT scans, the improvement is over 80%;

- for hip replacements, the improvement is almost 65%; and

- for cardiac bypass surgery, it's almost 80%.

And now tens of thousands more residents in our region have a primary care provider that they didn't have access to before.

Percentages are helpful in giving an overview, but I said before that it's not just about the stats. Let's take it to the patient level and look at a personal example. Think, for instance, of a woman in her late 50s or 60s who's waiting for a knee replacement. In 2005 in this LHIN, she would have waited for roughly 15 months. Now, for two of our three hospitals, the wait times are closer to three months and five months, respectively. So we're looking at as many as 12 pain-free months for that same woman today, compared to the way it was before the LHINs were created. I know this matters, because I've talked to many people who have had hip and knee replacements. I've shadowed therapists on home visits, and I've had people tell me how much of a difference this surgery has made to their lives.

Before I talk about the importance of the local model, I'll briefly explain why it's also necessary to consider how targets are set when assessing performance. Let's look at the factor that measures the amount of time patients spend in the emergency department before getting admitted to hospital. These are the most complex patients and they often need diagnostic tests and assessments.

The average length of stay for patients in this category in Ontario is approximately 27 hours. Rather than setting

the target in Waterloo Wellington at something like 20 hours, which would still be a significant improvement over our starting point of 29, we set the target at eight hours. The average length of stay in Waterloo Wellington, through the collaboration of the LHIN and our local providers and the good efforts of our front-line staff, is now 14.6 hours. That's the lowest quarterly level ever recorded in Ontario history since we started measuring wait times in 2008.

Despite the fact, though, that there's almost a 50% improvement since the starting point, and we're number one in the province, this metric isn't green on our dashboard. That's because we don't set targets based on how easy they are to achieve; we set targets based on the lowest of the evidence-based clinical practice or the provincial average. In Waterloo Wellington, we believe this approach is in the best interests of our residents. It's simply the right thing to do.

The results I've shared over the past few minutes demonstrate just some of the improvements in this region's health care since the LHINs were created.

0930

Next I want to address the LHINs' role in this improvement and why a local presence is so important.

The provincial government operates, if you will, at a 30,000- or 40,000-foot level and sets the very important overarching vision for health care. Our health service providers focus on and are experts in their particular areas. They have a strong understanding of their patients' needs when they walk through the door. They work at what can best be described as the street level. Ideally positioned between these two levels, the LHINs have a regional system view. We think about how patients move through and across the system, and what they experience while doing so.

A concrete example of how this locally based, system-level approach has improved the patient experience is a program we call Easy Coordinated Access. The LHIN had more than 33 community support services across more than 24 different agencies. Residents found it difficult to access the best services and providers based on their particular needs; multiple phone calls or visits were required. Also, service levels and wait times were uneven, and primary care providers and agencies struggled with referrals. The experience was very frustrating for our residents. I know this because our residents told me so. They'd talk to me about having to call one agency for transportation, another for adult day programs and yet another for a home visit.

LHIN staff worked with health service providers to design the Easy Coordinated Access program, which was introduced to make it easier for individuals to access these kinds of community support services. Using a new web-based search and mapping tool, it centralizes intake through the community care access centre and it ensures a coordinated approach that dramatically changes the experience of the resident.

As the example I've just given illustrates, having LHIN staff focus on the system from a local vantage

point is key to improving the patient and resident experience. But why is that the case? It's because we're local. Because we're local, the medical and business professionals who work at the LHIN interact with our health service providers on a personal and professional level. We bring together providers who would likely not connect otherwise, and we can do this effectively because we know them and we work with them regularly.

Because we're local, we can readily support providers as they collaborate to make improvements each and every day. When necessary, we intervene to ensure the decisions that are made are in the best interests of the residents. We lead the creation of programs that increase quality and ensure consistent levels of care across the system.

Because we're local, we're immersed in the very environment we're trying to improve, and we understand and share the needs of our residents. We interact regularly with our residents who contact our office, and we formally engage our communities, as the legislation requires.

Our LHIN physician leads and our staff—they've been nurses, physiotherapists and so on—work or have worked on the front line as well as in our system. In fact, our physician leads work with us and with their patients on the same day. In this way, we hear about needs—what needs to be done now, what needs to be done in the future—and we make investments and funding decisions based on their input.

Before I close, I'd like to provide one final example of the current model in action. It's about achieving best practice. It's about the patient experience.

Because we're focused not just on what's happening at one individual organization but at all our health service providers, the LHIN recently made the decision to change the system of stroke care so we can meet best practice for all the residents in our region. As a result of this action, every year from now on, 20 more Waterloo Wellington residents will survive their initial stroke. Every year from now on, 65 fewer people in this area will die or experience serious debilitation from stroke; and every year from now on, between 40 and 105 more patients will return home rather than go into long-term care.

Are there more challenges like stroke? Yes. Is Ontario's vision for health care achievable? Yes. Do the LHINs play a necessary role in the system that's distinct from the roles that our health service providers play in realizing that vision? Most certainly. The results speak for themselves.

When the LHIN was created, hospitals and other health service providers in our region were running deficits. Our local hospitals are now working with balanced budgets. Despite the fact that we've held the line on smaller increases for several years so we could increase home care services and expand primary care, hospitals in this region are generating slight surpluses, and that has been used for things like the purchase of new equipment.

Quality has also improved, and volumes of service for many hospital and community sector organizations have increased. We are increasingly shifting the focus of the system to health promotion, primary care interventions and better management of chronic disease.

The improvements I've talked about this morning tell a story of a sector that's realizing a health care vision because of the work that's done at the system level by the LHINs and at the front-line level by our health service providers—everyone working locally together.

The strength of the current legislation is that it recognizes the importance of local, so that the patient is at the forefront. Government can focus on the overall vision for health care in the province; health service providers can focus on the individual patients; and the LHINs right across the province can focus on the regional system and the patients' journey through it, while sharing their learnings and best practices with each other. Each role is vitally important, and we're deeply committed to the part we play.

Thank you, again, for the opportunity to present today and for your work on behalf of Ontarians.

Joan and I would be happy to take questions.

The Chair (Mr. Ernie Hardeman): Thank you very much, but the time has expired—15 minutes and 15 seconds. Thank you very much for your presentation. It is very much appreciated and was very well done.

GRAND RIVER HOSPITAL

ST. MARY'S GENERAL HOSPITAL

The Chair (Mr. Ernie Hardeman): Our next presenter is from Grand River and St. Mary's hospitals: Jordan Golubov. Thank you very much for being here this morning. As with all presenters, you will have 15 minutes, and you can use any or all of that time to make your presentation. If there's less than four minutes left, we will have questions from just one caucus; if there's more than four minutes, we will split it evenly with the others. With that, the floor is yours.

Dr. Jordan Golubov: Good morning. My name is Dr. Jordan Golubov. I'm the head of gastroenterology for Grand River Hospital and St. Mary's General Hospital. Thank you for allowing me to speak at this forum. I'm speaking on behalf of the eight gastroenterologists who care for patients in this community. I've been practising here for over 20 years.

Our LHIN has thus far not played a substantive role in shaping the delivery of gastroenterology and endoscopy services. This will change as the LHIN takes on an important responsibility in determining the role of privately administered and operated endoscopy clinics in our region. This could have a profound effect on the nature and quality of our gastroenterology and endoscopy services.

The eight gastroenterologists who work exclusively at these two hospitals have significant concerns about the Ministry of Health and Long-Term Care plan with regard

to these private clinics. The ministry proposal could result in a substantial shift in these procedures from our public hospitals into these private facilities.

I am a member of what is the largest gastroenterology specialty group in the Waterloo Wellington LHIN. We're the only service that provides 24/7 gastroenterology call in this LHIN. Our two hospitals have the LHIN's best-equipped endoscopy units. There has been tremendous community support for our new endoscopy units, as evidenced in particular by the donor plaque outside of the St. Mary's General Hospital unit.

We have a highly skilled pool of dedicated endoscopy nurses. They are required to optimize patient outcomes, whether for the so-called routine procedure or the complex intensive care unit patient.

We provide a comprehensive and integrated model of care for community members, whether they are in-patients or outpatients. This comprehensive care model includes our pathology, radiology and general surgery departments, as well as our centralized and integrated Waterloo Wellington regional cancer program. Our working environment fosters the development of advanced endoscopic skills, which benefit the entire community. We always strive to provide the highest quality of care. We have a culture of stewardship of our health care system's limited resources.

The action plan for health care by the Ministry of Health proposes community-based so-called specialty clinics for so-called high-volume, routine procedures, such as colonoscopy, in order to offer patients access to high-quality care at less cost. The Ministry of Health states, "We will not compromise on quality, oversight or accountability." Our LHIN will be a key player and key part in this decision-making process in conjunction with our hospitals.

I can unequivocally state that there is no so-called "specialty clinic" or endoscopy unit in our LHIN that has more well-trained gastroenterologists or better equipment than what we have right now at Grand River and St. Mary's General Hospitals. Our procedures are performed in a highly regulated and monitored environment to perform procedures safely and effectively. A true specialty clinic first requires the cognitive ability to assess whether or not a patient needs a procedure and, if so, what kind of procedure; how to interpret the findings of that procedure; and then to make appropriate follow-up and patient management decisions. The largest true specialty clinics in our LHIN are already to be found at Grand River and St. Mary's General Hospital.

In contrast, these out-of-hospital clinics are really privately operated procedure centres that frequently do not provide the aforementioned comprehensive model of care. These private clinics need to perform procedures in order to generate revenue. This will bias these private clinics towards performing procedures. This is not an environment that is supportive of stewardship of health care system resources but rather one of utilization. Studies have shown that 10% to over 30% of endoscopic procedures may be performed unnecessarily. I think that a retrospective audit comparing procedure indications at

private clinics versus hospitals would be very instructive to identify where the most unnecessary tests are done based on current standards of care. We may find that the cost benefit of a possible lower procedure cost in a private clinic is overwhelmed by the cost of the unnecessary tests that are fostered by this utilization-driven environment.

Is the cost of the procedure truly cheaper in these private clinics? Many private facilities and some hospitals employ anaesthetists in their endoscopy units. They are very costly to the taxpayer. Their fees are multiples higher than the cost of the hospital registered nurse that they replace. They're unnecessary to the performance of endoscopy. The Ministry of Health currently is not choosing to measure this cost to the taxpayer in their endoscopy cost calculation. This is a negative bias against the cost of our endoscopy units, which do not employ this form of costly endoscopic care. Is this fair?

0940

Private clinics also avoid doing any procedure that incurs equipment costs that will reduce profit margins. The procedures are repeated at the hospital, leading to higher equipment costs for the hospital and further OHIP billings for repeat procedures and more patient risk. As clinics do not provide a comprehensive model of care, repeat consultations may be required, adding additional costs to the taxpayer. In the end, if the Ministry of Health does not look at the total cost of care, it will produce a flawed conclusion.

What about patient outcomes? During colonoscopies, it's vital that adequate time is spent visualizing the patient's colon in order not to miss growths that are or could become cancerous. However, the Cancer Care Ontario Guideline for Colonoscopy Quality Assurance in Ontario states that no minimum time needs to be spent inspecting the colon for quality assurance purposes as this would have a negative impact on productivity and efficiency, for negligible gain. This is in contrast to Canadian, American, European and UK guidelines. So here we see that in the name of efficiency, which is a very popular term, colonoscopies can be completed without a minimum inspection time. This fits with the Ministry of Health price-per-volume reimbursement model and rewards physicians financially. However, as a patient, I would not want the time inspecting my colon, which may not be repeated for 10 years, reduced in the name of efficiency. I would want my physician to spend as long as was necessary to inspect every nook and cranny of my colon so that I was protected from developing colorectal cancer to the greatest possible extent. The focus for the taxpayer and for patients should be quality, not quantity of care. It is better to do procedures less often and to do them as well as is possible to maximize benefit and minimize risk.

The Ministry of Health reimbursement model may also create a conflict of interest. What is good for the physician financially may not be good for the patient clinically.

In terms of outcomes, we do have a study published from this province, which I have referenced for you in

the handout. It looked at patients who were diagnosed with colon cancer here in this province between 2000 and 2005. This study suggested that a patient who had had a colonoscopy performed at a private clinic had a 1.7 times greater risk of developing colon cancer over the next three and a half years, compared to if they had had it done in hospital. We should have more information from Ontario about the performance of these privately-run facilities before we decide to move more procedures to them. My colleagues and I feel that the Ministry of Health's price-times-volume model is not supportive of optimal patient outcomes.

Any shift of endoscopy services from the Grand River and St. Mary's hospital endoscopy units to private clinics will not enhance the current quality of GI care that patients receive in this area. We believe it will be diminished. We believe that the operating characteristics of private clinics require compromises to be made as a result of the Ministry of Health's reimbursement model. These compromises are not made in our hospital environment.

Now let me tell you about one of the most dire consequences of moving care out of hospital to private clinics. If the majority of GI practice is moved out of hospital by the proposal of the Minister of Health and the Ministry of Health, there may be a loss of gastroenterology service to the hospitals. Many physicians increasingly value a less-demanding professional lifestyle. This potential shift of endoscopy to these private clinics will allow gastroenterologists to practise without the use of hospital resources. One will no longer have to worry about being awakened at 2 in the morning to see a gastrointestinal hemorrhage in the intensive care unit. We have seen other specialties such as plastic surgery walk away from our hospitals, resulting in on-call coverage difficulties. It will be a setback.

The issue with gastroenterology is that one needs a highly skilled and experienced group doing hospital work frequently enough in order to maintain their skill and judgment. A private clinic physician who does irregular hospital work would not be able to offer the same clinical and endoscopic expertise. This could compromise patient outcomes. GI care requires a pool of highly skilled on-call endoscopy nursing staff. Will we have enough to cover both hospitals if our endoscopy units are downsized?

Lastly, the hospital environment is an intellectually and technically dynamic environment that is the product of a varied and large patient population and the interaction between a large number of gastroenterologists, endoscopy nurses, pathologists, radiologists and surgeons. It is this hospital endoscopy environment that has advanced patient care for residents of our region. Moving much of hospital-based endoscopy to off-site private clinics would substantially weaken the heart and soul of the region's gastroenterology care.

It's all too easy for our Minister of Health to stand in front of a private eye clinic in Toronto and state how wonderful private clinics are. I would ask her to come to Waterloo region to see the outstanding endoscopy units

at Grand River and St. Mary's, so that she has a better understanding of the model of comprehensive care that we provide to community members. Though she'll have to pay for parking to visit them, she'll find that our units are focused on optimizing patient outcomes and that we value quality of care above quantity of care. Is that not what she would want for herself?

Our LHIN should maintain the current level of high-quality endoscopy services at Grand River and St. Mary's General Hospital. Our community and hospitals depend on them. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have just four minutes left, so the official opposition has the questions.

Mrs. Christine Elliott: Good morning, Dr. Golubov. Thank you very much for coming to present to the committee this morning.

You've raised some significant concerns with respect to endoscopy procedures and where they should be located. For the purposes of this committee, it would be helpful to know if you've raised these concerns through your LHIN to get to the Ministry of Health. How have you approached it? Has it only been directly with the ministry? What role, if any, has your local LHIN played?

Dr. Jordan Golubov: Well, it's a new process. I've met with the CEO. Both hospitals are very concerned about what could happen to GI call. They've had real issues in the past.

We're actually a pretty critical service. If you look back 20 years at the kind of care people were getting, it was not very good. So, the community here sort of doesn't—you know, I think they can appreciate now what we do. But if you look at the potential for fragmentation and piecemeal care—this is the first forum in which I have presented it publicly, but we have met with our chief of staff and CEO of Grand River.

Mrs. Christine Elliott: At this point, you haven't had any contact with the LHIN to advance the cause?

Dr. Jordan Golubov: No.

Mrs. Christine Elliott: That might be helpful. I would suggest—

Dr. Jordan Golubov: Yes, we will. They're very well aware of what this means.

Mrs. Christine Elliott: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated, and we look forward—

Ms. Catherine Fife: Is there any time left?

The Chair (Mr. Ernie Hardeman): No. There was less than four to start with, so there was only one questioner.

Thank you very much for your presentation. We very much appreciate it.

REGION OF WATERLOO

The Chair (Mr. Ernie Hardeman): Our next presenter is the region of Waterloo: Chair Ken Seiling. Mr. Seiling, welcome.

Thank you very much for being here, Ken. As with other delegations, you have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If you don't, if you leave more than four minutes, we will divide that time equally among the three caucuses. If you leave four minutes or less, it will go to one caucus. The floor is yours.

Mr. Ken Seiling: I propose to be very short so you can catch up on your scheduling. You don't need to use all the time, because I just have two or three points that I want to make in the presentation.

As you know, I'm the chair of Waterloo region. We've had significant contact with the LHIN over the years, whether it be through our public health unit, through social services, the CMSM for housing, long-term care, Sunnyside Home—a whole range of things. So we have ongoing contact with the LHIN and quite a bit of experience with it.

I just want to come today to speak very briefly to the topic of LHINs. There has obviously been a lot of discussion on whether LHINs should exist or not exist, whether they should be changed, and uncertainty around the future of the LHINs. I just wanted to come here to express and voice my support for the continuance of the LHINs as a planning tool and a functioning tool within the municipality and around us here.

I really do not like the idea of moving back to a centralized, bureaucratic approach to the provision of health care within the communities, setting things up in Toronto. When they first started up, there were some questions about start-up and how they operate, but I think the last few years have seen quite a bit of success here. I would say that in our own LHIN, the last two or three years have been a model—quite a bit of success. That's not to say that some fine-tuning can't take place, but I just want to be here to voice my support for their continuance because I think their closeness to and their knowledge of the local scene allows them to do a lot of rational planning for the system that reflects local needs and local interests. I would hate to lose that. I think that has been very successful here.

It has been very successful on a number of fronts. One of the examples here I'll give is the work done on seniors and keeping people in their homes, providing care for seniors. The coordination of that work for the last two or three years has been exceptional here. We're seeing a great deal of that, working with grassroots organizations.

One of the things the LHINs have the ability to do is to have knowledge of what happens at the grassroots in communities and an ability to work with organizations and grassroots organizations to build a better system for people locally that responds to people locally. My concern is that if we take that away from the local planning function, we'll lose that ability to work with grassroots.

One of the models we've had here, particularly in this region—a long history, particularly in social services but also in the health field—has been the success of the grassroots delivery of services or a consolidation of some of those to provide better services. I think the LHIN has

done quite a good job of pulling some of those things together. You heard some of that earlier. When I walked in, I think I was hearing some evidence of what has been going on in that particular field. I would hate to see the loss of that.

I think centralized planning would see a cookie-cutter approach that's not reflective of what goes in local communities, so I would say that has been a success.

One of the issues that we have identified is that we think that the whole question of the determinants of health needs to be broadened within the scope of the LHIN and the ability of the LHIN to work within areas, because the determinants of health are not just simply medical determinants. They're issues of poverty; they're issues of housing, supportive housing, employment, community supports—all those sorts of things. Sometimes there's a role for the LHINs to be more active in trying to pull some of those things together.

A good example of that is the whole question of supportive housing. I don't think there's a community in Ontario that doesn't have a dearth of supportive housing. That's a major issue. Yet trying to pull together those projects has been problematic over the years because we have the Ministry of Health doing part of the funding; we have the Ministry of Community and Social Services doing some funding; we have the Ministry of Municipal Affairs and Housing doing some funding; and then community groups trying to pull us all together. Somehow there needs to be some mechanism to pull some of this together—and whether there's a better role for the LHINs in helping to coordinate and breaking down some of those provincial silos that get in the way of building some of this housing.

You might want to turn your minds to how the provincial silos could be weakened somewhat through the provincial framework here. I just raise that as an example of where I think—if you're looking at legislation and what the legislation allows the LHINs to do and not to do, and other ministries—you might want to turn your minds to doing that.

I think that covers off a lot of what I wanted to say. I just wanted to come here and speak generally in support of the concept of the LHINs and their importance to community and community-based planning for health care, and say that I hope that whatever you do strengthens their role and not weakens it.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about 11 minutes left.

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Mr. Ken Seiling: You don't need to use it. You can pass it and catch up.

The Chair (Mr. Ernie Hardeman): It starts with the official opposition.

Mrs. Christine Elliott: Thank you very much for your presentation and your comments today. We have heard from other groups—I think the RNAO also recommended that we have some way of bringing in the determinants of health, more broadly speaking. Have you

thought a little bit more about exactly how that could be brought in, and what kind of a role the LHINs could play in coordinating that for each community?

Mr. Ken Seiling: Well, I think my reference to supportive housing, for example, is a good example where, if the LHIN's mandate was a bit broader, it would allow it to—I'm not sure what the vehicle is to try to coordinate ministries and the funding of ministries, but if they had a role in being able to pull some of these projects together more easily—because quite often what we have is that the LHIN may have funding for some supportive housing but the Ministry of Housing doesn't at that particular point in time. There are a lot of hoops to jump through in some way.

We try to broker those roles at the region, because we have the mandate for housing here, so we're trying to get this group here and this group here, pull them all together and pull the money together at the same time. Somehow, if the LHIN had the ability to perhaps be the quarterback for the provincial side of it in terms of a supportive housing project, maybe that would be helpful.

I really haven't thought it through, but we just know that there's a problem there that needs to be addressed.

Mrs. Christine Elliott: Well, I quite agree with your comment about the government silos, as well. We're experiencing that right now with the Select Committee on Developmental Services, where there are a number of provincial ministries that are involved but they don't necessarily communicate with each other. I think that there are things that need to be changed in government and the way government operates, as well as the way the LHINs operate.

Mr. Ken Seiling: All of our governments have that issue. We work very hard, even at our level, to try to keep silos reduced as much as possible.

Mrs. Christine Elliott: Thank you for your comments.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Fife?

Ms. Catherine Fife: Thank you very much, Chair Seiling, for coming and for raising the issue of the social determinants of health. You're quite right: There does need to be a renewed focus on those factors and how they impact health.

The housing is interesting. This committee is going around the province. We're looking for ways to improve, and you mentioned fine-tuning the LHIN model as it stands because there are great inconsistencies across the province with regard to the LHIN model. Can you identify any particular area around duplication of services that you see that we could bring back as a recommendation from this committee? We are trying to get those admin costs back to the front line. That's a shared goal, I think, of this committee.

Mr. Ken Seiling: Well, I'm always a great proponent of rationalizing services, given my role, and I think that one of the things that the LHIN can do, because it has local—it's always a delicate balance when you're dealing with community groups, because community groups do a

lot of volunteer work. They raise a lot of money, they provide a lot of resources and they have contacts that they have, so it's always a delicate balance of trying to rationalize a lot of community groups doing a service versus keeping them functioning, because if you take away their raison d'être, sometimes they disappear.

It's always a bit of a balancing act there, and that's why I think the LHINs are well positioned to be able to do that sort of thing. They have a feel for the community. They're not somebody from 50 miles away saying, "Well, there can only be one group doing this sort of thing instead of three groups."

What the LHIN has done here locally, I think, in some of the seniors' programs—where they haven't been able to necessarily say, "There's going to be one group," what they've done is they've said, "One agency will be the lead agency coordinating that work." For example, in the region, one of the seniors' services is the lead agency in dealing with some of the seniors' services, in an effort to try to coax the best out of the system and avoid some of the duplication that takes place.

As I say, I think it's a delicate balance. We can't do away with all of the grassroots groups, but at the same time I think there needs to be a good examination, a very healthy examination, of what duplication can be removed from the system without destroying the system itself.

Ms. Catherine Fife: Okay. But no specific suggestions from you? Because it's a delicate balance, you know.

Mr. Ken Seiling: That's right. It is.

Ms. Catherine Fife: Okay. Thank you.

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

Ms. Helena Jaczek: Thank you, Chair Seiling. We have heard a number of recommendations from deputants that directly affect municipalities. I will share with you what those are, and I'd like your reaction. I'm a former medical officer of health for York region, so some of these were a bit surprising to me.

One was the structural integration of public health units within LHINs—no commentary related to the municipal funding contribution to public health. The other was a recommendation that EMS be integrated into the responsibility of the LHIN. And there was another suggestion that perhaps a municipal member of a council, presumably one, representing the entire LHIN, might be an improvement—to have a fixed position on the board of the LHIN that was a municipal councillor. I'd just like your reaction to those three suggestions.

Mr. Ken Seiling: Well, you're speaking to somebody who's a firm believer that public health units should be integrated in the municipal structure because of the holistic approach. If you separate the health units out, they become—for municipalities, outside bodies become an outside body, whereas we've never fought with our public health. We fund it properly. We have interactions between public health and engineering, for example, water and sewage, and EMS. All of those are integrated together, so we act as a unit. We've broken down those silos instead of setting up bodies. So I would be opposed

to taking the public health units out of our municipal framework.

For example, we talk about determinants of health. Our social service department works very closely with the public health department, because we have a broader view of determinants of health and how they can work together to do those sorts of things. So I would be very much opposed to pulling those functions out and setting them up outside, because then they'd be competitors as opposed to partners in the whole thing.

In terms of putting people from municipal councils on the bodies, that's one I'm not particularly hung up on, one way or the other. I trust the government to make the appointments—and they're community-reflective appointments. I think then you get into a competition, particularly with the LHINs, with their broad areas, about who has which representation and how many numbers there are.

I think the efforts should be put into good health.

Mr. Mike Colle: Every municipality in the region would want a member.

Mr. Ken Seiling: That's right.

Ms. Helena Jaczek: And EMS?

Mr. Ken Seiling: I think EMS belongs in the framework too, because we work with our police services. They have all the supports that are necessary to do those sorts of things. I don't see any value in pulling them out.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, Ken.

Mr. Ken Seiling: Thank you, Ernie.

MS. STELLA LEVEAN

MR. JEREMIAH STUZKA

MS. LIA STUZKA-SARAFIAN

The Chair (Mr. Ernie Hardeman): Our next presenters are Stella Levean, Jeremiah Stuzka and Lia Stuzka-Sarafian. Thank goodness that my pronunciation isn't always right but the Hansard will record it perfectly.

Thank you very much for you folks being here this morning. We very much appreciate it. As with other presenters, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If you have less than four minutes left, in this case, it will go to the New Democratic Party. If it's more than four minutes, we will divide it equally among the three caucuses. With that, the floor is yours.

Ms. Lia Stuzka-Sarafian: Thank you. My name is Lia Stuzka-Sarafian, just to correct that.

I'm speaking on behalf of my husband, who passed away. Excuse me. His name is Mike—

Ms. Stella Levean: I'll continue with it. These are complaints from the Trinity nursing home hearing.

Mike had heart bypass surgery on October 6, 2010, at St. Mary's hospital. From here, he was released to Freeport, Grand River Terrace, for rehabilitation in November 2010, where he remained until February 1, 2011.

He went home on February 11, 2011, and was living a somewhat normal life until October 23, 2012, when he had a heart attack, with congestive heart failure, and went back to St. Mary's hospital. He was released on November 12, 2012.

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Shortly after returning home, it was determined that, due to poor circulation and an infection in his toe that turned to gangrene, he would also need his leg amputated. Before this surgery, he also suffered a round of gout, delaying the procedure. Surgery took place on November 23, 2012, at Guelph General.

He was then released to Freeport, Union Terrace, for rehabilitation on December 5, 2012—prematurely, as his leg was swelled up like a balloon and he was still very sick. He ended up back at St. Mary's hospital on January 13, 2013, for two days for cellulitis and pneumonia. This proves again that he was released too soon to begin the rehabilitation process, as his body was not in a healthy state indicative for success. He remained in their rehabilitation program until March 11, 2013, when he was transferred to Trinity nursing home.

Mike's physiotherapy at Freeport Union Terrace was inconsistent at best, with the various trips to St. Mary's and the additional blood transfusions required to maintain his white blood cell count. He eventually was making progress, although it was slow.

He was able to transfer from the bed to the wheelchair with a sliding board with assistance; stand from the wheelchair—on January 9, 2013, he achieved this; stand on one leg for 45 seconds, on February 19, 2013; stand on one leg holding onto a rail for 1.5 minutes, in mid-March; transfer in and out of a car with help—he did this on several occasions to go out with Lia.

However, after about six to eight weeks of rehabilitation, around January 25, Freeport Union Terrace decided that Mike was no longer making any improvement and he would need to start looking for long-term care. Although Mike's weight was always a concern for his success, it was brought to the family's attention that it was due to his weight that he was unable to continue at Freeport Union Terrace.

Concerns of the family at this time were: Why was Mike not given an extension for his rehabilitation program at Freeport Union Terrace, given his rough start and continued need for hospital care at the beginning of his stay? Why is being overweight a criterion for discontinuing said rehabilitation?

