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Jeudi 30 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

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Thursday 30 January 2014

Jeudi 30 janvier 2014

The committee met at 0902 in the Holiday Inn and Suites Ambassador Bridge, Windsor.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning. I thank everyone for being here. The reason I did slam the gavel—I was going to wait on doing that until everyone was finished. There were very interesting conversations, but I realize that that may be when we were supposed to finish this meeting as opposed to when we started it, so I thought it was time to get started.

So, we'll say good morning and thank you very much for being here for the Thursday, January 30 meeting of the Standing Committee on Social Policy. We're here to review the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act. We're doing public consultations, travelling around the province, hearing from the people involved and getting their comments to help us write a report for the government to consider moving forward on the operations of the LHINs.

DR. GLENN BARTLETT

The Chair (Mr. Ernie Hardeman): Our first presentation this morning is the Windsor Essex Community Health Centre: Glenn Bartlett, executive director. Is Glenn here? No?

Interjection.

The Chair (Mr. Ernie Hardeman): I'm just told that Glenn is just arriving. Oh, there he is.

Mr. Mike Colle: Come on right up, Glenn.

The Chair (Mr. Ernie Hardeman): If you want to take a seat at the front of the table here. Thank you very much for being here. It's always a little tough being the first one in the morning, but anyway, I just wanted to point out to you, Glenn, that it's no tougher for the presenter than it is for those of us who have to be here on time. We do want to get started.

Thank you very much for coming in to make a presentation. We're looking forward to the presentation. You will have 15 minutes to make your presentation. You can use any or all of that time, and if there's time left over, then we'll have questions from the caucus to your presentation, and any comments that they may have.

With that, the floor is yours for the next 15 minutes. Thank you.

Dr. Glenn Bartlett: Thank you very much. Thank you for the opportunity to present to this committee. First off, I feel a need to explain briefly the context from which I make my observations. These are mine alone, and should not be attributed to any one organization.

As is very apparent, this is not my first rodeo. I practised surgery for a considerable period of time before going over to what my colleagues would call the dark side. I have worked with district health councils and district offices of the Ministry of Health and Long-Term Care. As well, I have worked for six years in another province with a different, but not necessarily better, regionalization model. I am just completing a half-time position at the community health centre in Grand Bend as their ED and a half-time position as CEO of a small rural hospital in Exeter. As such, I work simultaneously with both the South West LHIN as well as the Erie St. Clair LHIN. I'm about to become the executive director of the Windsor Essex Community Health Centre.

Perhaps it is my surgical background, but I would like to dissect the title of "local health integration." The LHIN's mandate controls roughly one half of the total Ministry of Health's budget, but that control, as I see it, is tightly exercised centrally—i.e. this is a centralized, not a local, delivery model of care. Secondly, this is not a health system but rather an illness system. The concentration of effort and dollars is on large urban hospitals. It is difficult for organizations such as CHCs, which provide health promotion and illness prevention services, among other things, to gain economic traction. LHINs do not have the financial mandate to deal with health promotion. In my opinion, this is a short-sighted oversight which will affect future generations.

Thirdly, integration has focused on hospitals integrating with one another, so-called horizontal integration. However, collectively, as a population, as we move from cradle to grave, we don't necessarily go horizontally. We tend to go from public health to primary community care to community hospitals to tertiary care, and some of us to long-term care. Why, then, aren't we talking about vertical integration rather than horizontal? That, indeed, is the average life trajectory of our population who depend on us.

Finally, I think it is it apparent that, at this point in time, there still is no system as such but rather there

continues to be multiple silos and fiefdoms, although fewer than there used to be.

However, in spite of all the above, it is my opinion that the LHIN model is far superior to any previous Ministry of Health model that this province has had. It does allow input into local issues.

The shortcomings of this LHIN model fall under two headings in my mind: first of all, issues arising from the act itself, and secondly, issues arising from the implementation of the act.

It is widely recognized that Ontario health care transformation is necessary to keep our public-funded health care system highly performing and sustainable. This cannot be achieved in isolation. This is a collective challenge requiring combined involvement and effort from the health services providers as well as, in our case, the Erie St. Clair LHIN and our health care partners.

By establishing the Erie St. Clair LHIN, the province has given us the support needed for local health transformation by communicating with us in several ways, such as local planning, coordination, integration and delivery of key publicly funded health services.

We support the Erie St. Clair LHIN's integrated health service plan number 3, and the strategic direction that we are working in is in collaboration with that initiative, as outlined by the LHIN.

As a passing comment, it is my opinion that the omission of ambulance services and public health from the mandate of the LHIN is not a good one. The fragmentation that currently exists does not serve the needs of our patients, clients or residents in a true systematic, cost-effective way. These essential services should, in my opinion, be above local politics.

The second issue is how the act is implemented. I have first-hand knowledge of concurrent comparison of our two LHINs in the western part of the province. I have found Erie St. Clair to be responsive and approachable when it comes to problem-solving. They do have a true appreciation of the impact of decisions on our patients. We sure do not get everything we ask for—far from it—but we do get a thoughtful hearing if our requests are rational and persuasive.

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Now a bit about Windsor Essex Community Health Centre: We're one of five CHCs in the Erie St. Clair network. The Windsor Essex Community Health Centre was established in December 2009 by the amalgamation of Sandwich Community Health Centre and the Teen Health Centre. It is now one of 73 community health centres located throughout the province.

The CHC model of care—for those who aren't familiar with it—focuses on primary care, illness prevention, health promotion, community capacity building and service integration. The model of care attributes include comprehensive, accessible, client- and community-focused, interprofessional, integrated, community-governed, and takes into a great deal of consideration the social determinants of health.

Our centre serves the vulnerable population of this city and the surrounding region. Vulnerable populations are individuals who face barriers to accessing and navigating health care-related programs and services. The following are some examples of the current vulnerable population that we are serving: children and youth; seniors; individuals suffering from chronic diseases such as diabetes, hepatitis C, heart disease and stroke; immigrants and refugees; individuals who are homeless or at risk of homelessness; individuals with disabilities; and individuals who are geographically or culturally isolated. The Windsor Essex CHC services are targeted based on the unique needs of this community we serve.

Some ways in which Erie St. Clair supported the Windsor Essex CHC:

—community engagement related to integration activities and facilities planning by providing facilitation for such an engagement;

—an operational review of the organizational structure and internal workflows to ensure that we are making the best use of existing resources—governance, staff, facilities and funding—within the context of a fully integrated organization;

—recommendations were made and a 12-month follow-up report was achieved;

—a review of all programs and services to determine appropriateness within a defined mandate and sustainability;

—a review of back office integration opportunities which resulted in the integration of payroll services with the Brockville General Hospital;

—a review of external relations with key health service providers and non-health service providers to evaluate the impact on primary health care for our residents, and to align with the LHIN and the Ministry of Health's strategic priorities;

—a review of the corporate culture following integration and the degree to which a new culture and leadership had been successfully implemented was determined—there were a few words there but it's an enormous undertaking for a corporate culture of two organizations merging together;

—a comparison with other CHCs in Erie St. Clair as to resources and availability and distribution, and adjustment of same;

—a consultation with the Association of Ontario Health Centres, which is the overarching organization for CHCs in the province, to clarify actual and emerging practices and look at best practice trends.

We have two ongoing capital projects, supported by the LHIN: (1) the relocation of teen health services, and (2) the relocation of Sandwich community health, both of which are located in some centre facilities.

We have engaged in a collaboration with Leamington memorial hospital in providing satellite services to their area.

We are participating with the Essex South Shore Health Link. Health care providers in Leamington, Essex, Kingsville, Wheatley and elsewhere have come together to create a health link, which is a new model of care where all providers in a community—including family

care providers, specialists, hospitals, long-term care, home care and other community supports—are charged with coordinating care for the people who rely most heavily on their services. Through this approach, clients, caregivers, providers and stakeholders co-design a desired future state of local health care that removes waste, increases capacity for change and improves value for patients who live in our communities. The health link data committee identified people diagnosed with congestive heart failure—which is really a failing pump, if you will—as an initial patient cohort for review.

We participate in regular one-on-one meetings with the LHIN to identify challenges and opportunities so that we can continue to improve.

The LHIN has provided us with dollars to support a mobile falls clinic assessment—one-time funding, a trial basis for the rest of the LHINs. This is in partnership with the VON, the Chatham-Kent CHC, the Grand Bend CHC and the tri-county public health entities. In other words, we're not doing it alone; it's a collaboration.

The LHIN has provided an annualized base funding increase for a nurse practitioner at our Street Health program that serves the homeless and those at risk of becoming homeless.

We are involved in collaboration with the LHIN to support the Southwest Ontario Aboriginal Health Access Centre by providing new base funding for a nurse practitioner for fiscal 2013-14. This will address the significant health care gaps and poorer health care outcomes of the aboriginal community by increasing effective, culturally appropriate service delivery.

The LHIN has provided one-time funding for minor supplies for our disadvantaged populations.

Finally, the LHIN has stabilized our chronic disease management activities by providing long-term, secure funding for that staff.

In summary, while LHINs are not a perfect model, they certainly are far superior to anything else that I have worked with in this province. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about two and a half minutes. It will be the official opposition. Ms. McKenna.

Mrs. Jane McKenna: Thank you so much, Dr. Bartlett, for your dedication and hard work and the recommendations that you've brought forward. We're getting a bit of a consensus now, in doing this for the last few days, with people saying quite similar things that are very thoughtful. I really liked your vertical integration that you mentioned there.

But I have a question for you. You mention here that we have your current vulnerable populations. I would gather that you measure your success by the success of the patient going through the system. So when you're dealing with children, seniors, chronic disease—the list is quite extensive here—how do you measure the outcomes of those patients to see where you could better service them?

Dr. Glenn Bartlett: I'll answer it another way. One of the things we're trying to achieve is to provide care for people in the community so that they don't go to the emergency department and plug up the emergency department. We've done some analysis of that, and I think we can show by numbers that the efforts that we're making are effectively decreasing the number of patients accessing the emergency department inappropriately.

For example, COPD patients, if they're not treated in the community appropriately, have a track record of recurring—sometimes 12 to up to 28 times for one individual. It's the same problem, which could be adequately dealt with in a community fashion. So I think the things we're doing help them provide that.

For the homeless people, if we can give them food, if we can deal with hep C, if they've got that, and other entities that are troubling—diabetes—then we can keep them out of the acute care system and living a more fruitful life.

So we measure it indirectly rather than—I think our impact is felt in other parts of the system.

Mrs. Jane McKenna: Yes, because it's—

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the time, so we thank you very much for coming in, and I'm sure we'll use your presentation as we formulate recommendations in the report.

Dr. Glenn Bartlett: Thank you very much.

ERIE ST. CLAIR LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation is the Erie St. Clair Local Health Integration Network: Martin Girash, chair, and Gary Switzer, chief executive officer. Welcome, gentlemen, and thank you very much for taking the time to come in today and make a presentation to us. As with the previous one, there will be 15 minutes in total that you can use all of or any part of that you wish. In any part that's left over, we will have questions from caucus.

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Dr. Martin Girash: Thank you, Mr. Chairman and members of the Standing Committee on Social Policy. Good morning. My name is Martin Girash and I am a psychologist by profession and the new board chair of the Erie St. Clair LHIN. I want to thank you for the opportunity to speak to you today on the impact of the Local Health System Integration Act, as well as our local health integration network, and the impact that these have had on our health care delivery.

My entire career of over 40 years has been in health care, from early years in children's mental health, to acute care as a retired hospital CEO, to more recently as a consultant for a number of community health agencies. As a result, I have worked through an era when there were no local health integration networks and, more recently, during their formative years.

One of the most important themes within the legislation is the requirement for community engagement. The

importance of including the public and our stakeholders in health care decision-making is very, very critical.

Characteristics of our communities within the Erie St. Clair LHIN range from medium-sized cities such as Windsor to rural communities like Petrolia, and everything in between. How citizens could best access health care varies greatly from one community to another. It's more related to where they shop than where health care services may have been located. Each community should have a say in how the system is structured, and needs a voice to represent their unique access requirements. The local health integration networks provide that voice. Prior to the LHSIA and the LHIN organizations, there was very little opportunity to have that say.

At the Erie St. Clair LHIN we believe in interactive communication, accessibility and engagement, and see ourselves as forerunners across the province in these areas. We are the local connection to the community and stakeholders—a role we take very seriously.

For example, we post online all reports, our public scorecard, expenses, community reports and other important information. We provide direct phone or walk-in contact with our staff and CEO for issues management. We have a two-business-day response policy to all email and letters, and are proud to say that we normally exceed that. This service is widely used by the public, stakeholders and all MPPs.

We post online our entire board package within 24 hours of our board receiving it, and we webcast our open meetings, so that everyone has the opportunity to both observe and comment on our work. We offer an open mike session at the start of each board meeting where the public can speak to us about something important to them. Additionally, we rotate our board meetings' locations throughout our LHIN and have a public session where we hear from the residents on a health care topic that is important to their community.

Through all of our work, we rely on input and advice from health care professionals, patients and the community. This is often done through town hall sessions, forums, surveys and working groups, to name a few.

An excellent example of this type of collaboration is our work on orthopaedic surgery. We have at the table all the chiefs of orthopaedics throughout our LHIN—

Mr. Vic Dhillon: Sir, can you just back off of the mike?

Dr. Martin Girash: Yes. Too loud? Sorry. We have at the table—how's that? Is that better?

Mr. Mike Colle: You just don't have to be that close to it.

Dr. Martin Girash: Okay. How's that? Okay? Sorry.

We have at the table all the chiefs of orthopaedics throughout our LHIN, patient representatives, health care providers and primary care physicians, all working together to improve care and make the system more coordinated, so that people can get their surgery as soon as possible. Our CEO may say more about that in detail; we're pretty excited about that effort.

The other day, I was at an announcement for our Chatham-Kent health link. The health link project identifies natural communities within a LHIN jurisdiction so that we can build on the existing relationships and the naturally occurring traffic patterns to form a meaningful and efficient flow for citizens of the community through their health care journey. As I said earlier, where people shop is as important as where they go for their health care, because of convenience and access.

As each partner spoke at this announcement, I saw in action how health links provide a linking of the many partners in a given community. This enables the various health care providers to connect with each other to provide a seamless transfer from one agency to another, something our patients have requested for years. So often throughout my career, I have heard from patients that services were excellent once you received them, but accessing them was a nightmare. The LHINs and the health link initiatives are finally addressing this concern.

Provincially, the LHINs provide a voice for our citizens to be heard at Queen's Park as well. Now we have a local body that is there to hear from our citizens on their health care needs and to be their voice at Queen's Park. Whether you come from Grand Bend, Windsor or anywhere in between, someone is working for you at Queen's Park, something those of us in the deep south have not felt that we've always had.

In summary, working in health care for over 40 years, I can attest to the fact that prior to LHSIA and its LHINs, there was a sorrowful lack of systematic connection among services, and this was the primary complaint of our citizens. While we still have work to do to connect the dots, LHSIA and the LHINs, particularly with the additional responsibilities for more of the health care system, are the threads that tie our quilt of a health care system together.

Now I'd like to turn the mike over to Gary Switzer, our CEO, who will provide specific examples of our work.

Mr. Gary Switzer: Good morning. My name is Gary Switzer, and I am the chief executive officer of the Erie St. Clair LHIN.

The LHINs have been around since 2006, and I have been here since the very start, as I joined in 2005.

In the past nine years, I have seen how the LHINs have matured. We have come a long way and, like any new or established endeavour, we still have room to improve, and reviewing the legislation will assist in our evolution. This is why we are here today.