His weight was an issue and he was told that he would need to lose about 60 pounds to be able to progress any further. Even though all his caretakers knew that Mike needed to lose weight, it was not until January 28, 2013, two months after being at Freeport Union Terrace, that the nutritionist finally spoke to Mike about his dietary needs, to reduce his dietary intake from 1,500 calories to 1,200 calories a day. Even though he was receiving a complete diabetic diet, his calorie intake was not being monitored.

It was discussed with Mike's health care team that Mike's goal was always to come home, and if he was

sent to a long-term-care facility, it would only be temporary, until he was able to successfully transfer and get home. On February 3, 2013, he was told that he was nowhere ready to go home yet, so he should go to a nursing home until he was ready.

These are the concerns of the family about this statement: Why send him to a nursing home if it is nowhere near equipped for the type of rehabilitation Mike required? If he wasn't successful at Freeport Union Terrace, how would it ever be possible for him to be successful at Trinity nursing home?

It was clear that Mike was set up to fail before he was even there. It is at this point of Mike's case where the structure of the hospital system and the policies of the Freeport Union Terrace rehabilitation program threatened to halt the success of Mike's rehabilitation.

After the transfer to Trinity nursing home on March 11, 2013, Mike's progress started to deteriorate. The following complaints are made against Trinity nursing home: the diet plan, the rehabilitation, and the health care.

The diet plan: For Mike to keep his weight under control, it would be essential for him to remain on a strict diabetic diet. At Freeport Union Terrace, this was set up automatically for him. However, at Trinity nursing home, things were very much different. He was given an option of two different meals at each meal time: one was sometimes a healthy option; the other, not so healthy, especially when it came to desserts.

When he chose which meal he preferred, the cooks would then cut the portion in half, thinking it would be sufficient as a diabetic portion. This is not the way to determine a diabetic portion, as no calories, no carbohydrates or sodium amounts were ever taken into consideration. Any certified nutritionist would concur with this fact.

Mike tried his best to select the healthiest option for himself but was often given two poor choices, neither one beneficial to his dietary requirements. Often, meals were too salty or overcooked, thus being too hard to eat, or had no flavour. Some examples of the foods he was given are Campbell's soup, original style, not low-sodium; salmon, overcooked and too hard to eat; roast beef, overcooked and too hard to eat; cheese cannelloni, too salty; Oktoberfest sausage on a bun, too salty and high in fat; and burgers and some fish, undercooked.

In addition, Mike was also not supposed to eat potatoes due to the high level of potassium. However, many of Mike's meals included potatoes even after Lia provided TNH with a list of foods he was permitted to eat which she received from St. Mary's hospital. A copy of this list is available upon request. Mike was given peanut butter and jam sandwiches as a substitute instead of brown rice.

It is without question that Mike was often not satisfied with his meal choices, which forced the family to bring things in to Trinity for him. In the summer of 2013, fresh vegetables were being cut up for him and replenished on a weekly basis. His wife, Lia, brought in several

replacement meals for him for alternative dinner options. A special roast beef was in the freezer for Mike to be used as a meal alternative.

After a few weeks, both these ideas fell through as it became too much of a hassle for the cooks to remember to give Mike his vegetables from the fridge or for him to get them himself. Although the nutritionist knew about the roast beef, the servers would often forget that his roast was there, and when they did, it was often overcooked and too hard to eat.

Many discussions were had between Lia, Mike and the nutritionist, and they did go through a meal plan to determine what Mike did and did not like from their meals list. Although this helped somewhat, it still did not assist with the diabetic aspect required for his diet.

During his time at Trinity, Mike was admitted to St. Mary's hospital two times, in July 2013 and December 2013, for congestive heart failure. In July, Mike and Lia were told by the nurses and doctors at St. Mary's that if his diet was not under control, it would kill him. However, nothing ever changed when he returned to Trinity.

It was in the month of November that Lia and Mike, beyond frustration and noticing the deteriorating health effects associated with his diet, determined to order food for him from an outside company named Copper County Foods. This ordering started on December 2, 2013, and ended on December 9, when Mike died. The family feels that it was the lack of his dietary needs taken care of by Trinity—no diabetic diet, no consideration of sodium levels in the food and not checking for his fluid intake—that caused him to be sent to the hospital on both occasions, which did end in his death.

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The transition process for Mike's rehabilitation from Freeport hospital to Trinity home also demonstrates how the system breaks down and inhibits Mike's full recovery. Mike was sent to Trinity nursing home on March 11, 2013. It took them over a month before he was set up with his first rehabilitation session. This 30-plus-day delay did not assist in his progress but in fact put him in a relapse state. When he finally began his sessions on April 15, 2013, he was not able to start off where he had left off at Freeport Union Terrace because he had to start back at the beginning. He mentioned several times that he had lost all the strength in his arms and could not even do any lifting up from his wheelchair.

Worse than that, Trinity nursing home only offered basic daily muscle movement to prevent patients from losing muscle mass and becoming atrophic. They gave him two-pound weights that did nothing to help Mike improve his strength. He needed to be able to lift his whole body up from his wheelchair. This program was not going to get him able to do that.

Trinity nursing home also did not have the physiotherapy equipment that he needed to practise the transfers as he did in Freeport. This is another reason why he should have remained at Freeport Union Terrace. To try and increase his rehabilitation efforts, he was put on a

waiting list to start back at Freeport Union Terrace as an outpatient two times a week.

The concerns of the family about this transition from Union Terrace to Trinity were:

—Why was there such a long delay in getting him started on rehabilitation after he moved into Trinity nursing home?

—Why did he need to be put on a waiting list for rehab at Freeport Union Terrace as an outpatient? This should have been set up and organized before he was transferred over so there would be no delays in his program.

—Knowing he was not going to get what he needed at Trinity, steps were also taken to sign up for rehab programs at St. Mary's hospital, which he attended after his heart biopsy. He too was on a waiting list here, and was eventually told he did not qualify for the program.

—His rehabilitation program as an outpatient at Freeport finally did resume in May 2013 until July 2013, and September until November 2013.

Why was his rehabilitation program ended when he again was not able to go home? This is where he should have received numerous repeats until he was ready to go home. The doctor knew at Trinity that Mike had congestive heart failure, diabetes and the beginning of kidney failure, yet the progress of the symptoms of serious kidney failure were not noticed by anyone or discussed with the patient or the family.

On November 10, 2013, Mike was not feeling well. He was shaking so much that he dropped the phone three times in a five-minute span when his daughter Tina tried to call him. She called the nurses' station to see what was wrong with him, and as this was a very unusual behaviour, she was told by the nurse that she would check his vitals and call her back. She did, and said that all his vitals were fine and suggested that he was very tired because he hadn't been getting much sleep. Something was obviously wrong at this time, but it was uncertain what the reason was. In retrospect, it was quite likely that his kidneys were starting to fail more rapidly, but nothing was followed up on this with his kidney specialist. In fact, I am learning just now that he hadn't seen his kidney specialist since the beginning of the year. Why would he have not followed Mike on a regular basis to monitor his kidneys?

When Mike had his cataracts removed on November 14, 2013, Mike was feeling very nauseated and was given Gravol. However, upon reading all the symptoms of kidney failure after the fact, it turned out that Mike was experiencing severe symptoms of kidney failure at this time. It was nausea, fatigue, shortness of breath and itchy skin. I'm not sure what his blood results were to see the protein level, but my guess is that they were off.

He was admitted to St. Mary's hospital on Thursday, December 5, and lost consciousness on Friday, December 6. He died on the ninth due to kidney failure.

The many questions from the family are below:

—Why was Mike dismissed from Freeport Union Terrace in the first place when he was not successfully rehabilitated to go home?

—If only so many days and weeks are allotted per person in Freeport Union Terrace, why was he sent to a long-term-care facility which could not provide him with the necessary rehabilitation to get him home?

—Why did the doctors and nurses at Trinity nursing home treat him as a regular resident who would be remaining at Trinity nursing home, instead of trying to assist him in getting back home with the type of care he needed to do so?

—What can be improved in the system so that this doesn't happen to anyone else?

—Why are diabetic needs not considered vital needs inside nursing homes? Why is it not mandatory and not voluntary?

The Chair (Mr. Ernie Hardeman): Thank you very much for that heartfelt presentation. I wish the committee was able to answer those whys at the end of it, but our review is on the big picture. But I commend you for making the effort to be here today to bring that forward, so thank you very much for your presentation.

Mr. Jeremiah Stuzka: If I can just take 10 seconds really quick: One thing that was brought up by me with many of the health practitioners that were working with Mike was the idea of his mental care. Anybody who has poor thinking abilities is going to make poor choices. If his thinking isn't put into perspective, on his own he's not going to do anything. You guys never—I'm sorry that I just wasn't better prepared. I think the point's been made.

The Chair (Mr. Ernie Hardeman): I appreciate that, but we do have to keep everybody on the 15-minute limit. We do, as I say, appreciate the time you have taken to bring that forward.

HOME OF THEIR OWN

The Chair (Mr. Ernie Hardeman): Our next presentation is Home of Their Own: Moira Hollingsworth, Deborah Pfeiffer and Sue Simpson. Good morning, and thank you very much for coming in. We appreciate that. You will have 15 minutes to make your presentation. You can use any or all of your time. If you leave time less than four minutes, it will go to the third party for comments and questions. If you have more than four minutes, we'll divide it equally among the three parties.

With that, thank you again, and we look forward to your presentation.

Ms. Sue Simpson: Thank you. Members of the standing committee: Good morning, and thank you for the opportunity to speak to you today. My name is Sue Simpson, and I'm here this morning with two other mothers, Deb Pfeiffer and Moira Hollingsworth, to share our story.

We are three families with adult sons with developmental disabilities living at home. We came together five years ago to discuss concerns about their future housing needs, which will become critical as we, their primary caregivers, age and can no longer care for them at home.

In April 2011, we purchased a home for our boys in Waterloo, and our goal is to secure funding to allow them

to live there full time. Currently, with support from Elmira and District Association for Community Living, they spend one respite weekend there per month.

In the 2006 ministry document Opportunities and Action: Transforming Supports in Ontario for People Who Have a Developmental Disability, the Ministry of Community and Social Services acknowledged the need to encourage families to work collaboratively with service providers, the community and other families to create innovative alternatives for residential support. It cited examples of models that included joint family creation and ownership of housing and pooling of family resources in conjunction with MCSS dollars to create homes in the community for their family members.

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So that's exactly what we did. We came together with each other and a service provider and created an appropriate housing option for our vulnerable sons, all of whom have very high needs. We are still waiting for funding.

We are aware of many other families who are concerned about the lack of suitable, person-centred residential opportunities in our community. There were a large number on the former developmental services access centre waiting list for residential services who are now registered through Developmental Services Ontario as interested in and requiring residential services. This list continues to grow, with no apparent ministry plan or strategy to address it. Money has stopped flowing to agencies for the creation of more group homes, but families cannot obtain funding for other creative options.

We do acknowledge and appreciate the positive steps taken by the ministry in recent years to give families more choices in day supports with the creation of the Passport Program for adults with developmental disabilities. There is also potential use of the federal Registered Disability Savings Plan for their future financial needs.

I also came here today with my son and his support worker, Aaron. My son is Kevin, and Aaron is his support worker there at the back of the room. Kevin is 24 years old. He lives with my husband, Mike, and me in Kitchener. We recently had to sell our family home of 20 years in Waterloo to address our accumulated debt related to Kevin's profound needs. We unfortunately had to choose between a future home for our son and the home that our children grew up in, as we could no longer maintain both. We believe so strongly in the home that we have created for Kevin, and we now have to rent a family home.

Kevin has cerebral palsy, profound developmental delay, epilepsy and chronic asthma that can result in mucous plugs and respiratory distress if not carefully managed. He is referred to as being medically fragile and technologically dependent. Kevin has an open stoma, which requires cleaning and monitoring. He is non-verbal and uses a photo schedule for receptive communication and a voice output device and body gestures for expressive communication.

When Kevin finished high school at the age of 21, despite his significant needs he was put on a waiting list

for Passport funding for a year. We paid out of our own pocket for the necessary one-on-one support needed five days per week for that full year. Existing day programs were not suitable for Kevin, due to his need for one-on-one support and the inability to meet his physical activity needs in order to maintain good health. Existing respite programs were not appropriate either. His medical needs were too high for one, and he was too mobile for the other.

Kevin enjoys life and participates in various community opportunities to fill his days with meaningful activity. He is generally a happy, active individual with an engaging smile and laugh. Kevin is always out and about in our community. In fact, some of you may have seen him swimming, listening to music, going to the library, skating, sledding, bowling, playing blastball and basketball, or attending sports and music events.

Kevin, like all members of our community, has the right to be treated with dignity and respect and to have choices. As caregivers of adults with developmental disabilities, we feel it is essential to make sure that our adult children live in a safe, happy and secure environment. We cannot rest as parents until this goal is accomplished. Our supports intensity assessments are supposed to be tied to the levels of support that indicate funding equivalents of \$80,000 to \$90,000 per individual per year, if we look at precedents set historically for the creation of group homes.

We are asking that the ministry fulfil its commitment, as promised in 2006.

Ms. Deborah Pfeiffer: Good morning. My name is Deborah Pfeiffer. My son, Hayden, is 20 years old, and it seems like just yesterday I was walking him to JK. He will graduate high school this June, and at that time, his father and I will be responsible for developing a program for him, as there are no suitable programs available for him.

He also requires one-to-one support. Those support dollars will be paid for out of pocket by us at roughly a cost of \$450 per week. In a year, it is over \$22,000 that we will need to come up with on an annual basis, along with the additional costs of maintaining Hayden's home, which does not include operating dollars.

We, like many families, struggle with what will become of our children when we are no longer able to care for them. Our sons are growing up and we are aging, with no answers in sight. I don't want to be in my senior years still struggling with where and with whom Hayden will live. I need to know that his good life will continue long after I am gone.

We, as families, are willing to do our part, but we need the support of operating dollars in order to make this happen.

Ms. Moira Hollingsworth: Good morning. My name is Moira Hollingsworth, and I'm here today with my 30-year-old son, Ian, who is sitting in the back there with his support worker. As with Kevin and Hayden, Ian is non-verbal and requires 24/7 support. His primary diagnosis is autism, and he also has epilepsy.

Like Kevin, who is also here, Ian has some funding, which partially covers the day supports that we have in place for him. We supplement this to make sure he's as active and stimulated as possible.

My husband, Roger, and I are now in our 60s and feel more urgency now that we must have a safe, secure home for Ian before we are unable to take care of him ourselves. In fact, we feel we cannot retire until we have this in place.

Ian has been on the developmental services access waiting list for 22 years. In that time, he was never offered any kind of residential placement, because that list really only serves those families who are in immediate crisis. We always wanted for Ian something that we chose for him, with people he was compatible with.

In the last five years, we've worked very closely with the executive director of Elmira District Community Living, Mr. Greg Bechard. I've attached in the notes his own submission on our behalf about our group, which is called HOTO, to the developmental services committee.

I just want to reiterate what Sue mentioned earlier, that in the legislation of 2006, it was certainly implied that the ministry was no longer in the group home business and that we, as families, should collaborate with each other and be creative to come up with something of our own, and this is what we've done. We've purchased a home. We've each put in \$52,000 in the last few years. But because of the high needs of our sons, we do need those support dollars as well. There are major health issues involved here, as well as the developmental delays.

We would hope that this committee would make recommendations to the Legislature that there needs to be some process by which we can obtain the type of funding we need.

We would be happy to answer any questions you might have today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about seven minutes. We're going to start with the third party. Ms. Fife?

Ms. Catherine Fife: Thank you very much, Deb, Moira and Sue, for coming forward and sharing your story. So, essentially, you want this committee to make the government do what they said they were going to do back in 2006. Is that right?

Ms. Deborah Pfeiffer: That's correct.

Ms. Catherine Fife: The \$52,000 that you've each invested to create a group home for your children: How is this sustainable? Many people in the province can't do it. I know, Sue, that you've actually had to sell your own home. Can you tell the committee a little bit more about the personal and financial sacrifices that you've made to follow through on this plan from 2006?

Ms. Sue Simpson: Sure. As I did say previously, we did have to sell our home. It was a very difficult decision. It was another move for Kevin that's very difficult, but we were not able to continue to pay for the new home that we're creating with the other families, and it was an essential decision that we had to make. It was extremely difficult and heartbreaking, but we believe very strongly

in the opportunities that we're trying to create with these other families, and it was worth that sacrifice.

Ms. Catherine Fife: A quick follow-up: If the operating dollars don't come from the government, as was promised, what will happen, then, to your children? What is the future for them?

Ms. Sue Simpson: We don't really know. The expectation from the ministry is that they will live with us. They can't live with us. Their needs are so significant, and having to monitor them 24/7 is just not possible to do, especially as we're aging. My husband was very ill two years ago and almost passed away, so that brought things to a real head for us, to realize that this is the reality of our situation.

Ms. Moira Hollingsworth: In our case, too, my husband turned 65 this year. We just can't sustain this forever, and we don't want to be in a position where we are unable to make the right decisions for him. We have to do something now to make sure that our son's needs are looked after while we are capable and able to do that. Time is running out.

Ms. Catherine Fife: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mrs. Cansfield?

Mrs. Donna H. Cansfield: Thank you for your presentation. I think you identified a number of areas where we actually need to do some significant work.

First of all, I want to say thank you, as well, for taking the initiative around purchasing a home, finding a place for your children, and looking to their future. That's a hard decision to make as parents, but kudos to you for having done that. Now the situation becomes: How do we manage that with you? I think we do have a role to play in that.

I think you also identify something that's really critical. I've been in this for 26 years, and for 26 years it's the same problem: What happens when they're 21? They fall into this chasm until they're 22 or 23, but that one year is really, really difficult. We still haven't managed.

That's one. The other one I think you identified is that we have three different ages for these young people—16, 18 and 21—depending on which ministry you're in, which also creates an enormous issue around accessing programs and funding.

Again, I think what you've done is raise a significant issue. I believe that Mrs. Elliott probably has more that she'd be able to share with you, because she's on a panel looking at this. Unfortunately, our mandate restricts us just to the LHIN capacity. Maybe that's a discussion or a place you should go.

The Chair (Mr. Ernie Hardeman): We'll now go to Mrs. Elliott.

Mrs. Christine Elliott: Thank you for coming to present to us today. As Mrs. Cansfield has indicated, we're not able to really deal with that specific issue because we're dealing with the LHIN review right now, but we do have a select committee that has been established at the Legislature to look at developing a compre-

hensive developmental services strategy. I'm pleased to be the Vice-Chair of that committee.

1030

Sadly, I have to say that what you're telling us is happening across the province. We are in crisis right now. We are not serving you or your children well at all. We've heard about the problems with a lack of respite; it sounds like you've had a little bit of respite help, but in many places across the province there isn't any respite.

There are no opportunities for young people after they turn 21; it's like they fall off the edge of a cliff. There are no day programs or employment opportunities, and of course housing is the biggest issue of all. We've heard from families who've had to drop their children off at developmental services offices because they've not been able to care for their needs. We know that even though you can qualify for Passport funding, the reality is that there isn't any money there, so it really doesn't serve any purpose.

All I can tell you is that this is something that a number of us around all three parties feel very strongly about. We are taking this very seriously, and we are going to be writing a report that is going to advocate for major change in the system. We've just concluded our public hearings, and we are going to be completing an interim report by the end of February that will basically summarize what we've heard so far. Our final report will be coming out in May, and we will be speaking to the very issues that you've been discussing.

I really applaud you for the innovative, proactive approach that you're taking to finding a place for your children. We need to give you the support that you need to make that dream come true for them. I'd love to hear more about it, so perhaps we can chat offline. Thank you very much.

Ms. Moira Hollingsworth: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you for your great presentation. We very much appreciate you making the effort to come here and talk to us even though this wasn't the committee that's going to be able to solve your problems. At least you're getting the word out there that there are problems there.

Ms. Sue Simpson: That's right. Our goal is to increase the awareness. Thank you.

MS. DENISE JENNINGS

The Chair (Mr. Ernie Hardeman): Our next presenter is Denise Jennings. Thank you very much for coming in this morning. Like all the others, you will get 15 minutes to make your presentation. You can use any or all of that time for your presentation, and if there's less than four minutes left over at the end, that will go to one caucus; if there's more than four minutes, we'll divide it equally among all the caucuses. With that, the floor is yours.

Ms. Denise Jennings: Thank you. Good morning. I'm Denise Jennings, and this is my husband, Dwayne. We're here talking as parents today. We have concerns about the youth mental health system.

My husband and I journeyed through the labyrinth of the youth mental health system with my son from the time he was 11 until he was 18. In our estimation, the youth mental health system in this region has a number of huge cracks ready-made for youth to fall through, and we know all too well the tragedy that can ensue. I think our experience reflects all the good, the bad and the ugly that the system has to offer, and I'm hoping that in sharing our story with you today, it may spark some resolve for improvements.

I'll leave you to read the grim statistics about youth mental health. I think the most striking one is that it's the number one cause of non-accidental death for Canadian youth. Despite the enormity of that problem, there's little help. Only one in four kids will get the help that they need, and the wait is very, very long. This may have something to do with the fact that funding for children's mental health amounts to only 1% of the total health care budget.

Sadly, our beautiful boy became a statistic. This is our son Iain in the early days, before he became ill. Our son was a gentle soul. He had lots of fun and lots of friends, and he was loved by many people. He did have a number of mental illnesses, though, that were linked together and that increased in severity as he got older.

He had an illness. He didn't have a mental health issue. I can't stand the term "mental health issue" because I think it's really too soft a term for the hell that these youth go through. "Mental health issues" suggests that something can easily be done to overcome them—a few little programs, a couple of parenting sessions, perhaps, or just better parenting in general. Certainly, issues don't get as much funding as serious illnesses such as cancer or cystic fibrosis.

What my son had and what many other children suffer from are brain-based neurological disorders, which, when left untreated, can cause high rates of lifelong disability and can result in death. Treating mental illness requires a combination of research, proper medications, expert team interventions and skill development directly with the kids who suffer.

I'll leave you to look at this slide. It's from the World Health Organization and it really just reflects the magnitude of life-long disability caused by mental illness.

As I mentioned before, there has been the good, the bad and the ugly in our journey with Iain. From age 11, we knew that he needed help but we were hard pressed to find it. We did finally see the good, but it arrived much too late, after five years of trying to get help through the Ministry of Children and Youth Services.

The good came from LHIN-funded services, in fact—services that were funded under the Ministry of Health and Long-Term Care. LHIN-funded services were only accessible, though, at the end, when my son was 16 and was very ill. He had become psychotic and delusional. He thought he was being followed and filmed. He non-violently—I'll stress "non-violently"—approached someone whom he had incorporated into his delusional system, and he was charged with harassment. The police

realized he was mentally ill and they took him to hospital, but unfortunately, after being in hospital for a while, his next stop was jail because secure treatment units were unavailable.

Iain did receive expert assessment and care at Grand River Hospital in the child and adolescent unit. They knew he was lacking in judgment and they knew that parents needed to be appointed as substitute decision-makers at that time. This unit then referred Iain on to the best service that we experienced, and that was the first psychosis early intervention program. I wish Iain could have been involved in a service like this much earlier. I think it would have made a world of difference.

1040

Again, this is a LHIN-funded service. This service was excellent on a number of fronts. It was one-stop shopping; it was a well-integrated service package. It was treating illness, not an issue. The team had expertise in psychosis. They used evidence-based treatments. There was psychiatry consultation. There were intervention programs directly for youth. I think the most important thing is that they used an assertive outreach. That team realized that they were treating a serious illness, that the consequences of leaving a kid to languish as ill were serious, and they did not give up easily. They were at our house come rain or shine. They came in hospital, they came in jail and they kept in touch with Iain. But really, it was too little, too late.

The bad: The bad is that youth mental health is one confusing system. There are no guides and there are a lot of hard stops along the way. We lived in this labyrinth for five years, and what follows are some of the biggest frustrations that we experienced. Our son had an illness as serious as childhood cancer, as serious as cystic fibrosis, but services fell under the Ministry of Children and Youth Services. You can see from this ministry's mandate that it's broad, diffuse and mixed. The focus is on solving social issues, not on treating mental illness. Accordingly, after a very long wait, the only help provided was education and parenting support. There was no direct treatment for Iain, and I really think earlier on he needed direct treatment and he could have benefited the most at that time.

Fragmentation: As a parent, when your child is ill and out of control, you try to access everything you possibly can but you hardly know where to start and nothing seems connected. Even if they're housed under the same service umbrella, there are these lengthy intake procedures that need to be completed many times in many places. Early on, our son did have a few minor scrapes with the law, and this often comes with the territory with kids who have ADHD—the impulsivity, the increased substance use with that particular disorder. We knew that there were programs for mentally ill kids in conflict with the law and there were certainly lots of mental health workers at court, but we were not able to get connected up with any kind of intensive supervision and support program that would have helped him at that time.

There's a huge gap for 16- to 18-year-olds. In theory and on paper, they say that services go up to the age of

18, but if your child is sitting on a wait-list and he's 17, he may be passed over for services. And if he's complex, difficult to treat or a little bit surly, they may even sit on that referral until he ages out of the system.

There are also many critical services that stop before age 18. There's Ray of Hope youth addiction services; it stops at 17—a lot of the residential treatments and a lot of the in-patient mental health treatments as well. So in that critical period between 15 and 24 years of age, youth will be switched between ministries and they'll be switched between services, and they're probably going to fall through the cracks.

Mental illness and substance abuse often go hand in hand, and they need to be treated concurrently. Unfortunately, the system in Waterloo region is not set up for that. If a kid happens to have both psychosis and a mental illness, you're out of luck. You've got a problem. The concurrent disorder forms the basis for exclusion from either service stream.

Early on, our son would have benefited from residential treatment, but there was none to be had. He wasn't going to school. There weren't any alternative schooling programs. He was becoming very difficult to manage at home and he was engaging in risky, impulsive behaviours, often fuelled by substance use. We were unable to sleep at night because we didn't know about his whereabouts or his safety. Despite our best efforts, we were not able to keep him contained. There was absolutely no hope of getting residential treatment at this point, so we had to resort to a boarding school for kids with learning disabilities and behaviour issues. This was not mental health and addictions treatment, and it was expensive. And I'm afraid a lot of parents, out of love and desperation, go that route and end up paying \$40,000 to \$80,000 a year for what are pretty dodgy, unregulated services. If you can't borrow that money, what do you do?

This is the most important point: the fact that there's insistence from many services on youth consent for treatment before they receive services. You're on a wait-list for months. You have a child who's ambivalent about services. Providers come in and they stress his need for consent; child consent is paramount. He says no; service gone. Your chance for help goes out the window. It's a huge problem. It's iffy whether healthy adolescents have the capacity to understand risks and benefits and consequences. When you add mental illness in on that, it becomes even more risky. The most difficult kids to treat are going to say no, and it's no surprise that agencies might be a little bit relieved when they do say no.

The ugly truth is that our child, because he was charged because of a mental illness, spent six months of his short life in secure youth custody. There was no place for him to go. The folks in youth custody were very nice, but they'll be the first to tell you that they know absolutely nothing about treating youth mental illness. And while in jail, Iain was very sick. He was very psychotic. He thought his room was bugged. He was putting papers over cameras and vents and so on. We, as

parents, could only see him for two hours a week. Halfway through the six months, he did come out of jail, but there was no follow-up from the youth addictions services, and he relapsed and he became psychotic and he went back to jail again.

We had to get him out of there. We tried to get him to Regional Mental Health Care London, but we had to go through this committee of the Ministry of Children and Youth Services to get him there, and that took months. So on our own, we pleaded with Ontario Shores, and he did finally get into residential treatment. He was there for three months, and he did get better, but too little, too late.

Iain is one of the statistics here; 60% of the kids in juvenile detention have a mental illness or addiction, and he was certainly one of those. You can see how mental illness is becoming criminalized and that a lot of people in jail have mental illness or addiction. As you can imagine, a downward spiral ensued. He comes out with the dual stigma of having a mental illness and being perceived as a criminal. He fell through the cracks.

The First Step program was still there, but they weren't big enough to manage the complexity of the problem.

One day, Iain went missing. Several days later, he was found dead. Adding insult to ugly, we got a request from the Ministry of Children and Youth Services to complete a satisfaction questionnaire, and this came the day before our son's funeral. I did respond to that—rather curtly, I might add.

We have recommendations. We never want this pain and hardship to happen to any other parent or any other child, and we hope this never happens again to anyone else, so our recommendations are:

—Please treat mental illness as an illness and fund it under the Ministry of Health and Long-Term Care. Hopefully, there will be coordination and accountability there.

—Funding needs to be proportionate to the magnitude of the problem. This is a huge problem for youth, and it has high mortality.

—Treatment for mental illness, instead of incarceration: It's much easier to get into jail than it is to get into treatment, unfortunately.

—I hope this can be looked at: There needs to be a mechanism for parents to get help for non-consenting minors long before they come to the point of imminent harm to self or others.

That's what we have to say. Thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much again for that heartfelt presentation. We very much appreciate that. Obviously, it fits right in with the committee's work as to how we need to do a better job of coordinating the services that are available, to best serve the people that need them. Thank you very much for your presentation.

Ms. Denise Jennings: There's also a rant on consent on the back page. I think it deserves a look. It's a huge problem.

The Chair (Mr. Ernie Hardeman): Thank you.

SERVICE EMPLOYEE INTERNATIONAL
UNION HEALTHCARE CANADA

The Chair (Mr. Ernie Hardeman): Our next delegation is Service Employee International Union Healthcare Canada: Abdullah BaMasoud, research and health policy, and—there's another one—Emanuel Carvalho, vice-president. Welcome to our committee. As I've said to some of the other delegates, if I mispronounce the name, Hansard will print it perfectly, so not to worry.

Thank you very much for being here. You will have 15 minutes to make your presentation. You can use any or all of that time. If there's time left over but less than four minutes, it will go to one caucus. If there's more than four minutes, then we will divide it equally among our caucuses for questions.

With that, the floor is yours. Thank you again. We're interested to hear your presentation.

Mr. Emanuel Carvalho: Thank you, and good morning. My name is Emanuel Carvalho. I'm the executive vice-president for SEIU Healthcare. I am accompanied by my colleague Abdullah BaMasoud. He is our health policy and economics researcher. I'd like to thank the committee for giving us the opportunity to be here this morning.

We are with SEIU Healthcare, an organization that advocates on behalf of over 50,000 health care workers across the province. Our members work in hospitals, nursing homes, retirement homes, and in the community and home care sectors, which gives us a unique perspective across the spectrum of care in the health care system.

Our membership is diverse in population. It includes personal support workers, registered practical nurses, RNs, health care aides and a variety of other front-line health care workers, including DSWs, who work in the mental health sector.

As an organization, we're committed to forging constructive partnerships with health care providers and with other stakeholders to find innovative solutions that drive quality and value while maintaining our public health care system. The overwhelming majority of our 50,000 members work for health care providers that receive a good chunk of their funding through the local health integrated networks.

1050

In my time today, I'd like to talk about three aspects of the LHINs that we think must be addressed in the future amendments to the LHINs act.

The first aspect is accountability for taxpayer money in the home care sector. In the last few years, the home care sector across the province and its funding have grown to meet the increasing demands of our aging population. Investments in these services are projected to increase by over \$700 million over the next three years, including \$260 million in the current fiscal year.

Home care has been identified as vital to improving health care outcomes while constraining expenditure growth in the more costly acute care and long-term-care

sectors. As Ontarians age, demand for home care services is projected to continue to grow. Academic studies show that the demand for formal care in the home setting, such as personal support services, is projected to double by 2031.

The legislation gives the LHINs the authority to fund hospitals, long-term care, mental health and addiction, community health centres and community support services, including the community care access centres, the CCACs. The LHIN act requires LHINs to enter into service accountability agreements with service providers. The accountability agreements with the CCACs require that the CCACs do not spend more than 10% on management and administration. We think that's a good thing; however, such accountability requirements do not extend to home care agencies, which receive the most part of the funds transferred to the CCACs. Currently, only a fraction of home care funding finds its way to front-line care.

Our analysis, based on data from the Ministry of Health and Long-Term Care, health data branch, shows that approximately a third of each public dollar is absorbed by private home care agencies for expenses that include executive compensation, CEO bonuses, administrative costs and profit margins. With hundreds of millions of public dollars being funnelled into the home care sector in these lean times, taxpayers want to see a higher return on their investments in the publicly funded and privately delivered home care services.

Increasing financial efficiency in the home care sector is crucial for the province to see a higher return on its investment in the home care service, that is, to see more hours of personal support care for the same amount of funding.

We believe that the LHINs should require that public funds transferred to the CCACs aren't spent to inflate corporate profit lines or CEO perks. LHINs should require that any agency or corporation that receives funds from the CCACs to provide publicly funded home care services should spend at least 90% of every taxpayer dollar they receive on clients, with no more than 10% that is spent on administration or scheduling of the contracted services. This is not an unprecedented expectation.

In the long-term-care sector, funding is given in what is known as funding envelopes. Three of the funding envelopes are recoverable, that is, unspent money in that envelope is returned to the public funder.

We appreciate that this review is about the LHINs act and, therefore, we recommend expanding the LHINs act, part IV, funding and accountability responsibilities, to set requirements that contracts between the CCACs and home care agencies that receive the bulk of the home care funds reflect stewardship of taxpayer money.

The second aspect of the LHINs act is community engagement and consultations. The act requires that the "local health integration network shall engage the community of diverse persons and entities involved with the local health system about that system on an ongoing

basis, including about the integrated health service plan and while setting priorities.”

However, LHINs have been criticized over and over for failing to conduct meaningful consultations with Ontarians. The secretive process that LHINs use for health facilities closures, in particular, drew frustration from the public. Closing the Revera Thunder Bay nursing home in 2012 and the hospital restructuring in the Hamilton-Niagara region are but examples of the process that caused an uproar among locals.

This perception is shared by the Ontario Ombudsman, who, in 2010, slammed one of the LHINs for a secretive and meaningless consultation process. The Hamilton Niagara Haldimand Brant LHIN held over 11 closed meetings over hospital restructuring without access from the public. In the North West LHIN, the closure of the nursing home in Thunder Bay resulted in a loss of 55 long-term-care beds in a community that is underserved and that has the longest wait time for long-term-care beds in Ontario.

There is a need for a clear minimum standard required by the LHIN to meet for soliciting community views on regional priorities or for future integration plans. We recommend that such engagement requirements include meetings with representatives of client and patient advocates and labour organizations that represent health care workers, as these two types of organizations deal with front-line care providers and care receivers.

The third aspect is transparency. When the LHINs were created, the health minister at the time, Mr. Smitherman, said that the requirements of the community engagement by the LHIN would make it “very clear that decisions must be made on the basis of public interest and in the full view of the public.”

As the Ombudsman said, “LHINs must make difficult and sometimes unpopular decisions about health services. They will never please everyone. But people will be left confused, dissatisfied and distrustful unless the process is open and transparent. The integrity of the LHIN system across the province depends on it.”

Last December, the Hamilton Niagara LHIN refused to disclose the background material for board meeting agendas to a local newspaper. To make the decision about it, the 14 LHIN chairs met to discuss whether they should disclose the background material for board meeting agendas. They have reached a decision wisely; the CEO of the Hamilton Niagara LHIN decided to release the material after all. On the other hand, the Erie St. Clair LHIN not only shares information about meetings, it also has webcast meetings and invites citizens to participate during open-mike sessions. Such great differences between LHIN practices highlight the need for the province to set clear standards on what Ontarians may expect in terms of transparency and openness. It is clear that different LHINs interpret the transparency expectations differently.

We see the model by the Erie St. Clair LHIN as an example for a transparent network, and we’d like to see it replicated at the other 13 LHINs and mandated in the LHIN act.

I want to thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have five minutes left, so we will start with the government. Mrs. Cansfield.

Mrs. Donna H. Cansfield: Thank you very much for your presentation. I think you’ve identified an area that has had some consistency in other presentations, and that’s the inconsistency in and amongst the LHINs in terms of their mandate. They all have the same mandate, but they all seem to interpret it somewhat differently.

The area around consultation and disclosure is absolutely paramount, as you identified, for engagement in the community for those very difficult decisions that sometimes have to be made. It’s interesting in this day of communication that we don’t do a very good job at this. But you must have some ideas how you think we could in fact present some recommendations or some models around how that consultation should take place. You identified one particular LHIN that seems to be doing fairly well. Are there other examples where you think we could improve in terms of consultation?

Mr. Abdullah BaMasoud: I’ve attended a few of the LHIN public consultations, and sometimes in the room there would be more LHIN staff than public in attendance. So you’d have up to 10 of the LHIN staff, and maybe five or six attending. We are based in Richmond Hill, yet when we held an event for the public here in Kitchener, we had close to 80 attending our event. I think that part of it is doing proper work, your own work, right? If you want to reach out to the public, you have to find ways, mechanisms to reach out to them, either through organizations that represent the clients and stakeholders—and reach out to them and make sure that they also communicate to their own audience to solicit their input in whatever you’re consulting them on.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Elliott.

Mrs. Christine Elliott: I’d also like to thank you very much for your presentation. I found the idea of having the minimum standards for consultation to be a very good one, because there is so much discrepancy among the various LHINs. But I wanted to ask you a quick question, if I could, about putting more people into the front lines and some of the concerns with the CCACs.

As you may know, the Registered Nurses’ Association of Ontario has made a recommendation to basically collapse the CCAC into the LHIN and to have the case managers basically working on front-line service and less on administration. Do you have any comments on that? Do you agree with that, or do you think it’s a worthwhile idea?

Mr. Emanuel Carvalho: I’m not sure if I agree with the total argument that they’re making at this point, because I’m not really too familiar with their arguments, but it has been a consistent argument of ours that the system, in some ways, is cumbersome. It just doesn’t make sense. When we ask people about the system itself, there isn’t really a clear expectation of what group does what. What we do understand is that there’s a lot of

funding coming down from government and there are all these layers, and it's almost like a filtering process that happens.

The bottom line is what we deal with on the front lines. We have governments out there doing the right thing, in our opinion: putting the funding into the home care system. The problem is, when the money gets into the system and it goes through that leaching process, it doesn't hit the front line. In fact, there's more money going into the system but we have members telling us they're being laid off. How is that possible?

So there are some real problems with the system. We find it to be cumbersome, and we do have to fix it.

Mrs. Christine Elliott: Thank you.

1100

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

Ms. Catherine Fife: Thank you very much for the presentation.

Around the transparency and accountability around the funding: It's not always easy to find out where that money is actually going. You did reference one relatively alarming piece of data: that one third of some funding around long-term-care homes is going to executive compensation and profit margins. Certainly, that's not the goal of those health care dollars. Do you want to comment on that?

Mr. Abdullah BaMasoud: I just want to clarify. Our analysis looked at the home care funding, not the long-term-care funding. In the home care funding, you have different layers. The money comes from the ministry to the LHIN. At the LHIN, it's pretty much an accounting exercise—transfer that money that is earmarked for home care to the CCACs. The CCACs take about 10% for administration, and then about 20% is spent on case management for home care clients; that is, assigning them the hours etc. Out of that 70%, we estimate, based on what we know about what PSWs make and what benefits they have etc., that only 41% of that 70% goes to front-line care; and that 29% is somehow absorbed by the private agencies, whose role is not case management, which is a pretty expensive role. The role is just the scheduling and hiring and—

Ms. Catherine Fife: That's right. So it's really going to profit margin—

The Chair (Mr. Ernie Hardeman): That concludes the time. Thank you very much for your presentation.

GRAND RIVER HEARING CENTRE

The Chair (Mr. Ernie Hardeman): Our next presenter is Grand River Hearing Centre: Calvin Staples. Welcome. Thank you very much for being here. You will have 15 minutes, and you can use any or all of that for your presentation. If there's less than four minutes left over, it will go to one caucus; if there's more than four minutes, we'll try to divide it equally among the three caucuses. With that, the floor is yours.

Mr. Calvin Staples: Thank you for your time. I'm a little unfamiliar with this format, so I'll try to be as quick

as I can in respect of the time that you are dedicating today.

As I was introduced, my name is Calvin Staples. I'm a local citizen. I'm an audiologist. I'm a business owner. I coordinate, teach and run the hearing aid program at Conestoga College. So I'm relatively busy, but at the same time, I thought, as I was invited to come here, that this was something that should be brought up to the government and the players who are at the table today.

Approximately six months ago, I contacted a local MPP with regard to some of the changes that are going on in our province's support structure for those who require hearing services. As an audiologist, I'm all too familiar with the social, financial and emotional losses that accompany untreated hearing loss. I'm not sure if anyone has been following some of the stuff that has been written in the *Globe* or the *New York Post* lately with regard to untreated hearing loss and its linkages to depression, dementia and social isolation. They're not just kind of related; they're extremely correlated. As our population ages, the need to look at hearing loss and how we treat that is very important.

In 2013, the Ontario Disability Support Program, along with Ontario Works, started to make some changes to their funding schedule. The changes resulted in a system that I believe is less effective, less efficient and less focused on the needs of Ontarians who rely on these services. If I can borrow some words from our local MPP, the new policy also violates the principle of choices embedded in our health care system. I'll explain what the new policy is in a second, but I'll go a little bit further here.

The new policy actually asks those who are in financial need to seek out a second quote to cover the costs of devices. Many times, the cost difference to the taxpayer is actually negligible, and thus it costs the taxpayer more money, as the agency then pays for transportation costs as well.

Ignoring the proximity of the clinic to the patient's home—hearing health care is an ongoing process which requires many appointments, and thus, the costs can become quite substantial. In order to actually properly treat hearing loss, it needs to be an ongoing process that actually fully entails all aspects of hearing health care.

As a taxpayer, I totally respect the need to be sure that the funding is allocated appropriately. However, with our current system, we have non-hearing health care workers who admit to being completely untrained, making hearing health care decisions. This really is quite bothersome and actually quite frightening to me if this is going on in other fields of health. As an educator, I have volunteered several times at our local branch to provide some basic hearing health care education, but at no time has this education opportunity been taken.

If a second quote is requested, the branch then cannot defend their decision with any evidence. As a health care provider who believes in evidence-based practice and patient-centred practice, which appears to be paramount in our province, this is quite frustrating.

Finally, this mandate by the Ontario Disability Support Program is not being implemented across branches or even within branches in any form of consistency. One patient can have no requirement for a second quote and the very next patient with very similar recommendations will require a second quote, which is very frustrating for the patients.

As an example, I recently had a patient who has his counsellor, family physician, pharmacist and audiologist all working together in the same building and working together for months to facilitate his progress back into the world of employment. ODSP has now requested a second quote from another provider, whom he is completely unfamiliar with and he feels uncomfortable with and they're unfamiliar with his background. The patient cannot understand why he cannot choose who provides his care. Additionally, he only lives three blocks from his audiologist.

With reference to Ontario Works, they have now asked the province to provide funding for only one hearing aid. To put this in a simple analogy, this would be like asking to have only one lens for your glasses. The anatomy of the ear relies on binaural stimulation and bilateral stimulation that localize and to be able to function in background noise and to follow a bunch of other things that I could get into in great detail.

This is the one that probably bothers me the most from an emotional side and from a parent of three: Ontario Works has stopped paying for children's hearing tests. Hearing is a vital sense for speech and language development, social development and future socio-economic status. Research will suggest that the economic loss can be in the order of tens of thousands annually, if a hearing loss is left untreated.

The choice appears to fly in the face of our universal infant hearing and screening program that was adopted in 2003. If hearing is important, then I think the province should maybe recognize that in all aspects for all Ontarians.

My hope is that ODSP and OW will consult with audiologists, which I do not believe has been done to this point, or, I should say, prior to the implementation of this new mandate, to ensure the best support is provided for those who require hearing services and to hopefully cease their current policies and ensure fairness is provided to all Ontarians.

That's all I have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about nine minutes left, so it will be three minutes per party. I think we start with the opposition. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation. You've really given us a good view of what's going on. Did you say that Ontario Works has started to only fund one hearing aid?

Mr. Calvin Staples: Yes. It's never been formally presented to us, but then, when the cases are presented, this is the message that we receive back. There has been very little communication from the ministry that governs

Ontario Works to the health care providers. It seems to come down as kind of a trickle-down effect through the branches, and I tend to feel sorry for the people at the branch and the caseworkers making the decision, because they're just following a mandate that they clearly don't understand.

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Mrs. Christine Elliott: I suppose, because it's funded through MCSS—that's where it would come from, through Ontario Works—then it wouldn't fall under the mandate of the LHIN because that's the Ministry of Health. Is that correct?

Mr. Calvin Staples: I wouldn't know. I'm assuming that you may know.

Mrs. Christine Elliott: I'm assuming that too, but clearly it's something that needs to be addressed. We'll certainly take it back with us, even though the mandate of this committee—it's not something we can do anything about, but I really thank you for bringing this to our attention.

Mr. Calvin Staples: No problem.

The Chair (Mr. Ernie Hardeman): Thank you. Ms. Armstrong?

Ms. Teresa J. Armstrong: Thank you very much for presenting that perspective.

I had someone contact our office who was a hearing agency, and they were kind of confused about the two-quote process that they now selectively ask patients to go through. One of the comments, though, that they had made was that even though a patient gets a second quote, if it's a lower quote than what they were given, it's not necessarily the quote that's chosen.

Mr. Calvin Staples: Anecdotally, I can say that that's not happening. Anecdotally, it has almost become a bit of a race to the bottom. To speak relatively candidly, it's also a system that has created dealings going on that I won't participate in. As much as we think all things are created equal, they're not.

They're not looking at the actual care of the patient that needs to be put in place. Hearing health care—the device is the device, but how you manage that device and how you present that device and the training that's provided is not even acknowledged. So to provide just a quote on a device—and sometimes the devices aren't even the same.

Ms. Teresa J. Armstrong: Is there a purpose to the second quote?

Mr. Calvin Staples: The second quote is to ensure that pricing is accounted for, and I respect it because I think there were some things that were going on that shouldn't be going on in our industry. That being said, it has been achieved.

Ms. Teresa J. Armstrong: One of the things that they were confused about, especially with the ODSP—they wanted to know if there was a directive from ODSP specifically asking for a second quote, because it wasn't a standard for every patient. We looked into that. Apparently there wasn't a directive. Any knowledge on that?

Mr. Calvin Staples: Our understanding is that there has been some communication with—I could look up the

name, but I can't remember it. Anytime I've dealt with a branch worker, they've vocally told me that they need to find the cheapest cost.

Ms. Teresa J. Armstrong: Apparently that wasn't the situation with—

Mr. Calvin Staples: No. It's not being implemented across the province, across branches similarly, so it's very inconsistent. It definitely appears to be that certain—based on some of the discussions we've had earlier today, especially the last one, different places are implementing this differently. What we've asked for is to put together some sort of funding schedule, and use audiology as a consulting basis to ensure that, "Yes, this hearing aid meets the needs of the patient and we probably don't need to spend this amount of money."

Ms. Teresa J. Armstrong: And one last thing—

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Mr. Staples, for coming by. Even though perhaps this is a little outside the scope of what we're looking at, you've presented us with some interesting facts. I just wanted to clarify: When you say that approximately one third of Americans between ages 65 and 74 and nearly half of those over age 75 have hearing loss, is the implication that they actually require hearing aids?

Mr. Calvin Staples: That's untreated hearing loss that requires it, yes. And those stats can range up to—that can be higher. That's from the American speech and hearing association. I've seen 40%; I've seen adults at 80% and up to the 90% range.

Ms. Helena Jaczek: Okay, good. I'm going to present that to my husband very, very shortly, as he falls in there.

The other question I had: When you were talking about this move to only fund unilaterally, one side, are you saying that previously both sides were funded?

Mr. Calvin Staples: Yes.

Ms. Helena Jaczek: So this is definitely a change?

Mr. Calvin Staples: A change, yes.

Ms. Helena Jaczek: Okay. That's useful to know, and I feel sure we will need to find out why. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

GUELPH WELLINGTON HEALTH COALITION

The Chair (Mr. Ernie Hardeman): Our next presenter is the Guelph Wellington Health Coalition: Magee McGuire, chair. Welcome. You will have 15 minutes to make your presentation. You can use any or all of it for that presentation. Any time left over, we'll have questions and comments from the committee. If there's less than four minutes left over, it will only be one party doing it; if it's more than four minutes, all three parties will have their share.

With that, the time right now is all yours.

Ms. Magee McGuire: The Guelph Wellington Health Coalition is pleased to present to you this morning. We

want to demonstrate that health, education and social determinants of health need to be addressed as a matrix problem for essential good health. Therefore, we will speak to those issues conjointly, with health care as the pivotal focus.

Our summary statement will be to ask that the money goes where it is needed the most. Statistics demonstrate that 20% to 30% of the population uses 70% to 80% of the money. Therefore, why not focus on that 20% to 30%?

As an RN with 37 years of experience in both family clinic and hospital venues for all the areas of the hospital, I believe that they have intrinsic worth. We hope you will agree that one priority is home care management, as our stories unfold.

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We also request that you withdraw funding of any service formerly done in-hospital and now done by private companies. The subsidy for this has been costly. What start-up business has ever been guaranteed income, clientele and business incentives by the bank? There was no foresight here, and if there was, then there is a hidden agenda. Takeovers or price undercutting of service is a common business expansion strategy that we'll see. This can eventually lead to speculation, non-inclusiveness, member policies and higher costs, all without transparency.

We request that you consider planning a not-for-profit model within the hospital by using the empty operating rooms and local physicians to do the small surgeries that might enhance the envelope of the hospital, while being transparent and evaluated. The law permits you to do this.

We also ask that any additional unnecessary services now being offered persuasively by cataract clinics in addition to cataract removal be stopped. Patients must be advised that this procedure is unnecessary unless deemed essential by their family physician, who can be monitored for validation. These clinics need to pay the government for the subsidized benefit of referral and advertising. There is no competition in this business. Is that development of business the mandate of medicare?

Let's review the social determinants of health. We cannot be healthy unless we have affordable housing, balanced nutrition, education and safe environments. Healthy Canadians make a healthy country. This needs to be a message delivered and understood by government and facilitated for the citizen.

Limiting the number of glucose monitor strips is a step backwards. Does this ministry now diagnose and treat? This decision needed input from the College of Physicians and Surgeons and their members.

Decades of studies have proven the inferior health status of disadvantaged persons. In an inner-city study done on new moms, low income was connected with three to five adverse conditions: birth outcomes, postpartum depression, serious abuse, frequent gestational hospitalization and frequent episodes of stress. New moms had more multiple health problems as a result. I

encourage you to support the case coordination that is about to be employed in the new mental health strategy in Guelph Wellington, which links to other services as needed to this situation.

Time and again, we have heard about the massive negative effect that the aging population will have on the cost of health care. This leaves most people worried about what care they'll receive as they get older. This is a myth, and it is your responsibility to dispel this myth. Annual profiles within information from the Evidence Network compared 1993 to 2013 and found that the cost for every age has grown. Costs are incurred from treatments, diagnostic tests and doctors, not to speak of pharmaceuticals. CIHI figures show that the aging population will drive the cost up only 1%, and Stats Canada has suggested that only one in 100 persons will require long-term care. So please stop the rhetoric and tell the truth.

For dying patients, barriers to a dignified death have been patient-referenced. Patients feel they are being patronized because of age, and are ill advised about advance care planning. Only 4% of patient preferences were documented by doctors, and a major complaint was that the doctors were not explaining the meaning or the intent of the legal document for advance care planning. This results in treatments that patients neither want nor need. It also permits the dysfunctional family to squabble over what to do at such a stressful time. Do you want to spend your money on poor strategies or on giving a voice to patients, their needs and their responsibility? When their pension papers arrive, they could receive advance care packages to complete as part of the process. Nurse specialists can do this work.

CCAC elderly clients, especially from rural areas, are paying up to \$160 out of their monthly government pension for a taxi to see a specialist four hours away in a centre of excellence. There is no assistance even when they have a walker. Taxi drivers do not add this service to their job. Is this what you call value for health tax dollars?

Private clinics are soon to be embraced by the Ministry of Health with open arms. What are you going to invest in? Will there be tax breaks and incentives for the building of the new \$45-million for-profit medical centre in the Hanlon business park in Guelph? Will you continue to subsidize the medical doctor who receives tax-deductible office expenses and who practises there in both family practice and a for-profit service like acupuncture and vein salination, losing precious patient hours for the publicly funded system? We request that you claw back for doctors practising this way to create a more responsible, accountable and ethical payment model.

The general hospital in Guelph has lost its outpatient lab, its mother-baby clinic that was installed because of a baby death inquest recommendation, a preventive respiratory and cardiac clinic, a short-term rehab centre, its pacemaker clinic, its diabetic education clinic and a medical and surgical ward, all this after a strategic amalgamation of services between two hospitals to give full

central services and built to suit. It will soon be obsolete and retain only emergency care patients. However, "emergency" and "essential" are not synonymous.

Did a 0% increase to the Guelph General Hospital give it any extra money to upgrade its pacemaker service or restore important clinics? Did it stabilize its budget? No. Did the solution satisfy the needs expressed? No. Solutions being offered are not being integrated for prevention. That is the unfruitful mantra of the ministry. Even our central lab was closed in the black. Labs popped up to be bought and sold. Unfortunately, only those with cash or credit can have many deleted tests done. The result: People without means do not get the test, and the doctors' hands are tied for diagnosis.

About the pacemaker clinic: In July 2013, the Guelph General Hospital announced the closure of the pacemaker clinic to satisfy its promise to the LHIN that it would integrate this service with the clinic at St. Mary's. It served approximately 750 patients. The reasons changed from day to day. Three patient advocates took on the responsibility of approaching the hospital for a solution to the transport problem. They were told that the VON would provide a return trip for any person who could not get transportation for the cost of \$24 a trip. The VON, which was never consulted at all, learned of this plan through the media. The GGH stated it would pay for any applicant who could not afford it.

In October, St. Mary's announced a new collaborative plan for remote monitoring of pacemaker patients at the Evergreen centre, but only of those with Medtronic pacemakers. The Honourable Liz Sandals, MPP, suggested having travel teams come to Guelph to offer this service. The advocates have suggested that this new idea be upgraded to a traveling remote facility that can serve all of LHIN 3. Stakeholder involvement is critical to best decisions. Indeed, this may even have been a solution for St. Mary's hospital, which has invested in expensive technology for a cardiac program, which in all essence will suffer some decline as some new technologies come forth.

Community-centred health teams or the family health team models are not always available 24/7. Doctors and patients have told us that many answering machines still direct patients to the emergency centre of the hospital or are not responded to. This service needs evaluation and oversight.

Do the increased payments to physicians guarantee better outcomes? The wait lines haven't decreased, yet the average number of visits to both family doctors and specialists has stagnated or dropped by 5% to 7%. Doctors are also choosing to work less to improve their personal life quality, especially the growing number of female doctors. We agree with the Evidence Network that there is a failure in policy. Shall we continue to increase incomes and get less care? There needs to be better oversight.

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In northern and rural areas, there is a great need for specialists, but one in six graduate specialists cannot find

enough work. Regional distribution is an issue. Wait times in remote and northern areas are twice as long as here; yet the solution for the north cannot be a degradation of service in south and central Ontario, where wait lines are increasing.

Then one wonders at the Guelph “Schlegel Villages” plan for a family practice on-site of their long-term-care home, and a college ed centre, without any due diligence by management or the doctors involved as to whether the site was appropriate for a family practice. Dr. Mercer, chief medical officer of public health, would have questioned this oversight. The only concern of the proposal by these private operators was to gain zoning for such an enterprise. This is not good pandemic prevention planning. As for education, nursing programs have already invested in rigorous precautions for students who do their practicum at the bedside of any health care facility.

Call it what you will, but the CCAC was meant to be a hospital without walls. Initially, the government saw it as the ultimate solution for hospitals to gain more beds without expansion and permit patients to go home with essential services, costing less. Sadly, the funding required never transferred with the responsibility.

What really happened over time is a change in following the patient with continuity and a nursing care plan for discharge goals. Did it save the ministry money? Absolutely not. The facts rest in the ministry reports. Family physicians gave up admission privileges and were replaced with an increasingly expensive hospitalist program. The discharge team excludes the family physician, a key consultant. Medical staff who specialize review part of the patient and do not implement holistic principles. The special nurses often underutilize their comprehensive training.

The CCAC RN would assess to accept the patient on home care but was not the provider—usually a private, for-profit administrator who hired staff to do the work. Add to this the bidding process, which took thousands of extra dollars to just process an application instead of using it for front-line work. Most often, the bid went to the lowest bidder for the same or better number of services. If this were accomplished, then why, when their budgets start to run out, usually in the spring, do these agencies cut back the hours of workers and patients? This is not working.

The rhetoric expressed by the recent home care workers’ strike is still the same rhetoric the public has heard from the initiation of the integrated health act in 2006. Is it smart to continue to ignore the failings in this act?