As these hearings have progressed across the province, common themes are developing regarding the legislation and the value of LHINs in their local communities. I'm sure you will agree that the LHSIA legislation exists to make people's quality of life better by ensuring they receive the care they need, when and where they need it.

While I could talk about the details of LHSIA, it's more important to capture the spirit of the legislation as it is realized through the lens of patients, and it's why today I will speak to you about how the LHIN made a difference by improving end-of-life care in Erie St. Clair.

Death is one of the most difficult topics to discuss. However, it became easier when the voice of the community came together with the LHIN and our system partners to openly discuss and acknowledge that we were not living up to the expectations of people in their final days and that we needed to do something about it.

What I will speak about is a real-life example of what can happen when you bring people and providers together to improve the delivery of health care in their communities. The example I want to share encapsulates the value of our legislation; supports the themes of improved access, system coordination and value for money; highlights the importance of being local; and most importantly, demonstrates how care is being improved for patients.

My intent is to speak for a few minutes, then turn the floor back to you for questions. I hope that works for you.

It's amazing, what we have learned over the years by listening to our communities. In 2006, we were hearing that too many people were dying in hospitals when they wanted to die at home. Surveys indicate that over 95% of Canadians wish to die in their own bed, in their own home. Almost all of us want a choice of where to spend our final days.

It became obvious to us that throughout our LHIN, there was no common approach to support people to die at home, and there was not equitable access to the wraparound care families and patients needed. With the help of our End-of-Life Care Network and community partners such as the CCAC and hospice, we took action. The goals were simple: Provide specialized palliative care and wraparound services for patients and families. It took a team effort and local investments to make this goal a reality.

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The in-home team now consists of palliative care physicians, nurses, social workers, spiritual care, personal support workers and volunteers. People who once had few options regarding their end-of-life plans now have greater knowledge and trust in the care that is available in their communities.

The results were immediate, and news of the palliative outreach team spread quickly. The team had very rewarding experiences as they engaged patients and families at this very special time in their lives. The percentage of people dying in the hospitals who were diagnosed palliative was on the decline. Now, when patients and families are in distress, they have an alternative to the emergency department.

We know that for dying patients and their families, the emergency department is not their location of choice. Yet in Ontario, 40% of the patients who are within the last two weeks of their life visit the emergency department. Over 85% of patients made at least one visit.

Our Erie St. Clair palliative team now averts over 2,430 emergency department visits each year. Additionally, primary care providers report an increased comfort level in caring for patients at end of life now that they have specialized expertise to assist them, should they need that level of care. Our initial evaluative survey confirmed that primary care providers were more confident in assisting their patients knowing that they could work in partnership with this specialized team. This team won a provincial award from Cancer Care Ontario and the Ontario Association of CCACs.

We rapidly expanded our palliative outreach teams to all corners of our LHIN. I'm proud of the efforts of these teams, and so far they have been able to bring comfort to more than 1,150 patients per year. More than 80% of the patients we help are able to have their wish fulfilled by dying at home.

Although it's easy to talk about success and show the measurable results, the real benefit to us and the LHIN and to our system partners is the positive impact to the patients, their families and the care team. Not only did we receive letters from families thanking us, but we know that the professionals on the palliative outreach teams are very fulfilled in their work. They now see the system coordination and how it all centres on the patient and their family. This includes integrating these teams into our health link structure to ensure access for our most vulnerable patients.

The good news is, we didn't stop with just the palliative outreach teams. Our board also approved funding for two new hospices so that every community in our LHIN has access to this type of care.

I remember the day our board approved the funding. There were over 60 people crowded into a small boardroom. People of all ages were there to tell us how important a hospice is to a community and how much of a difference a hospice program can make. I don't think there was a dry eye left in the room after the presentation.

As a result of these local investments, people in Erie St. Clair now have more options and specialized care when faced with end-of-life decisions. We can now proudly say that the same considerate care that was given to them at birth is now also available to them in death.

My involvement at the local level allowed me to leverage my experience to work with the Ministry of Health to establish a province-wide cross-sector committee to look at end-of-life and hospice care. Over 80 providers and stakeholders have now come together to form a declaration of partnership with the goal to improve the end-of-life experience of the patient while working to improve our health care system for everyone in Ontario.

I've always referred to our role in improving health care as a race that never ends. So let's make this a race and pick up the pace of transformation by making necessary changes to the legislation and continue to devolve more authority to the LHINs. Our legislation has enabled us to accomplish many things. However, changes are required in order to make the health system more effective and to improve the care for the residents in Ontario.

In closing, because we are local and in touch with our communities, we were able to develop a LHIN-wide end-

of-life strategy. Our community spoke and we listened. End-of-life care is just one program that has allowed us to improve access to care, improve quality and ensure the work we do is focused on the needs and wishes of the patient. As a result, we're building capacity in our system, not only in Erie St. Clair, but across Ontario.

Thank you for the opportunity to speak today. I have additional information that we've left behind as well. Dr. Girash and I will be pleased to take any questions that you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have one minute left, so if you can have a half-a-minute question, we'll have a half-a-minute answer.

Mr. Percy Hatfield: I'll do the half-minute question. You talked about the orthopaedic example. Do you have a real-life example of how that coordination has worked for a patient in this area?

Mr. Gary Switzer: Do I have a real-life example? Yes. It was last year that we had a number of patients come to our office with a member of Rick Nicholls's staff, with the surgeons, to talk about the delays in surgery. We were able to educate the patients, and the surgeons as well, and provide the patients with the information that they can go anywhere in our LHIN or other LHINs for surgery. I happen to know for a fact that a gentleman I've talked to a number of times from Bell River actually went to Sarnia to have his surgery, because it enabled him to get to Florida faster.

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

Mr. Gary Switzer: You're welcome.

MS. AGNES SOULARD

The Chair (Mr. Ernie Hardeman): Our next presenter is Lambton Elderly Outreach: Agnes Soulard, chief executive officer. Good morning.

Ms. Agnes Soulard: Good morning.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presence. As with previous delegations, you have 15 minutes of time. You can make your presentation. You can use any or all of that time in your presentation. If there's time left over at the end, we will have questions and comments from caucus.

Ms. Agnes Soulard: Very good. Thank you very much. Thank you for the opportunity to appear before this committee to provide my perspective of the Erie St. Clair LHIN and its effect on the health care of Sarnia–Lambton. I must attest that these opinions are mine and mine alone, and I can speak only on my experience in the community support sector.

My name is Agnes Soulard, and I am the CEO of Lambton Elderly Outreach. I have extensive experience—probably more years than I'd care to admit to—in the health care field as a staff registered nurse, a supervisor, a manager in a hospital setting and now, of course, community. You might say that I have experienced both sides of the coin.

Our agency is a not-for-profit agency that provides home and community support services to seniors and adults with disability in Sarnia–Lambton. We offer a host of services that include transportation, homemaking, home help, home maintenance, Meals on Wheels, diner's clubs, community fitness programs, respite, friendly visiting, grocery shopping, client intervention and assistance, the SAFE fitness program to rest and retirement homes and, finally, a 55 Alive driver refresher program. We are truly a one-stop shopping experience.

The organization has been in existence since 1970, so we have a long history of working with many ministries and various branches of the ministries. I began my tenure with this organization 11 years ago, so I worked with a regional representative and a regional office based in London. The communication at best was fragmented, and monies to continue to operate were always scarce for the home and community support sector. The model was truly a medical model. A centralized, regional model was truly not the answer.

A key priority of the health care system right now is the move in care from acute-care facilities to home and the community. The LHINs are best suited to do this, because they are closer to their communities and recognize their communities' needs. Our LHIN has demonstrated their responsiveness to provider questions and concerns, and has increased their engagement with the community. They are very transparent in their communications and have held town hall meetings to obtain information regarding health care needs, or to address concerns that the community may have. Their website provides information regarding meetings, and frequently they circulate newsletters regarding new programs or initiatives.

Overall, the Erie St. Clair LHIN, through this local administration process, has given organizations like ours the opportunity to be included at tables to which we were not invited in the past. This is very important for making local decisions, local planning, sharing visions of health care and best practices.

Our voice has been heard. For example, we were at the Aging at Home table and were able to obtain monies for local initiatives. We received monies to expand our Meals on Wheels program, our friendly visiting and our transportation program, all in an effort to assist clients to remain independent in their own homes. I might comment that our transportation alone in five years has tripled in terms of the number of rides provided.

Ontarians and Canadians may be living longer, but we are not becoming healthier. A recent House of Commons health committee showed that the number of years lived in good health peaked in 1996 and has been declining since. As we know, the majority of seniors have at least one chronic condition; as many as one in four has two or more. More startling, 5% of health care users rely on our health system and account for as much as two thirds of public expenditures. Therefore, we realize that with an aging population, chronic diseases are becoming more prevalent. Our LHIN has become responsive to this need

and has established chronic disease prevention and management teams, as well as health links, and community support has again been invited to participate.

0940

Smaller families are often scattered across the country, making caregiving more challenging. We all must be as innovative and as efficient as possible. In an effort to assist caregivers and families, we are caring for clients on a 24-hour-per-day, seven-days-a-week basis. Our LHIN has expanded the respite programs available to caregivers, to avoid the burnout that often accompanies this role. We often find that the caregiver will be admitted to hospital before the actual client who is experiencing the disease, just because of this burnout.

The LHIN is not perfect. However, we are prepared to and want to work within the current structure to make the system work. Dissolving of the LHINs will not immediately improve the health system and may distract from the more immediate issues impacting the delivery of home and community care. Any review of the local administration of health care cannot ignore other interconnected structural challenges required to meet the dual policy goals of developing and maintaining a healthy population within manageable public health budgets. A progressive, modern health care system keeps people healthy and connected in their homes and communities, and not sick and alone in institutions. I believe that home and community support works because it offers local, flexible solutions which the LHIN has supported.

We conduct a yearly client satisfaction survey, and we frequently receive comments such as, "Were it not for your service, I would not be able to live independently in my home." This is a true testament of how our services accomplish the goal of keeping people in the community and out of hospital and long-term-care facilities. Therefore, it is a more cost-effective means of health care delivery than institutional care.

We are very conscious of the government's health care objectives to effectively deliver high-quality health care services to help prevent people from getting sick or requiring more acute care. These are the objectives of the home and community sector. We strongly encourage government to continue with these strategic investments, such as investments to help reduce hospital admissions or readmissions.

Caring for seniors at home costs 67% less than care provided in long-term-care homes and 95% less than care provided in the hospital. Investing in home and community care frees up hospital beds and unclogs emergency waiting rooms—we've heard that in some of the presentations we've had previously—while also decreasing long-term-care home placements and long-stay hospitalizations, all at a lower cost to the health care system. An example of this, in our LHIN, is the establishment of a Home First team to address barriers to discharge for hospitalized clients. Remaining at home as we age is where we want to be.

There are ongoing concerns in our sector—this is the community support sector. One concern is the shortage of home and community health care workers. One of the reasons for the difficulty in recruiting and retaining workers is the disparity in compensation and working conditions between the community health sector and the institutional sector. Our recruitment and retention challenge is magnified by the inability of agencies to offer wage increases for PSWs, either due to the absence of base funding increases or, as in our situation, due to the wage freeze that was initiated three years ago. I have been told that in some agencies, this may create labour difficulties, which threaten client care.

We must therefore ensure that to meet the current and future demand for home and community support services, there is sufficient funding and flexibility afforded to agencies to attract and retain qualified personal support workers.

I would therefore request that the government review their present policies regarding the wage freeze.

As I suggested earlier in my presentation, the LHINs are not perfect, but I believe that a hospital model or a CCAC model is not the answer. The hospital model at one time was most appropriate, but at the moment it is not, with the many challenges I have already identified. The CCACs are not the answer, and it was demonstrated that competition drives down quality and CCACs are a very expensive model of care.

Achieving the widely shared goal of providing the right care in the right place at the right time may sometimes require integrated service between two or more agencies to maximize the effective and efficient delivery of care. We must therefore pursue smart integration. More can be done to streamline functions between the LHINs and CCACs and make for a more efficient delivery of service for our sector.

I would therefore support the continuation of the LHIN as the local model to make decisions. I would however, suggest that the CCAC and LHIN integration be explored. Certainly, a great deal of administration costs could be saved.

I would also suggest that not all the LHINs across the province are equitable and that there be a greater effort made to ensure that best practices are shared and implemented across the LHINs.

In closing, I encourage you to think strategically. Investing in home and community support services now will save the government money and improve the health of residents living in Ontario. I could speak to many more examples of how the LHIN has supported and worked with our community support sector to ensure that the right care is provided to the right client at the right time, but time is prohibitive. I look forward to continuing to work with our LHIN to improve the face of health care in our community.

Thank you for your attention today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about three and a half minutes left. Ms. Cansfield.

Mrs. Donna H. Cansfield: Thank you very much for your presentation. It was very thorough, very comprehen-

sive, and I learned something I didn't know, that we have a Wyoming, Ontario.

Ms. Agnes Soulard: Actually, we're the centre of Sarnia–Lambton, Wyoming, for those who aren't aware of that.

Mrs. Donna H. Cansfield: Wonderful. One of the things that I particularly appreciated was that you identified how difficult it was to navigate the system. You identified that in the health links it's 5%. That's a huge amount of money that goes to 5% of the population and therefore it spreads the issue, and I particularly was interested—I would like to ask the question around the CCAC and the LHIN integration model and how it could be, in your eyes, accomplished.

Ms. Agnes Soulard: The CCAC at present is really a brokerage model that has very little hands-on care. I believe that by eliminating the competition—the competitive model—and by integrating the CCAC and the LHIN, the LHIN can provide the delivery care model that the CCAC is presently providing.

Mrs. Donna H. Cansfield: So in essence, they're both in the procurement business and you're really just taking out one middle person or one—

Ms. Agnes Soulard: That's correct.

Mrs. Donna H. Cansfield: Excellent. The other question that I had for you, in closing, is how—again, you spoke to that important process of integrating services turf in order to provide for the client. How do you see that happening here?

Ms. Agnes Soulard: I think we can all work better together. I think that many organizations have excellent programs and maybe we need to amalgamate those programs and ensure that we're offering the best to all the clients and that it's less fragmented.

Mrs. Donna H. Cansfield: And do you see that as a role of the LHIN, to take the lead?

Ms. Agnes Soulard: Yes.

Mrs. Donna H. Cansfield: And that has to be supported by government.

Ms. Agnes Soulard: It has to be supported by government and have the buy-in of the participants at the table.

Mrs. Donna H. Cansfield: You realize it's a very uncomfortable conversation?

Ms. Agnes Soulard: Yes, I realize that.

Mrs. Donna H. Cansfield: But a necessary one.

Ms. Agnes Soulard: Yes.

Mrs. Donna H. Cansfield: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. Very well done.

BRENTWOOD RECOVERY HOME
WESTOVER TREATMENT CENTRE

The Chair (Mr. Ernie Hardeman): Our next presenter is the Brentwood Recovery Home and the Westover Treatment Centre: Mark Lennox, administrator of Brentwood Recovery Home, and Ron Elliott, executive director of the Westover Treatment Centre. Thank you very much, gentlemen, for coming in this morning.

0950

As with the other delegations, you will have 15 minutes to make your presentation. You can use all or any of that time for the presentation. If there's any time left at the end of the presentation, we will have questions and comments from our committee. With that, the floor is yours, and the next 15 minutes are yours.

Mr. Mark Lennox: Thank you. With your indulgence, we will both present, and then all the questions at the end.

I do thank the Standing Committee on Social Policy for this opportunity to address the issue. I've been working in administration for a residential addictions agency since before the LHINs were first incorporated in 2005 and the subsequent passing of the Local Health System Integration Act in 2006. I say this as I would like to be clear that I experienced that transition.