When the Ontario training colleges report from 2004 forecasted a severe shortage in resources by 2017, the strategic operational plan of the LHIN did not reflect this information. Their goals have consistently been to seek efficiencies in the system that had nothing to do with the need being met by an adequate workforce. There were no goals for succession, recruitment, retention, worker satisfaction or governance evaluation. Participating communities of interest initially posited the connection between the hierarchy and the communities, but these were

cancelled without notice to members in favour of hiring a consultant. I observed that the chair was unable to draw out common issues and solutions from the competitive personalities of the navigation COI.

I do want to give you a case scenario for costs. One day in hospital costs approximately \$1,250. Eighteen hours of home care costs approximately \$360 for four weeks. The government pays a long-term-care facility approximately \$1,700 a month per client, and the client loses their pension but gets an allowance. It’s obviously much cheaper to care for a patient at home. So what happened to all the money that was saved?

Also, the truth must be faced in CCACs. Sixty-two cents out of every dollar buys a service from an agency. That is \$72 million out of \$116 million. The Red Cross agency reported a further reduction to paid hourly care of 22 cents.

On the last page, I would like to—I’m skipping a lot of stories that you can read later. The reason for these cuts was stated by Hugh Mackenzie and Richard Shillington, who are economists. They stated that the average cost per annum of service for a client family is \$41,000, which a person without insurance would have to pay themselves. This option is not possible for the 20% who use 80% of the health dollars. The conclusion is that the top 10% of wage earners pay less health taxes than the lower middle class.

I’ve pretty much covered the essence of what I want to say, and I thank you for your time.

The Chair (Mr. Ernie Hardeman): You’ve also pretty much covered the time allotted, but we can assure you that obviously the committee will read the rest of the report that we didn’t have time to include.

Ms. Magee McGuire: That’s fine.

The Chair (Mr. Ernie Hardeman): We thank you very much for making the presentation.

Ms. Magee McGuire: You’re welcome.

GUELPH POLICE SERVICE

The Chair (Mr. Ernie Hardeman): The next presentation is the Guelph Police Service: Bryan M. Larkin, chief of police, sir. Welcome and thank you very much for being here. We appreciate that. You will have 15 minutes to make your presentation. Any time left over will be divided equally among the three parties, unless there are less than four minutes and we’ll just give it to one party.

Mr. Bryan Larkin: Good morning, and thank you so much. I think I’m going to take a page from Chair Seiling and make my comments brief and sort of shift focus a little bit from your previous presentations. I want to thank you for the opportunity. I hope that many of you are sitting here thinking, “What is a police chief doing sitting at a LHIN legislative review standing committee?” Hopefully, you’re thinking that. I want to bring some context as to why, as chief of police, I’m here, and provide some background. I’m an active member of the Ontario Association of Chiefs of Police and the zone 5

director; as well, I sit on the Canadian Association of Chiefs of Police drugs and substance abuse committee.

A couple of years ago, when I was appointed the chief of Guelph, I became intersected with the public health system. I currently sit as a member of the working group on Guelph Health Link as well as Mayor Karen Farbridge's advisory committee on community health and well-being, which is focused on the social determinants of making change within the city of Guelph, and systems thinking change and collaboration and integration. For the last six years, I've served as chair of the Stonehenge Therapeutic Community, which is a drug residential rehabilitation centre in the city of Guelph that provides long-term care for those seeking rehab. That particular organization is funded about 52% by the Waterloo Wellington LHIN and the other 48% through the Ministry of Community Safety and Correctional Services. So I find myself intersecting with the public health care system.

I want to really speak a little bit and echo the comments of Chair Seiling. Probably three years ago, I would not be sitting here, because I thought that the local health integration network and some of the systems reform that were happening were misaligned and there was a misunderstanding in our community. There were different focuses—not necessarily sure what was happening or where the money was going. But I want to reiterate and I want to reaffirm, from the position I sit in as a community leader and a community builder whose organization intersects daily with the health care system, whether it's supporting and working with agencies that are supported by the LHIN, the Wellington Dufferin public health unit that also serves the city of Guelph, as well as our hospitals, that our police officers are supporting different activities. Whether that's through mental health support, whether it's through child and sexual abuse investigations in our hospitals or working with treatment centres, we intersect consistently. There was some misalignment, but earlier today, we heard from Mr. Lauckner, the CEO, and Ms. Fisk, about the number of successes that are happening. I truly believe that we're blessed in Ontario to have a wonderful health care system. It's great that we're having discussion about improving this. I want to reaffirm my belief that over the last three years, locally, change is afoot. There is discussion about being bold. There's discussion about bold public policy. There's discussion about changing the way that we do business, not only in the health care but also in policing. We're under a significant amount in policing of sustainability, discussions about the economics of policing, and working with the Ministry of Community and Safety and Correctional Services on the future of policing.

One of the challenges is that we're doing this in isolation. We intersect consistently, and I'll speak to that in a little bit. I'll certainly agree that the province and the Ministry of Health is responsible for that 30,000- or 40,000-foot provincial strategy. That large ceiling has required policing supports and provincial and national strategies on many different issues, but there's a localized

function. That localized function is really on the health care system delivered locally by the Waterloo Wellington LHIN.

We deal with unique issues. We deal with the diversity of our neighbourhoods. We deal with the diversity of what's actually transpiring around the demographics of our community. So there's not a cookie-cutter approach across the province—although it also balances the provincial health care strategies, and it brings about the change, and we've seen that. Mr. Lauckner talked about cancer treatment and access to the Grand River cancer centre, hip and knee replacements, wait times in our emergency rooms etc.

Those things are fantastic, but the discussion that we're not having here, or the discussion that we're having in isolation, is around the social determinants of health, the national well-being index on healthy communities. It's about redefining when we use the words "health" and "well-being" in our community. It's not necessarily thinking about hospitals. It's not necessarily thinking about hips, knees and all those different pieces. If we do not focus now on poverty, child obesity, access to food, affordable housing and leisure, then 50 years from now we'll still be dealing with knees and hips and different issues, but we'll also be dealing with crime and social and public order issues. We know that people commit crimes to feed themselves, to find housing. They're all intersecting each other.

So I want to reaffirm a position where we're all intersecting. The impact on our health care system, our education, our family child welfare, public health, our community safety—all of these different agencies all intersect with the health care system, but we're having discussions on reform in isolation.

One of the things afoot in Waterloo Wellington—and I want to credit the leadership of Mr. Lauckner and the board chair, Ms. Fisk—is that three years ago, we started having the dialogue collaboratively, looking at the collective impact that we can have on our communities about change, about using the ratepayers' dollars in a more efficient, more effective opportunity. It's about capacity. We have capacity in our respective systems. We know we can find efficiencies within our respective systems, but if we don't have the dialogue collectively, then the capacity keeps getting used and the escalation of costs continue to increase. With the Waterloo Wellington LHIN budget just on the verge of \$1 billion, we recognize that we have to do business differently.

I want to use an example in Guelph: our "Million-Dollar Murray" in Guelph, with 500 calls last year to one address for the police service, equating to over \$150,000 of police resources. That doesn't include our health care system. It doesn't include our emergency medical services system, our public health intervention, our mental health association intervention. As the chief, I'm not necessarily proud that we went there 500 times, because if you were to look at that, we're failing the client. We're actually doing a disservice to the individual who needs the service most. Yet there are many success stories, and we're doing many things right.

As we move forward, we talk about human service delivery, and we talk about changing the process and really pushing and urging this legislative committee to look at inter-ministerial discussions, dialogue.

We look at some experiences out of the province of Saskatchewan, where all the major players—emergency services, police, education, the health care sector—are now sitting at the same table discussing budget allocation, discussing community priorities, discussing provincial and national strategies.

I certainly want to encourage the legislative committee to look at the capacity of localized LHINs. Again, three years ago, it was probably a different story. I think there has been some great success, and I'm speaking, obviously, as a community leader and community builder within Waterloo Wellington. That system change is afoot. But I want to reiterate that if we don't look at a mandate that includes prevention, promotion and actually changing the way we do business and redefining our discussion around health and well-being, our future leaders, 50 years from now, will likely be having a similar discussion—the whole repetition process here. When we look at the impact, from a policing perspective, of the mental health system and the use of illicit and other social addictions—drugs, gambling—on policing, it then impacts our mental health system, which impacts our health care system. Essentially, we're in a cycle.

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It's time for change, and I'm very pleased to say that Waterloo Wellington has certainly come to the table to look at change and integration change.

So I want to reaffirm the localized approach for the LHIN delivery of services, with a balanced approach to a provincial strategy, which hopefully ties to a national strategy, but also encourage that we expand the mandate around social determinants, the national index of well-being.

I'll simply leave this item for discussion: Healthy communities are safe communities and safe communities are healthy communities.

I want to thank you for the opportunity to speak to the committee.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about two minutes for each caucus, so we'll start with the third party. Ms. Armstrong?

Ms. Teresa J. Armstrong: You're participating, obviously, with the local LHINs, and the mental health piece is the one that you're kind of focusing on and how that can benefit people in the area. So what kind of contributions or what kind of meetings have you had? Do you see that making a difference? Is there some collaboration, that they're taking your ideas to try to have a formation of some better system?

Mr. Bryan Larkin: I think a step forward is actually having access to the CEO of the LHIN, having discussions and having them meet with not only me but my colleague in Waterloo region and actually discussing where we can move this, bringing all the players to the table to look at collaboration.

It's no different than on the drug piece. We're leading two separate—a Waterloo drug strategy and a Wellington drug strategy, so they respond to respective needs, but previously the attempt to move that forward was not successful, and now we're actually getting traction where we're looking at: This is important. How do we find funding? How do we look at different forms, including harm reduction and different pieces, to make this work?

Because there's this other impact on the judicial system. We're sending people through the judicial system who ought not be in the judicial system; they need to be in the health system.

Ms. Teresa J. Armstrong: We had a presentation earlier about—

Mr. Bryan Larkin: That's right.

Ms. Teresa J. Armstrong: —a very sad and unfortunate story.

Do you know of any other LHINs in the regions that are actually consulting with police chiefs? Do you know if that's something that's happening elsewhere, or are you the first?

Mr. Bryan Larkin: I'm not familiar with that, although we're trying to have a discussion at the provincial level from an Ontario perspective with our minister, Madame Meilleur, around making this an inter-ministerial discussion about systems change and systems reform.

Ms. Teresa J. Armstrong: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Mr. Colle?

Mr. Mike Colle: Anyway, I'm most impressed. This is really unprecedented. Being on various committees on health and everything, to have a member of the police force really go above and beyond the norm, let's say—that's not to say that other police officers don't do this; I know Chief Blair in Toronto does this quite well, but I think the people of Guelph and this area should be very, very proud to have a leader like you there who goes to the root causes and talks about the social determinants of health and about prevention, and looks at the whole picture.

To be involved with LHINs and the health care providers—I think that this kind of leadership coming from, let's say, not the usual partners in health care really strikes a chord. It certainly has with me, and I just want to encourage you to keep doing what you're doing. I think you're doing something that's really to be admired, and I just want to say, keep doing it.

This is real leadership. As I said, I'm most impressed, and I've been doing this for 20 years. I don't usually get this impressed, so keep doing it, okay?

Mr. Bryan Larkin: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms.—

Mrs. Jane McKenna: McKenna.

Laughter.

Interjection: Ms. Sandals, actually.

The Chair (Mr. Ernie Hardeman): I didn't know which one it was. Ms. McKenna?

Mrs. Jane McKenna: Thank you so much for being here today. It was very inspirational listening to you. I think the thing I loved the most that you said was—I was a critic for children and youth, and I've done my white paper on that, and I just realized how many systemic problems we actually have.

For an example, 70% of the kids in the crown end up on the street. Building more places for them to go is a band-aid; it's not actually the prevention of helping the person. The amount of taxpayers' money that we actually waste because we don't help these people from beginning to end is in the millions of dollars per person.

I think my one question I want to ask you is, at what point did you realize—I know you said three years ago that you needed to look at prevention. Not everybody loves prevention, because it's not a fast dollar back, so people like to just do the band-aid—I hate to use the word “band-aid”; I apologize—but the fast fix. It'll be a hard sell in that sense, but at what point did you realize that you needed to do it?

Mr. Bryan Larkin: Well, probably at multiple points. Prior to becoming the chief in Guelph, I spent over 20 years in Waterloo region as a police officer, and I think that the region of Waterloo was well known for social and community development.

Former Chief Gravill took a very different approach, largely based on some different processes around our Mennonite culture and victim-offender reconciliation and different pieces. We started to focus that way, but clearly, when I started to look at profit and loss and finance sheets as a deputy chief and then a chief, it's not sustainable. You start examining the cost of individuals through our health care system and then we start looking at examining the amount of time we spend in hospitals with mental health patients, but then also intersecting with family and children's services. We could put a family and children's services worker in a police car and go call-to-call with a mental health worker and probably provide better service and totally reform our service—and maybe throw a public health nurse in there—and actually provide a total systems approach to serving our community, which is non-traditional and which worries people. I think that this was the discussion I had internally and with some of our collaborators in Guelph and Wellington. As a chief and as other executive directors or leaders of agencies, you fear loss of control. But if we don't make change today—so it's come through that.

Mrs. Jane McKenna: Great.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, Chief. We appreciate you being here and bringing your view forward.

INDEPENDENT LIVING CENTRE OF WATERLOO REGION

The Chair (Mr. Ernie Hardeman): Our next presentation is Independent Living Centre of Waterloo Region: Brenda Elliot, executive director.

Interjection.

Ms. Brenda Elliot: Good morning.

The Chair (Mr. Ernie Hardeman): The Clerk just informed me I should have told the committee that the one just ahead of you cancelled, and I said it becomes quite obvious when we introduce this one that the one that's in between isn't here.

Thank you very much for coming forward and being here and sharing your views with us today. You will have 15 minutes to make your presentation. If you don't use it all, if you have less than four minutes left, we'll have one caucus ask questions, and if it's more than four minutes, we'll divide it equally between the three caucuses. With that, right now, the 15 minutes is yours.

Ms. Brenda Elliot: Great. Thank you so much for allowing me to present. As stated, my name is Brenda Elliot; I am the executive director for the Independent Living Centre of Waterloo Region. I am a recent incumbent to that role; I've only been in the role for about seven months now, and I'm new to the Waterloo Wellington area. I still reside in London, but I'm getting quite familiar with Waterloo Wellington.

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The Independent Living Centre of Waterloo Region is the largest not-for-profit organization providing attendant services and assisted living for individuals with a physical disability in southwestern Ontario. ILC was the first independent living centre in Canada and is proud to be a part of the independent living movement for over 30 years. ILC consists of attendant services and an access and awareness side that provides individuals with a disability skills to self-advocate. We also offer education and awareness for the general public, AODA and barrier-free training as well as our youth in transition program. We provide services to over 270 individuals and employ a workforce of approximately 250 people and over 50 volunteers, the vast majority of this workforce being comprised of personal support workers. ILCWR is a member of the Ontario Community Support Association. As an organization, ILCWR is well positioned to contribute to the current discussion on the local health integration networks.

Ninety per cent of ILC's funding is received from the Waterloo Wellington LHIN. This funding is for outreach attendant services and for our three assisted-living sites. In our three assisted-living sites, we have 12 individuals at each site that we support, with a variety of physical assistance required.

The relationship with the LHIN is based on open information-sharing and timely communication. Our LHIN has worked consistently to engage their key stakeholders in collaboration and identification of best practices. The LHIN has engaged the community support services network in examining gaps in the system and a structure to support individuals in the community. They have demonstrated a commitment to the community and to individuals with a disability. They have recently invested over \$400,000 in attendant services for individuals with a disability. This is the first significant investment in over four years, and it took a wait-list that resided in this

region that was well over 200 individuals down to under 70. That's a significant closing of the gap.

They have also made a one-time funding commitment for the purpose of creating more accessible housing for individuals with a disability. The LHIN has demonstrated that they are in the position to make informed decisions on health care as they act at the local level.

While I'm somewhat reading from the script, I will digress the odd time to interject a key point.

Accessible housing is an incredible barrier for individuals. We have individuals on our wait-list for assisted living that are currently residing in long-term care or in alternative-level-of-care beds in the hospital as a result of not having access to accessible housing. These are individuals who are 30, 35, 40 years old who are in long-term care who would be better situated in the community—better supported, able to maintain an active life and the life that they would like to choose to live.

While ILCWR acknowledges a positive relationship with the Waterloo Wellington LHIN, that's not to say that there are not areas that require improvement. With any relationship, there are always things that can be better. I have teenagers, so I'm well versed at saying that on a daily basis.

In the area of disability supports, we continue to be co-opted with seniors. I believe this happens across the LHINs, that when they're comparing services and how services are delivered and the common denominators, individuals with disabilities are very often lumped in with seniors. While the consumers that we support will age, they're not seniors. The care they require is very different from a senior care model. It creates discrepancies in care levels as seniors' needs are significantly different than those of individuals with a disability. While the Waterloo Wellington LHIN has acknowledged that this is an issue, there's been little done yet to make these corrections when it comes to reporting service and validating service needs.

In the funding corridor there exists a continual shortfall to community support services. We have not had an increase to our base funding in over six years. Under the LHIN funding mandate, budgets with providers do not properly take into account administrative costs. We are tasked with keeping our budget to a zero increase. As a result, we are continuing to serve an ever-growing consumer base with no increase to our base budgets.

As our fixed costs of rent, heat and hydro continue to rise, we struggle to meet our financial commitments. Our employees receive minimum pay equity increases, and we place training for staff at a basic level.

I was quite shocked when I came on board with ILC to find out that we won't reach pay equity until 2025. What shocked me even more is, we are really not alone. The fact that we can give a 1% to a 1.3% increase a year is pretty normal for community support services, and it's a real struggle. It's a real struggle on health human resources. Health human resources remain a key risk for the community support sector. While many organizations continue to lag behind in reaching pay equity, the

institutions such as long-term-care homes and hospitals continue to pull further away in pay for personal support workers.

ILCWR is on par with other not-for-profit organizations but falls significantly behind institutions. The average pay for a PSW at ILC is \$16 an hour. In an institution, this same PSW will start at a rate of \$21 to \$22 per hour. This creates a revolving door of CSS agencies training PSWs and these PSWs then leaving for institutions once they have experience. So we provide them with the skill set. We provide them with the training. We take them on when they're fresh and young and new because we need the resources, and within three months to six months, a lot of times they're leaving for a place that can offer them permanent full-time. Even with us offering benefits at 25 hours, we just simply cannot maintain the hourly rate that the other organizations do. And I come from a long-term background, so I'm well versed in what they pay and their collective agreements. I wish we could get there but right now we're not there.

To meet the future demand for community services, the Waterloo Wellington LHIN needs to invest in community support services and allow us to close the gap in health human resources.

It is well identified that supporting individuals in the community promotes better health outcomes while reducing the strain on ALC beds and long-term care. Further, community support organizations provide care in a community that would otherwise be done by nurses. This results in a saving of approximately \$30 an hour and provides continuity of care for an individual being served. For example, it's \$26.50 an hour for a PSW but \$58 to \$64 an hour for a nurse. An average cost for one day of assisted living is under \$200; the costs for one day in an ALC bed are currently recorded at over \$1,000.

ILCWR PSWs provide services from housekeeping and meal preparation to catheter and trach care to personal care. A lot of our PSWs do what are called delegated tasks. They're trained by a regulated health professional, and then our PSWs do this care. Where a CCAC would send a nurse out to do catheter or trach care, our PSWs are trained and are able to support this, so our individuals are supported with one person, seamless care, somebody who is well adapted to qualify any changes in health status and report it to individuals.

As the demands for home supports increase, it's critical that we receive an increase to our base funding. Without this increase, our wait-lists will continue to grow and organizations will continue to struggle to meet pay equity demands without closing the gap to ensure a living wage for our employees. I know that "living wage" is thrown out there a lot, with the minimum wage now going up to \$11; \$16 an hour might seem great, but to try to provide and work two to three part-time jobs making \$16 an hour to make ends meet leaves little time for quality of family and quality of life.

The average wait-list for an assisted-living bed in Waterloo Wellington is nine years, and that hasn't changed. We have individuals who are sitting on there

for nine years. They end up in long-term care at the end of nine years. They've just given up and they end up staying there because it's what they're used to. It's not what they deserve or the value of life they should be able to maintain, but it's what they're forced to take.

Another identified gap is in primary care for individuals with a disability. A recent survey conducted by ILCWR shows that over 60% of our consumers have not had a complete physical exam since they were a teenager. These are individuals who are 45 to 65 who haven't had a physical since they were a teenager. They advise that while they can access care for basics such as vaccines and a general exam—a cough-cold kind of symptom—that having a pap smear, mammogram or prostate exam does not happen. The reason given is that while clinics are accessible—so a wheelchair can get in the door, someone with a visual-acuity issue can get in the door or with a hearing issue can get in the door—once they're in there, in the exam room, the exam tables are not accessible; there are no lifts or supports to transfer an individual to the table. A lot of times you'll find that while a building will say it's accessible, it's truly not. Either the font is not acceptable for visual reasons, or the tables aren't accessible for somebody, so unless they have somebody going with them to do that transfer, they can't access that sort of care. Somebody with a hearing impairment—there is not always somebody there who can assist with those sorts of little things that make primary care essential. A lot of our consumers just simply choose not to go: "Why bother? They're not going to listen to me." They have to go to the hospital for a lot of their care, and they just give up trying.

We would ask that, moving forward, the LHIN critically examine any increase provided to organizations and institutions to ensure that the dollars are spent on quality care. We acknowledge the long-term care has long struggled to balance their budgets. However, we would ask how they qualified the need for this increase that they recently received—I believe it was 4%—when they continue to pay dividends to stockholders and bonuses to their executives. When the not-for-profit world has to continue to balance our budgets, and stockholders are being paid dividends and bonuses—it simply does not merit an increase to me.

ILCWR firmly believes that the key priority for our health care system is to continue the move toward community services. Individuals deserve the right to stay in their homes and maintain their quality of life. The LHINs are best suited to do this as they are closer to the community. A better effort is required to coordinate the functions between the LHINs and CCACs. There remains duplication in services provided and in administrative roles. While the LHINs have made great efforts towards consistency, this must remain an ongoing process.

The LHINs have afforded organizations like ILCWR to be part of discussions regarding health care that we were not formally involved in in the past. This move has allowed community support agencies to review services delivered and collaborate to ensure seamless delivery in

supports. Community support service organizations in Waterloo Wellington now use a system called Caredove. This program allows any organization to make a referral for a consumer, creating an "any door is the right door" opportunity. The LHINs' continual review of services has resulted in consistency to care provided, costs in certain areas have been validated, and collaboration has allowed organizations to leverage learning and training for continued success.

In summary, while the LHINs face their challenges, ILCWR believes that they are well suited to meet the community's needs. They are local, and as such have the ability to be at the grassroots level and be reactive to the ever-changing health care needs of the community. Devolving the LHINs would not immediately improve the health care system and could negatively impact the delivery of home and community care.

Any review of the current health care delivery system needs to take into account the challenges of maintaining a healthy population while managing our health care budget.

ILCWR is committed to working with the LHIN and government in delivering the highest-quality health care to our community. We look forward to the future and greater investments to health care in our community. Thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have an opportunity for one question. I think it goes to the third party: Ms. Armstrong or Ms. Fife.

Ms. Teresa J. Armstrong: No. If you would like to add anything else to your presentation, I'm happy to hear the feedback that you have, or—take that time.

Ms. Brenda Elliot: Well, Waterloo Wellington is not the only LHIN that is having the challenges when it comes to accessibility. It's not just for individuals with a physical disability; it's for anybody with any sort of disability. I think that it's been a long time since there has been a focus on that. The government has recently released a lot of money towards direct funding. That's excellent. A lot of those resources will stay in Toronto because their wait-list is the longest.

So when you're looking at resources and you're looking at the commitment, I think we need to start separating out groups and understanding that the service needs required for individuals are different. Our consumers aren't ill. A lot of the conception is that somebody with a physical disability is ill. They're not ill. They become ill because they lack the opportunity to access things like primary care and the basic community supports that a lot of us can just take for granted and walk out and go and get.

I think the LHINs have done a great job. Just in the last four months, there has been a significant improvement in this open communication, in getting the parties to sit down and collaborate, looking at best practices and making us examine exactly how we're spending our money and where we're spending our money. I think more of that needs to be done.

Coming from a long-term-care background—I know my compatriots will be upset with me for saying this—when you’re getting a bonus on a yearly basis and then laying off PSWs on the front line, where are we putting the value? To me, that’s not the value. I made the choice to exit long-term care because morally and ethically, I couldn’t be there anymore.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation and your comments. That does conclude the 15 minutes. Well done.

That was our last presenter, so we will now recess and resume in London at 2:30. It’s going to be healthy eating, because I’m sure it has been stored in this room. There’s a boxed lunch on the way out. It’s been kept cool all morning.

Thank you all very much for having suffered through this morning. We look forward—from here we will be going further west. We will be going through Oxford county, the centre of the world, the heart of the universe. I’m sure by the time we get to London, it will be warm.

The committee recessed from 1203 to 1431 and resumed in the Queen Victoria Room, Hilton London Hotel, London.

The Chair (Mr. Ernie Hardeman): Good afternoon. Welcome to the meeting of the social policy committee. We’re here this afternoon to do public hearings on the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act. We’ve been travelling the province, and we’re happy to be here in London, in the South West LHIN area. We welcome everybody who’s participating here.

PARTICIPATION HOUSE SUPPORT SERVICES—LONDON AND AREA

The Chair (Mr. Ernie Hardeman): Our first delegation this afternoon is Participation House Support Services: Brian Dunne, executive director. Have a seat at the end of the table. Thank you very much for being here to participate this afternoon. You will have 15 minutes for your presentation. You can use all or any part of that for your presentation. Any time that’s left will be used for questions and comments from the committee. If there’s less than four minutes left, it will go to one caucus; if there’s more than four minutes, we’ll divide it evenly for the three caucuses to all have an opportunity to put forward a question to you. With that, the clock starts now, and the next 15 minutes are yours.

Mr. Brian Dunne: Thank you, Mr. Chair and honourable members of the Standing Committee on Social Policy. Good afternoon. My name is Brian Dunne. I am the executive director of Participation House Support Services—London and Area, a multi-system service partner organization providing services and supports to people with significant physical and/or developmental disabilities, including those who are medically fragile and ventilator-dependent.

The organization is 25 years old and currently operates 53 locations in the South West LHIN. We provide those

supports and services in partnership and collaboration with hospitals and other community organizations and services.

This presentation is informed by our experience working with the South West LHIN and reflects our mission as a community organization. Our mission is as follows: Participation House Support Services supports individuals with developmental disabilities and/or complex physical needs to live in their own homes, participate in the community and enjoy life with family and friends.

We support people in the community in a flexible way that meets their unique needs and contributes to their role as active, valued and included members of this community. This approach is in keeping with a progressive, modern health care system that keeps individuals healthy and connected in their homes and communities, not sick and alone in institutions. We know from international studies that an integrated health care system that is locally derived and driven results in the best solutions when it comes to increasing efficiency and effectiveness of care delivery for vulnerable populations. This includes people with disabilities, who represent the largest minority group in our society.

The Local Health System Integration Act gives responsibility to the LHINs to plan and set priorities at the local level with input from all local stakeholders. This is a very important and effective principle that should never be lost.

Each LHIN has unique geography and historic variability, which reflects the diversity of Ontario and presents unique challenges. The South West LHIN has a large and extensive rural geography. Local planning and priority-setting is the best approach to addressing these unique challenges, as well as province-wide needs.

As a service provider, the LHIN has given organizations like Participation House an opportunity to be included at tables where we were not invited in the past. This is important if we are to share a vision of health care and for best practices. Because Participation House is funded by both the Ministry of Health and Long-Term Care, through the South West LHIN, and the Ministry of Community and Social Services, we see the need to enhance the seamless integration of planning and care delivery between all organizations within the health and supportive care sectors, and this should include housing and transportation.

The LHINs can further build on their leadership role by enhancing the seamless delivery of care across the region. This is especially important for initiatives targeting populations with specialized care needs who are in the top 1%, 5% or 10% of the highest-cost users in the health care system. Many of these individuals are also extensive users of support care services.

Why is local planning and priority-setting so important? I want to tell you about one person whose life has been changed, and about a locally developed partnership that is creating a difference for persons with chronic mechanical ventilation locally and is becoming a regional model for support for this population.

Devon is 18 years old and lived at home with his mom. Devon has Lennox-Gastaut syndrome, which means, in addition to numerous physical challenges, he has uncontrolled seizures. He has a vagal nerve stimulator implanted in his chest. He has an ostomy bag and a GJ tube. He uses a wheelchair. He requires constant, total support for everything, all aspects of personal care, and can never be left alone.