The failure or success of the Local Health System Integration Act will not be measured by us, but rather by our consumers. Quick, consistent and responsive quality service across our geographic and demographic areas is paramount. We must all stay the course together in a unified effort to reach a truly people-centred treatment plan. But which plan? I believe that for real gains to be made in our sector we need to have long-term commitments from both the health care providers and the government of Ontario. The Drummond report recommends that Ontario "must set out a 20-year plan with a vision that all Ontarians can understand and accept as both necessary and desirable." I support this fully as I see no benefit in having a system that is bombarded with threats of being dissolved. To my mind, this is counterproductive to the effectiveness of the health care system as a whole and emotional blackmail for those we serve. Changes in messaging and direction do nothing to advance our work.

The LHINs have their champions and their detractors. Although the transition period may have been painful, I truly believe that we've rounded the corner. I can only speak for the Erie St. Clair LHIN, but over the past two years I've seen a dramatic upswing in communication and co-operation with the health care providers. Coupled with the new programs introduced over the past year, we have the potential to provide great benefits through easier access to appropriate care for our consumers. At this time, I'll speak only to the programs and committees that I'm directly involved with as a committee member or as a community partner.

The first would be Fast Access to Community Experts. In the youth system review published by the Centre for Addiction and Mental Health, all stakeholders identified insufficient access to service as a significant concern and area for improvement. The FACE program couples agencies willing to provide and set aside consistently available time slots to serve new clients and make those times available for referrals from other agencies. A facilitator has just been hired to assist those agency staff

to book the appointments for their clients, which will reduce wait times for access to many services.

The mental health and addiction network: The original committee was disbanded several years ago, which was unfortunate. A lot of time and effort had been put into that by both the HSPs and the LHINs. At the time it was quite upsetting. Today, I see it as an example of growing pains during that transition period. The network has since been revitalized with Dawn Maziak from the LHIN, and the network is comprised of representatives from key partner organizations to provide high-level strategic counsel to the Erie St. Clair LHIN to advance system-wide planning. So far, it has created the Erie St. Clair LHIN's mental health strategic plan and is now moving toward the creation of the addiction strategic plan.

I must note that this two-pronged approach is seen as unorthodox by many, but it is a local solution in response to both the unique and common priorities of local mental health and addiction treatment agencies and our stakeholders. In order to ensure that planning remains consistent, committee members are expected to commit to a minimum of two years.

The Windsor-Essex community capacity committee was formed to work with the Windsor hospitals to support the stage 1A submission for the new acute care hospital, but it included community agencies at the table. The purpose of the committee is to ensure health care services are delivered in the right place by the right provider. To date, approximately 50 initiatives have been identified as services that may move from acute to community care if it would improve the consumer experience.

The Erie St. Clair balance-of-care project: a collaborative effort to bring together the best available data and best available people, using input from both front-line providers and senior leaders, to consider the needs of our aging population. This co-operative project of the Erie St. Clair LHIN and the University of Toronto shows great promise for our community to access alternative levels of care.

Education: The Erie St. Clair LHIN's first governance webinar was January 14, with a presentation on strategic relationships. Our board of directors and I found it most instructive and are looking forward to future seminars.

The inner-city initiative: a short-term community transitional stability centre for persons with mental health and addiction issues. The program will accept males and females, over 16 years of age, not requiring hospital admission but in immediate need of service coordination. The target population will be frequent users of emergency departments, ambulance and police services. The goal is to stabilize the lives of these people through a more holistic treatment plan and supports, which will lead to less dependence on those emergency services.

Of course, the Ontario Telemedicine Network: The proliferation of this valuable tool by the LHIN promises to assist interagency and interdisciplinary services for communication. In our case, it allows consumers to have access to psychiatric services without even having to leave the property. This cuts down on wait times, travel times and transportation.

The mental health and addiction nurses: New this school year, these nurses are embedded in our local secondary schools and have already become a huge asset. Their ability to facilitate communication between the school board, parents, local agencies and the young person seeking help with addictions has made a dramatic difference in the time it can take for some of these young people to access treatment.

The Brentwood care path: A serious gap in service was discovered, relating to the withdrawal management of chemically dependent youth under the age of 16. In a very short time, Dawn Maziak, from the LHIN, put together a working group, representing a broad spectrum of agencies and disciplines, to work toward establishing a safe pathway to treatment. This project is ongoing, and my best information is that we are very close to announcing a solution.

The Salvation Army Men's Addiction Support and Treatment Program: This outpatient program had suffered year to year with inconsistent funding from different sources and was in danger of being closed due to lack of funding. Last year, the Erie St. Clair LHIN committed to provide permanent funding. The eight-week program has an eight-person capacity, and 71 consumers have used the program in only the first three quarters of this fiscal year.

As we move forward, I cannot stress enough that we need the ability to plan our care paths well into the future while remaining nimble and responsive. Some believe that the LHIN system may not be perfect, but I agree with the Drummond report that they are our best option. As one who experienced the last transition, I can tell you that if you feel it's time for change, the benefits of modification will far outweigh the burden and time and expense of a "slash and burn and rebuild from scratch" approach.

In summary, I remain cautiously optimistic. If you had asked me my opinion six or seven years ago, my response may not have been as positive. As I said in my opening, I believe that we have rounded the corner. I submit that it is the Ontario government, with the assistance of all stakeholders, that is best suited to plan the health care vision to guide the LHINs for the next 20 years.

On a local level, my feeling is that if the direction and level of commitment from the Erie St. Clair LHIN continues or is allowed to continue, we may truly make a difference in the lives of those that we serve.

Thank you.

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

Mr. Ron Elliott: Well, good morning—

Interruption.

The Chair (Mr. Ernie Hardeman): We'll just hold until—

Interruption.

The Chair (Mr. Ernie Hardeman): It would seem to me that the test works. We will carry on, and if the noise

starts again, we'll just stop and let them—and listen to that.

The floor is yours.

Mr. Ron Elliott: Thank you, Mr. Chairman. I appreciate that.

Good morning. Thank you for allowing us to present to you. As said by my colleague, I appreciate the opportunity to present to this committee as the executive director of Westover Treatment Centre.

I've been the executive director since April of last year. I've been a pharmacist for over 40 years in the health care system.

Interruption.

The Chair (Mr. Ernie Hardeman): We'll just hold it. We'll just recess until the sounds have stopped. We do have a cancellation following this presentation, so we have enough to time to get yours in.

Mr. Ron Elliott: Thank you, Mr. Chair.

The committee recessed from 1000 to 1005.

The Chair (Mr. Ernie Hardeman): Thank you. We are patient but not so understanding.

Thank you again. We'll call the meeting back to order, and we will reset your time so we can carry on from the time that was left. Thank you very much again for your patience and understanding.

Mr. Ron Elliott: Thank you, Mr. Chair. As said by my colleague Mark, I too appreciate the opportunity to present to the committee as the executive director of Westover Treatment. I've been the executive director since April of last year. I spent 40-plus years as a pharmacist in the community, and I served on the Westover board prior to that for many years.

The Erie St. Clair LHIN, like the rest of the LHIN structure, I believe, is finally hitting its stride. After years of becoming established and understanding their rightful role, I believe the LHIN structure is now on track to make a difference.

I can remember attending LHIN governance meetings as few as five years ago where the question from the LHIN was, literally, "What do you want us to do?" But today, with exceptional leadership, our LHIN is saying, "This is where we need to go. Here are some tools and resources. These are the expectations. How can we do it together, and how soon can we get there?" This is definitely not a time to be considering a wholesale change in structure.

Let me just touch on a few highlights. This LHIN at Erie St. Clair is visionary. A great deal of effort is expended in looking at future delivery models and how they can improve patient care as we're moving forward. There is an incentive to improve not only in financial ways but in client service delivery in the belief that the agencies and the professionals involved are engaged in that improvement objective. There is input from local providers, with open discussion and inclusiveness. Ways are being found to reduce duplication. There are incentives in place for innovation such as health links, a mental health and addiction network and the use of the Ontario Telemedicine Network. The development of an integrated health service plan is focused on improving the patient experience.

Our LHIN has the same mantra, different words, that I often use at Westover: "What do we do? Why do we do it? What can we do better?"

Westover has received great support, resources and advice from the LHIN at every request, with positive suggestions and follow-up.

The LHINs need to have leaders who are savvy to political and community issues at play in the regions, using executive search best practices to ensure independence and that an appropriate combination of skills and expertise is brought to the table. That was a summary from the Drummond report.

The current LHIN structure underscores accountability. The Erie St. Clair LHIN is moving to an outcomes-based measurement that will cause all health service providers to look at their success in meeting their improvement targets.

The LHINs add value to the health care providers by encouraging integration of services, more rapid transfer of patient information, rapid access to specialties and consistency of service. Examples include health links, working towards an integrated care plan and a health passport for those high users of health care in Chatham-Kent, and the Fast Access to Community Experts, or FACE, program.

With another example—some may see it as simple—the Erie St. Clair LHIN supports the addiction assistance service at Westover, which offers a 24/7 emergency phone line and transportation to Windsor or London withdrawal management services and to treatment on an as-needed basis.

Addiction services are funded, but to a limited degree compared to the population with addictive disorders. Funding should be broadened with barrier-free access to a variety of service models, including abstinence, harm reduction and even home recovery. The creation of a strategic plan for addiction services within this LHIN has demonstrated their commitment to treatment options.

1010

It can be shown that individuals with addictive disorders are frequent users of the health care system. Responsible and well-delivered services will encourage recovery and reduce the demands for hospital and home care. Follow-up and aftercare programs, coupled with relapse prevention initiatives, are being supported by the Erie St. Clair LHIN.

Addiction treatment services play a vital role in helping individuals find a healthy lifestyle. Working in tandem with all health service providers and sharing of services such as aftercare continues that recovery process with easier access and reduced costs. Providing links to supportive housing, self-help groups, women's shelters and the like extends the continuum-of-care concept to these individuals—all of which are encouraged and enabled by the LHIN structure. Taking another line from the Drummond report, "A regional health authority should be clearly identified as the key point for integra-

ting services and institutions across the full continuum of care for a geographic area."

Health links and the timely and co-operative interaction of all health service providers localized in the LHIN will reduce significantly the need for so many government ministries to be involved. It will remove the silos; it will improve the response. The LHINs provide local integration, sensitivity to the area, collective wisdom within the agencies served, community need and demographics, and a much more nimble response to change.

The Erie St. Clair LHIN has established a number of working groups and committees across the region to develop common approaches to health care and, along with other organizations such as providers of addiction treatment, encourage all of the local agencies to work together, improve care and reduce duplication.

Local influence within a region is more effective, responsive and cost-saving, as opposed to a centralized bureaucracy far removed from the patient population. Supportive LHIN involvement has encouraged development of aftercare programs, co-dependency programs, relapse-prevention programs, initiatives for youth services and services for pre- and post-natal women within the population dealing with addictive disorders.

The Ontario Legislature would be well advised to continue with the LHIN structure and encourage inter-LHIN co-operation and communication, but more importantly, empower the LHINs to make the best decisions possible for the communities they serve. Thank you, Mr. Chair.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the time and just a bit. So thank you very much for being here this morning. That makes up somewhat for the interruption that we had.

Mr. Ron Elliott: Thank you, sir.

The Chair (Mr. Ernie Hardeman): For the committee, the 10 o'clock and the 10:15 one have both cancelled.

ERIE ST. CLAIR COMMUNITY CARE ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Next is the 10:30 one: Erie St. Clair Community Care Access Centre. Are they present?

Interjection.

The Chair (Mr. Ernie Hardeman): Okay. Well, if they are here, then we'll just move on to that: Betty Kuchta, chief executive officer. Welcome. Thank you very much for being here. As with the previous delegations, you have 15 minutes to make your presentation, to use any way you wish. You can use any or all of it. Any time that's left over after your presentation will be questions from caucus. Thank you very much.

Ms. Betty Kuchta: Great. Thank you very much, Mr. Hardeman, Chair. Good morning, committee members. I'm Betty Kuchta, the CEO of the Erie St. Clair Community Care Access Centre, and I'm delighted to be here to inform the committee and to advise the committee in this important matter of the Local Health System Integration Act review. I can say that in the gallery I have our board chair with us, Kathryn Biondi.

I wanted to tell you a little bit about myself. I've held the position of CEO of the Erie St. Clair Community Care Access Centre and its predecessor organizations—Chatham-Kent and Sarnia-Lambton—since 1997 and have enjoyed a long career in the public sector. I served in municipal government for the first half of my career, as the deputy clerk of the county from 1986 to 1996, working with the CAO and more than a handful of county wardens over the years.

I'm no stranger to being accountable to citizens for the delivery of value for money in a public sector environment, where your constituents are your neighbours and friends, and where collaboration was embedded into the design of the structure.

Upper-tier government, as the county was at the time, is a collaboration with member municipalities. Municipal governments—no matter what form they take, from single tier to regional—are a collaborative enterprise with a wide range of providers and citizens. I have carried this philosophy of listening to the constituent and translating their needs and wants into action through collaboration into my work as a leader of the CCAC.

I wanted to tell you a little bit about the Erie St. Clair Community Care Access Centre. We serve a constituency of 650,000 people, covering the area of Windsor and Essex county, Chatham-Kent, Sarnia and Lambton county. We provide health care services to nearly 37,000 individuals annually, allowing them to remain safely at home or assisting them with transition to facility care. We manage 900 calls a day coming in with respect to service requests and information about health care in our area.

During my presentation today, I will be addressing the following key points: the patient perspective on CCAC care coordination and services, the value of our work with patients to community capacity planning in our area and outcomes achieved through collaboration in governance leadership. Finally, I will offer my perspective on the work of the Erie St. Clair LHIN, in particular the value of a regional model of health care, and I would also like to make some comments on the question about the merger of CCACs and LHINs, since that was raised earlier.

Care coordination is at the heart of what we do at the CCAC. Patients value this aspect of our work, and tell us so. Our volunteer board of directors of 12 invites patients and caregivers to address the board to tell us their stories about their health care experience. We learn from these very personal accounts, and have implemented service improvements to address concerns expressed. A repeated theme in these accounts is the deeply held respect and appreciation for the advice and expertise provided by the CCAC professional staff who coordinate care for these patients. Using a combination of vignettes and quotes, I will briefly relay what we have heard.

One patient describes his experience as follows: "This care coordinator saved my home life, my family life ... at a time when I didn't even think I could go home and resume normal living. She negotiated an effective care plan for and with me ... working with my physician, specialists and others, helping them to translate their treatment into my home environment. She even arranged for a social worker for my wife. I am at home doing the things I want to do and can do for and with my family."

A family caregiver describes his experience thusly: "CCAC's community resources and supports were essential in keeping my parents in their home; it was the quality and dignity of care that made the difference." This family caregiver went on to acknowledge our care coordinators for their exceptional quality of service, noting he was very pleased with the flexibility in scheduling, the services provided and the knowledge and support from the care coordinators.

Here is another patient's story: We became involved with this patient through a referral from the hospitalist to our behavioural supports care coordinator, who has special training and expertise in the transition of individuals with difficult conditions back into the community. With the CCAC's involvement, the patient's family noticed improvements in behavior. The family caregiver presenting to the board members referred to her mother's care coordinator as "her guardian angel," noting that the care coordinator's approach was holistic and involved the family by asking their opinions on what would be best for their mother. As these adjustments were incorporated into the care plan, the patient's aggressive behaviours declined. The patient has since moved into a community residence. Her mental state has greatly improved, and she continues to thrive in her environment.

Another patient reported that his care coordinator, through the innovative hospital-to-home resettlement program funded by the LHIN, was able to remove the barriers that would have prevented him from remaining at home. These are stories that we hear time and time again. They're oft-repeated.