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In April 2013, the day Devon turned 18, he was admitted to hospital. He was very sick, and his already significant care needs increased. With the changes in his health, the loss of support from children's services and the fact that he was bigger than his mom—she had to face the heartbreaking reality that she simply could not care for him at home any longer. She is a single parent; her husband had died of cancer a few years previously.

Even though Devon's health was stable within two months, he remained in hospital for six and a half months while the system struggled with where he could go. He needed 24-hour care in a place that could be suitable for an 18-year-old man with his special needs. The only option seemed to be a long-term-care facility. Devon's mom was very clear this was not appropriate for him, and everyone agreed, but there didn't seem to be an alternative solution. He was 18 years old and he needed one-to-one support several times throughout the day, eight hours a day minimum—support in eating, bathing, changing, all of those support needs.

Then, as she calls it, a miracle happened, and she heard that Devon would be transferred from the hospital to Participation House Support Services where he could receive the 24-hour support he required, funded by the South West LHIN. This was the collaborative work of Participation House, the community care access centre, Access to Care and the local health integration network. As of October 2013, Devon lives with three peers in a fully accessible home, where staff have been trained to meet his needs. He is healthy, happy and thriving, and his mother is extremely grateful for this outcome.

The chronic mechanical ventilation project, sponsored through the South West LHIN, is part of a partnership that was developed to bring people living with chronic mechanical ventilation out of intensive care and back to the community. People who were in intensive care for over nine months are able to return to the community. This solution was locally created in partnership with London Health Sciences Centre, St. Joseph's, Parkwood Hospital, the community care access centre and Participation House Support Services, and we are now developing a regional integrated strategy for this population.

By providing community-based supports and services that are planned and designed locally, in consultation with all stakeholders, including those that are directly affected by them, it means people can stay in their own homes longer and be full, participating members of their communities. This reduces costs to the health care system by keeping people safe, healthy and at home, where I

believe we all want to be as we face the aging process or encounter an event that permanently changes our health status.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about seven minutes left, so we will start the questions in rotation: Ms. Jaczek, from the government side.

Ms. Helena Jaczek: Thank you, Chair. Thank you so much, Mr. Dunne, for coming here today. I'm very familiar with Participation House in my riding in Markham and the wonderful work that you do. So we're always grateful for the work done locally and in my riding as well.

You've been very clear about the assistance that the LHIN gave to the process through which Devon was placed in your facility, and in essence, you're supportive of the whole principle of the LHIN structure. This is your opportunity to tell us: Do you have any recommendations for change, anything that you've seen as being a stakeholder and participating with the LHIN that you see that could enhance health services in this particular area?

Mr. Brian Dunne: We need to continue to engage the community, to engage the partnerships. I always go back to the person, because that's why we do all of this. And so, is the system seamless for the person? We hear from families that they have to tell their story many, many times, and I think through this collaborative, integrated process, a family has to tell their story once, and the providers come together in a seamless system, hopefully to provide the best care and support to that person.

Ms. Helena Jaczek: Has there been any development of any sort of common referral tool or assessment that many agencies use?

Mr. Brian Dunne: Yes. We have a collaborative assessment process for community services now through the collaborative, which is part of the change that's happening within the South West LHIN, and also the coordinated access through the CCAC. So I think that has been helpful and is less confusing for families, and hopefully better outcomes for the person.

Ms. Helena Jaczek: Thank you.

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

Mrs. Christine Elliott: Thank you very much, Mr. Dunne, for being here and for the great work that you do in the community. I also have a great Participation House project in Durham region that did some wonderful supportive work for our most vulnerable citizens, so thank you for that.

You're in a somewhat unique situation because you're funded by two different ministries. You mentioned that. I'm assuming you get the money through the LHIN from the Ministry of Health and then get separately funded through MCSS. Could you maybe comment a little bit further on how the LHIN has been helpful in making the process easier for you in being able to bring a more coordinated approach to services for your clients?

Mr. Brian Dunne: Certainly. Some of the areas that we see that are complex are the transitional-age youth

moving from the children's system to the adult system, regardless of which ministry that is in the adult sector. Services for children are mandated to some degree. When they move to the adult system, they lose school, so that full-day sort of program that families have that they rely on is no longer there. And that's across the two ministries; I think we see the issue in both.

Certainly, I think there's been an acknowledgement that the ministries need to work together to have a more coordinated approach for that transitional aging from children to adults so that the families have a bit of hope that there will be something there for them when their child turns 18 or 21, depending on the transition from the children's system. Certainly, South West LHIN has been paying some attention to that population, and the families are incredibly grateful for that.

Hopefully, there will be also some collaboration between the different ministries because when we're talking about people who have very complex needs, whether they have a developmental disability or multiple disabilities, with ministries, we need to work together. So there are some transitional opportunities for families to be able to move through that without the complexities of different funding and mandates. I think the two ministries need to have more conversation about that so that the families don't fall through the cracks of rules and regulations in the different funding ministries.

The Chair (Mr. Ernie Hardeman): Thank you very much. The third party: Ms. Sattler.

Ms. Peggy Sattler: Thank you very much for your presentation, Mr. Dunne. I had a question that really follows along the question that Ms. Elliott asked you. You mentioned the need to draw in housing and transportation, as well as health care and support services. Do you see the LHIN playing a role in terms of integrating housing and transportation along with health care and support services?

Mr. Brian Dunne: I think if we're looking at trying to build healthy communities where we all want to be, all of the supports and services need to work together. That would include housing and transportation, because if a person doesn't have a good place to live that's safe, if they don't have good community supports, if they don't have transportation, those are major barriers to their ability to manage in a community. If you look at the rural areas, transportation is a very big problem. So I think the ministries—I think the LHIN can play a lead role in that. They're in a very good position to do it. Again, I think, because the LHIN can plan and drive decisions locally, they can draw in those local different ministries and different bodies to talk about how we collaborate and work together to create the best possible supports and services in a broad sense for citizens. Whether it's transportation, whether it's the municipality in terms of housing or other services, I think it's in a good position to do that and could take a lead role.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. I'm sure it will help our deliberations as we proceed.

SOUTH WEST COMMUNITY CARE ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Our next delegation is the South West Community Care Access Centre: Sandra Coleman, chief executive officer. Ms. Coleman, welcome.

Ms. Sandra Coleman: Thank you.

The Chair (Mr. Ernie Hardeman): As with the previous delegation, you will have 15 minutes to make your presentation. You can use any or all of that in your presentation. If you do not use it all and there's four minutes or less left, the government will get the time. If you have more than four minutes, we will divide the time equally between the three caucuses.

Ms. Sandra Coleman: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much, again, for being here.

Ms. Sandra Coleman: You should have a copy of my handout; just check to see if you have that.

Mr. Mike Colle: We're just getting it now.

Ms. Sandra Coleman: All right.

Thank you very much, Mr. Chair, and hello to all members of the committee. My name is Sandra Coleman. I'm the CEO of the South West CCAC. Our board chair, Mary Lapaine, had intended to be here. Not much would keep her from here, other than the legendary snowstorms that occur in Canada's west coast, namely Huron county, which is where she is from. So she gives her regrets and wishes she could be here today.

We believe LHSIA, on balance, is working reasonably well in the southwest, and our suggestions today are intended to strengthen the current framework. The CCAC sector as a whole will be making a written submission with a much more detailed series of recommendations for submission when your committee returns to hearings in Toronto.

Today I'm just going to highlight one of those recommendations and then use a patient's story to explain that recommendation a little bit to bring it to life and also, in that, talk a little bit about the CCAC role, but also then how we and our partners work with the LHIN to improve health care services and outcomes in our region.

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The recommendation, as you'll see, is here. It's about health system capacity planning that includes health human resource planning for professionals and personal support workers to ensure that future investments are aligned with population needs and provide optimum value for taxpayers.

Sections 15 and 16 of LHSIA, right now, require the LHINs and their local communities to engage with them and develop an IHSP, as it has become known—that integrated health services plan. That does set out the vision, the priorities and the strategic directions for the local health system and the strategies to integrate the local health system.

What we're suggesting is that beyond that IHSP, we need a long-term-capacity plan. In other words, what

beds and services are needed and where for each LHIN in order to assess what will be necessary to meet the current and future needs, and that further, that capacity plan needs to look at current and future human resource needs, including professional services, but also critically important support services such as personal support.

Now on to the patient story. This is about Faye and about Home First. In the spring of 2012, Faye fell in her home, which is in lovely Oxford county, and was admitted to the Tillsonburg hospital. During her stay there of several weeks, she lost a lot of weight. She started to become disoriented, as often happens with the elderly. Her health was declining and she missed her home in the country.

When the CCAC care coordinator, Nancy, first approached her about going home, though, Faye, as well as her daughter Robin, were sceptical. They didn't hold out much hope. They were assuming that she was on her way to long-term care. But they decided to try, after a few conversations with the care coordinator, particularly about Home First.

So Faye was discharged to home in July 2012, just as Home First was getting started. Faye was one of the first for Home First out of Tillsonburg. It had been in other parts of our region, but not yet in Tillsonburg. She had her arm in a sling and she had multiple medical conditions. She had 24-hour care from personal support workers through the CCAC, as well as visits from occupational therapy, physiotherapy and nursing. The CCAC care coordinator met her in her home on the day of discharge and touched base in person and by phone several times a week thereafter. I've got to say, though, the first few weeks were not easy. Because of that, at the end of the second week, Faye and Robin—you'll see they're both there in the picture, Faye seated and Robin, her daughter, to the right—made the decision that she would, unfortunately, likely have to move forward with a long-term-care application.

But then, at the start of the third week—we see this a lot with Home First; the first few weeks are tough—but at the start of the third week, Faye's health improved remarkably. The sling was removed; she was able to use her arm without pain; she got around more; her mobility increased. Most importantly, not just her personal health but her personal outlook bounced back quickly to where it had been. Two weeks later, she changed her mind about needing to move to long-term care. She still needed regular help, certainly, but only for a couple of hours a day.

Fast-forward to today—since July 2012—almost two years later. She continues to do well. She has remained in her home. She has not had a single day in hospital or ER since. Her care coordinator continues to check in with her regularly and adjust her care plan as needed. Also in the picture there on the left is the care coordinator, and in the back is Betty, her personal support worker.

From Faye's story, there are two messages that I thought were relevant for the committee regarding the LHSIA review. The first is about the CCAC role. I know

that's been a topic of conversation, so I'll touch on that briefly first, but second, that Faye would not be at home had the LHIN and its many partners not come together with the knowledge that the capacity simply wasn't right in the southwest, and to recognize that we together needed to make changes to the system capacity and shift funding to make that care at home happen. In that, the support from personal support workers was absolutely foundational to Faye's outcome.

Let me talk first about the CCAC role and then a little bit more around those capacity shifts that I'm talking about that relate to the recommendation.

CCACs get people the home and community care that they need to help them live and age safely in their own homes and to heal after a stay in hospital. When someone can no longer live safely at home, we help them find and transition to the right care setting to meet their needs. We serve about 60,000 people in a year, about one in 17 who live in the southwest. Every month there are over 3,000 discharges from hospital to home that we support, and about 250 seniors who transition to long-term care every month. The complexity of our patients is increasing. It's up over 23% since 2009. Now, over 80% of our care is for high- and moderate-needs patients at home and the patients coming out of hospital. The other largest segment would be school health supports.

Care coordination is our core service. It is not administration; it is patient care, and it is essential. Our care coordinators are all health care professionals, mostly nurses. They work directly with our patients, their families and other health care providers to identify each person's individual needs, develop care plans and ensure that people get the right care in the right place to meet those needs. Our care coordinators work in every hospital and every emergency department, with every family physician. In fact, we're on-site now regularly with over 330 physicians as part of their teams, but have connections with all 700 or so physicians in the South West—the same with every school, every community agency and every long-term-care home. So that connected, South West-wide network of care coordinators helps to ensure consistent care and practices across the South West and indeed across the province, through our network of 13 of my sister CCACs. This is essential work that someone must do. Families simply cannot be burdened with all of this coordination activity. The system is too complex; the care needs of these patients are too complex.

Some of the Home First outcomes: Faye is at home because of Home First. This was funded by the LHIN as part of the system capacity planning work that the South West LHIN has led. They call it Access to Care, working with all the system partners. Several years ago, there were literally hundreds of patients in the wrong place—too many people in hospital and long-term care who didn't need to be there—and underutilized community supports, or community services that were in need of expansion, such as home care, adult day programs, assisted living and supportive environments like Participation House, which you just heard about. In other

words, that catcher's mitt in the community needed to be bigger and stronger. So the LHIN funded key roles to lead change, to monitor progress and to support spread from hospital to hospital, as well as with all the community agencies. The LHIN increased funding to the CCAC. Last year, it was a 4.8% funding increase, and that resulted in an 8% increase in the money that we spent on patients and a 10% increase in the number of home visits. Part of that return on investment is because we spend only 3.6% of our budget on administration, and we've been reducing that every year. The LHIN also funded additional adult day programs and assisted living or supportive housing environments. Again, you heard the Participation House example. This level of increased funding to the community's catcher's mitt has to continue if we want to provide more care at home to free up hospitals to provide only the care that they can provide.

Home First also increased our personal support volumes. This has been key to the success. Since 2010-11, before Home First, to today, our personal support visits have gone from 1.3 million in a year to 1.8 million. That's a 40% increase. We also changed the model of care, to have eight-hour shifts with Home First. That made it much easier for our provider partners to recruit and retain staff and to enhance the training to support what are pretty sick people in what is really a hospital-in-the-home setting for this first four-week period of Home First, when they are receiving these intensive services, hoping that then their health will stabilize and, like Faye, they bounce back and then can remain in their home. This model has also meant greater continuity of workers for our patients.

On a broader scale, some of the results: 800 people per month, like Faye, are able to be at home instead of in a hospital or long-term care, so we've diverted about the size of a community hospital out of the 20 hospital corporations and 35 sites in the South West; 168,000 hospital days avoided, and we're on track this year for about 200,000; two thirds of all Home First patients are able to remain at home after that first four-week period on usual CCAC and community supports after that three-to-four-week period; ALCs have been cut in half—those waiting for long-term care. You see the graph here. Those show the ALCs as recently as two years ago at the hospitals, and then declining as each hospital—each of those little tags is the name of a hospital—embarked upon Home First. You'll see they've gone from about 180 down to 92. We also did an economic impact analysis. The link is there; it's on our website. It's showing savings of about \$10 million in one year.

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Again, to relate this back to the recommendation: Beyond the IHSP, what will be essential to really enable health system transformation, of which I think Faye is a prime example, will be this type of system capacity planning province-wide, using a consistent approach; to have a plan for how many beds and services we need and where, and it needs to include the realities of funding shifts and different HR models and resources, especially enhancing those important personal support workers.

Working with our LHIN, we are making important changes to improve care that people receive. We know there's much more to be done. In your consultations, you will hear about people who haven't had good experiences. That's a reality; that's where we can learn. Our patient satisfaction rate is 94%; that's the good news. The bad news is that 6% aren't, and we have to keep working at that. But our annual complaints amount to less than one tenth of 1%.

Overall, though, the system works well. It's getting better, but our population is aging, so it's only going to get tougher.

We support the changes that are under way to more fully engage primary care and planning and integration, especially health links. We see a lot of benefit from that type of functional integration, having CCAC care coordinators work on-site with every physician and health link, coordinating care for those high five—that 5% of the population that consumes the majority of the health care resources.

Structural change to the health care system is the most costly and disruptive form of change. It absorbs time and energy at every level, from leadership to the front line. It really should only be considered when it is truly the best solution to an issue or problem. The result must be worth the price.

Home First would not exist in the southwest if we were back to being seven individual county-bound CCACs, the way that we were in 2006, or if, as some suggest, care coordinators were dispersed to be part of hundreds of disconnected primary care practices or disconnected hubs in the southwest. There would be no way for those siloed care coordinators to then ensure consistent care across the southwest, let alone the province. And what about people without a family doctor? Our 35 hospital sites would also then need to connect with hundreds of primary care-based access points or multiple hubs instead of one integrated organization. All Ontarians would lose a single point of access to home and community care, to care in schools, to care in long-term care, and to all other parts of the health care system that we are an access point to, working in partnership with others.

Dispersing accountability for care coordination won't work, so what will? We have to support and create that long-term plan to ensure quality care and, to that end, there's a series of position papers. The links are here.

Thank you for the opportunity to speak with you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. You're 29 seconds short of the full time. Thank you very much for your presentation. It's much appreciated and very helpful in our deliberations.

Ms. Sandra Coleman: Thank you.

DALE BRAIN INJURY SERVICES

The Chair (Mr. Ernie Hardeman): Our next presenter is Dale Brain Injury Services: Sue Hillis, executive director. Thank you very much, Ms. Hillis, for being here

this afternoon. We thank you for the time you've taken to come. As with the others, you will have 15 minutes to make your presentation. You can use all or any of it. If you have time left over, less than four minutes, we will give it to one caucus; more than four minutes, we'll divide it equally among the three caucuses for questions and answers, to the extent that 15 minutes allows. With that, at this moment, those 15 minutes are your 15 minutes. Thank you.

Ms. Sue Hillis: Thank you. Good afternoon, Mr. Chair and honourable members of the committee. Thank you for the opportunity to present to you today. As the Chairman said, my name is Sue Hillis, and I'm the executive director of Dale Brain Injury Services, which provides assisted living, supportive housing, outreach and day program services to adults living with the effects of an acquired brain injury across the seven counties of the South West Local Health Integration Network geographic area. We receive half of our funding from the South West LHIN and half from the Ministry of Health and Long-Term Care directly.

As you may be aware, acquired brain injuries are the number one cause of death and disability for individuals under the age of 45. Every day in Ontario, 44 people acquire a brain injury. These folks need a multitude of supports and services to assist them in making a new life while dealing with their physical, emotional, behavioural and cognitive challenges. They need help acquiring and maintaining skills to enable them to participate in their community and attain their maximum level of independence.

We have found that some of the fundamental barriers to successful community placement for individuals are housing and transportation issues, as mentioned by my colleague Mr. Dunne. This is not unique to this population. When longer-stay alternate-level-of-care patient reviews were done in hospitals, not just here but across the province, it was discovered that it was as much a housing problem as a health problem that was preventing someone from going home. As well, if transportation was a barrier to accessing their primary care provider or other health services when home, they could not go home, as it would likely result in more acute situations.

As the LHIN continues to work towards integration of services and improving the local health system, it must work with the other sector partners to ensure that the social determinants of health are addressed, in order to be successful.

I'm speaking to you today with the perspective of my current roles as well as almost 25 years working in community-based health care, and five and a half years spent as a bureaucrat working in the southwest regional office of the Ministry of Health and Long-Term Care under two governments and three different Ministers of Health.

Since the inception of the South West LHIN, I have had the opportunity to sit at a variety of tables sponsored by the South West LHIN and participated in several planning and engagement activities, some of which provided

recommendations to the LHIN on investments they were considering. I think it's fair to say that I can give a reasonably educated opinion about the decision-making styles and processes of the two models, the LHIN and the regional office, at least in the southwest.

I believe I have given more input and, I feel, have even had a small amount of influence on some decisions made by the LHIN, much more so than I ever had working in the regional office. Local input and local decision-making is vitally important to ensuring that people get the supports and services they need in their local communities.

I'm the co-chair of the southwest community services council, which is a 10-member group that represents the 65 community support service agencies in the South West LHIN and which was formed in 2010. The 65 agencies wanted to have a body that could facilitate collaboration and knowledge transfer among the agencies, oversee projects and enhance communication with the LHIN and other community partner networks, with a goal to improving client services across the LHIN area.

The council has overseen several projects, including the development of some community performance indicators, which were ultimately included in the multi-sector service accountability agreement; the implementation of common assessment and referral tools and processes; and a LHIN-wide common client-satisfaction survey for the community support service providers. I'm happy to say that the South West LHIN community support service organizations, overall, have averaged 93% satisfaction with our services for the last three years.

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Last year, the council presented to the South West LHIN board on the importance of providing a base increase for CSS agencies, which has not occurred for several years. We had the opportunity to outline the potential impact on the clients in our LHIN area of another year with no base increase. As well, we presented the likely effects on other parts of our southwest health system resulting from this erosion of services, and the ongoing human resource challenges, such as recruitment and retention, arising from this. We were not successful in convincing the South West LHIN board to make an investment in an overall base increase for CSS this time. However, it was a good opportunity to educate the board and, hopefully, influence some later decisions.

Local input through community engagement, and local governance for planning, funding and accountability, is a vital component of the LHIN legislation which needs to be retained and strengthened. Community members sitting as governors of the LHIN, making decisions on investments that will directly affect the lives of their families, friends and neighbours, ensures that they view the decisions through the lens of someone who truly understands the unique characteristics of the area, the providers and the citizens. I'm sure that many of the LHIN board members could picture their friends and neighbours as we told the client stories and described our services and the impact that having less service might have on their communities.

Some might argue that these types of investment decisions should be made by a more objective party, perhaps sitting in an office in Toronto, but I think local governors are very committed to working with their partners to make a difference in their community. Accordingly, the health service providers feel much more like partners and strive to work with and understand the pressures on the governors when they know that the governors truly understand their community and the providers' pressures. We are all aware that decisions are challenging, with scarce resources, and can work together to maximize what we have.

For the last few years, I've been a member of the Health System Leadership Council, an advisory group to the South West LHIN, perhaps similar to the advisory panel described in recommendation 5-13 of what is known as the Drummond report. Our local Health System Leadership Council is made up of representatives from various sectors and stakeholder groups, whose purpose, in addition to providing advice to the LHIN, is to guide and lead change efforts across the system. People sit around that table with a system perspective and make decisions and recommendations accordingly.

The Health System Leadership Council was also very involved in the development of the most recent integrated health services plan. As well, there was input sought from all health service providers and a large number of stakeholders.

With this particular IHSP, the South West LHIN has really focused on educating HSPs about the importance of aligning their strategic directions with those in the IHSP. There seems to be a much stronger understanding and sense of the need for responsibility and accountability across the HSPs, to be aligned and to assist in achieving the goals in the IHSP and improving the system for citizens across the southwest. This is certainly an important step forward towards ensuring that all HSPs are engaged in the system and that individual providers are no longer making decisions in isolation.

I think this is one area that could be strengthened even more, with the LHIN taking further advantage of the power available to them. The indicators or performance metrics in the IHSP are still very acute care-focused—reflective, I'm aware, of the ministry-LHIN performance agreement—but going forward, these metrics need to reflect all aspects of the system, including the community, which is where we are trying to shift care. As well, there need to be more metrics that reflect our interdependencies and the need to collaborate to provide the optimal care for our community members. These, then, could be included in the various sector service accountability agreements, so they could be monitored by the LHIN.

There is also opportunity to develop metrics that show that we are working further upstream, focused on prevention and wellness. This would mean that the LHIN would have to engage further with community health and social service providers, including housing and transportation, and have more responsibility for other partners such as

health units and primary care. There are good relationships in place in our LHIN, but more could be done if the LHIN had more direct influence on these partners.

Thank you for your attention.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have enough time for everybody to have a turn at it. We have about two and a half or two and a quarter minutes per caucus. Mrs. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation—very interesting. I just had one factual question I wanted to ask you about first, about the fact that you receive half of your money through the LHIN and half from the ministry directly. Is that because of the nature of the work that you're performing? Is there specific money allocated for brain injuries?

Ms. Sue Hillis: Yes. The ministry-managed programs have retained some of the funding for brain injury programs across the province. We're considered to be a provincial resource, so we actually have beds that are a provincial resource as well.

Mrs. Christine Elliott: Okay. Thank you. The other question that I wanted to ask you about was: The council that you're sitting on, the community services council—is there one in every LHIN? Is that something that's mandated? I should know that, but I don't.

Ms. Sue Hillis: No, it isn't. We developed this on our own. The agency has determined that we thought this was a good idea, and several other LHINs' agencies have begun to develop councils as well, or some collective body. But no, it's not mandated at this point.

Mrs. Christine Elliott: It seems to me a really good way of bringing together those agencies that may be funded both by health and community and social services, to take those not strictly health-related factors into consideration, and to make sure that that is included in the entire package, so that you can see the client holistically. Is that the purpose it was intended for?

Ms. Sue Hillis: Well, the purpose is to improve client lives and the services that we provide, so yes, that would be—

Mrs. Christine Elliott: That's a really good suggestion. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you. The third party: Ms. Sattler?

Ms. Peggy Sattler: Thank you very much for the presentation. I was really interested in your recommendation at the end of the presentation about additional metrics. In particular, you mentioned metrics that reflect our interdependencies and metrics to show that we are working further upstream. I wondered if you had specific ideas in mind when you made those recommendations. What would that look like? What would be metrics that reflect our interdependencies and metrics to show that we're working further upstream?

Ms. Sue Hillis: Well, to start with, the interdependency piece: We're just in the process, as has been mentioned, of developing coordinated access here, through the CCAC, for all community services. I think that, going

forward, it would be a good idea to now reflect on how we're working with that coordinated access, both from the community support service side as well as the CCAC side, to hopefully show improvement in terms of access for people as a result of that interdependency. That would be one example.

Similarly, talking about wellness and working upstream, we really don't measure our prevention and wellness programs at this point, certainly not as part of—unless it's a service that we're providing. We're showing output, the number of people who have gone through the program, but not really outcomes of those people. So I think it would be important to develop some outcome measures that would really reflect whether we're making a difference down the road.

Ms. Peggy Sattler: Thank you.

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

Ms. Teresa J. Armstrong: Thank you, Ms. Hillis, for presenting today.

You also mentioned a couple of fundamental barriers. I have heard of this reoccurring situation—the housing and the transportation issue. Can you just quickly describe how the outcome of the people that you serve would benefit from the housing and transportation—what it looks like now without it, and then what it would look like if it was integrated into the LHINs?

Ms. Sue Hillis: It's very difficult to find accessible and/or affordable housing. The combination is almost impossible to find. So we find that we're putting very vulnerable people in less-than-safe housing. Obviously, it makes them less successful if they're in an area that is not appropriate for them. I think it often sends them back to other situations that we're trying to prevent, where they may end up in long-term care or in hospital because they can't manage.

Similarly, the transportation issue, particularly for our rural clients—they're unable to get to our day programs and our group services unless we have staff picking them up.

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

Ms. Helena Jaczek: Thank you very much for your presentation. I'm also very interested in this Health System Leadership Council. How many people are around the table, approximately?

Ms. Sue Hillis: Approximately 20.

Ms. Helena Jaczek: I presume you report into the board of the LHIN. What exactly is the connection?

Ms. Sue Hillis: It's not a direct reporting relationship. It's an advisory relationship.

Ms. Helena Jaczek: Yes, but how do you physically do that? Do you do that at LHIN board meetings, or do you write a report?

Ms. Sue Hillis: No, the LHIN staff reports through to the board.

Ms. Helena Jaczek: Okay, so you don't physically come together. Do you have public health at the table? You've talked about the LHINs—

Ms. Sue Hillis: Yes, but they're on the health system leadership—

Ms. Helena Jaczek: They're on that particular group.

The LHIN legislation requires something called a Health Professionals Advisory Committee. Are you aware if that's where your group came from or of it's an adaptation of that?

Ms. Sue Hillis: No, it's not directly an adaptation of that.

Ms. Helena Jaczek: Are you aware that there is another committee—

Ms. Sue Hillis: Well, there was earlier on. I'm not aware at this point.

Ms. Helena Jaczek: Okay; I'm sure we'll end up clarifying that with the LHIN itself. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated.

SOUTH WEST PRIMARY CARE NETWORK

The Chair (Mr. Ernie Hardeman): Our next deputation is South West Primary Care Network: Rob Annis, co-chair. Welcome. Thank you very much for your presence today. We look forward to your presentation. You will have 15 minutes to use as you see fit. If there's less than four minutes left, one caucus that will be taking the time; if there's more than four minutes, all three caucuses will have questions. With that, your 15 minutes starts now.

Dr. Rob Annis: Thank you very much, Mr. Chair, and committee members. It's really great to be here to give input on this subject. My name is Dr. Rob Annis. I'm a family physician in Listowel, Ontario, which is about an hour and a half away from here, where the weather is not quite as bad as here today, luckily. I'm also on LHIN staff as the primary care lead. I'm one of four primary care leads. Each of us works one day a week with the LHIN. I'm co-chair of the South West Primary Care Network. This is a structured way of engaging primary care in regional and local planning that we've put together over the last two years here in the LHIN. I've been on many committees with the LHIN since about 2008, as well, so I guess I'm well versed in how the LHIN has been doing. I did speak with our primary care network, which is a group of primary care leaders from around the geographic area, to get their input for the comments that I'm giving you.