Here is how our care coordinators describe their work:

"My personal philosophy is that knowledge provides confidence even in the most vulnerable patients and families, and provides them with the tools to better cope when making the transition to home from hospital."

"The individuals with whom I work value the fact that 'I'm in their corner' during a difficult time."

"I think our biggest contribution is the time we can spend with our patients. So many patients over the years have said 'this is the longest time that anyone has listened to me … ever.'"

1020

Care coordination is our core service. Our care coordinators work 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 to meet their needs.

As a result of this unique professional role in the health system, we are privileged to work with all health service providers in our area: nurses, personal support workers, therapists, physicians, specialists, community health centres, family health teams, community support service agencies, rest and retirement homes, and long-term-care facilities. As well, we work with our civic and municipal partners in social housing, emergency services and public health.

Our reach is broad. This vast knowledge of community, health and social care resources, and the application of these to patient care, places us in an ideal position to make significant contributions to health system improvement, and we are doing so in a number of initiatives. The one I choose to talk about today is community capacity planning.

Major health care services in Windsor are undergoing a hospital capital planning process. A complementary and necessary process to this undertaking is community capacity planning. This initiative, directed, supported and funded by the Erie St. Clair LHIN, is being led by a steering committee co-chaired by our Erie St. Clair CCAC and the Alzheimer Society of Windsor-Essex County. The steering committee is comprised of community health and social care providers and hospital partners, so development of the plan is being managed by those on the ground delivering patient care, those with the expertise to fashion new models of community care that will work for patients.

This is an example of our Erie St. Clair Local Health Integration Network making good use of CCAC expertise and the collaborative partnership model to deliver on its mandate of health system improvements, driving towards better health outcomes for our area residents.

We expect the same exercise to occur in Chatham-Kent and Sarnia-Lambton, where other capital projects are under development, and we expect our LHIN to similarly use our CCAC expertise and the collaborative partnership model to develop the plans.

I want to move on to talk about governance leadership.

Our volunteer board members contribute their time and a great deal of energy to serve the residents of our area. The diversity of our area is represented on our board. It's the board's objective to be engaged in regional health care solutions, working through the voice of the patient. This is clearly stated as one of our board's values.

These volunteers serve in order to do the right thing. When it comes to community-based health care delivery, governance leadership extends beyond accountability and oversight. It is about representation, and the belief that our patient and their caregivers will be heard.

Regional demographics contribute to particular care needs. For example, compared to the province, the Erie St. Clair population has higher rates of occurrence for a number of conditions, such as arthritis, asthma, diabetes etc. These needs warrant local action undertaken by those who know the region and our residents best.

Our board has a great deal to contribute to the conversation about health care priorities and health care improvements. Our board is working hard and has had success at establishing board-to-board relationships

within Erie St. Clair. This has led to new developments in service delivery. Examples are agreements with our First Nations communities for a shared-service delivery model; an agreement with the John McGivney Children's Centre for a new financial model to support sustainability and improve service to children; and the Sarnia-Lambton integrated care centre, a joint capital and services delivery initiative of the Canadian Mental Health Association Lambton Kent, the North Lambton Community Health Centre and the Erie St. Clair CCAC. These have all been supported and encouraged by the LHIN.

Our recommendations are twofold, and I'll make a comment about the third with respect to the question that was asked earlier.

A regional model of health care planning is important to our patients. The current model in place is working well in Erie St. Clair. We observe that the successful result of such a model is realized by pursuing strong consultation and partnership development, as well as ensuring that all health care organizations and medical practitioners are driving to provide care that is less complicated, delivers more value for money and, above all, improves the health of those we serve.

As you've heard, the Erie St. Clair CCAC has well-established relationships with a vast array of health service providers throughout our Erie St. Clair area, through our front-line work, through organizational leadership, outreach and partnership, and through the strength of our board trustees.

A strong community care system in Erie St. Clair is dependent on a strong care delivery network, one that sets out a clear path from the point where a patient will enter the system and addresses individualized care needs throughout their experience. This creates a level of expertise which is valued by all partners.

A large community web of services and supports exists in Erie St. Clair. The CCAC has used its technical capacity and human capital to access these resources for the direct benefit of our patients and caregivers. As noted, we have also struck our own partnerships and leveraged our expertise in creating new opportunities for care in the community.

As well, our LHIN has been using our expertise to positive effect. There are many examples of this: the implementation of resettlement and restorative beds, convalescent care beds and better housing options in Sarnia for young people with chronic conditions transitioning into adulthood in Sarnia.

A regional model allows for local care designed with the voice of our local residents in mind, with the ability to choose to use our area investments differently based on local needs. This has been occurring in our area, and this will continue to occur with the leadership of organizations such as ourselves and the LHIN.

We wish to highlight section 24 of the Local Health System Integration Act. This provision outlines that each LHIN and health service provider will identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services. Our LHIN has initiated governance leadership forums to address this requirement. We wholeheartedly support these forums while suggesting the development of measures to assess how well the LHIN is utilizing the leadership and expertise of existing entities to deliver on its integration agenda.

As local areas make the shift to community-based care and innovative care delivery models, the Erie St. Clair CCAC and others have a lot to offer. We encourage the LHIN to continue to leverage the expertise and the services of the CCAC.

I will now address the question about the merger of the CCAC and the LHINs, since the question was raised in a presentation. I don't think that major overhauls are what is required at this time. I think our system is working well. What we really have to focus on most is the separation of functions, and I think people sometimes forget that. We deliver care to patients. The LHIN plans and funds and demands accountability; it doesn't deliver patient care. This is a unique model for Ontario, which allows the LHIN to be in a neutral position to actually demand that accountability. If they were in the business of delivering direct care, there might be a tendency for them to favour that particular entity and to also miss out on the opportunity of the board governance leadership that's available from that particular group of volunteers, who have devoted service to the entity of delivering care to those in the home, in the community. I think you really have to think about that.

The neutrality that the LHIN offers to our area through two distinct functions of planning and funding—and of course, accountability—is really important to the landscape of health care in Ontario. Every single other entity delivers care to patients. The LHIN can demand accountability from each of us in a very neutral and objective way. So I don't believe it's the right thing to do at this time.

The Chair (Mr. Ernie Hardeman): That does conclude the time. Thank you very much for making your presentation, and I'm sure it will be of assistance to the committee as we move forward in this review.

Ms. Betty Kuchta: Thank you.

HOSPICE OF WINDSOR AND ESSEX COUNTY INC.

The Chair (Mr. Ernie Hardeman): The next deputation is the Hospice of Windsor and Essex County Inc.: Carol Derbyshire, executive director. I understand that we're slightly ahead of schedule, but she's here, so we look forward to hearing from her.

Thank you very much for your insightfulness to realize coming in a little early was going to pay off today.

Ms. Carol Derbyshire: That's exactly why I did it.

The Chair (Mr. Ernie Hardeman): Thank you very much for being here. As with the previous delegation, you will 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 at the end, we will have questions and comments from the members of the committee. With that, the next 15 minutes are yours.

Ms. Carol Derbyshire: I thank all of the committee for the opportunity to present to you today. My name is Carol Derbyshire. I am the executive director of the Hospice of Windsor and Essex County.

1030

I'd like to begin by providing you with a bit of information regarding the Hospice of Windsor and Essex County. For many, the hospice symbolizes hope, providing care designed to enhance quality of life for patients and families in our community. It is the first community-based palliative hospice village in North America. Founded in 1979, we are currently celebrating 35 years of providing services in Windsor-Essex county.

The hospice village serves all patients and their families dealing with a life-altering diagnosis. In simple terms, this means that hospice services are available to patients and their families from pre-diagnosis to bereavement. Services are holistic in nature and can include wellness programs, support groups, fitness programs, counselling, education, pain and symptom management, and, of course, palliative care.

Hospice currently has one eight-bed residential home in Windsor and has been approved for a second home to be located in Leamington. It is expected that this second home will be operational later in 2014. The hospice is proud to offer all services at no cost to patients and families and provided in a space that is both serene and welcoming, responding to the diverse needs of a multicultural community. However, because the operations of a residential home and hospice services are not fully funded, substantial volunteer hours are required along with fundraising initiatives.

The success of our program is a result of our dedicated staff of approximately 55 that consists of palliative care physicians, nurse-educators, social workers, alternative health care providers, administrative staff and a virtual army of over 600 dedicated patient care volunteers. We offer a comprehensive program that addresses the physical, social, emotional and spiritual needs of our patients and families available on a one-to-one basis or a family basis.

We receive approximately 35% of our funding from the ministry. The Erie St. Clair LHIN has recognized the need for services in our community and has provided funding support to us. The remainder of the funding for our many programs comes from a group of dedicated volunteers through such initiatives as fundraising, donations and grant-writing initiatives. We enjoy wonderful support from our community. They have embraced palliative care right from the very beginning.

As I speak to you today about the role of the local health integration networks and more specifically the Erie St. Clair LHIN, I want to acknowledge the important role the LHIN plays in identifying the unique needs in each of the communities throughout the Erie St. Clair region. The ability of the LHIN to work with the community health care providers to identify local needs and then be able to allocate funding based on these needs ensures the more timely provision of services to patients and family members. With local representation, the LHIN is able to advocate for funding for community-based services that ensures patients and family members have access to and receive services in the most appropriate location. Their local presence means that there is active community engagement that not only involves health care providers but also includes the residents within Erie St. Clair.

As I begin, I'd like to acknowledge that this review process provides a key opportunity for community health care agencies to continue to advocate for the role of the LHIN and to ensure that health planning remains integrated within the region by:

—enhancing the capacity and mandate of the LHIN as it relates to planning across the complete continuum of care that not only considers illness but that also includes prevention, education and self-management, and the dying and grieving process;

—providing for greater accountability for the LHIN to promote processes for community engagement;

—continuing to build a system of viable community-based health services; and

—being responsive to community needs.

The LHIN's existence is critical and essential in ensuring the funding of community agencies that provide programming to meet the regional needs of the area. The objects contained within the local health integration act indicate that the LHIN is responsible to plan, fund and integrate the local health system. The Essex county LHIN has been successful in working collaboratively with its funded agencies to achieve this goal.

Our LHIN has also worked within the context of the broader health system to ensure the voice of both health care providers, and patients and their family members are supported in the context of care planning. This is clearly seen in the palliative care system that is being developed here in Windsor and Essex county. The LHIN has recognized that palliative and advanced care planning is essential, not only for cancer patients but for persons with chronic disease as well. They have heard from the community that people want to remain in their homes, and in order to enable that to occur, education is essential. We have seen funding enhancements to support this education both for care providers and for patients and families who support their loved ones. We are expecting patients and families to keep their loved ones at home, and these people don't have formal training, so they need a lot of support and education.

In addition, the LHIN has acknowledged the need for residential palliative care beds in the community and Hospice's role in providing continuity and managing these beds within Essex county. As we plan and develop a new 10-bed hospice residential home in Leamington, we are working collaboratively with both the LHIN and Leamington District Memorial Hospital to ensure that the service needs of the south Essex community are met. We all recognize that the demographics of this community

are different than those within the city of Windsor, and collectively we remain committed to meeting their needs as well.

The Erie St. Clair LHIN recognizes the important role they play in planning for a truly integrated health system that is broader than their mandated role. They are currently participating in meetings initiated by the Leamington District Memorial Hospital to plan, in a broader health context, to meet the health and social needs of patients, clients and their families within the south Essex area. This initiative involves community agencies that receive funding from a variety of governments—provincial, federal, municipal—that are all committed to providing services more efficiently to address the broader determinants of health. The outcome is to achieve greater collaboration in health and social services that effectively address the well-being of everyone.

Leamington hospital is developing a campus; many of the Windsor agencies are setting up satellites on their site; St. Clair College will be setting up out there, offering teaching education to health care providers—a one-stop shopping approach.

The LHIN has also supported the community in its deliberations to develop a single acute care hospital site. They participated in processes to realign the Windsor hospitals, with the result being one acute care hospital, governed by Windsor Regional Hospital, and a second health care organization, Hôtel-Dieu Grace Healthcare, governing all non-acute care services as well as specialized community-based services.

This realignment has been supported by the LHIN, and was achieved in a timely manner because of the local representation and the dedication of the boards of directors for each of the hospitals and the LHIN as well as their management teams.

As all health care providers seek to improve community engagement activities, enhanced supports are required to involve the active engagement of our residents. At Hospice, we make this a priority and an objective as part of our planning process, to ensure services provided are based on consumer needs.

We recognize that as health care evolves in the future, the community needs to be involved in building design and layout, including parking. They also need to provide input on administrative functions, such as registration; the functionality of the programs; and quality indicators, including those elements that are important to the patient or family member.

Patients and family members often have important insights into the care they receive that provide for better experiences and improved outcomes. We believe that the LHIN can actively facilitate this type of engagement and support health care agencies in ensuring the active role of our residents in providing input, as the success of the service and the LHIN goals is not only based on costs and outcomes, but on how the patients and families perceive the services and the care they receive.

1040

In building a viable, effective and efficient integrated system of health services, there is a need to develop an aligned system that spans the various components funded by the LHIN. While we typically plan for the transition between the acute care and the non-acute systems, or the hospital and community sector, we should expand how we view the need for services. We need to think in terms of there being one health system that serves the population and the patient, and supports the family and/or non-professional care provider. The LHIN has facilitated this mindset and acknowledges the need for staff roles that span acute care hospitals and community-based services. An example of this that I can speak to is the palliative care liaison nurse. She is a hospice nurse who works within the hospitals and within the community to effectively plan for the movement of patients between the hospitals, to either the hospice residential home or their own home. By funding this position, the Erie St. Clair LHIN has supported this mindset. It is more of these types of positions that would benefit a patient's care, whether for acute care, chronic disease or end-of-life/palliative care, and the LHIN recognizes this.

As a community agency, we recognize the need to ensure that the funding we receive from the LHIN produces results that align with the integrated health service plan they develop and, equally important, meets the needs of patients and families. We recognize the need for due diligence and stewardship for the funding we receive, and work in collaboration with the LHIN to ensure results. The local presence of the LHIN ensures recognition of needs based on communities within the LHIN. This is important in ensuring that the funding they provide produces results based on quality outcomes for patient care.

As the LHIN and health-funded agencies plan for their future, it's important that the LHIN support and facilitate the continued development of a system plan for services that the community needs, and not necessarily for service gaps identified by many of us, the provider agencies. We can assess and plan for services to be divested from the hospital, or even to the hospital, but changes must be made in the best interest of the person receiving care.

These services and programs that result from planning exercises should be planned, funded and executed equitably, regardless of the location or organization responsible for the management of the service. In the future, as the need for community-based services grows, it is important that the agencies can attract the required human resources and infrastructure to support this growth, have the systems that support best practices and achieve a greater level of stability in order to assure accountability and accurate reporting. The local presence of the LHIN allows for collaboration in this level of planning as they recognize the needs and challenges of community-based agencies.

During the past seven years during which the LHINs have existed, our hospice has had a very positive relationship and great support from the board of directors, the CEO and the staff. They have recognized that hospice care and its programs are a priority, because they address the needs of the person served. They are advocates for

local communities within Windsor and Essex county, Chatham-Kent and Sarnia-Lambton, and understand our needs. We look forward to their continued support as all health care partners—whether they be funded by the LHIN or a different payer—plan for services that meet provincial priorities and, more importantly, meet the needs of our patients, clients and family members.

As someone who has worked in the health care field for—I'm in my 35th year this year, and I've lived through many things, and was very active when the district health council was here. I sat on many committees. We did some excellent planning and reports would be sent off, but very little came of them. There was a lot of frustration in those days. Once the LHINs came and were set up—we're seeing things happen, so I encourage you to support them.