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Basically, I have two points from the primary care world, and one is that the South West LHIN has enabled front-line primary caregivers to have a say in regional planning, from a voice that puts the system first as opposed to any particular viewpoint. That has been very much appreciated. The second is that the LHIN could be given more control, in my opinion, over primary care accountability and resource or capacity planning for primary care. Just to go into that a little bit, before the LHINs existed there were 800-plus family physicians and nurse practitioners in this area who were more or less doing their own thing, disconnected from the system. If

people were planning programs, their health care organizations—CCAC, mental health organizations and some of the other presenters here today—they had no structured way to engage primary care in any of those programs. So when they got to our doorstep, frequently they didn't work for us because we hadn't had input before. It was a loss in the system. Many decisions were made in Toronto; we didn't really have a voice in that at the ground level.

With the LHIN, starting back in 2006, especially in the southwest, there has been a very passionate and hard-working attempt to engage primary caregivers. With that, I mean mostly family physicians and nurse practitioners in the work that they're doing, and bringing them to the table with other health care organizations, CCAC, mental health, community service providers, so that more or less we're planning together so that things work better all around. That culture, that work that they've done to really welcome us to the table has paid off and has become more structured, and part of that structure is the South West Primary Care Network, which I mentioned. Again, this is a group of primary care leaders from around the LHIN who meet regularly to offer advice on regional program planning, as well as communicate backwards to the local areas about those particular issues. So we're sort of fanning out in both directions.

To give you some examples of things that we've talked about and maybe successes that we've had with the LHINs, I've just made a short list here:

—SPIRE is an electronic medical record solution that downloads hospital data directly into family doctors' electronic medical records;

—MRI wait times, not so much that we've pushed that, but certainly the primary care world has really appreciated what the LHIN has done with MRI wait times in our LHIN;

—The primary care network has discussed, in particular, the location of CCAC flex clinics, which are wound care clinics mostly, cancer screening and the diagnostic assessment programs through CCO. We've given input into those programs and the rollout of those in our LHIN;

—We had discussions about the loss of thoracic surgery in the Owen Sound area. We had a lot of discussions about hospice palliative care development in the north, which was a big issue for a while;

—We are sort of leading referral reform in the province. Referral reform between GPs and specialists is a big problem and needs to be changed. We're starting to develop a process in engaging other provincial organizations in potentially solving this;

—We've had success with colonoscopy access in London, which was horrible, and removing barriers to dealing with Health Care Connect to roster unattached patients, specifically we've had success with diabetic unattached patients;

—Health link development: You've heard of health links. Health links are supposed to have a very strong primary care component—voice, input, involvement—and that has been difficult to do provincially. What we're

doing is developing the South West Primary Care Network locally, in line with the health links geography. For example, the Huron Perth Health Link, which my particular family health team is the lead for, is working with the Huron Perth Primary Care Network, which is a subgroup of the South West Primary Care Network, so we have a very structured way of engaging family physicians and nurse practitioners in the work of the health link as it goes; and

—Partnering for Quality and Partnerships for Health: These are both South West LHIN initiatives. Partnerships for Health was a quality improvement initiative that touched more than 70 practices in our LHIN to improve diabetic care using QI, quality improvement, techniques and data mining. It has been written up in at least two peer review journals with very positive results. Out of that has grown Partnering for Quality, which is a LHIN resource in terms of IT support for data mining, for practices, as well as quality improvement coaching that is well used.

So all of these are examples of how the LHIN has touched primary care and we have a really great working relationship. There are very hard-working staff, frequently stretched by what's coming from the province, and I really have to give them credit as a staff for engaging us in the process.

The time is ripe, in my opinion, to move forward with more LHIN involvement in primary care, specifically around accountability and resource planning. Right now, the LHIN really has no levers into changing primary care. They've done many good things despite that. They do control the finances for community health centres, but in no way for family physicians or nurse practitioners. I think there are certainly barriers to having them fund family physicians that you would likely see from the OMA, but there are probably interesting ways to get accountability in the system, either by holding primary care boards, which are developing right now in the CHC family health team, a nurse practitioner-led clinic world—holding boards accountable for some of what they do or potentially having financial mechanisms like they do in the medical home model in the States where if you do do certain QI and access initiatives in your practice, you are given a larger percentage of base funding. So I think there are, potentially, mechanisms to give the LHINs more control over what happens in the regional and local primary care world to drive quality in that sector.

In resource planning, right now there's absolutely no control. If we have sections or a LHIN that need primary care, really, we leave it up to that community to hope to find somebody. I think that a more regional approach to planning, so that we can aim community health centres or family health teams or even solo practices at certain areas, is something that would really help the people in our LHIN.

Those are my two basic points. It's a very positive report from the primary care world for the existence of LHINs. I've really appreciated the way they've worked

with us, and I'm happy to take any questions if I have a few seconds.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do have a question from each one. We have about two minutes for each party. We'll start with the NDP, the third party: Ms. Sattler.

Ms. Peggy Sattler: Thank you very much. I just had one quick factual question. This South West Primary Care Network: Is there a similar network in place in all of the LHINs across the province or is it unique to the South West LHIN?

Dr. Rob Annis: I would say that the South West Primary Care Network was the first one off the ground, but what's happened is that every LHIN hired a primary care lead about a year and a half ago. So that's my job, as well. The South West Primary Care Network existed before my job did. In this one, it kind of grew up without those hires, but the mandate of every one of the primary care leads is to formalize a network in their respective LHINs. That's happening in each LHIN right now.

In particular, in Champlain, they're very well advanced. In each health links geography, they have a local primary care network with a chair picked and regular meetings, and in the Central group as well. In the South East LHIN, it also is fairly well advanced. I think those are the three that are furthest along in the process.

Ms. Peggy Sattler: Have there been challenges for you to find primary care physicians, to bring them in to this LHIN network that you're creating?

Dr. Rob Annis: Yes. The usual term is "herding cats," so yes.

Ms. Peggy Sattler: So how have you dealt with that?

Dr. Rob Annis: Again, the lack of levers for the LHIN makes it difficult, but what we've been able to sell is input. Family physicians, at the end of the day, want to do a good job and they want the system to work. They know it doesn't, frequently. It makes their day harder, plus it makes things worse for their patients. Having the ability to have a voice in what happens is the selling card, and people buy that.

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

Mrs. Donna H. Cansfield: Thank you very much. A very interesting presentation. From the statistics, the area you represent has probably one of the fastest-aging populations, and yet I haven't read anything about what you're doing in terms of dementia, Alzheimer's, and dealing with aging and rural issues.

Dr. Rob Annis: Yes, that's fair. I'd have to think about the agenda to see where—I mean, certainly, the work we've done with cancer and connecting with many of the groups—most of our work is with elderly people with chronic disease, actually.

The health links initiative, as you know, is aimed at the top 5% of users, which are people with chronic disease and tend to be the older age group, although not always. And so a lot of what we're doing is involved with them, but I don't think we've done anything per se with dementia. I think that's probably fair.

Mrs. Donna H. Cansfield: So it is always an opportunity.

Dr. Rob Annis: Yes.

Mrs. Donna H. Cansfield: Thank you very much.

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

Mrs. Christine Elliott: Thank you, Dr. Annis, for joining us today and for your presentation. A lot of presenters have mentioned to us that primary care should be included as part of the work that's being done through the LHINs, and so congratulations on the success of your network.

From what you're saying, it sounds like one of the major barriers to it being fully embraced is objections that other groups—primarily OMA—might make, so that we'll have to do indirectly what we can't do directly through some of the other funding mechanisms. Am I taking the right point from this? Or is this—

Dr. Rob Annis: Yes. I certainly don't feel comfortable speaking for the OMA on this particular issue, but I would guess that funding family physicians through LHINs would be problematic to develop. Certainly, the OMA is on board with the health links development, which does have a measure of accountability in it. Plus, the OMA is agreeable to the governance development that's going on right now in the primary care world. I think there would be ways of—and I think family physicians would be for this; it would have to be clever, I get that—adding accountability regionally so that things can work better at the local level for patients. A lot of money goes to family doctors in the primary care world right now, and it really is without any feedback on whether it's a bang for the buck.

1530

As a family physician, I'm comfortable and confident that what I do every day is helping people, but I want to see the data too. I think there is a lot of buy-in for having data mining and accountability for what we're doing every day with the taxpayer dollar. It's only been recently that we've had the EMRs so we can start to get at this data, but now that we can, I think we need to develop those mechanisms, and that will really drive improvements to the system.

Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. As was mentioned, we have heard a lot about primary care being involved. I think you're the first doctor who came up with the thought that it was a really good idea, so we appreciate that.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation is the South West Local Health Integration Network: Michael Barrett, chief executive officer, and Jeff Low, chair. Welcome. Thank you very much for being here. Actually, you live here; right? We're visiting. But thank you very much for being here this afternoon to help us with our public consultation. As with all the other delegations, you'll have 15 minutes to make your presentation

and you can use it any way you like. If there's less than four minutes left over, one party will ask the questions or make comments; and if there's more than four minutes, I'll divide that as evenly as I can to make sure everybody has a say. With that, the floor is yours.

Mr. Jeff Low: Thank you very much, Mr. Chair. I am Jeff Low, the board chair of the South West Local Health Integration Network. I'm here today with Mike Barrett, our CEO. I want to thank the members of the committee for taking time out of a busy schedule, and at a very cold time of year, to travel around the province and come to London, Ontario this afternoon, as you undertake the review of the Local Health System Integration Act.

We're certainly pleased that we could have a few minutes of your time to talk about the role that the South West LHIN plays in creating what we think is a sustainable, high-quality health system and, more importantly, the role that we play in improving the health system for patients, clients and residents in all of our communities.

As board chair, I am delighted that so many of our colleagues from the South West LHIN and the other health service providers have joined us today as well, talking about the role the LHIN plays and the role that they play in health care throughout the southwest and hopefully providing you some serious input on how LHINs can be better and serve the population better moving forward. I hope that we'll be able to address the committee's questions today and assist this committee in fulfilling its mandate with the review.

I'm going to pass it over to Mike for his comments, but before that, I would like to talk about the LHIN in general.

I've been involved as a volunteer in health care in the southwest for over 20 years. I was here before LHINs, and I can honestly say that the difference is remarkable, in my opinion. I remember what it was like back then, before LHINs. I remember district health councils and some well-meaning people who tried very hard to do the very best they could, but the difference is remarkable. Having seen both models in progress, I can't imagine a program or a health system moving forward without something like a LHIN—call it macaroni, if you like—on a moving-ahead basis. We all live in this area, in the southwest. All the people you've heard from today are from the southwest. They're neighbours, they're colleagues, and we're all working to make the system better. I hope the LHINs are here to stay—as I say, whatever you want to call them—because I think they do make a difference, and I would ask you to bear that in consideration as you consider your deliberations as you go ahead.

I was also the board chair of the London Health Sciences Centre for two years. I was on the board of the London Health Sciences Centre for many years, so I get it when it comes to health care.

Having said that, Mike, I'm now going to turn it over to you, please, and maybe to take the document we handed out and share some examples of progress.

Mr. Michael Barrett: Great. Thanks, Jeff. Thanks, Mr. Chair, for having us today. My name is Michael

Barrett. I'm the CEO for the South West LHIN. I appreciate the committee taking the time to talk with us today.

There are two documents that we circulated around. One is our speaking notes, and the second one is a handout, which I'll refer to throughout my presentation.

I've spent the last 14 years in health care working with the Ministry of Health regional office here in London, and I've also held a number of positions with London Health Sciences Centre, St. Joseph's Health Care and the Children's Hospital here in London as well. I came to the LHIN in 2007 and was appointed to the CEO in 2008 by the board of directors.

Over the next eight or nine minutes—and we're trying to make sure we save enough time for questions for the committee members—I'd just like to talk about the advantages of LHINs, what we think the advantages of LHINs are and how our work has positively impacted the population here in the South West LHIN.

One of the first advantages, we believe—and this going down that first page of the handout—is less bureaucracy. You've heard this from a couple of speakers already. The 14 LHINs replace seven regional offices of the Ministry of Health and Long-Term Care and 16 district health councils. What that translates into for us, here in the South West LHIN, is that we have 40 employees. Previous to us being here, the district health council, plus the regional office, had 80 to 90 employees, so a significantly higher number than what we have here now. We believe that LHINs are actually reducing big government, not creating big government.

I've worked in the regional office. I've worked closely with district health councils. Both of those organizations were missing the key part of decision-making, and that's the decision around the allocation of funds. Without that decision-making on funding, these organizations didn't have the ability to implement their work and, more importantly, influence system partners. So it was very difficult to make system change.

LHINs now have the planning work undertaken by DHCs and the transactional funding responsibilities of the regional office and have the ability to make these funding decisions, which I referred to. Not only do LHINs have the authority to make decisions around funding allocations, plus much more, we're doing it with less people than what had existed in the system before us.

The second advantage of LHINs, we believe, is local decision-making. I'm sure you've heard this at other committee meetings. All of our decisions of the LHIN, including funding decisions, are made locally at our board meetings that are open to the public. All of our board agenda packages are posted publicly on our website five working days in advance. The third part is that local health service provider boards have been maintained. We believe that's a strength within the system.

The monthly meetings of the South West LHIN board have been held in all corners of the LHIN, including rural and aboriginal communities. Our board has held its meetings in communities from Port Rowan to Tobermory, and, after eight years, we have visited most towns

across our geography. We've also had a board meeting at the Chippewas of the Thames First Nation and another board meeting at the Kiikeewanniikan healing lodge on the Munsee-Delaware First Nation. The list of those previous board meetings are on the back page of the handout as well for 2013-14.

What that means, and you've heard this from other presentations, is that no longer are decisions made in Toronto by someone in the ministry. That used to be what they'd say: It's someone in the ministry. They're made by board members who live here in our communities. The public sees them in the grocery store or at the arena and at community events.

Another important part is that the media is there for all of our board meetings. Whether we're in Owen Sound or Tillsonburg, the media is there. They can see first-hand the staff recommendations, the debate of the board and, finally, the decision. And the media can interview the board chair immediately following the meeting. So there's no filter or barrier between the decision process and the public.

The third advantage for LHINs for us is increased accountability. LHINs have a formal accountability agreement with the Ministry of Health and Long-Term Care. We then have accountability agreements with our health service providers. We have over 200 service accountability agreements with our 150 health service providers. Those agreements did not exist prior to LHINs, with the exception of some simple hospital service accountability agreements.

Another advantage to LHINs is a system approach to health care, breaking down the silos. The health care system functions differently than it did in the past. Partnerships have been created and are enhanced where they may have not existed before.

Brian Dunne mentioned earlier the relationship between University Hospital and Participation House. I won't repeat the story, but there's an example of where a patient went from the most complex place in the health care system—an ICU bed—to a community organization, living in a residential setting. Not only is it the most complex, but it's the most expensive. So we've been able to help bring those partners together. It's not all us; it's the partners working as well to ensure that a young man can live independently where he wants to live, in a residential setting. There's a picture of Ricky on page 8 of our handout, which are some of the patients' stories. He's a big Toronto Maple Leafs fan.

Lots of other stories are captured in our handout today. You're hearing some from the presenters today, and I'll also let you look at that handout.

Health performance: We're setting targets and measuring performance. If our health service providers do not meet those targets, there are interventions that we take. It starts with a simple meeting and can escalate to a performance improvement plan if the provider is not meeting the targets. That's really key, that those targets set the standard for what we want to see within the system in terms of system change.

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Finally, community engagement: We do extensive community engagement in a number of ways. You'll see on that back page of the handout that at every second board meeting, we do a board-to-board engagement session. We also do a community engagement session. So last Tuesday night, on a cold Tuesday night in Goderich, we did a board-to-board session and a community engagement session, where we engage board members from health service providers across and within that community. If we're in Tillsonburg, we hold the meeting there; if we're in Goderich, we do it there—in Owen Sound, and all around the different parts of our LHIN.

We also ensure that we connect with physicians—we do physician engagement—our local MPPs and also with municipal governments. A great example of meeting with municipal governments: Sandra Coleman had spoken about the redistribution of complex continuing care and rehabilitation beds across the LHIN. We had three hospitals that, through this process, were actually getting a reduction in the number of beds. We're taking the resources and putting them into a place elsewhere within the LHIN that needed those resources.

The municipal councils were quite concerned, but they had the opportunity to meet with us face to face. I had to go present in front of these municipal councils, and they gave me a rough ride. I also met with county council. But there they had the chance to ask someone face to face, in person, why we were making these decisions, why we had those recommendations and why we were going about doing this.

What I'm trying to convey is that we take community engagement very seriously. With a large LHIN with 150 health service providers and includes 27 emergency departments—it takes about six hours to drive from tip to tip of our LHIN—it's not easy, but we engage the public and stakeholders to make sure they're informed and have input into our decisions.

Just to wrap up: We really remain humbled by the amazing work done every day by our front-line providers in the hospital community and long-term-care settings. As the South West LHIN, we're proud to have a leadership role in this system.

But we do believe that we can do better and that changes to the LHSIA legislation will help us accomplish that.

You've heard about the need to make changes around primary care. We're fully supportive of that, and I think, with primary care being the foundation of the health care system, those changes will be beneficial to all of us.

So LHINs are not perfect, but we do believe that we have brought positive change to the system. We're so pleased, as Jeff said, that so many of our health service providers are here today to give the committee advice and input so they can make the necessary changes with the LHSIA legislation.

Thank you, and we're happy to answer any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about four minutes left for questions—

just slightly over four—so if we can keep them all very short. We will start with the government side.

Mrs. Donna H. Cansfield: Thank you very much for your presentation. I'm going to ask the same question I asked before. You identified the large proportion of seniors, and yet I see no Seniors Strategy in any of your notes or in any of the handouts, so that's one.

The other is, I want to ask you about the issue of how you could see reducing—you have 150 organizations. Obviously, the administration costs are high. Do you participate actively in helping to merge or integrate services?

Mr. Michael Barrett: Sure. Through you, Mr. Chair, to the question about seniors: A significant amount of our work relates to seniors. Two examples that I'll give are the Behavioural Supports Ontario program, which provides additional funding and training to long-term-care homes—here in the South West LHIN, we have 79 long-term-care homes—to ensure their staff are trained and knowledgeable about how to deal with seniors with dementia and with behaviours. That funding is allowing those long-term-care residents to remain in their homes longer.

Mrs. Donna H. Cansfield: But that's done through the CCACs.

Mr. Michael Barrett: It's funding that's provided through us, through the South West LHIN.

Mrs. Donna H. Cansfield: Right. So do you do the monitoring and assessment, then, of those programs, once they're in?

The Chair (Mr. Ernie Hardeman): Time's up. Ms. McKenna?

Mrs. Donna H. Cansfield: Sorry.

Mrs. Jane McKenna: Thank you so much for your presentation today. I just have a couple of questions.

When we were in Niagara, there was a lady there named Pat Scholfield, and she was trying to find out when these meetings were on and decided, instead of complaining, she was going to just dive in so she could have some input of what she was doing.

She said that it was so difficult to actually find out when these meetings were, and even when she got there, there was hardly anybody there for her to give the information to that she wanted to give. Then she was concerned about the information she fed back to them: Where was that going? Because she had a hard time getting any email back from people that she was asking.

My question to you is, where do you actually advertise this so people know where to go?

Mr. Michael Barrett: We do extensive advertising. I'll give this example: We had a board-to-board engagement session and community engagement session in Lion's Head, which is halfway up the Bruce Peninsula. We advertised it in the local paper, we advertised it on the radio station, and we also put it on our website, to ensure that people had that information.

The interesting part is, when I got there, the front row was full of a group of senior ladies, and they said I

should have used this radio station as opposed to the other one. So they gave us advice back.

But we do try and get that message out as clearly and quickly as possible.

The Chair (Mr. Ernie Hardeman): Third party?

Ms. Teresa J. Armstrong: Thank you very much, both to Michael and Jeff, for coming today. Just kind of building on that question, it sounds like maybe some LHINs get the word out better than others when there are board meetings or community engagement meetings. Perhaps that's something the LHIN needs to work on: collaboration with other regions.

We had a presenter today in Kitchener–Waterloo, and it was the first time in a long time that someone mentioned—he was a police chief. He was speaking about how the mental health services, when they go out on calls—how their roles have changed and how the services that they provide should be enhanced.

Do you see that role with what the police are doing now with regard to the escalation of mental health out in the community because of the transformation? If you could elaborate on that, I'll let you—

Mr. Michael Barrett: We've worked closely with the police department here in the city of London, and it is around mental health patients. Mental health patients should not be in the back of a police car; they shouldn't be in the emergency department. They should be receiving supports either in hospital, if it's an acute episode, or within the community.

We work closely with the chief of police here in the city of London to update our mental health crisis response team. With the community mental health provider, CMHA, working with the police and working with us, we've been able to establish that team, and it has been very successful.

The chief is to be reporting back the stats in terms of how much of his officers' time was actually tied up prior to this change versus after. That information will be coming probably in the next six months or so.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, both of you. It was very informative. We appreciate you taking the time to be here.

DR. MICHAEL SHARPE

The Chair (Mr. Ernie Hardeman): Michael Sharpe, professor at Western university. As we're getting the presentation ready, we thank you very much, Mr. Sharpe, for being here. We also want to tell you that you have 15 minutes to make your presentation. You can use any or all of it for the presentation. If you do not use all the time, less than four minutes will go one caucus and more than four minutes will be spread amongst them.

With that, the next 15 minutes are yours. Thank you very much.

Dr. Michael Sharpe: Thank you, Mr. Chairman and members of the Standing Committee on Social Policy.

I'm Michael Sharpe. I'm a full-time intensivist at University Hospital, London Health Sciences Centre. I'm

a member of the coordinating committee for Critical Care Services Ontario. I'm a member of the provincial repatriation committee for Critical Care Services Ontario. I'm a member of the LHSC access and flow steering committee as well as the regional steering flow committee. I've been intimately involved in developing critical care policy for the province of Ontario.

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My comments today pertain to my role as the South West LHIN critical care LHIN lead for the province of Ontario and the work that we've done in the South West LHIN and how this has driven health care policy province-wide.

I must also add that at some point in time, I probably voted for each and every political party that's represented this morning.

Should we go?

Interjection: There's some button you have to push—

Dr. Michael Sharpe: It's F4. If this doesn't work, I don't really—that's fine. It's frozen here.

The advisory board for the province of Ontario was developed in 2007, and we had one critical care representative from each of the 14 LHINs. There was a reason for this, and that was the SARS epidemic.

We all remember SARS. What it taught us was that we have tremendous expertise in providing critical care to patients. What lacked was the system. The system was terrible. We all worked in silos, and we had no organization and structure to deliver appropriate care to all our citizens in Ontario.

In 2010, we had a letter from the regional coroner regarding coroners' cases of patients who did not do very well. It wasn't a failure of appropriate treatment; it was a failure of the system. What they recommended at that time was that, within each LHIN, there should be a defined process to ensure access to each of the services defined as life-or-limb. In other words, if you did not receive appropriate therapy within four hours, your life was at stake or a limb was at stake.

There was a need for a no-refusal policy. This idea of "I'm sorry, we can't accept this patient; we have no beds" had to stop, so we had to change that philosophy. It became "patient first, bed second."

As a result of that, we presented our program to the South West LHIN: a new life-or-limb, no-refusal policy, the first of its kind in Canada. They were fully in support of this, and they provided us with a project manager to carry this out.

It was a lot of work. It was collaboration with all of our stakeholders within the South West LHIN: not only administrators, but physicians of all of our hospitals in the South West LHIN, and also all of the other services that involved critical services, not only within our hospital, London Health Sciences Centre, but community hospitals as well.

So, "patient first, bed second" was our philosophy. With much hard work and the results of this pilot project, two weeks ago Monday was a major breakthrough in critical care services in Ontario. This policy became

implemented as provincial policy in all our hospitals across the province.

Following that, we did better, but we could have done much better. The problem is, we talk about equality of care and access to all critical care services. That's impossible. Our geography doesn't allow that. If you're going to have a stroke, if you're going to have a heart attack, you're better to do it in the lobby of London Health Sciences Centre as opposed to a walk-in clinic in Warton. That's the nature of the beast.

What we need to do is to have immediate access of individuals who are taking care of these acute, critically ill patients. Therefore, we went back to the South West LHIN and asked them again for another project manager, so that we could develop the Extramural Adult Critical Care Response Team. That is, we have ICU physicians now on call 24/7 to respond to these people who are calling for help. The family physicians in their emergency rooms in these small community hospitals, where the care of these patients is exceeded—the resources are not available to them. We will respond to them within 10 minutes. We will accept these patients and find the hospital resources to take these patients within 30 minutes.

This has been a tremendous improvement in terms of communications between physicians referring critical care patients to tertiary-care hospitals. Again, this was a result of the hard work that was provided by the people within the South West LHIN.

We also presented this to the provincial board, Critical Care Services Ontario. Our response was lukewarm. A similar response to the life-or-limb policy was lukewarm. That's when Michael Barrett came in and said, "Mike, we've got to go to the LHIN boards across the province. We have to tell them that this is what we need to do." That's what happened, and the life-or-limb policy is now provincial policy.

So, these results show that increasing efficiency of care by ensuring timely access to consultation with critical care intensivists and other consultative services.

Using the one-number system from LHSC—timely referral to the appropriate care institution. We accept them within 30 minutes of the physician calling us.

Optimal resource utilization, such as transport—I'll refer back to transport near the end of this talk.

All life-or-limb referrals are coordinated through the provincial CritiCall system, and that allows us to capture all data.

We improved collaboration by developing an operational algorithm, effective for all South West LHIN hospitals and CritiCall, and aligned one-number protocols within the South West LHIN hospitals, so we're providing immediate care for these patients who need it.

We also enhanced patient-physician health care team experiences by facilitating stabilization recommendations with respect to stabilization and transport of critically ill patients between hospitals in our LHIN. We also maintain a high degree of satisfaction among physicians on both sides of the phone, including the health care teams,

in the handling of life-or-limb patients. These patients will not now inappropriately die because the system did not work.

In 2009, we again went to the South West LHIN for another project. Every time Michael sees me come in the front door, he runs and closes his door. This is another project—again, a project manager—which allowed us to build an interprofessional system that optimizes delivery of care to long-term ventilation patients. It's a small number of patients, but they're consuming a large number of ICU beds in our acute care and intensive care units. These patients often live for months in our intensive care unit.

We've heard about Ricky. He spent over a year in our intensive care unit. It's a cold, unfriendly environment. Ricky is now in the community with Participation House, who care for this patient appropriately. He's now in a residential setting. What a better way to live the remaining years of his life.

This clarified resources needed to effectively, efficiently manage the system and how we deal with people with long-term ventilatory requirements. It also developed an educational strategy to augment all caregivers, and it created tools, care maps and checklists to encourage standardized care. As a result, we now have an 80-page document, which is sitting in the South West LHIN office. It's a systems model to meet the health and supportive care needs of adults living with chronic mechanical ventilation in the South West LHIN. This is what we're going to take to the province.

The next step is to determine how we can manage the resources and what we need in the community to allow this to happen so that we have the knowledge and expertise to care for these patients in the community—not only hospital communities and Participation House, but some of our patients are in their own home with mechanical ventilation. So it's a very complex but very appropriate system for management.

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The role of the LHIN: They're making the system work. They approve access to critical care. They improve flow: taking these patients into our hospitals but repatriating them back to our community hospitals. They decrease the bottlenecks. Remember, if you don't have a healthy intensive care unit in your hospital, the entire hospital breaks down. We have patients sitting in an emergency room, trying to get into the ICU. We stop elective surgeries because we cannot take cases from the operating room because we're full of patients. Some of those patients should not be taken care of because they should be back in their community. So we take a geographical and population perspective. We offer the best care we can in the most efficient and immediate way possible.

Driving to the future, changing the philosophy or practice of physicians, you can only do it two ways: money and data. You don't have money to give them; they're paid well enough. What we need to do is collect data that's accurate so that we can change practice and

we can change the accountabilities of everyone in the health care system: administrators, physicians and so on.

We need to match funding with activity. I think the funding of hospitals is archaic, inappropriate and bizarre. There's something wrong here. We need to take a hold of that and match funding with activity and make that also in line with the accountabilities.

We also need to invest into end-of-life care. We need to match expectations with resource utilization. We all know about the Rasouli cases. Those are becoming more and more frequent. This is inappropriate and inaccurate utilization of health care dollars. The ICU is a very expensive business, second only to the operating room, and we need to use our resources and we need to utilize our monies very efficiently and as effectively as we can. We have to get control of our health care costs, and critical care is one of the first steps to do that.