Thank you for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We very much appreciate you coming in and being here early.

COMMUNITY LIVING ESSEX COUNTY

The Chair (Mr. Ernie Hardeman): Eleven o'clock: Community Living Essex County. Are they present? Oh, very good. Nancy Wallace-Gero, executive director, thank you very much for coming in, and we very much appreciate you being here. You will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's any time left at the end, we will share it with the committee for questions. With that, the next 15 minutes are yours. Thank you.

Ms. Nancy Wallace-Gero: Thank you very much and, really, thank you so much for the opportunity for Community Living Essex County to speak to you today. We're not a typical health care provider, but I'm going to relate to you a number of issues that I think are very important ones if we're going to really have a coordinated health care system that includes the needs of people with an intellectual disability.

First of all, I'm Nancy Wallace-Gero, and I'm the executive director of Community Living Essex County. We are a service-providing agency, primarily funded by the Ministry of Children and Youth Services and the Ministry of Community and Social Services.

We have a history of over 50 years in our community and, of course, are part of a network of Community Living organizations across Ontario, across Canada and, indeed, across the world.

Our fundamental belief is in the inclusion of all people within their community, so that they utilize the supports and services that are available within their community and have equal access and equal opportunity to all forms of care, including health care.

One of the reasons that we felt it was very important to come here today is—my message is about improving communication between developmental services and the LHINs and the Ministry of Health. We need to be included in planning and processes if supports are going to be improved for people with an intellectual disability. The voice of people with an intellectual disability, their families, and agencies serving people with an intellectual disability need to be included.

I have a package of information that will be distributed, or has been, to you. I'm not going to read my report. Rather, I'm going to highlight, because it's too long and I will run out of time.

I want to talk to you, first of all, about a couple of successful collaborations. As I said, inclusion is very important to families and individuals who have an intellectual disability. They're not asking for separate programs, but they are asking that the needs of people with an intellectual disability be considered and addressed in community, in a similar way to all people.

We have some really good examples of some great collaborations that are going on, but I don't know that the Ministry of Health or the LHINs are even aware of them. For example, in-hospital dental procedures: There's a local dental surgeon, Dr. Paul Smith, who has opened the door to dental surgery within the hospitals. Many of the people supported by agencies like the one that I represent are people that cannot have some of their dental procedures, or maybe even all of them, conducted in a traditional dental office, so they need to be in a hospital setting. Dr. Smith has fought tirelessly with all kinds of people to ensure that those opportunities are available. That door should be opened. It's a need; it has got to be addressed within the community.

Another great partnership has been with the Alzheimer Society, both provincially and locally. We had some really good collaboration and a community conversation about community-based homes for people with very challenging needs, including dementia. We, in Community Living, as you may know, support many, many people with all kinds of needs, and I'll speak a little bit more about that in a moment.

1050

A bit about our operations: Our annual budget at Community Living Essex County is just under $30 million. All of that is not provided by the province. We do fundraise and we do have a number of contributors. We serve over 600 people of all ages and their families, and increasingly, we're supporting people with very, very challenging needs, especially in this time of huge need within our community. We've been forced to, of course, offer our supports and services mainly to people who have the most significant needs and just can't live in community without our supports. We're a grassroots organization. We're formed by families, and so we remain responsive to community stakeholder needs.

Some 8% of our total expenditure is administration. This is very typical in the DS sector because of the way we've grown and emerged. I don't know that that's true in most other organizations in other sectors or even within the community services sector.

We operate 55 affordable, accessible residential homes in typical neighbourhoods throughout our community, both rural and urban. On average, three or four

people live together in a home. We offer 24/7 support in these homes. We utilize direct support professionals who have a developmental service worker degree, a two-year college program. It's a community residential model that works for affordability and quality of life.

Some of the challenges that we face: We are indeed different from the health care sector. People with an intellectual disability have a lifelong condition that doesn't change. You can do a lot of things that can improve and offer opportunities, but their condition is what it is. The support needs are therefore lifelong.

We use a person-centred planning model. We moved away from institutions in 2009. The government closed all provincial institutions for people with intellectual disabilities, which was a wonderful move, the right thing to do, and since that time we are very focused on building a strong community support system.

It seems to us that health care and the LHINs are still somewhat focused on an institutional model, and that's of concern. We support people with very complex needs. I mentioned that earlier. People in our homes have insulin injections, oxygen therapy, tube feeding, suctioning, colostomy care, tracheotomy care; people with severe osteoporosis, dementia, palliative care, end-of-life care. We utilize community services to train our staff to support us when something is beyond our knowledge, and that works. It's much more affordable, and it truly does provide a quality of care that is quite unique and I think something that needs to be considered in our community health care.

When changes are made in the delivery of community health care without our input and knowledge, gaps in service and access to service problems can result. So we really feel strongly we need to be a partner in decision-making around health care in our community.

Long-term care: There are 12,000 people on waiting lists in Ontario. Unfortunately, there is a crisis spilling over into the Ministry of Health, especially in long-term care. Inappropriate placement of young people within long-term-care facilities—people who have an intellectual disability—is happening, at great expense to the people of Ontario. This is inappropriate and can be prevented. It's so unfortunate that we're allowing this to happen because we're not sitting down and talking about it and making sure that we come up with better solutions for everyone.

So two solutions—a few things we'd like to suggest; I have five quick recommendations. One is that the LHINs and Community Living need to have improved communication and collaboration at all levels. There needs to be collaboration between the Ministry of Health and the LHINs with MCSS, the Ministry of Community and Social Services, and MCYS to fund preventive services for families to avoid the inappropriate crisis admissions to both acute care hospitals and long-term care.

The LHINs need to explore the mental health system to ensure appropriate care for all people with mental illness, including those who have an intellectual disability, and to further facilitate collaborative relationships for mental health providers in the DS sector. The LHINs need to also look at facilitating enhanced awareness of the DS sector in the health care community.

Just a quick sideline: We have developed from our organization very strong collaborative relationships with several faculties at the University of Windsor. Particularly, I'd like to mention the nursing faculty, as well as the department of kinesiology. We're doing extensive work on educating students who are within those faculties, so that they go out into the world understanding the needs of people with an intellectual disability. This needs to be more than just an off-chance one-off because we've developed the relationship. This should be a coordinated system of understanding that's going on around the province.

Finally, we recommend that the LHINs and the Ministry of Health and Long-Term Care reference a document that was developed in November 2013 through CAMH: Dr. Yona Lunsky's work, which is called the Atlas on the Primary Care of Adults with Developmental Disabilities in Ontario. This is a very good document that covers a lot of the health care concerns and issues, and I've put an executive summary in your package.

Just quickly, thank you for your time. I hope that my comments and recommendations are not seen as criticisms—that's not how they are intended—but rather are taken as positive opportunities to do better in health care for people with an intellectual disability and their families. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your great presentation. If you'd went five seconds shorter, we'd have to leave it with one, but we have time for about a minute and a quarter from each caucus, starting with Mr. Nicholls.

Mr. Rick Nicholls: Thank you very much, Mr. Chair. Nancy, thank you for your presentation and the passion that you bring to your role. Also, it's good to see you again. Thank you for the tour that you gave me of two of your resident homes in Leamington a little while ago. You educated me in that as well, so thank you for that.

Also, I appreciate the concerns and some of the solutions. A lot of times, people just give us problems without solutions. The solutions that you've brought forward will certainly be examined by this committee and reviewed, and hopefully we can come up with something again.

Again, nor did I take your comments of the LHINs as criticism. I've had first-hand knowledge, working with our Erie St. Clair LHIN back in Chatham, with the executive director, Gary, and his staff, and I know the work that they are doing in many different areas, so again, thank you very much.

I don't really have a question. I just had some comments for you.

Ms. Nancy Wallace-Gero: Thank you.

The Chair (Mr. Ernie Hardeman): Good thing, because you haven't got time.

Mr. Percy Hatfield: Thank you, Mr. Chair. Nancy, good to see you again.

Ms. Nancy Wallace-Gero: Hi. Thank you.

Mr. Percy Hatfield: You mentioned off the top that you and your group should be included in the planning. I'm just wondering: Does that mean you're not included now, but you want to be in the future as we go ahead?

Ms. Nancy Wallace-Gero: Yes. We often hear about reports when they're issued to the public. We really don't get called to tables within health at all for discussion or for representation of the needs of people with an intellectual disability, so when we read reports, we're often reacting, which is not the right way to go around the fact that people's needs are being left out.

Mr. Percy Hatfield: So is that a shortcoming with how the local LHINs coordinate their activities with you?

Ms. Nancy Wallace-Gero: I don't know. I think that they just tend to look at health partners more than they do beyond. I think my recommendation is just that they take a broader look, include other people beyond health care partners and look at social services, especially a sector like ours that is so involved in health care in the way that we deliver services.

Mr. Percy Hatfield: Thank you.

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

Ms. Helena Jaczek: Thank you so much for your presentation. For those of us who've been on this committee all week, we're hearing a lot from support organizations such as yourselves that deal with different ministries, and we have heard of some successes in terms of the South West LHIN, in terms of bringing the type of agency that you represent in a little bit more.

1100

And so, I guess one of the things we're learning is that it's really important for all the LHINs to get together and examine best practices. As you know, LHINs were essentially formed to try to break down the silos within health, and that has been quite a struggle and is coming along nicely, I would say, at this point. I think the next incremental piece is clearly to bring agencies such as yours in.

I don't have a question, but thank you, again, for bringing this to us, in our face. The impact on health is absolutely there, in terms of the work that you do.

Ms. Nancy Wallace-Gero: Thank you for that encouraging comment. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for coming to make the presentation—

Ms. Nancy Wallace-Gero: You're very welcome.

The Chair (Mr. Ernie Hardeman): —and to express those concerns.

Ms. Nancy Wallace-Gero: Thank you. Yes. Good luck with your work.

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

Mr. Mike Colle: Thank you for your work.

ENTITÉ DE PLANIFICATION DES SERVICES DE SANTÉ EN FRANÇAIS ÉRIÉ ST. CLAIR/SUD-OUEST

The Chair (Mr. Ernie Hardeman): The next one is the French organization to provide French services in the Erie LHIN: Jacques Kenny. Thank you very much for coming here. I would remind the committee that number one on your translator—if you're looking for translation, the number one on your gizmo—is the French-English translation. Thank you very much.

You will notice from your introduction that I'm not too fluent in French, so I apologize for that. But we do thank you for coming in and making a presentation to us on this very important subject. So thank you, again.

For the next 15 minutes, the floor is yours. You can use all or any of that time. If you have time left over, we will then have comments and questions from the committee as it relates to your presentation. Thank you, again, and the next 15 minutes are yours.

M. Jacques Kenny: Chers membres du Comité permanent de la politique sociale, je me présente : je suis Jacques Kenny, directeur général de l'Entité de planification des services de santé en français Érié St. Clair/Sud-Ouest. Je suis accompagné de mon président du conseil d'administration, M. Nil Parent, qui arrivera sous peu.

Un long chemin a dû être parcouru pour en arriver à la présence des entités de planification des services de santé en français dans le paysage du monde de la santé. La présence francophone en Ontario remonte à plus de 400 ans, mais ce n'est qu'en 1984 que la Loi sur les tribunaux judiciaires confère au français le statut de langue officielle dans les tribunaux. Ce n'est qu'en 1986 que la Loi sur les services en français garantit au public le droit de recevoir des services gouvernementaux en français dans les 25 régions désignées bilingues. Et ce n'est qu'en 2006 que la Loi sur l'intégration du système de santé local prévoit la création d'un conseil consultatif provincial sur les services en français. Elle indique comment les francophones seront impliqués dans l'organisation du système de santé tant au niveau provincial qu'au niveau régional.

En octobre 2008, le ministère de la Santé et des Soins de longue durée émet un premier projet de règlement sur l'engagement de la collectivité francophone en santé qui propose des comités consultatifs.

En mai 2009, le commissaire aux services en français de l'Ontario publie un rapport spécial sur les services de santé en français recommandant de modifier le projet de règlement de 2008 et de prévoir de réelles entités de planification des services de santé en français pour chacun des RLISS.

Et en janvier 2010, la ministre de la Santé et des Soins de longue durée, l'honorable Deb Matthews, annonce un nouveau règlement sur l'engagement de la collectivité francophone en application de l'article 16 de la Loi de 2006 sur l'intégration du système de santé local, proposant la désignation de six entités de planification des services de santé en français en province.

Suite à tout ce cheminement est né en mai 2011 l'Entité de planification des services de santé en français Érié St. Clair/Sud-Ouest, communément appelé l'entité 1. L'entité 1 appuie et conseille deux RLISS, soit Érié St. Clair et celui du Sud-Ouest. Son territoire comprend les

comtés suivants : Grey, Bruce, Huron, Perth, Oxford, Middlesex, Lambton, Elgin, Norfolk, Chatham-Kent et Essex. Le territoire desservi compte près de 30 000 personnes qui ont le français comme première langue officielle parlée.

Le RLISS d'Érié St. Clair compte environ 18 000 personnes ayant le français comme première langue officielle parlée alors que le RLISS du Sud-Ouest en compte 11 000. Dans l'ensemble du territoire, 24 % de la population francophone est âgée de 65 ans et plus. Il reste encore plusieurs milliers de francophones dit bilingues ou allophones qui ne sont pas inclus dans ces statistiques.

Le rôle de l'entité de planification est d'épauler et de conseiller les deux RLISS sur différentes questions, à savoir :

—les méthodes d'engagement de la collectivité francophone dans la région;

—les besoins et priorités de la collectivité francophone de la région en matière de santé, y compris les besoins et priorités de différents groupes au sein de cette collectivité;

—les services de santé mis à la disposition de la collectivité francophone de la région;

—l'identification et la désignation des fournisseurs de services de santé relativement à la prestation des services de santé en français dans la région;

—les stratégies visant à améliorer l'accès, l'accessibilité et l'intégration des services de santé en français au sein du réseau de santé local; et finalement

—la planification et l'intégration des services de santé dans la région.

Suite à ce cheminement, j'aimerais vous donner un bref aperçu des accomplissements, des collaborations et des changements effectués depuis l'arrivée de l'entité Érié St. Clair/Sud-Ouest.

Notre entente d'imputabilité parle de comité de liaison mais ne stipule pas sa composition. Nous avons, avec l'expérience vécue, élaboré un processus de rencontres que nous considérons comme meilleure pratique. Suite à l'élaboration du rapport conseil par l'entité, les agents de planification et les coordonnatrices se rencontrent pour préparer un plan conjoint qui est suivi d'un plan d'action plus spécifique à chaque RLISS.

Pendant l'année, des rencontres régulières ont lieu à tous les niveaux par les partenaires pour tenir compte du progrès dans la réalisation du plan d'action conjoint. Des ajustements sont faits au besoin. En plus de cela, les directeurs généraux de l'entité et des RLISS se rencontrent au besoin également. Les RLISS invitent l'entité à venir présenter annuellement au conseil d'administration les réalisations de la dernière année et les projets pour la prochaine. Voilà la structure mise en place pour assurer une meilleure communication de part et d'autre.

En 2012, l'entité a entrepris une étude intitulée Santé des francophones et utilisation des services de santé dans les Réseaux locaux d'intégration des services de santé d'Érié St. Clair et du Sud-Ouest. Vous en avez une copie dans vos pochettes. Près de 1 200 personnes ont pris le temps de répondre à ce questionnaire quand même assez exhaustif. Nous avons élaboré ce questionnaire avec les coordonnatrices des services en français des deux RLISS ainsi qu'avec d'autres professionnels des RLISS et des épidémiologistes du bureau de santé publique. Le taux de réponses a dépassé de loin nos attentes et celles des RLISS, et nos francophones ne se sont pas gênés pour faire des commentaires sur les services de santé en français.

Suite à ce sondage et les commentaires de plusieurs aînés, nous avons entrepris une deuxième étude, celle-ci avec deux objectifs spécifiques : le premier, tenir une étude de marché et de faisabilité pour la construction d'un établissement multifonctionnel d'hébergement et de santé, ou autres options, et le deuxième objectif, étudier les besoins spécifiques en matière de services de santé des personnes âgées francophones. Nous venons de recevoir le rapport préliminaire et le partagerons en temps et lieu avec la communauté. Nous savons cependant, d'après les commentaires de nos aînés, que s'ils doivent se retrouver dans un foyer ou une maison de soins de longue durée, ils aimeraient recevoir leurs services en français et être entourés de gens qui parlent français, afin de pouvoir socialiser dans leur langue maternelle qu'ils ont maintenue tout au long de leur vie.

Comment avons-nous procédé pour entreprendre cette étude? Encore, nous sommes allés chercher la collaboration de nos RLISS. Nous avons travaillé un appel de proposition qui conviendrait aux besoins et préoccupations et des RLISS et de l'entité. Suite à l'embauche du consultant, les agents de planification ont travaillé de pair avec les coordonnatrices pour organiser des groupes de discussion et des rencontres avec des intervenants et des informateurs clés de la communauté et des RLISS. Ce partage d'efforts et d'informations fera en sorte que le document final soit mieux étoffé que si notre travail avait été fait en vase clos.

Un autre projet de collaboration est celui d'une trousse d'outils sur les services en français. Cette trousse est une initiative conjointe des coordonnatrices des services en français des deux RLISS. Elle est destinée aux fournisseurs de services de santé, en particulier ceux qui sont identifiés et désignés pour offrir des services en français.

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La trousse est un recueil de renseignements et de ressources utiles pour soutenir la planification et la prestation des services en français. Elle met l'accent sur le principe de l'offre active et sur les façons pour les fournisseurs d'y parvenir. La trousse a été partagée avec les coordonnateurs des services en français de tous les RLISS et présentée aux directeurs généraux des autres entités de la province, ainsi qu'auprès de plusieurs partenaires et intervenants. Elle sera aussi présentée aux 17 directeurs généraux des réseaux de santé au Canada. Le commissaire aux services en français de la province, M. François Boileau, était présent lors du lancement officiel à Chatham récemment. L'entité est heureuse d'avoir joué un rôle de consultation dans cette initiative

menée par les coordonnatrices des services en français des deux RLISS.

Il y a d'autres façons dont nous avons travaillé ensemble avec nos RLISS lors des trente derniers mois de notre existence. Je vais en signaler trois ou quatre :

Nous avons travaillé avec deux groupes et nos RLISS à l'identification et la désignation de deux fournisseurs de services, Services à la famille Windsor-Essex et le Centre d'aide et de lutte contre les agressions à caractère sexuel du comté d'Essex. Ces deux organismes sont dans le RLISS d'Érié St. Clair. Nous avons été invité par le RLISS à participer à l'élaboration et la préparation de la désignation et l'identification de ces deux organismes.

Nous avons eu aussi une discussion initiale en octobre 2012 avec un exploitant de maisons de soins de longue durée concernant l'identification d'une aile francophone dans nouvelle maison dans le RLISS d'Érié St. Clair qui est en construction et qui ouvrira ses portes cette année. C'est le RLISS qui avait coordonné cette rencontre, et nous attendons le suivi de cette rencontre.

Il y a deux autres projets qui ont été mis en place par les RLISS. Premièrement, il y a le programme de télépsychiatrie qui a été financé par le RLISS du Sud-Ouest. Nous sommes au tout début de ce projet. Nous espérons que l'organisme qui va piloter ce projet va pouvoir offrir des services en français aux francophones de la région. Il y a aussi une autre initiative, celle-ci qui a été financée par le RLISS d'Érié St. Clair. Le RLISS d'Érié St. Clair a financé un projet où une infirmière praticienne est située à Pain Court, une communauté francophone de la région, et cette personne-là offre des soins primaires aux aînés de la région.

À la lumière de toutes ces belles choses que je viens de vous partager, est-ce que nous avons vécu des frustrations? Absolument. Est-ce qu'il y aurait place pour amélioration? Définitivement. Est-ce que l'entité est prête à contribuer pour faire avancer le dossier des services en français? Sans aucune hésitation.

Parfois, on se pose des questions, à savoir si les services en français seraient meilleurs et plus efficaces si le fonctionnement du système et/ou ses exigences étaient différents. Par exemple, les RLISS développent un plan de services de santé intégrés de trois ans qui est approuvé par la suite par le ministère de la Santé. Est-ce qu'il serait possible de faire le même exercice mais au niveau des services de santé en français?

Est-ce qu'on devrait demander aux RLISS de préparer un rapport annuel sur l'amélioration et l'augmentation des services en français offerts sur leur territoire? À qui diriger ce rapport? Le ministère de la Santé? Au commissaire des services en français de la province? Quelles seraient les solutions apportées s'il n'y a aucune amélioration appréciable des services en français?

Comment peut-on assurer l'intégration de la perspective francophone dès le début et tout au long du développement des politiques, programmes et initiatives entrepris par les RLISS ou ses fournisseurs de santé? Pourquoi ne pas être proactif et exiger un plan de service en français pour toute nouvelle demande de financement ou de renouvellement avant l'approbation par le conseil d'administration du RLISS?

Comment procéder à l'identification des francophones de façon systémique afin de pouvoir mieux planifier les services en français au niveau provincial?

Mesdames et messieurs, je ne possède pas les solutions à toutes ces questions, mais je sais pertinemment que certaines de ces stratégies pourraient nous aider à avancer le dossier des services en français dans la province. Ce ne sont là que quelques réflexions de notre part.

Vous recevrez d'ailleurs un mémoire beaucoup plus détaillé et d'envergure lorsque le regroupement des entités vous rencontrera à Ottawa et vous présentera son document.

Que de chemin parcouru, mais il en reste encore beaucoup à faire, et la coopération de tous et toutes est requise pour arriver à bon port. Mesdames et messieurs, merci de votre écoute et votre attention.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about a minute and a quarter, and it goes to the third party.

Mr. Percy Hatfield: Jacques, thank you for coming in. It was very hard with this. The translation devices weren't working very good. It was all full of static. I think I caught a lot of it, but right towards the end, it got too bad. I had to take it out of my ear.

Your recommendations at the end: You were saying you wanted more attention paid to the issues of health care for francophones?

Mr. Jacques Kenny: I've known you for so many years; we took courses at the university together.

When we did our study on health care and use of health care services by francophones—as I said, you have a copy in English also of that document—it was fairly universal. A lot of francophones indicated that they would like to have health care services in French, but they don't know where to get them and they're not sure if they would get them anyway. I can give you examples. Recently, an individual called me and said, "I asked for services in French when I went to emergency at a hospital. They asked me if I wanted my services in French. I said, 'Yes,' so after triage they put me in a room, and I waited an hour and a half. No one came to see me. I came out and they said, 'Where are you going?' I said, 'Well, no one has come to see me.' They said, 'Well, you asked for services in French.'" And she said, "Well, if I ask for them in English, would I get them faster?" And within a few minutes she was served.

It was nice to say, "Would you like services in French?" but then after that, it went through the same ritual that a lot of francophones go through when they ask for services in French. Yes, they're available, but once you actually ask for them, what we call active offer, they're no longer there; they disappear.

It's only one example. There are a number of other issues. I spoke briefly to seniors, and our consultant who is working on another document has indicated that, according to statistics, we have probably about 200 francophones in homes; however, none of them are regrouped

into one area. We have asked a provider if we can have a wing in one of the buildings that is being built. That would be a pod of 32 beds. We have yet to receive an answer, and that was in October 2012 that we asked for that.

The Chair (Mr. Ernie Hardeman): I'm going to have to stop you there. We've exceeded the time. We thank you very much for your presentation. I just wanted to point out how bad my French is. As I was looking at the name, I saw "south west." I didn't realize that referred to the South West LHIN until you mentioned the places in my riding in your presentation. I'm not only listening to the LHIN story, but I'm learning French today.

Mr. Jacques Kenny: Exactly. As I said, we work with two LHINs.

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

M. Jacques Kenny: Merci beaucoup.

VON WINDSOR

The Chair (Mr. Ernie Hardeman): Okay. Our next presenter is the VON Windsor, Jon Jewell. Is Jon Jewell present?

Thank you very much for being here. We welcome you and we thank you for taking your time to come. You have 15 minutes to make your presentation. You can use all or any of that in your presentation. Any time left, if it's less than four minutes, will go to one caucus, and if it's more than four minutes, we split the time evenly between the three caucuses. With that, the floor is yours and the next 15 minutes are yours.

Mr. Jon Jewell: Okay. Thank you. I'd just like to say a big thank you, first off, for the opportunity to be able to come and present to the committee today and to represent the views of the VON in Erie St. Clair. Just to put a little bit in context, I'm going to talk a little bit about VON Canada as an organization, and then I'm going to talk about some of the issues that are affecting our life and reality within this LHIN area.

The VON Canada is Canada's largest not-for-profit home and community care organization. It has been around for well over 100 years, created back in 1897. We're a registered charity and it's a substantially large organization. We currently have, nationwide, around 14,000 staff and volunteers, and locally within the Erie St. Clair LHIN, that translates into about 350 paid staff and literally an army of well over 800 volunteers who deliver many of the essential services that we deliver on a daily basis. Across Canada, we are present in 52 sites, 1,200 communities, and we have a portfolio of over 75—I think it's exactly 75, actually—different programs and services.

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We are a part of the Ontario Community Support Association. That is a network of agencies, as you're probably aware, that service over a million Ontarians on a regular basis with a whole variety of services.

VON branches respond to the unique and changing health care needs of communities across Canada. We like to think that one of the things that we're able to do is to be able to respond very rapidly to gaps in service. We provide programs and services that no other home care provider offers: volunteer visiting, meal programs etc.

We touch the lives of sick, lonely and isolated people who other providers cannot and often will not serve. So it really is reaching out to people who are extremely disadvantaged in their home communities and providing services as close to home as possible.

VON's approach has resulted in programs that are cutting edge. They are things that are innovative. We've opened some of the first nurse practitioner clinics in Ontario. We provide services to, often, communities through our clinics. We've developed respite care services—and particularly in this LHIN area, in Erie St. Clair, some very innovative respite programs. Our ability to adapt and transform is what has given us longevity.

Just to list some of the things that we do: We provide caregiver supports and programs, personal home and support services, a whole range of community support and volunteer services, and crisis services. We're active in health promotion and education. We provide occupational health services. We're active in the provision and design of mental health services. We offer a range of palliative care services. We have seniors' exercise and wellness programs and senior respite programs. We are active in prenatal education and parenting classes. We have children's programs, including the Kids' Circle children's bereavement program. We're the lead agency for the Ontario Student Nutrition Program in southwest Ontario, so we're actually the flow-through agency for the funding for breakfast and snacks for kids. We have a chronic pain management program to help people who live with daily pain conditions. So there's a whole range of activities from prenatal right through to end of life. That's a little bit about VON.

What I wanted to talk a little bit about in addition to setting that as a context was a little bit about this area and some of the challenges that present in this area. This is the southernmost LHIN and, as you're probably aware, it comprises Essex county and the municipalities of Chatham-Kent and Lambton, including the city of Sarnia. Our footprint matches exactly the LHIN footprint, so our basket of services matches exactly the geographical boundaries of this LHIN.

This LHIN has a growing seniors population, which is not uncommon across Ontario, but it's actually more pronounced here in that our population in this LHIN is aging faster than Ontario as a whole. At the same time, our younger population is dropping, so where we've got an increase in numbers of seniors aged 65-plus, it has actually increased from 14% in 2006 to 16% at the most recent count. We actually have a reducing younger population as well, which impacts on issues like volunteer recruitment and the provision of volunteer services.

The residents of Erie St. Clair think they're healthier than they actually are, as well. We've got a very high

level of chronic disease, we've got a higher-than-average mortality rate and we have a lot of people who endure years of ill health. If you measure that in terms of life-lost rates, we actually have a population of people who bear co-morbidities and chronic disease for extended periods of time.

We have some pretty poor health practices across Erie St. Clair, as well. Nutrition, smoking, alcohol consumption and obesity are all disproportionately high in this area and present a challenge.

Chronic disease places a burden on the health care system, and it reduces quality of life for those who bear those chronic diseases. Forty-one percent, at the most recent count, of Erie St. Clair residents have a chronic condition, and 17% have multiple chronic conditions. This increases dramatically with age, and if you look at Erie St. Clair residents who are 65-plus, more than half have two or more chronic conditions that they live with.

The reality is that this puts a huge burden on acute hospital care, but when those people are not in hospital and not receiving acute care—and oftentimes that's not the most appropriate place—then there is a challenge about providing the extent of services in the community to be able to meet the needs of those individuals.

Within VON, we remain very supportive of the principles that were laid out by the government when establishing the LHINs through legislation. It's all about local planning and accountability, community integration and co-operation, and respect for the Canada Health Act.

The LHIN has worked to create a strategic framework for organizations like the VON to operate within, and they have a very comprehensive integrated health service plan which sets the pathway forward and creates a lot of the detail for focus. We are extremely supportive of the direction of that plan.

The LHINs are focused on community service provision. There's a realization that acute care is the most expensive type of provision, and there is a utilization of acute care that is inappropriate and very draining on budgets. I know that the LHIN are working very diligently to consult with the community about finding solutions that allow services to be delivered in community locations as close to the home as possible, which, in reality, is what most patients would prefer as well.

We don't see that dissolution of the LHINs would improve the health system in any way. Actually, it's the view of the VON that that would be very disruptive to some of the work that is ongoing at the moment, so we're very supportive of working within the framework that is currently existing. It's our experience that the LHIN has been extremely responsive to questions and concerns and has sought the interaction of organizations like the VON.

If I could quote a couple of examples here of ways that we are very actively working with our LHIN in consultation and in design of programs: We've been brought together as part of the integrated health service plan priority of tackling chronic disease, and there's a huge consultation exercise at the moment which is designing pathways for our patients that are dealing with issues such as CHF, COPD, diabetes and stroke.

Those pathways are looking at how people can be triaged away from acute care and into community locations with the support of organizations like the CCAC, and how those programs can be delivered out into the community at much reduced cost, and with better returns for the individual. So, we've been very active in helping with the design of those pathways, and it's as a result of the LHIN reaching out in consultation.

The LHIN has been driving the move toward health links, and VON have been invited to be present at a lot of the tables for these health links as they start to become operational. For instance, within this LHIN boundary, the first health link was in Chatham-Kent. Our director sits on the leadership team. Myself, I sit on the leadership team of the health link out in Leamington-Essex-South Shore. The Sarnia health link, which is going to be following on behind very quickly—we have an invitation to participate in that consultation piece as well.

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That's about understanding the needs of individual communities and the specific needs that they need, and then helping to design how that basket of services works for the needs of that specific population.

The VON is very active, again with the LHIN's leadership, in the design of mental health services as well. We've been brought to that table to see if we can assist. There's a lot of activity at the moment around an inner-city site for mental health and addictions in Windsor, and the VON is delighted to say that we are a very active participant in designing those services. We will be providing the nutritional component for that site and also some of the nursing when that site comes on stream. We're very excited about the difference that that will make. We see the LHIN's bold leadership as being very integral to redesigning the way that that particularly disadvantaged group receives service.

Obviously, there is more that can be done. There are huge challenges out there. There's an over-demand on acute services. There is a lack of trained workers within the health and home care system. It's becoming increasingly challenging to recruit volunteers to deliver services. Some of these challenges sort of interact to make a big problem and create huge challenges, as I say, but we're confident that, working together, we will find a route, a way out, and we will find the solution to these individual difficulties.