What I'm really referring to is palliative care. A lot of our patients that continue to be admitted to our intensive care unit should not be there. Let me give you an example: someone with end-stage lung disease. They know they do not want to be intubated and put on a ventilator; they are at their end of their life. But if palliative care fails them, they are suffering at the time of their death, and what happens? They run into the emergency room; they're intubated, and they end up in the intensive care unit. No one wants that, including the patient. That's palliative care, not only within our hospital walls, but also palliative care out of the community. They will develop and form a very important role in how we deal with these patients within our community. There are spots of excellent palliative care systems within our province, but for the most part, we do a lousy job. So that's where we need to invest our future investments with respect to that.

I have nothing more to say. I'll be happy to answer your questions.

The Chair (Mr. Ernie Hardeman): I was just going to say you have two minutes left to say it, and then I find out you didn't fill it in.

Dr. Michael Sharpe: If the committee wishes, I can make copies of this presentation and then give it to them.

The Chair (Mr. Ernie Hardeman): Yes, that would be—

Dr. Michael Sharpe: I apologize.

The Chair (Mr. Ernie Hardeman): Thankfully, you did speak very clearly, and Hansard will record every word that you did say. Copies of the presentation would be beneficial, I think, and I'm sure the committee would agree. With that, I just want to say thank you very much for making the presentation, because I've just about used it up from the time you took—so thank you very much. You were very informative, so that's why we didn't need a lot of time for questions, I'm sure.

CANADIAN NATIONAL
INSTITUTE FOR THE BLIND

The Chair (Mr. Ernie Hardeman): Next is the Canadian National Institute for the Blind, Vijay Chauhan, director of government relations and advocacy, Ontario-

Nunavut, and Sherry Malcho, regional director, west, of services and operations. Welcome, and thank you both for being here. You will have 15 minutes to make your presentation. You can use any or all that time, and any time left over, the committee will use it and ask you questions and make comments about your presentation. Thank you very much for being here.

Mr. Vijay Chauhan: Thank you, Mr. Chair, and members of the committee for giving us this opportunity to speak with you today. My name is Vijay Chauhan and I'm the director of government relations and advocacy for Ontario-Nunavut CNIB, and, of course, I'm joined by Sherry Malcho, who is our regional director of services and operations for western Ontario.

CNIB is a registered charity that provides community-based support, knowledge and a national voice to ensure Canadians who are blind and partially sighted have the confidence, skills and opportunities to participate fully in life. To do that, our specialists work with people of all ages who have experienced vision loss to provide emotional support and personalized restorative rehabilitation services that foster everyday living skills and allow people to remain independent in their own homes. We also offer access to a range of innovative consumer products, assistive devices that make life with vision loss easier, as well as the CNIB library, Canada's largest collection of reading materials in alternative formats like Braille and audio. In addition to our community-based services, we work hand-in-hand with Canadians who are blind and partially sighted to advocate for a barrier-free society, and we strive to eliminate avoidable sight loss through research and public education.

Vision loss is a complex issue, with many underlying challenges. It is common for individuals to feel depressed, angry and alone after experiencing vision loss, and feelings of isolation and dependence are commonly reported. CNIB helps those struggling with the emotional challenges by assisting with the adjustment to vision loss through our essential support services. Our clients have achieved basic living skills, such as how to safely travel. We work with career and employment services providers to help our clients access the information resources they need to build their job skills and achieve a satisfying career. Given that less than a third of Canadians with vision loss are employed—more than half live below the poverty line on annual incomes of less than \$20,000 a year—employability is a key area of concern for this disability group.

When it comes to children and youth, CNIB is an essential, trusted expert in the habilitation of children and support for families. We help children who are blind and partially sighted achieve developmental milestones and grow into successful, confident adults by giving children the support they need to excel. We also provide parents with educational materials, peer groups, access to local resources and workshops on raising a child who is blind or partially sighted.

Our vision rehabilitation services are essential to ensure that a loss of vision does not equal a loss of life,

which is why CNIB's mandate is to help people see beyond vision loss.

CNIB supports the concepts underlying the local health integration networks, whether it's coordinated services that are customer- or patient-focused, services that match community needs, an efficient health care network and the promotion of wellness and independence.

We come before you today in two capacities: as a community health care partner in the voluntary sector and as an agency serving people with disabilities.

In 2006, CNIB and other agencies serving Ontarians across LHIN boundaries made four recommendations regarding the local health integration act. While the act has been genuinely useful in building better local relationships between health service providers, today we would like to focus our comments on an area where it's been less than successful.

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In 2006, we recommended that the drive for local planning and accountability be balanced by the need to account for province-wide priorities and consistency of service and not increase the administrative burden on provincial health care providers. As it stands, the act is silent on the issue of provincial programs, agencies and their interface with the Ministry of Health and Long-Term Care and the LHINs. These agencies provide the best of both worlds: responsiveness to local needs and provincial planning standards, controls and cost-effective centralized structures.

We cross LHIN boundaries and have many funders and several interconnected programs. CNIB would like to see this type of approach considered very carefully in this review. We believe that the scope and quality of services should be consistent from community to community. However, the community support sector in which most of these agencies are represented account only for a very small portion of LHIN budgets, and their attention to planning in this sector reflects that relative budgetary unimportance. In fact, funding allocations to CNIB are not based on the needs or numbers of people who are blind or partially sighted in communities across the province but on previous allocations the LHINs inherited when provincial programs were devolved to them. We believe the current contracts are not respectful of the role we play in patient care within the LHINs, as they are based on an outdated charitable view of rehabilitation of people living with vision loss. As a result of the current multi-LHIN funding model, there is a disappointing inconsistency in the share of service costs in each LHIN.

Patients referred to CNIB by their ophthalmologists rely on CNIB's ability to raise money through donations within each of the LHINs based on the varying levels of LHIN support across the province. A CNIB study conducted in 2011 showed that LHIN contributions to the cost of CNIB services ranges from 77% at the high end to just 31% at the low end. We are also concerned that inefficiencies and added costs have resulted from CNIB having to manage 13 different service agreements that provide identical services across the province.

In 2006, we suggested that applications, agreements, funding formulae, forms and processes be as consistent as possible across LHINs so that service providers who deal with more than one LHIN would not have to detract from service delivery to manage different types of paperwork. In short, that's not happened. Today, there are 13 different interpretations of our 13 different LHIN contracts. It should be inconceivable that there could be more than one interpretation of what constitutes an administrative expense, but there is, and we are required to account for our costs in different ways because of these many different interpretations. Costs and effort that could be dedicated to identifying and implementing program enhancements are utilized instead to remit reports in 13 different formats to 13 different LHINs. I guess I should clarify: We have 13 contracts, not 14.

We are also required to complete 13 different surveys designed to satisfy a single provincial requirement that LHINs report on to the province; for example, French language services. There is a significant cost to this unnecessary duplication of effort, and those costs are ones that we are explicitly not permitted to recover from LHINs or the government. Instead, that funding is coming from charitable donations to our organization. An unintended side effect of the devolution of our services to LHINs was the loss of any province-wide lead for policy and planning in our sector. While we do have local point people at LHINs on financial matters, we do not, generally speaking, even have a local policy or planning lead to turn to. It will be difficult to address the future needs of blind and partially sighted Ontarians without an open dialogue and long-term planning. Disturbingly, at the moment, it appears that it is no one's responsibility.

CNIB recommends that this review considers carefully the need for some central and provincial contracts to ensure equitable service and controls across the province and, to the extent possible, to ensure that there's a consistency in LHIN paperwork so that administrative burden on service providers operating in more than one location doesn't divert resources from service delivery.

CNIB would like to see a more macro approach to planning and include organization or sector-specific point people within each LHIN. Thank you very much for your attention. Sherry and I will be happy to take your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have just less than seven minutes. We will start this one with the official opposition.

Mrs. Christine Elliott: Thank you very much for your presentation. You've raised some issues that we were not previously aware of, so it's very important for us to know that. But generally speaking I guess what I'm hearing you say is—and I hope I'm right—that you like the concept of the LHINs, but you want them to be more fully brought in and in a consistent way across all of the LHINs with the paperwork reduced, and recognize that the service you offer isn't going to just be based on charitable fundraising.

Mr. Vijay Chauhan: I think that the one issue is that we need—we're such a small portion of what the LHIN

funds. I mean, hospitals, long-term-care facilities and CCACs—when you get down to our sector, we're this much. You tend to get that much attention. We need a stronger voice at the table. Where we do get a voice, for example, at one of the tables that was mentioned earlier today, Sherry is a member of that council. There are similar tables around the province but, unlike here in South West LHIN where there might be 20 or 30 people at the table, in Toronto there are 100, 150 or 200, and our voice is diluted. We would like the opportunity to have someone that we can go to and talk about the specific needs of our agency, as they are unique—everyone has got unique needs—but we need to have the opportunity to go in and talk about those needs. There needs to be a venue to talk about planning for a community that is going to grow, in terms of blind and partially sighted people, as people age. We need to be planning for that. There's no point person provincially anymore. That person is being devolved or, through this process, that person doesn't exist anymore. So there's no place for us to go and say, "Look, we need to be thinking about what's going to happen in 10, 15, 20 or 25 years."

The Chair (Mr. Ernie Hardeman): The third party: Ms. Sattler?

Ms. Peggy Sattler: Thank you very much for the presentation. You mentioned that in 2006, I think you said, there were a number of service providers who came together to create some recommendations—four recommendations were put forward. I have two questions, and I'll ask them both.

Mr. Vijay Chauhan: Sure.

Ms. Peggy Sattler: You focused today, I think, on just the single recommendation around the issues that you raised. So I'm interested in knowing, first, what were some of those other agencies that were involved in putting forward those recommendations at the time? Second, is this single recommendation that you spoke to today the big issue that you think is still outstanding that needs to be resolved?

Mr. Vijay Chauhan: The other agencies were the Canadian Hearing Society and the Canadian Paraplegic Association, which I believe is now Spinal Cord Injury Ontario. From our perspective, the question of the administrative burden, in particular, and having a voice at the table is the single biggest challenge that we're facing. As we're looking at entering into another three-year contract with our LHINs, we've been told how much we're going to get in terms of the LHIN contribution to our services. We've been told how many people we're going to have to serve for that money, but we haven't been told that in so many words. There's going to be a negotiation, but the starting point is that you're going to serve the same number of people with the same amount of money, and that's something that is going to be a challenge for us. That is going to mean that we're going to be diverting more charitable dollars to cover provincial health services.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Jaczek?

Ms. Helena Jaczek: Thank you for bringing this to our attention. Earlier today, when we were in Kitchener, we were given a very informative visual of various services provided in the Waterloo Wellington LHIN. Of course, it was the Canadian Hearing Society, the Canadian National Institute for the Blind and the Canadian paraplegic society that in fact, at least from the patients' point of view, were providing service across that entire LHIN.

We've been very concerned about lack of consistency, and one thing, I think, that your three organizations do actually bring is at least a very consistent approach to patients in terms of what you deliver. That's a good thing, but I think we do understand your frustration in terms of now dealing with each individual LHIN in terms of the contract, the way it looks and the interpretation. Is that really the crux of the matter?

Mr. Vijay Chauhan: I think that's precisely the challenge. If I could tell our financial services people, "This is what our administrative cost is," and it's going to be different than what we consider in our accounting process in administrative costs, that's fine; we could still work that into how we work our budgets. As it stands now, I have to do that five or six different ways.

Ms. Helena Jaczek: So is there one LHIN you feel is sort of the ideal model, at the very least? Can you point to one and try to convince the LHIN world across the province that, if only everybody agreed to this, it would work for everybody?

Mr. Vijay Chauhan: Well, I think that the answer to that is actually "No," because my problem is not with any one specific interpretation, although I might quibble about some of those. My problem is that they're not consistent. It's just inconceivable that there could be, in what is supposed to be a health care system, more than one interpretation of the word "administration." Every single LHIN has said, "Well, this interpretation came from the ministry." Obviously it didn't, right? So let's have some means of getting some consistency there.

I think there's a lot of reporting to the province, which is appropriate and important, but the province wants whatever it wants, and it doesn't need to be asked 14 different ways. I'll give one example of a question that does drive me nuts, which is in the French-language services surveys that were sent out. Some LHINs ask us how many French-speaking board members we have, and some ask us how many francophone board members we have. They're probably reporting that as the same statistic, but those are two different questions, and they mean two different things.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do appreciate your input, and I'm sure it will be beneficial to us.

HURON PERTH HEALTHCARE ALLIANCE

The Chair (Mr. Ernie Hardeman): Our next delegation is Huron Perth Healthcare Alliance: Andrew Williams, president and chief executive officer. Thank you very much for coming in.

As you're setting up, we first of all thank you for taking the time to come in here today. Secondly, we'd just point out that you have 15 minutes to make your presentation. You can use all or any of that time in your presentation. For anything that's left over, we will have questions and comments from the committee members. With that, thank you very much, and the next 15 minutes are yours.

Mr. Andrew Williams: Thank you very much. Mr. Chairman and committee members, it's a pleasure to be here. I want to acknowledge the great work that you're doing on this file. I don't think there's a more important issue to Ontarians and Canadians than health care, so it's greatly appreciated, the effort and energy you're taking in this.

As was pointed out, my name is Andrew Williams. I'm the president and CEO of the Huron Perth Healthcare Alliance, and I'm here to speak to a number of issues as they relate to the LHIN and our relationship.

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I'm starting with a picture of a couple of dogs, not because I think the system has gone to the dogs, but because to me this reflects what health care is all about. If you've seen this before, this is Lily and Maddison. Lily lost her eyes, and Maddison became her eyes. For five years, everywhere they went, she was her eyes. To me, that speaks to what health care should be about: caring, compassionate support based on individual needs—and I think this is a very powerful image for that.

What I will do—just a bit about who we are—is talk quickly about some of the selected patient-care improvements that LHIN leadership has led to. I think that if we're not talking about patient-care improvements, then we're not at the right table. When I talk about LHIN leadership—the LHIN in the southwest engages all of the stakeholders and brings us together, so the solutions that we come up with are systems solutions, not driven by any one particular organization. I'll talk about some of the specific activities that we're involved in, and then a few recommendations, as was requested by the committee.

We represent four hospitals in southwest Ontario, in Clinton, St. Marys, Seaforth and Stratford. We came together 10 years ago. We were four individual organizations with four separate boards. Now we're one board, one organization. Geographically, if you know the area, Clinton and Stratford are about 55 kilometres apart, so that gives you some context. The LHIN breaks itself down into three planning regions: the north, the central and the south. We are the central region.

If you've been in our area in the last few weeks, this is probably the road sign that you've seen most often, because most of our roads have actually been closed due to snow. It adds a different perspective when you're dealing with health care issues and accessibility in communities like ours, where conditions and access can be such a big issue to address.

A bit about the alliance: We were formed in 2003. We're a voluntary arrangement; we weren't forced to come together. We have one board, with about 1,200

staff; 150 professional staff, those being physicians, midwives, extended-class nurses and dentists; and about 500 volunteers.

I'll tell you one thing: Our health care system wouldn't be what it is today if it weren't for our volunteers.

We have separate foundations and auxiliaries. We have a budget of about \$126 million. We have local advisory committees that operate in each of our hospital communities to support the board in decision-making.

From an activity point of view, we had about 58,000 emergency visits last year, over 15,000 surgeries, 86,000 imaging exams, and over 28,000 patient days. If you followed any of the patient satisfaction releases over the last little while, two of our sites were the top performers in the hospital system in "likely to recommend," in acute care services, and overall care in emergency departments. We take patient care, patient safety and patient satisfaction very, very seriously, as one of our top drivers.

Our vision as an organization is to improve the health and well-being of the people that we serve by leading the development of a sustainable, fully integrated rural health system. I think the word "integrated" is key for this discussion, because that's really what the LHINs were introduced to do: to help integrate the system, to advance patient care.

The guiding principles that we operate under are very simple: people, performance and partnerships. We feel that if we can support our people, improve our performance, and develop strong partnerships, we're going to meet our local mandates in our communities across Huron and Perth.

From a selected patient-care improvement perspective—some of these you've heard about, but I think it's important to remind ourselves, from a provider's perspective. The first is the one-number access to care that Michael Sharpe talked about a few minutes ago. The number one stress on primary care providers in small hospitals in rural communities is not knowing where you're going to send a critically ill patient at 3 in the morning. If you talk to anybody coming in, they will say that's the one thing that keeps them up at night: not feeling confident that their patients are going to get the care they need when they need it.

Introduction of things like this have elevated our ability to sustain recruitment/retention and have really improved our ability to provide high-quality care, and it's only through a system focus that you can do this.

Sandra talked about Home First. We have seen Home First implemented across most of our LHIN and the impact that it has on patient flow. Our ability to move patients from the ERs into beds that would otherwise have been occupied by patients waiting for long-term care has been significant. Again, help improve patient care through a system focus driven by the LHIN.

Timely access for hip fractures: another example of a project that was engaging all of our providers around how you get people into the OR within 48 hours after a hip fracture, whether you have access to orthopedics in

that site or not. If you look at the data, it's a concern. After 48 hours, patient outcomes become more serious; they have comorbid conditions. Through the LHIN leadership, we focused on this issue, and we've been able to bring our times down significantly. So, regardless of where you end up in this LHIN, you're going to get access to an orthopedic surgeon in some hospital that provides the service.

Overall wait times: We've seen a significant reduction. Rob talked about MRI wait times that have come down in the last number of years. We're focusing on CT, on hip and knees, on cancer surgeries, on cataracts. All have been really positively addressed by a system focus, rather than individual sites looking at their own needs—stepping back, looking at what the needs of the population are as driven by a more broad and robust assessment.

If you live in rural communities, you'll know transportation is a challenge. It's a challenge in any community, obviously, but in rural areas it can be doubly difficult for people. Our LHIN was the first LHIN in the province to standardize patient transport guidelines. We have gone out and we've issued an RFP and have gone to one carrier across the entire LHIN for patient transport. That does two things: Number one, it moves your patients around in a coordinated way, but more importantly, it sets quality standards in place that you can then hold the provider accountable to. To us, that is an absolute must, with the amount of time we're using these services to move patients around. It's not like a large, urban centre where you may have everything in one hospital. We don't, in most of our hospitals in rural Ontario, so we have to move them to a different hospital for an MRI or a CT or whatever the test might be. Having this sort of service is key.

Physician engagement: You've heard a lot about that. You cannot advance health care without engaging the players, and physician leadership is hugely important. Through our primary care network, through the critical care network, through the mental health network, all have really assisted us significantly.

The last area is just to highlight some of the projects that are ongoing now focusing on cataracts, endoscopy, stroke and mental health access through ERs—all things, again, that help improve patient care.

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In our particular case, we've put some pretty contentious suggestions on the table and we've stood in front of community forums with 500 to 600 people, all who have opinions on what we should or shouldn't do, and we've really taken it seriously. We know that to sustain and grow health care, you cannot look at it through the same lens today or that same lens that we've set up today. We have to look at things differently. We have to realign services. We have to reconfigure emergency departments, for example. And through the endorsement and support of the LHIN, we've been able to put really comprehensive engagement processes together that allow people to contribute to those processes in a positive, productive way to help us advance our health care needs.

Mental health integration: We've brought six disparate providers in our region together to work in a coordinated fashion to meet the needs of the mental health patients. If someone were to ask me what is the most important area of health care right now that we're not dealing with properly, it's mental health. We have to do better, and we're seeing some real advances in our area through this leadership, and it's going to continue.

Cataract surgery consolidation and long-term-care partnerships with our organization: We have not only seen system improvements to care, but within our own organization we've worked very, very closely with the LHIN and have been able to advance a number of things locally that we feel will improve health care.

This slide is a picture I took in Plaster Rock. I'm sure many of you don't know where Plaster Rock is, but it's on your way to PEI in northern New Brunswick. The sign reads, "Eight-hour ER. No lab. No X-ray. No deaths after 5:00."

We know that health care is remarkably emotional. Regardless of what changes you might put forward, there will be opinions on it. It is really key, in my view, to make sure that you are engaging all the players in the dialogue, but you cannot avoid making decisions, often difficult ones. LHINs need to be there and they have been here locally, standing beside the providers and assisting us in doing that.

If we look to the road ahead and a few recommendations: a couple of things, and again, things you've heard about already. Continue to build on the strengths of the LHIN model. Structural change on a system is huge. The transition from the district health council regional office model to LHINs took a lot of time for the system to understand the new way to deal with issues. Structural reform is massive, so we would say: Build on the strengths of what's working in the LHIN model. I'm sure you've seen very different approaches across the province. There are a lot of great ones, and our LHIN, in this area, I believe is a shining star that should be emulated across the province.

Maximize system planning and integration by including all health service providers under the planning umbrella of the LHINs. We've heard about the physicians and primary care providers. In rural communities, the primary care physician is much more aligned with the local health care system than in a large urban centre. In our communities, the physician not only provides family practice, they look after the long-term-care facility, they look after the emergency department, they look after our in-patients. Having a coordinated approach to planning is vitally important for us as we move forward and look at changes.

Clarifying roles and responsibilities across the system between the ministry, the LHIN and health service providers, I think, is something that needs to be addressed. A really good example is, right now, we have capital projects and we're dealing with financial reconciliation with the ministry. We deal with the LHIN on most of our operating budgets. We deal with Cancer Care Ontario on

some of our wait times. So we have different groups that we have to go to and are held accountable to. It makes it confusing at times, and I think there are some ways we can improve in that area, all based on improving quality, improving access and improving value for money.

Identifying and removing legislative barriers to health system integration, I think, from a provider point of view, would be beneficial. As we look at the different sectors and trying to integrate, whether it's acute care, long-term care, primary care—it doesn't matter which sector—there are legislative issues that often cause us not to look at opportunities, and I think there are some ways we can help in that area.

Enhancing public awareness around our health care system I think is a very important role for the LHIN to play, for the government to play and for health service providers to play. As I mentioned earlier, far too often, health care planning is driven by emotion, and we need to ensure that we have an engaged public who are aware of what the system can do, how they can influence the system and what changes we need to make to move forward.

The last recommendation that we've included here is maintaining and strengthening local governance, including moving away from order-in-council LHIN board appointments. There's a lot of good literature out there on best practice governance, and I think there's a real opportunity to further strengthen from that vantage point.

This slide—I really like this one. "There are only two things I don't like: change and the way things are." Change we must, whether we like it or not, but in a thoughtful, system-wide manner, with an organization that can help guide and pull the various players together with an eye to the future.

The future is what we're all about. These are my two boys. They're a little older today. I always like to remind myself that part of my role as a health leader is to make sure that when they're my age, they continue to have access to the great health care that I do. That won't happen unless we move the system forward in a coordinated fashion through regional planning in areas like ours.

I'm happy to answer your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much, and we have about two and half or three minutes left. It goes to the government: Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much for your presentation. I just want to focus a little bit, if we can, on your recommendations. Number 4: identify and remove legislative barriers to health system integration. What exactly are you getting at there?

Mr. Andrew Williams: The Public Sector Labour Relations Transition Act is in place and has to be adhered to in any type of integration. But if we were to take different sectors and try to merge or align them in a way that we think will improve care, there's significant disruption because of the legislative requirements that we have to follow, so I think there are ways that we can help smooth that out to make integration a bit more accessible to organizations, largely financial—significant financial

impact. It's not necessary, but would happen under the current legislation.

Ms. Helena Jaczek: So in other words, if you integrated two different bargaining units with different salary levels, you would have to go to the top.

Mr. Andrew Williams: You automatically jump to the highest, regardless of what that might be.

Ms. Helena Jaczek: Okay. And if we could quickly go to number 6: instead of order-in-council LHIN board appointments—what are you getting at there?

Mr. Andrew Williams: More locally driven within each LHIN; obviously being driven by some clear principles around geographic representation, but being able to, in essence, control the appointment process within the LHIN structure, not having to go outside that to receive approvals for the appointments.

Ms. Helena Jaczek: So sort of a nomination committee of the board that would look more, perhaps, at the way district health councils—

Mr. Andrew Williams: Yes, absolutely. We have, in our situation, a skills-based board that has a primary filter of geography, just given the four hospitals that we have. But we look at the different requirements. They do that in the LHIN, but they still have to go outside of our region to have endorsement. I think if it's local, it's more transparent and it would be more acceptable.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, and particularly the start and the finish. I think that really says it all.

LONDON HEALTH COALITION

The Chair (Mr. Ernie Hardeman): Our next presentation is the London Health Coalition: Peter Bergmanis, co-chairperson, and Jeff Hanks, co-chairperson.

Mr. Peter Bergmanis: Thank you, Mr. Chair. My apologies; my co-chair will not be here, so I'll commence on my own.

The Chair (Mr. Ernie Hardeman): It's a good thing we got the best of the two, right?

Mr. Peter Bergmanis: That's what I would say. I'll have to also add another apology: I'm probably going to have to apologize to the presenter ahead of me because I'm going to contradict him in many respects of what his presentation was. But I do agree with one thing: that we are all about public engagement when this process is being laid out before us.

I'll just get to the presentation and explain that our organization, the London Health Coalition, is a constituent chapter of the Ontario Health Coalition, with a primary goal to protect and to improve our public health care system. We work to honour and strengthen the principles of the Canada Health Act. We are led by our shared commitment to core values of equality, democracy, social inclusion and social justice, as well as the five principles of the Canada Health Act: universality, comprehensiveness, portability, accessibility and public

administration. We are a non-partisan public interest activist coalition and network.

Some of our key issues—and, again, this might contradict what our previous presenter had stated—are that we do see a lack of democracy in the community efforts around LHINs' development. The public health system belongs in the democratic arena. This includes meaningful public input, public involvement in the evaluation of decisions, access to documents and information, the right to appeal, and representational governance. None of these apparently exist in the local health integration networks as we speak today.

With little public desire, the LHINs were introduced by the province in 2006 to coordinate health care on a local basis. The province was subsequently divided into 14 LHINs for this purpose. Although responsible for disbursement of public funds to medical service providers, the LHINs' terms of reference never enshrined the principles of the Canada Health Act: the aforementioned universality, comprehensiveness, accessibility and public administration.

Although required by the Local Health Systems Integration Act, 2006, to achieve and sustain high-quality community engagement and to improve accountability and transparency to the public, in practice, community engagement is little more than a public relations exercise designed to persuade rather than truly involve, serving to antagonize communities at great expense to the public purse.

Misalignment between capital planning and LHIN service cuts has served to discredit the entire enterprise. The London Health Coalition's own experience with the South West LHIN has been a recognition of top-down management style, with local board members faced with the enactment of detrimental Ministry of Health and Long-Term Care pre-ordained decisions.

For its part, the Ontario Health Coalition has identified poor, inconsistent and wasteful processes, such as failure to make integration decisions when services are being transferred, for instance, in the Ottawa situation, Thunder Bay long-term-care beds etc.; inconsistent and poor access to information, with requests for documents pertaining to service planning decisions routinely going unanswered; and no apparent evaluation of the decisions made.

Moreover, needs-based planning is non-existent. The core function of our public health system should be to measure and meet population need. In reality, capacity planning has not been performed, not even sectorally, for almost 20 years.

Health system capacity planning must be done, and it should be based on evidence-based assessments. To date, LHINs have cut, closed and facilitated or forced off-loading of needed health care services, particularly in the hospital services, in regions all across the province. Health care planning has been completely divorced from the population need.

Amalgamated hospitals are a problematic situation under the system. They are not considered entities under

the act, and, therefore, whole hospitals for entire communities are treated as departments of larger hospitals and subject to disproportionate cuts and closures.

Since 1990, Ontario has aggressively cut more hospital beds than any other jurisdiction in the country. That would be approximately 18,500.

By the end of 2012, Ontario merged or shut 87 hospitals. Yet, in a process that cost nearly \$1.3 billion in the London area alone, the Ministry of Health and Long-Term Care confesses to neither tracking the money spent nor assessing the effects of restructuring and mergers on hospitals.

The city of London is a regional medical hub. The chaos of hospital restructuring has seen the South Street campus closed and University and Victoria hospitals merged, not to mention Parkwood Hospital, St. Mary's Hospital, Marian Villa, London Psychiatric Hospital, St. Thomas Psychiatric Hospital and St. Joseph's Hospital all amalgamated into one entity. From the wreckage, two health care conglomerates have emerged: the London Health Sciences Centre and St. Joseph's Health Care.

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Regrettably, over the course of the past two decades, the municipality has lost two thirds of its acute care beds and has suffered the loss of one of its emergency departments. Obstetrics has been cut in half, as has heart surgery. The city's intensive care units have shrunk from three to two. Hip and knee replacement is only performed at the London Health Sciences Centre. Through hospital restructuring and extensive program transfers, St. Joseph's has been transformed from an acute care facility to an ambulatory care centre. This dramatic decline in available hospital services has transpired while the city's population has grown.