A progressive, modern health care system keeps people healthy and connected with their homes and communities, not sick and alone in institutions. We believe very strongly that home and community support works because it offers local and flexible solutions. Keeping people living independently in the community and out of hospital is a more cost-effective means of health delivery than institutional care. Investing in home and community care frees up hospital beds and unclogs emergency waiting rooms while also decreasing long-term-care home placements and long-stay hospitalizations, all at a lower cost to the health care system. We really feel that organizations under the Ontario Community Support Associa-

tion umbrella—and speaking on behalf of VON—have a huge part to play in delivering these types of programs.

Many OCSA members are struggling to serve a quickly growing population while solidifying the services that they already provide. The community supports sector funding needs to properly take into account a comprehensive picture of administrative costs.

Interjection.

Mr. Jon Jewell: Okay, thank you. I'm just coming to the end.

To be realistic, we've designed a lot of new services, and when we provide these services—as a not-for-profit charity, we try to provide these services at best value, but there is a reality that these things need coordination and they need integration and administration.

The last thing I would say is, our LHIN has recognized the need for volunteer programming, based on the local community needs assessment. The LHIN's targeted funding to this aim assists greatly in staving off costly service utilization. I'd just leave you with the thought that volunteers are a cheaper way of delivering service than paid personal support workers or nurses, and we are able to offer that as part of our sector.

I'd like to thank you once again for the opportunity to speak.

The Chair (Mr. Ernie Hardeman): Thank you very much for making your presentation. Your time has been consumed. We thank you very much for taking that time to share your thoughts with us.

Mr. Jon Jewell: Thank you.

LA CHAUMIERE RETIREMENT RESIDENCE

The Chair (Mr. Ernie Hardeman): The next one is La Chaumiere Retirement Residence: Carolynn Barko.

Ms. Carolynn Barko: Hello. Thank you for having me.

The Chair (Mr. Ernie Hardeman): Good morning. Thank you very much for being here and taking the time to come and talk to us. You have 15 minutes to make your presentation, and you can use any or all of that time to make that presentation. Any time left over we'll offer to the committee for questions and comments on your presentation. With that, thank you very much for being here. The next 15 minutes are all yours.

Ms. Carolynn Barko: Okay. Thank you. My name is Carolynn Barko, and I am a Chatham-Kent resident, currently working here in the Windsor-Essex area. I have worked in long-term care, in the seniors' care business, for about 20 years. I was the CEO of a community service organization in Chatham-Kent, and I was also the CEO of a retirement home. Currently, I'm working with a for-profit retirement organization here in Essex.

I'm here today to talk to you about some of the great things, in my opinion, that the LHIN has done since its inception as it relates to non-traditional partnerships.

The retirement home industry, as you know, is large. We have over 50,000 beds in Ontario, and the expectation is that it grows by about 20% in the next decade. Recently, we have become regulated by the Retirement Homes Regulatory Authority. Most providers supply some type of care.

In 2006 or 2007, while I was working on a few committees with the LHIN, it was quickly identified that retirement homes provide a lot of care, and it was really great to see that non-traditional providers were being recognized for the amount of care that they give to seniors and that the Erie St. Clair LHIN quickly identified that retirement homes were going to be a large part of the solution for our aging population.

Our rates in the retirement home industry range from about $75 to $95 a day, which is significantly less, of course, than a hospital stay, which ranges anywhere between $500 and $1,500 a day. Our representative organization, which is the Ontario retirement home association, is working hard to bridge these partnerships between government organizations and non-traditional partners.

As I said, while working with the LHIN many years ago, originally we had some struggles working with non-traditional partnerships, but I can only say that since that time in 2007, there have been enormous strides in terms of the LHIN supporting these non-traditional partnerships through organizations such as CCAC. Both organizations have been just great to work with—truly—in terms of helping people, like those in retirement homes, provide care and to bring down the cost of the system.

One particular example: Recently, the CCAC of Erie St. Clair, supported by the LHIN, a retirement home and a community service organization, established a program whereby the patients who were in ALC beds and/or presented in emerg were redirected to a retirement home. The retirement home took these clients 24/7. They were supported by the CCAC in terms of physio and extra supports. As well, after their 90-day stay, they were supported by a community service organization that provided Meals on Wheels as well as day-away programming. So, in effect, we immediately reduced the ALC beds, and we immediately reduced the cost from, say, $500 a day to $85 a day. Those people were, then, with the help of the discharge planners from CCAC, supported to go back home. This was a plan to go back home, but while they were convalescing, they were allowed to stay in a supportive environment. Then the CCAC made the transition to home and included community supports.

When I started working with the LHIN, we talked a lot about system integration. It has been a very difficult go for system integration, but this project is an example of how far we have come from an acute care to a non-traditional partner, working with the CCAC to help these people get back home and to stay home with supports. That is such a great example of system integration—one of the best I've ever seen. I can also say that this LHIN in particular—we're the first in the province to try this.

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Some of my recommendations going forward are that the Ministry of Health support the LHIN in these endeav-

ours; that they support these non-traditional partners; that they should open up some of the HSP to allow some of these non-traditional partners to be part of the HSP scenario; that there be more non-traditional partners explored. Retirement homes are one of many that can provide a really economical, efficient way to provide care in this province.

The other thing that this particular project does is that we figured that it actually saved the system about $650,000. So this really needs to be recognized, and the Ministry of Health needs to support the LHIN in all of their endeavours as they go forward in these non-traditional partnerships.

I know that we're working on the dollars following the patients, and the LHIN has been very proactive in this area, but if we are actually going to support choice and accessibility to the Ontario residents, we need to work on this sooner and faster so that the dollars follow the residents. They don't just go to the HSP that provides the care. It needs to follow the residents so that you can get the most accessibility, you get choice and you get the most effective use of your dollars.

That is the example that I wanted to provide to you today, because it's really a glowing example of how the LHIN has progressed in terms of their system integration and their partnerships with non-traditional providers.

I just wanted to say, in closing, that the retirement home industry is really receptive to working with governmental organizations. I am very, very happy to be one of those non-traditional partners that has had the privilege to work with Erie St. Clair LHIN and all their leadership.

I thank you very much for having me today.

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

We have about two minutes per party. We'll start with the government side: Ms. Cansfield.

Mrs. Donna H. Cansfield: Currently, there are some regulations around retirement homes. But if, in fact, you end up with an HSP, there has been some criticism that you're not on the same set of standards as long-term care. How do you feel about that?

Ms. Carolynn Barko: It's true that we aren't on the same set of standards. I hope that we never become that, because I've worked in long-term care, and the standards actually work against the client, in my opinion.

I think you have to trust in your own government and their own regulations, so that is really up to RHRA to decide on whether or not the retirement home in question is qualified enough to be an HSP.

Mrs. Donna H. Cansfield: But it's the government that set those standards for the long-term-care home that you just criticized, and you now want them to set the standards.

Ms. Carolynn Barko: I don't want them to be the same. I'd like them to be very similar to acute care. There are all kinds of standards in health care, and the ones in long-term care in particular are overbearing and—

Mrs. Donna H. Cansfield: So it's just a higher funding level.

Ms. Carolynn Barko: Yes.

Mrs. Donna H. Cansfield: Thank you.

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

Ms. Helena Jaczek: I would like to thank you for coming, because it was really interesting. We were given some background, obviously, on Erie St. Clair. The number one priority of the LHIN was to improve outcomes and alternate level of care, ALC. You've given us a very practical example of how the LHIN addressed this as their top priority. They looked at the whole continuum of care in terms of the opportunities. Obviously, we know that retirement homes do form a very, very valuable part of that continuum. So I just wanted to thank you so much for giving us a great illustration.

Ms. Carolynn Barko: Thank you. Although I know I'm here to speak about the LHIN, it really is in conjunction with the CCAC, too. Those two organizations working so well together are really how this is happening. The LHIN is supporting the CCAC to have those partnerships, and I'm just urging the Ministry of Health to support both of those agencies.

The Chair (Mr. Ernie Hardeman): Mr. Nicholls.

Mr. Rick Nicholls: Carolynn, it's good to see you again. How are you?

Could you just give us a quick breakdown again? You talked about a savings of $650,000. How did that come about? What was included in that? How did you come up with that number?

Ms. Carolynn Barko: A part of it was the amount of days that the client would have stayed in hospital in an ALC bed, running at about $500 a day.

Mr. Rick Nicholls: At $500 a day. Okay. Yes.

Ms. Carolynn Barko: Yes, in comparison to being in the retirement home at $100 a day, in addition to the potential for them either to go to long-term care or to be integrated back into their homes. Those were all factors that were included in the cost.

Mr. Rick Nicholls: I see. Okay. Thank you very much.

The Chair (Mr. Ernie Hardeman): Anything further?

Mr. Rick Nicholls: No.

The Chair (Mr. Ernie Hardeman): Okay. Third party? Mr. Hatfield.

Mr. Percy Hatfield: Just curious: La Chaumiere—is that the one where the staff worked without pay for months and months last year?

Ms. Carolynn Barko: Yes. La Chaumiere is a retirement residence in Emeryville that went into receivership—it must've been last year. Since then, it's been purchased by a gentleman named Harmen Verbrugge, and it has had no labour issues since, I think, December 2012. It's actually an excellent organization. He's redoing everything.

We just recently took on the Brouillette Manor residence from Tecumseh, the long-term-care facility who had to evacuate. He was great. He stepped up to the plate in the community and took on 20 residents. Yes, it's a great organization—very happy to be a part of it.

Mr. Percy Hatfield: What does it say about the dedication of the people who work there, who continued providing a service without pay for months on end?

Ms. Carolynn Barko: Well, they were paid by the union, actually. They—

Mr. Percy Hatfield: The union paid them, but the employer didn't.

Ms. Carolynn Barko: And they did get all their back pay, but I can't tell you enough—they asked me to consult with them for a while, and the reason I stayed is because of the staff. Those staff are so committed to those residents and that organization, despite all the things they've been through. In 2012, they had some hardships, but they've had a lot of hardships over the years. They are actually amazing, amazing people who have made my job there a pleasure.

The Chair (Mr. Ernie Hardeman): Anything further? If not, I thank you very much for your time—

Interjection.

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Helena Jaczek: Nothing to do with this witness.

The Chair (Mr. Ernie Hardeman): Thank you very much for your time, and we really appreciate you taking the time to come here and inform us on the—

Ms. Carolynn Barko: Thank you for having me.

The Chair (Mr. Ernie Hardeman): I think it's the first presentation directly related to the retirement homes, so we very much thank you for your input.

Ms. Carolynn Barko: You're welcome.

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

Ms. Helena Jaczek: Just before we recess, Mr. Chair, I wanted to thank our researcher for getting us the figures on health care employment within the LHINs, but I would of course like a little further information, if I may, in relation to this. What I would like to see is also the staffing of the LHIN itself. We have the employment within the LHIN, but I do not see the LHIN's actual staffing of their own organization, so I was wondering if we could have that across all of the 14 LHINs.

In addition to that—and I think this would be very easy to do—what I'd like to see is a staff-to-population ratio in each of the boxes in the chart, because there are incredible disparities as we look at these numbers. In other words, as an example, just looking at the Central LHIN hospitals, we have some 10,230 staff; if we could put that in context in terms of the population of that particular LHIN, as a ratio, and in each of these boxes produce that number, as well as the staffing within the LHINs, I would be very appreciative of that.

The Chair (Mr. Ernie Hardeman): Okay. Anything further on that?

Mr. Mike Colle: I've asked for some further information about the number of people working in health care: the number of physicians, for instance, and the number of people employed by the CCACs through contract, the VON and all the other agencies that do the work of the CCACs, just to get an idea of how many people are involved in health care delivery in each LHIN area.

The Chair (Mr. Ernie Hardeman): Okay. Thank you. Nothing else? Lunch is pre-arranged at the restaurant upstairs, so the committee recesses until we finish lunch.

The committee recessed from 1149 to 1300.

ASSISTED LIVING SOUTHWESTERN ONTARIO

The Chair (Mr. Ernie Hardeman): Welcome back. We'll call the committee back to order.

Our first deputation this afternoon is Assisted Living Southwestern Ontario: Leo Muzzatti, director of human resources and strategy management. Leo, if you want to take a chair at the table there. Thank you very much for being here. You'll have 15 minutes to make your presentation. You can use any or all of that time. If you don't use all that time, then we will open up it up to questions and comments from the committee. With that, the next 15 minutes are yours.

Mr. Leo Muzzatti: Thank you very much, Mr. Chair. I welcome you and members of the committee. Those of you who are not from Windsor, I welcome you to Windsor. Those of you who are from around here, I welcome you home.

As indicated, I'm a director of HR and strategy management at Assisted Living Southwestern Ontario. Our organization is a not-for-profit agency that provides quite a number of community services, but I think it's fair to suggest that the bulk of the services that we deliver are to provide attendant care assistance to individuals with physical disabilities and limitations, and assistance with tasks of daily living. Our mandate provides us with many opportunities to embrace and to directly participate in implementing the provincial initiative of promoting the very excellent concept of aging at home.

We've been doing this as an organization for quite a long time. We've existed as an organization since 1938, having gone through a number of name changes and various evolutions. We now find ourselves today being a very integral part of front-line delivery of home care while promoting independence in this community of Windsor and Essex county and, more recently, expanding beyond those boundaries.

I am very happy to be here today to convey to this committee, what with your role, that our LHIN has been instrumental in recognizing, adopting and promoting accessibility to care in the home and in the community, particularly when acute or institutional care is not needed or is not the best option. We do believe that the LHINs are the vehicle to continue this role.

However, we do harbour some continuing concerns. There can be no question of the increasing general recognition of the economic value of keeping people healthy and connected in their home and in the community. I apologize if aspects of what I am delivering to you today in my message are something that you've often heard, whether it be here today or in your travels in other communities, but, if that's the case, I ask you to bear with it

and allow it to be testament to the importance of the principle and the concept, if it is repeated.

People's needs, in most cases, can be met in their home or in the community while significantly decreasing the costs that are associated with long-term care or hospital admission. Local and flexible care, and its administration, work best. That's already been well-demonstrated.

I'd like to tell you a little bit about a local experience for our organization, and perhaps focus on one of our consumers—we call them consumers; they consume our services. We had the good fortune several years ago of an opportunity, working closely with our LHIN, to foster the idea of bringing home to one of our supportive housing programs a consumer who had been hospitalized and, to make a rather long story short, came to rely upon a ventilator permanently. It was proposed that our staff and our organization could fulfill the daily needs of this consumer, notwithstanding the fact that it had never been done before, at least in southern Ontario.

There were many naysayers. There were many people who quite simply refused to consider that option. We had our work cut out for us convincing the consumer involved that it could be done, but, with a great deal of encouragement and, obviously, the importance of administrative and financial support from the LHIN, we succeeded in bringing this consumer home.

This was home; notwithstanding this being a supportive housing program, it was home for this consumer before the hospitalization, and I'm happy to report that, after greater than two years, it has proven to be a wholesale success for everyone involved. It involved substantial training of our staff, and it involved getting past the hurdle of concern and worry. Empirically, we've demonstrated that it can be done and it can be done very well. This is all while achieving substantial savings of the cost had the consumer been required to continue to be in hospital care—very substantial savings.

We have since taken on the care of a second consumer that requires ventilator assistance. This was something that was unheard of even 15 years ago. It truly is a win-win for everyone involved. That, for me, is demonstrative, better than anything, of the value of community-based care, but it involved substantial cost. It involved a lot of work to ramp up to the point where we were able to fulfill this need.