In order to achieve provincially mandated balanced budgets, both hospitals have cut staff and services. In the most recent round of austerity-induced measures, St. Joe's has been forced to reduce medical diagnostic imaging hours and operating room time and to institute two weeks of cataract suite closures. On weekends, the remaining surgical floor of the hospital must contend with the disruptive transfer of patients from the nursing unit to the PACU and back again so as to save on costs associated with operating a surgical unit seven days a week.

Also, with the closure of St. Joe's morgue, pickup of amputated limbs is contracted out to Hoffmans Patient Transfer, a private service provider. The limb rests in a garbage bag-lined box in a dirty utility room until the driver arrives to pick it up.

Naturally, due to the cutbacks, wait times for diagnostic imaging and cataract surgery are creeping up. The number of cataract surgeries the hospital provides has fallen to 4,171 this year, from a peak of 5,126 three years ago—a 20% reduction. Each month, the waiting lists grow, and by the end of 2013, wait times for cataract surgery had risen from 153 days to 230 days.

The closed St. Joe's ER department has reinvented itself as an urgent care centre, but is under-resourced and

plagued by staffing challenges. Originally operating from 8 until 10 on a daily basis, St. Joe's can now only muster an 8-until-6 operating time. Urgent care is intended for non-life-threatening conditions, but faced with long waits at the two remaining London ERs, patients are crowding the urgent care waiting room. The situation was recently exacerbated by the locally reported 140% patient capacity rate at the London Health Sciences Centre. LHSC was placed in a position of requesting citizens to stay away unless absolutely necessary.

Other deficit-busting measures implemented at St. Joe's have included closing a St. Thomas-based job-training workshop that helped 80 people in the mental health program, redesigning an intensive four-week fibromyalgia management program that helped 108 people a year, and the closure of an aquatic-therapy program, affecting about 400, many of them women in their 70s and 80s. They must now find relief elsewhere and quite likely will face personal out-of-pocket expenses to do so.

LHSC, the larger of the two health care conglomerates, for its part, is meeting fiscal constraints through reduced nursing hours, earlier patient discharges and rationing of OR time. Clearly, London and region have undergone serious cuts to hospital-based services without regard for patient risk. There has been no special treatment of cornerstone services and no trauma planning, the kind of care which simply cannot be provided outside of a hospital setting. With another anticipated flat-lined fiscal year approaching, the likelihood of devolving more hospital-based services into the hands of for-profit providers appears certain.

This is where we approach privatization. Although the Wynne government has recently publicly chastised the federal Conservative government for abandoning its obligations to provide services of national interest, Ontario's Liberal government has announced plans to bring in new regulations to cut services from our community-based hospitals and outsource them to private clinics. What social spending priority could be more in the national interest than the preservation of medicare?

Private health care, including private health insurance, is unfair and unsustainable. This is why Canadians opted for universal medicare in the 1960s. Not only is it a fairer and more just system of providing health care based on need; it is more sustainable.

Most of the outpatient surgery in Canada is done in non-profit hospitals, but for-profit clinics are waging an aggressive campaign to capture a larger share of the health care market. Most peer-reviewed studies have shown that publicly funded hospitals are much more efficient and, compared to their for-profit counterparts, provide a higher quality of care at a much lower cost, both in terms of mortality rates and price. In spite of such compelling evidence, some provinces, including ours, are providing space and opportunity to clinic owners.

Cuts forced under the LHIN system of accountability agreements and service integration have transferred services such as physiotherapy, endoscopy, cataracts,

colonoscopies, chronic care and long-term care from public, non-profit entities to private, for-profit entities. Many of these service transfers have been made without the required LHIN integration decisions.

Though the legislation prohibits the minister from transferring services from non- to for-profits, it allows LHINs to do so. Moreover, the legislation prohibits the forced mergers, closures and dissolutions of for-profits but gives extraordinary powers to enable the minister to force amalgamations, closures and dissolution of non-profits.

Oddly, the Liberal government's vision for health care does not include community hospitals. Instead, the government wants to take services that patients need, like MRIs, CAT scans, and cataract and day surgeries, out of local hospitals and outsource them to private clinics.

We, as Canadians, live next to the largest for-profit providers in the world. The United States is home to massive profit-seeking hospital conglomerates and companies that covet access to our public subsidies for health care. These corporations, and some home-grown ones also, are lobbying the government and funding campaigns to outsource our community hospital services.

In the model of private clinics proposed by the Ontario government, there is no legislated protection against for-profit privatization. In fact, the government expressly intends to establish private clinics outside of the Public Hospitals Act, and therefore without the protections against privatization that exist within the framework of the Public Hospitals Act.

The Wynne government's single-minded plan to gut public hospital services and contract them to private clinics bears close resemblance to the British government's experiments with contracting of public hospital services to private clinics called independent sector treatment centres. In the UK and in other jurisdictions, multiple studies report lighter caseloads and evidence of "cream-skimming" by private clinics, leaving the more expensive and heavier caseloads to the public, non-profit hospitals while depriving hospitals of needed resources, both human and financial, to treat them.

The health coalition's own research into private clinics across Canada revealed that the cost of procedures was considerably higher in private clinics than in public hospitals. These findings echo the Auditor General's report on his own audit of the Ontario system.

A case in point is that we have our own clinic here in Ontario, in London, which is Medpoint. The Medpoint clinics were established here five years ago under the ownership of Mr. Hanham and his co-owner physician wife, Dr. Murchison. They have expanded twice, doubling their space while adding a pediatric facility in the Byron area. The staff has grown to 28 employees from two full-time and three part-time. They're looking to move into the Ottawa region. They have basically provided services under OHIP, but they also contract out services at a fee of \$1,800 to well-heeled clients who are willing to pay for that, and to corporate clients. Unfortunately, this also means that it blurs the lines between

Canada's public and private delivery of health care. It also offends our sensibilities regarding access to care, one based on need rather than wealth. It is all the more galling that corporate clients can claim their membership fees as a business expense, thereby enjoying the subsidization of Canada's progressive tax system to jump the health care queue.

Unchecked, the introduction of for-profits raises questions of ethics. Does a physician-owned facility bear allegiance first to patients or to shareholders? What about quality and safety concerns? In a recent well-publicized case, an Ottawa area private endoscopy clinic was found to have failed to properly sterilize equipment, resulting in 6,800 patients being notified that they should be tested for HIV and hepatitis B and C. In a 2007 case, it was revealed that 13% of colonoscopies conducted in a private clinic were not completed because the scope had failed to reach the colon. Research also found that there are more missed cancers in private clinics that do diagnostic testing than in hospitals. The privately contracted radioactive isotope scandal touched the lives of cancer patients here in London, as well, at the LHSC.

Of course, finally, the ultimate threat posed by for-profits within Canada's public system is the onslaught of corporate challenges to medicare through international trade agreements. Such is the potential if current destabilizing government initiatives remain in place.

Queen's Park has the opportunity to create a comprehensive system of care driven by the needs of patients and their communities. LHINs should be at the forefront of the defence of medicare and not an unwitting instrument of its destruction.

I thank you for your time.

1650

The Chair (Mr. Ernie Hardeman): Two seconds, and it was 15 minutes up. Thank you very much for timing it out perfectly, and we thank you very much for your presentation.

Mr. Peter Bergmanis: Thank you.

MS. SHIRLEY BIRO

The Chair (Mr. Ernie Hardeman): Our next presentation is Shirley Biro. Welcome, Shirley. It's good to see you again. As with previous presenters, you have 15 minutes to make your presentation, and you can use any or all of that time. With any time you don't use, we will have questions and comments from our committee. With that, Shirley, welcome, and the next 15 minutes are yours.

Ms. Shirley Biro: Mr. Chairman and committee members, my name is Shirley Biro, and I'm a community representative at this table today. It is my pleasure to come before you today and share my thoughts about the direction of primary care in Ontario and the local health integration networks.

Since 1997, I have been involved at the local level with strategies to enhance the care of residents in my community. I am a retired registered nurse, retiring in

2003, and have been a community volunteer on many health-related committees such as the Elgin elder abuse resource committee. I'm a member of the Elgin Hospice Palliative Care Collaborative, the Elgin stroke working group and the southwest elder abuse network. I chair the East Elgin Family Health Team, and I recently retired from the Middlesex-Elgin VON community board of directors. I've also just recently been invited to the South West LHIN hospice palliative care leadership committee as a community representative. And I'm very proud to be a client representative on the South West Primary Care Network, with all those doctors.

The health of my community and other communities is of utmost importance, and if I can make any small difference to the health and well-being of persons in need, that is my goal.

In 2006, I had the privilege to be a community member of the strategic advisory group of the South West LHIN, which brought forward the first Integrated Health Service Plan. Recently, I've been a member of the Health System Leadership Council as a community representative again. This leadership council brought system leaders together from all sectors and geography across the South West LHIN to provide advice to the South West leadership on our health system responsibilities.

During this time frame, I have seen how the leadership from the South West LHIN has brought fiscal accountability to those organizations of which they are the funders.

There is now evidence of partnerships and linkages between organizations that can only be a benefit to those in the community being served, as well as having cost-effectiveness.

We are in a time of change in health care delivery, and the South West LHIN has been a leader in this area. We can no longer be reactive in the delivery of health care. Health promotion and disease prevention is where we have to be at this time, and the LHINs are poised to ensure that these strategies are implemented and direct funding to the areas which can provide the highest level of these services with the greatest possible outcomes for the individuals participating.

An example is the partnership between the Victorian Order of Nurses and the Parkinson's organization, as a pilot project, to provide an exercise program called Seniors Maintaining Active Roles Together, specially designed for persons in various stages of Parkinson's disease. The results of this exercise program have been effective and dramatic.

Now, since that pilot, the funding has come to the Victorian Order of Nurses through the South West LHIN to expand their SMART programs into long-term-care homes and the community. Please note that these SMART classes are led by trained volunteers. Organizations sometimes cannot exist without their volunteer base.

We have adult day programs and supportive housing to help seniors stay at home for as long as possible, and also support for the caregivers as well.

These are just two examples of how the South West LHIN has supported strategies to improve the health and well-being of the communities which they serve.

My recommendation to this committee is that you implement the recommendations in chapter 5 of the Drummond report immediately. We are already implementing elements of that report under such strategies as Access to Care, Home at Last and Home First. Pharmacists are being proactive and accountable through the interview process. Everyone is allowed 30 minutes per year for a medication review with the clients about their medications.

The report also outlines even more responsibilities for pharmacists in the prescribing of medications. The South West Primary Care Network is working with physicians in this province, as Dr. Annis alluded to, to assist in the implementation of open-access scheduling and the encouragement of technology through OTN and electronic medical records. These are only two examples of what the primary care network is doing.

The LHIN is taking a leadership role by the actions in their accountability agreements that relate to those organizations which receive funding through the LHIN. As we move forward in defining measurable outcomes, we will be able to demonstrate the best-practice use of funds and also identify gaps, if they still exist.

The LHIN leadership teams from across the province meet on a regular basis to network and share best practices. How can you not support an organization who can demonstrate the leadership and fiscal prowess to provide the highest quality of care to the citizens of this province in a fiscally responsible way?

If I could seek out a strategy for the LHINs to continue to push forward, it would be continuous education of the public. To quote Don Drummond, "An informed public is essential to the success of the reforms."

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for that presentation.

We have about eight minutes left, so that's about two and a half minutes per caucus. We'll start with the third party: Ms. Armstrong.

Ms. Teresa J. Armstrong: You're one of the few community representatives, so I'm glad to hear your presentation. It's nice to hear a perspective from someone just volunteering and working in the LHIN, working on boards and in community organizations.

I wasn't going to ask a question, but I have a question. You had mentioned that volunteers deliver seniors' exercise programs.

Ms. Shirley Biro: Through the VON. Their SMART program is taught by trained volunteers.

Ms. Teresa J. Armstrong: How do the volunteers get trained? Who trains them?

Ms. Shirley Biro: They have a train-the-trainer program, where an individual is taught the exercises, and then they in turn teach it to someone else.

Ms. Teresa J. Armstrong: Okay. Thank you very much for coming today.

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

Ms. Helena Jaczek: Thank you very much for coming. As has been said, it's great to hear from a community member and someone who has been so involved. I'm a physician; you're a nurse, and I have every confidence that you're keeping the primary care network in order.

Ms. Shirley Biro: It's difficult.

Ms. Helena Jaczek: I'm sure it is.

It's clear that you're a fan of the LHIN structure, particularly because of what you know the South West LHIN has been doing. You've talked about educating the public. We have heard, as has been said before, that in some areas people are just not aware. You're a great community representative. Is there a role—centrally, perhaps—for the ministry to make people more aware? Should it all be local? Should it be using the right radio station in a community? What can we really do to get people more involved?

Ms. Shirley Biro: The best way that I know of is by people sharing their positive outcomes—people talking to people. That's how I hear what works and what doesn't work. I've experienced the system; I know it can work. I have an edge, because I've been with the development of the system, but I always advocate for what works and try to listen to what went wrong and explain.

You've mentioned the only avenues that I really know of—the local radio stations. Everyone doesn't have a computer, so you have to use newspapers, flyers, bulletin boards and things like that to get the word out about meetings to inform the public. By now, the public have all heard about the LHIN, but they don't know exactly what it is or what it does. All they know is that when they're sick, they need a doctor.

So I don't have a magic bullet to say, "This is how we're going to do it," but we can't give up talking about it and explaining about it, because if we don't go forward, we're going backwards. That being said, we have to quit doing what we did for the last 50, 75, who knows how many years, and move into the new delivery system of health care. It won't be easy. We have an increasing element of seniors coming on board with the population growth in that area, so we've got to address access as we all get older. I'm in that category.

That being said, there are so many elements that we have to look at differently, and not just the absence of disease, Dr. Jaczek. We have to look at all the determinants of health. I see that in the conversations at the tables that I sit in, that we are looking at the social determinants of health at the education level, at the economic level. How can people be healthy if they don't have the funds to buy the proper food? I even question the food bank: "When you hand out food to people, do you give them education on, 'This is what you're getting and this is what you can do with it?'"—and they are. That small element is helping, as far as the health of the community is concerned. But it's a big challenge. Any time you have change, you have resistance and you have the hiccups that go with it. So we have to keep moving forward and

never give up, because it has to be done. We have to take a look at doing things differently.

1700

Ms. Helena Jaczek: Thank you for your words of wisdom.

The Chair (Mr. Ernie Hardeman): Thank you very much. Ms. Elliott?

Mrs. Christine Elliott: Thank you, Chair, and thank you, Ms. Biro, for being here today and for your presentation, but also the significant contribution that you've made to improving health care in your community, both as an RN for many years and now as a community representative. We really need people like you to continue to be engaged to help us transform the system.

I agree with you: We can't keep doing things the same old way. The challenge for all of us, including us as politicians, is: How do we have that dialogue with members of the public? How do we talk about the new ways of doing things in a way that it isn't going to frighten people? Because I think right now, people are hearing that our system isn't sustainable, that we can't keep doing things the same old way, but they're not really hearing answers from us about how we should change the system. I'd really be interested in your comments about how you would propose that we open up that conversation with the public to have a full discussion about what we need to do to make the changes in our system.

Ms. Shirley Biro: Well, my first thought would be the physicians: I think physicians are the champions of the system moving forward, in the sense that everyone trusts their physician. And as I mentioned in my presentation, health promotion and disease prevention is where we have to start. We have to work with the public health and start with the children, and build from there. Just a classic example is, when they started the anti-smoking dialogue years ago, little children would come home and say, "Daddy, you're not supposed to smoke anymore, because I heard that in school." So we need to start to build a healthier society; that's where we need to start.

I really believe that the physicians can be really key players because, years ago, if you went in and your doctor found you had high blood pressure—this is my example—he didn't tell you to go home and watch your salt and start thinking about losing 20 pounds and going for a walk for 30 minutes a day. He just gave you pills and you went on your merry way, and you came back for another visit which was billed to OHIP. Today, you don't need to do that. You don't need to see your doctor for that kind of simple thing. If we start focusing on health promotion and disease prevention, we're going to grow a healthier society.

The problem is that there are all of us in my era right now that we have to deal with, with multiple morbidities, and we have to treat those people. But we're starting in family health teams, having a team of collaborative health care deliverers who will work together to try to help these people have the highest quality of life for the life that they have left. I guess I would have to say that to move this forward, we have to work together as a team.

But it's not entirely resting on the shoulders of the physicians. I think we have to share the job with your nurse practitioners and your nurses and your dietitians and your social workers.

The other thing I want to comment to you, since I have this opportunity, is that I'm happy to see that primary care is embracing mental health care now. Before, it was mental health care here and primary health care there, and now we're bringing it all together, and that is such a revelation.

The Chair (Mr. Ernie Hardeman): Shirley, I'm really glad that you have had this opportunity too, and I use the word "had" because the time is up.

Ms. Shirley Biro: I know. I could go on forever.

The Chair (Mr. Ernie Hardeman): Thank you very much for taking the time to come here and speak to us today. It's much appreciated, and it's particularly nice to hear from a—

Ms. Shirley Biro: I'm a consumer.

The Chair (Mr. Ernie Hardeman): —a community-minded person who wants to make the system better. Thank you very much.

Ms. Shirley Biro: I hope you have good luck with the changes.

CANADIAN MENTAL HEALTH ASSOCIATION, ELGIN BRANCH

The Chair (Mr. Ernie Hardeman): Our next presenter is the Canadian Mental Health Association, Elgin Branch: Heather DeBruyn, executive director. Welcome, Heather. Thank you very much for being here. As with everyone else, you have 15 minutes to make your presentation. You can use all or part of it, and any part that's left over we will share with the committee for questions. The next 15 minutes are yours.

Ms. Heather DeBruyn: Thank you. I know it's very difficult going last, and you guys have been going all morning and all afternoon.

Before I actually do my presentation, I just want to clarify a point that was raised by the gentleman before Shirley about the closure of 80 vocational program spots in St. Thomas. I am in St. Thomas; this is what we do. That's part of the whole divestment piece with regional mental health care. We worked collaboratively for many years—over 10 years—to come up with comprehensive plans on what happens when those hospital programs close, and I can tell you, with that particular closure, a business plan was derived between Canadian Mental Health and Goodwill Industries to come up with a best-practices program around life skills, living life to the fullest, self-help programs to help those individuals who can get into competitive employment get competitive employment, and, for those individuals who need ongoing support, to get them ongoing support.

I just wanted to clarify that part, because it's not 80 things gone. It's 80 things gone from a hospital, but it has created space for almost 200 people in the community. So I'll just say that bit.

The Chair (Mr. Ernie Hardeman): Thank you very much for that.

Ms. Heather DeBruyn: What I have brought with me is actually the Jim Whaley report with regard to mental health and addictions and where investments needed to go. I wanted to bring this because this, to me, typifies how the process works.

1710

We have had a mental health and addictions committee in St. Thomas-Elgin for 15 or 20 years, and we have sat around and looked at gaps in services and we've done all of the efficiencies that we could possibly do. We've got all the partners, including the police, the hospital, VON—everybody and sundry—as have all these other communities across our LHIN.

When the LHIN came into being, they helped us create a coalition of all of those mental health and addictions networks so that we could look at themes of needs across the whole LHIN. What happened is that we were able to get the LHIN to hire a consultant to work with all of the local communities, to come to our committee meetings and talk about what the actual gaps in services were. We were a little worried about just investing monies without any expectation of outcomes. Both Canadian Mental Health and other community mental health organizations and our consumer groups—we all need more money, we all want to do more work, but we wanted to be able to demonstrate that we had some outcomes for the investments and that those were the outcomes that were intended with the investments.

The LHIN was able to come up with some money to hire a consultant who came to all of our local committees and talked to all of our regional people and then come up with a report on what was working well in what areas, how many staff that took, and how many clients you could anticipate that you would be able to help with that investment. I can tell you that over the last couple of years there has been strategic investment from the LHIN to go into what our report turned out as the needs, and now, after those investments are done, there are other things that are emerging in mental health and addictions, especially with regard to interactions with the law and court support and those kinds of things.

The LHIN again has hired Mr. Whaley to come back and do a refresh of this report so that we can look at: Did we meet the things that we thought we would meet with this investment? What were we not able to predict as emerging needs? And where might the future investments need to go?

I think it gives you a really good example of the local issues and concerns, being able to voice those, to look at the similarities across our LHINs so that we do have consistency with regard to what services are provided, and also what are best practices so that there is strategic investment and so that we can have outcomes that are going to mean that we are not in the emergency room, we're not having unnecessary hospitalizations and we're not having unnecessary incarcerations. I just wanted to bring that to you.

As somebody had mentioned earlier, if you could say how the system is supposed to work and what that looks like—I would suggest, if you look at this documentation and how local agencies were engaged and then rolled up to come and have an understanding of the whole LHIN-wide issues—this would be a good example of how I believe the system should work for all specialty groups.

The Chair (Mr. Ernie Hardeman): Thank you. That's the end of your—

Ms. Heather DeBruyn: Yes.

The Chair (Mr. Ernie Hardeman): Okay. Then we have about 10 minutes left for questions and comments. We start with the government side first: Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much for coming in. Both Ms. Elliott and I were on the Select Committee on Mental Health and Addictions and had a very interesting visit to St. Thomas and learned a lot about what was necessary, in terms of the community supports. So, obviously, your organization has been totally involved in that consultation.

You feel that the LHIN has been a really important part of facilitating that type of discussion, the shift from institution to community and appropriate supports. Without the LHIN, do you think you would have had such a smooth transition, or at least a plan for a smooth transition?

Ms. Heather DeBruyn: I think what the LHIN does is it balances the playing field between institutions and community partners, so that when you actually come to the table, you feel like you're equals.

We're just a very small agency. We have 50 staff. We have—\$5 million is our budget, which used to be less than the deficit of the general hospital. So it's not a balanced playing field.

I've been with the Canadian Mental Health Association for 25 years, so I've been through the district health council days. The planning was great, but you would get to a standstill between the planning and the ability to implement.

What I have seen with the LHIN is that because they have staff that come to the committee levels, they can help you frame your need in a way that it aligns with what the goals are so that you can plan and implement and then evaluate. To me, it has helped make the divestment of regional mental health care smoother, and there's more communication with community partners.

Ms. Helena Jaczek: Are you, by any chance, part of this Health System Leadership Council?

Ms. Heather DeBruyn: The Health System Leadership Council has just wrapped up, but, yes, I was a part of the leadership council. I chair the mental health and addiction Elgin component, and I co-chair the Elgin health systems council. There are a lot of pieces—because we're local and we're small, there's a lot of accountability. But because you have LHIN representation and LHIN reports coming to your local committees, it helps keep people on track with moving the system forward.

Ms. Helena Jaczek: So would you have any recommendation in terms of improving the system as you have experienced it?

Ms. Heather DeBruyn: I think our LHIN, the South West LHIN—I've heard from my colleagues across the province. They don't necessarily have as much input into the changes that are made. I think this type of a process of engagement and implementation and evaluation is a very successful process.

The other recommendation would be around streamlining some of the reporting between the LHIN and the Ministry of Health, because there still is a difference in categories. In our LHIN, we've had a data quality committee, and we've consulted with the LHIN and the Ministry of Health at the same table. They do not necessarily agree on the interpretation of some of the pieces with regard to mental health and addictions. So streamlining some of those processes would be quite helpful.

The Chair (Mr. Ernie Hardeman): Thank you very much. With that, Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for your presentation, Ms. DeBruyn. I'm really pleased to hear that this LHIN is really making mental health a priority. I hope that the other LHINs are doing so as well because we have seen the personal devastation that it causes, as well as the financial costs to our criminal justice system and other systems that would be greatly reduced if we really put more resources into mental health supports and services. Thank you for a copy of this report. I look forward to reading it in due course, but you mentioned that Whaley and Co. has been re-engaged to revisit the report. I'm just wondering where they are in the process, what they found out so far and what the progress has been on implementing the recommendations contained in it.

Ms. Heather DeBruyn: So that's very brand new. January is when Jim Whaley has started to come back, but he actually comes right to our town, to our committee, and then engages—and we have a committee of about 20 people who represent all kinds of different sectors of service provision in our area, not just mental health, but we have the police there, we have the hospital, we have all kinds—violence against women and all of that. It's a pretty cohesive group. So he comes back and says, "Has this met your expectations of investment? Where do you see the gaps? Are we seeing the numbers that we expected? If we're not, what do you think that that looks like?" He has come and started the conversation and he will come back again, now that people have a chance to go back and review their data to see whether or not this has made changes, and what we see as the trends that might be coming, whether or not it be with the criminal justice system or decent, affordable housing, those kinds of things. It opens up the whole dialogue around that again.

Mrs. Christine Elliott: It's so important to measure those outcomes and identify best practices, so I'm very happy to see that that's moving forward. But, anecdotally, how do you feel that things are coming along?

Ms. Heather DeBruyn: I think that the pieces that we addressed in this report have been met quite nicely, and I think that there's evidence to support that it has been a

good investment. I think the emerging trends are going to be more with the criminal justice system, especially in Elgin county. We have had such a tremendous loss of employment that there are also some pieces that are coming out with poverty and some of the issues around poverty that we would not have been able to predict when this report was first being done.

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

Ms. Peggy Sattler: Thank you very much for the report. It looks like it's going to be a very valuable resource for this process. I'm interested in hearing your perspective on the involvement of non-LHIN-funded agencies in the process that you undertook. One of the concerns that I've heard expressed about the LHIN model is the room that it provides, or doesn't provide, for non-LHIN-funded agencies that are obviously connected to the health care system, thinking specifically about some of the sectors you mentioned: violence against women, the justice system. Can you comment a little bit about your perspective on how that worked, involving those non-LHIN-funded agencies, and if you have some recommendations going forward on how LHINs could involve representatives from those other sectors that have an interest in the quality of health care delivery in the province?

Ms. Heather DeBruyn: Yes. There are two primary committees in St. Thomas that deal with health. One is the Health Services Council and one is the Mental Health and Addiction Network. We're small, so we only have three, four, or maybe five agencies that would be funded by the LHIN. The rest are all concerned citizens. Some of these committees were established before with the district health council and then we kept in place until the LHIN got up and running, because it's an area where we look at gaps in services and who can provide those services and how we can think out of the box to make sure that somebody doesn't end up falling through the cracks. That's the beauty of small community: There is a lot of accountability. For example, they city and their housing managers come and sit on the committees because they see a lot of emerging mental health and addictions issues in their housing and all of that. So our platforms that we already have in Elgin—and they are replicated across our LHINs with mental health and addictions networks—they already have non-LHIN-funded agencies that come to the table. They've been very good at partnering, because it is that whole spectrum of health that we're looking at. So we do have representation from doctors, for example, and from family health teams and all of those kinds of things to look at how we move the system forward, even though some of these other agencies are not under the umbrella of the LHINs—neither is the fire department and those kinds of things. And yet they become quite important, especially around hoarding and those kinds of things. We need them at the table because

it does end up interfering with the health of an individual. So we've been very good at bringing those around, and the LHIN has been very good about taking the voice from all of the players at the table.

Ms. Peggy Sattler: Is that model transferable, or does it work so well because of the very small community that you live in?

Ms. Heather DeBruyn: I believe it's transferable, because they have the same mental health networks and area-provided tables across our LHIN. London-Middlesex is huge, so it would have its own idiosyncrasies. But in all of our major areas, we do have both of those tables, and there is a forum to bring them back together with LHIN guidance. So the area-provided tables everywhere—we have teleconferences every couple of months to borrow what they have in other areas so we can replicate it.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It's much appreciated. We have reached the end of the road.

Ms. Heather DeBruyn: Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for being here.

That concludes the deputations for this afternoon.

I have one announcement. The committee will remember that early this morning, there was some trouble with the equipment because of the temperature in the room. It turns out that the recording did not work for the first presenter. So we do not have the record and Hansard of the first presenter. That presenter did have a written presentation, so we'll have the written presentation. I just wanted to point out that I think there was one committee member who asked a question, so that will not be on the Hansard. It was one that you may be happy got lost, and it did.

Mr. Mike Colle: I have a question about equipment.

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Mike Colle: Will we have heat on the bus? I don't want to go to Windsor without heat in the bus.

The Chair (Mr. Ernie Hardeman): I will have to refer that to the bus driver.

Mr. Mike Colle: No, I think the Clerk should look into this. We shouldn't be going in this weather without heat on the bus.

The Chair (Mr. Ernie Hardeman): Yes, we'll check to make sure that there's heat on the bus. In my bus, I have heat.

Mr. Mike Colle: I know, but the Clerk should be assuring that we get safe transportation here. We can't go out in this cold without heat.

Interjections.

The Chair (Mr. Ernie Hardeman): The meeting stands adjourned.

The committee adjourned at 1723.

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