Having said all of this, I submit to you that what has to come with the recognition of the value of increasing home- and community-based care is to accept that funding for that sector must also increase. As a front-line service provider, Assisted Living's experience is that while the LHINs themselves have received increased funding for this endeavour, we believe that it has not paced the increasing need and the expansion of these services.

I also submit to you that it's vital in considering the role of the LHINs in our society that your role in reviewing the legislation and the regulations must include responsibility to seek efficiencies. That's your public responsibility, and that must by necessity include reduction of expenses where it can be found, but it is our submission that that should not be done while losing sight of the need to increase the ability of service providers to implement a strategy of cost-effective home care, because we are under-represented in that sector now. We remain so. It's a relatively new concept. Quite simply, what we're saying is that this means funding needs to increase substantially in this sector in order to achieve the goal of overall efficiency in health care.

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With the implementation of any new strategy, there are certain costs that must be incurred, including new or increased administrative costs. Somehow, in this equation, that has not been properly recognized, and it's our belief that somewhere in the flow, the LHINs have not been armed appropriately to address that. It's inherent to the success of implementing this strategy that resources be allocated to the LHIN appropriately to engage community health providers to achieve this goal.

Trained, capable and caring workers are also vital to this endeavour. Greater funding is needed to address the issue of disparity of wages for those workers. You only have to be a recipient of the service to realize, in general, how underpaid these workers are in our society when you consider the value of the service that they provide.

We have difficulty, as a service provider, attracting and retaining these trained, quality workers, because this is a relatively new strategy, and the funding is needed in order to ensure that there is an ongoing development and monitoring of criteria for that training. Hopefully, as that role expands, that need also increases.

I'm not going to take any more of your time, because my message is relatively narrow. In conclusion, I wish to submit to you, as a committee, in plain-speak, that in doing your job, in reviewing this legislation, in fulfilling your public responsibility to seek out efficiencies in health care, that you also consider where we need expansion, where there are efficiencies to be realized, yet those areas require additional, increased funding in going forward. It's part of that overall fiscal efficiency.

Having said that, I thank you, and I beseech you to do what is within your power to let service agencies like ours—and, for that matter, for-profit agencies as well have a role to play. Help us to continue doing our job and also to increase our ability to do the job in our community. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We just have time for one caucus. Ms. Cansfield?

Mrs. Donna H. Cansfield: Thank you very much for your presentation and good words of wisdom. I'd like to ask a question about the service providers: for example, PSWs.

Mr. Leo Muzzatti: Sure.

Mrs. Donna H. Cansfield: Job descriptions are fairly narrow. When I look at home care, I look beyond the individual. For example, is there food in the refrigerator? Is the toilet clean? It's that sort of holistic approach. How can we integrate that into when the worker comes into the home? Because currently, I'm told by my PSWs, if they were to go out and get bread or milk when the fridge

is empty, they'd be fired. How do we get around those and look more holistically at the needs of the client as opposed to the siloed effect of the individual support mechanisms?

Mr. Leo Muzzatti: I can assure you that if you go from agency to agency, you're probably going to find a different job description in different environments. But what I would suggest is that what you are likely seeing is the product of limited funding. What I suspect is that there is a focus on the personal care component, and it's a question of limited funding to allow all of the assistance that might be needed with the everyday tasks of daily living. So I suppose that for most agencies, if you have to choose one or the other, the focus, in all likelihood, is going to be personal care. But I can tell you that, certainly within our agency, our job description includes the very tasks that you're describing.

It really comes down to, in our case, allowing our consumers to decide where the resources—and by that, I mean the hours of service that we can allocate—where they want to expend them. If they have a priority on tasks like that, we will do everything in our power to achieve it.

Mrs. Donna H. Cansfield: So it does speak to a standard of care.

Mr. Leo Muzzatti: It does.

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

Mr. Leo Muzzatti: You're welcome.

The Chair (Mr. Ernie Hardeman): Thank you. Any further?

Mr. Mike Colle: Just one quick question: It's on administration. I guess the general public thinks that you just get the doctor, the nurse, the primary care out there and the PSW, but they have no appreciation—because again, they're busy—of the fact that you need these front-line workers to be directed and to be efficiently deployed.

Mr. Leo Muzzatti: Absolutely.

Mr. Mike Colle: Yet there's no appreciation of having to fund that part of it. The doctors get paid well; meanwhile, the unsung people behind the scenes are doing all the arranging. Is that what you're trying to say with that administration piece?

Mr. Leo Muzzatti: Well, if I take the example I gave you of the vent-care consumer, our staff were providing a lot of the services that are daily requirements for that particular consumer that, had they been delivered in a hospital setting, would have been vastly more expensive. Our workers, quite simply, are paid a great deal less than high-level nursing staff, and yet many of the functions that would have been performed if that consumer had remained in hospital would have been straightforward tasks of daily living that don't require that high level of nursing or medical attention.

The reality is that we can deliver it for a great deal less. The question is, when I think about some recent comments, for example, from the Premier, about where we want to go with the minimum wage, I would suggest to you that the average wage of a PSW in this province is not a great deal higher than that objective. Somewhere, there ought to be a happy balance.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It is much appreciated and helpful in our deliberations.

Mr. Leo Muzzatti: Thank you very much.

CHATHAM-KENT HEALTH ALLIANCE

The Chair (Mr. Ernie Hardeman): Our next presenter is the Chatham-Kent Health Alliance: Colin Patey, president and chief executive officer. Thank you very much for being here. We very much appreciate you taking the time to come and talk to us. As with all our other presentations, you'll have 15 minutes to use as you see fit. You can use any or all of it. If you leave some time at the end that you don't use, we will have questions from the committee to fill in that time. But right now, you're in charge of the next 15 minutes.

Mr. Colin Patey: Well, thank you very much. Good afternoon, and thank you for coming out to this region. I thank you for this opportunity to address the Legislature's Standing Committee on Social Policy during this review of the Local Health System Integration Act.

I believe organizations like the OHA will be able to provide more depth and a broader perspective on this legislation than I can, but in my own experience, I've dedicated my entire career to health care administration. I've spent time in the public sector and the private sector in different provinces of Canada and, in fact, I've worked overseas in the UK.

I have two main objectives for participating in this process. The first is to affirm my view and support for the principles embedded within the act—that is, the principle that a local entity, not one centred in Toronto, can enable better access to quality health services, coordinate the local health system, and support effective and efficient management of the system. You see, I see it as we providers are the instrument and players, and the LHIN is the conductor of the symphony.

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My second purpose is to indicate the key area that, in my view, is the act's greatest limitation: where it is left open to potentially fail the system planning and integration it aims to achieve, and in doing so it may also fail patients. This point relates to the scope of authority, either through devolution or in the definition of defined health service providers in the act.

As set out in the legislation, LHINs can and should plan, fund and integrate the local health system. Therefore, I am here today to affirm that the act offers all of us—providers, clinicians, patients and communities—a tool to enable system transformation. However, it also has some limitations, which may compromise the potential intended, if not explicitly stated, in the legislation.

First and foremost, I want to provide greater detail on the strengths of the act. The principles embedded within the legislation reflect the need for local participation, dialogue and co-operation to plan and set local health care priorities. LHINs help to create local relationships and opportunities for shared planning, patient outcomes

and successful system transformation. A local, decentralized approach to health system planning embraces, importantly, flexibility in addressing differences across regions and communities and creates a more responsive entity to support and enable change that anticipates and addresses emerging needs. I offer the challenge to anyone to demonstrate that this can be done as effectively through a centralized ministry.

In my own organization, the Chatham-Kent Health Alliance, we have benefited from our relationship with the LHIN and other health service providers to enable change. A few examples include: a shared capital planning submission with two community-based partners, which recognizes the need to develop facilities and service delivery across—across—organizational boundaries. This work created a voluntary integration—a divestment of sorts—of select outpatient services to the community health centre, as one partner, and also created a fully integrated mental health management team between our hospital and a community provider, the Canadian Mental Health Association Lambton Kent. The latter of which is, as we understand it, the first of its kind in Ontario—much to be emulated, I believe.

On a more practical and operational level, having a local entity responsible for funding allowed us to negotiate a balanced budget waiver of $1.5 million last year, which we delivered at $1.2 million. This enabled us to implement at our own pace—and a sensitive one to our employees and patients—much-needed changes to reduce the challenges and operational constraints we continue to face as we migrate through the health system funding reform, which I'm sure you're well aware of. As a CEO, this is something that I value: the expectation for high performance on an ongoing basis but, when the circumstances necessitate, support and action that provide long-term solutions while mitigating the short-term impact of provincial policy change on local providers and patients.

On many occasions, having a local entity to speak with about system challenges and opportunities creates benefits for providers and patients alike; however, as I have also indicated, the act may require some adjustments or the fulsome support of the ministry to be the effective enabler of system transformation which Ontario requires.

On to my second point: I believe there is an inherent weakness either in the legislation or in its execution. This weakness can be attributed either to the fact that there has been little, or not enough, devolution of authority to the LHINs, or it may simply be that the definition of health service providers affected by the legislation and accountable to the LHINs requires revision.

In either case, it is my view that in order to fully execute the intention of the legislation, a LHIN must have the appropriate scope of power and authority to realize system transformation as intended, as I read and interpret part I, section 1, "Interpretation: Purpose of the act." It remains a mystery to me and to many of my colleagues as we chat how LHINs can be the enabling entities the system requires without having the accountability for all aspects of the local health system. LHINs should have authority for all primary care. System design and delivery cannot be achieved when a vital component such as primary care is left outside. It's not a system; it's a non-system.

Understanding the roles and responsibilities between the LHIN and the ministry is difficult for us who have been engaged in the system for decades. The legislation opens the door to expanded power through devolution of authority; however, it appears to be a clause that is in place but not one that is readily practised. If it is not going to be used to support system transformation, then it would be helpful if the committee considered the definition of health service providers to be amended to reflect the local providers that are critically important to the system yet are not treated inclusively in the legislation, particularly all providers of primary care, of which the current legislation, it is my view, only identifies CHCs. However, the majority of our patients in our community are served by organizations like the local family health teams for primary care, but they fall under a different authority.

I ask the question, who is responsible for the broader aspects of population health? Will this emerging concept be aided by a further delineation, an outline of the responsibilities of the ministry and the LHIN, and through this act?

In Chatham-Kent, we are fortunate to have a community where all providers, including our family health teams, collaborate to improve the system and quality of patient care. My point is simply that this may not be the case everywhere, and thus the legislation may impede rather than enhance the systems integration it is intended to drive. It seems logical that having a consistent set of rules and one local body of authority for approvals would expedite such changes. Recognizing that the change of a system is difficult and likely to be done incrementally, this appears to be one mechanism to broaden accountability without encroaching on other jurisdictions such as municipalities, who have responsibility for ambulance services, as one example.

It is my hope that as the committee works through its review, it gives great consideration to how adjustments to the legislation can support the system transformation that we all recognize is needed and that many providers, such as my own organization, are already supporting to the extent possible within the limitations of the legislation.

There are many other areas within the legislation that we could consider, but with limited time I have chosen to focus on what I view as the greatest strengths—the principle of local planning, funding and integration—and the significant limitation of a lack of inclusivity of key partners within the definition or execution of this legislation.

That's my submission, and I thank you very much.

The Chair (Mr. Ernie Hardeman): Well, thank you very much. We have just over four minutes, so we will try and split it. We start with the third party.

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Ms. Teresa J. Armstrong: Oh, sorry.

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

Ms. Teresa J. Armstrong: I wasn't sure if we were first.

Thank you very much, Mr. Patey—is it Patey?

Mr. Colin Patey: Yes, it is. A good Newfoundland name.

Interjection.

Mr. Colin Patey: Oh, you bet.

Ms. Teresa J. Armstrong: Thank you for your presentation. One of the things that you suggested was to expand the power of the LHINs.

Mr. Colin Patey: The scope, yes—

Ms. Teresa J. Armstrong: The scope.

Mr. Colin Patey: —of authority and responsibility.

Ms. Teresa J. Armstrong: Right. And one of the suggestions you had talked about was including primary care in that scope.

Mr. Colin Patey: That is a correct interpretation, yes.

Ms. Teresa J. Armstrong: Okay. Do you see any roadblocks or barriers in doing that, or do you think that that's something that is feasible, that can be done?

Mr. Colin Patey: Well, there would be any number of barriers, but it's an opportunity to take on what those barriers and challenges may be. Importantly, the broader picture is that we need to get past the silos in which we work and to look at the system as a whole, seek what's best for the patient, who needs to be at that centre, find efficiencies across multiple providers, and deliver value for the taxpayer of Ontario. For instance, you may know very well that if primary care centres aren't open on social hours, they're going to end up in the emergency department, and that's the last place they should be.

The Chair (Mr. Ernie Hardeman): Okay. Thank you. To the government: Mr. Colle.

Mr. Mike Colle: Thank you for your very decisive presentation. As you know, there are people still advocating going back to the centralized system—you know, the old regional health units and doing things from Toronto again—saying that getting rid of the LHINs gets rid of administration, so by going back to the old system we'll get rid of the middleman and just deliver health care more efficiently that way. What do think of that postulation?

Mr. Colin Patey: Well, there are many roads to get to Rome, but—for instance, you can go to a place like Ireland. They really have two health care boards to manage their entire system: one for quality and one for operations. That's one model that works in Ireland. We know that there are different organizational delivery mechanisms across this country, but I think that I put forward just a few of the views that very much support a local organization.

Now, I don't know if it should be 14 or 17 or 12—there are factors you would put into that to say how many LHINs you do need based upon patient referrals, population and geography—but I do know the principles of having a local organization who can respond flexibly to our needs and would know what our patient needs and organizational needs are on a local basis. It's the best way in order to be able to customize the health care delivery service that looks after the patient and maximizes the limited taxpayer dollar that we do have.

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

Mr. Colin Patey: A rose by any other name.

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

Mr. Rick Nicholls: Thank you, Chair. First of all, Mr. Patey—Colin—it's good to see you, and I'm glad to see that Zoja is here with you today as well—and again, publicly to thank you for the opportunity I had to do some job shadowing in the ER at Chatham Kent Health Alliance.

Now, knowing you as I do, I know that you're far more solution-oriented to the challenges that are facing CKHA. What would you say would be one of the greater challenges facing CKHA and your relationship with the Erie St. Clair LHIN, and then, what would you suggest a solution to that greater challenge might be?

Mr. Colin Patey: We as a hospital deal with the failures of the health care system to keep people as healthy as they can be for as long as possible. There's an emerging concept called population health. Training in some of the universities—physicians and others—is emphasizing more on prevention and training our doctors that way. There are certainly more health care practitioners emerging who are dealing with the holistic matter of the human being and, frankly, keeping them healthy for as long as possible.

That's the future. That's the challenge: How does government and a public-funded health care system deal with population health, when it has some of its bodies that it holds accountable for parts of that—how does it migrate to a more holistic, inclusive and comprehensive approach for our citizens—to address that issue of prevention and keeping people healthy for as long as possible and staying out of—by institutions? Because that's a failure.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. For the committee's information—I'm sure you noticed—it went slightly over what we should have, but it was the last one of the day, so I didn't want to leave any good information behind when we came all the way to Windsor to hear it. So thank you very much for your presentation.

I thank everyone on the committee for all the hard work that you've done in the past four days to get us this far. We look forward to proceeding with this process next Tuesday in Timmins—no, Sudbury.

Mr. Mike Colle: Thunder Bay, isn't it?

Interjections.

The Chair (Mr. Ernie Hardeman): No, Sudbury is first; Thunder Bay is second.

Anyway, is there anything else for the good of the committee or, they say, for the good of Rotary? If there's nothing else, we're adjourned.

The committee adjourned at 1336.

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