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# Official Report of Debates (Hansard)

**Tuesday 4 February 2014**

# Journal des débats (Hansard)

**Mardi 4 février 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

Tuesday 4 February 2014

Mardi 4 février 2014

*The committee met at 0907 in the Radisson Hotel, Sudbury.*

## LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

## INDEPENDENCE CENTRE AND NETWORK

**The Chair (Mr. Ernie Hardeman):** Good morning. We'll call the Standing Committee on Social Policy to order. We're here to do the public hearings on the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of the act. We're here to hear deputations.

I see we have the first one, the Independence Centre and Network: Marie Leon, chief executive officer. Thank you very much for being here this morning to make a presentation. We appreciate you giving us your time. You'll have 15 minutes to make your presentation. You can use any or all of that for your presentation. If there's any time left over, if it's less than four minutes, we will have just one party ask questions. If there are more than four minutes left, we'll divide that time equally between the three parties, but that doesn't have to direct you as to how much time you have to leave. Thank you very much for being here. The next 15 minutes are yours.

**Ms. Marie Leon:** Thank you. Good morning. I'm honoured to be speaking to this committee today. My name is Marie Leon. I'm the chief executive officer at ICAN, the Independence Centre and Network.

We've been providing community support services for 35 years in this community. Our original mandate was to support adults with physical disabilities. In recent years, we've expanded our services to include high-risk seniors. Currently, we have about 130 employees and about 150 clients. Our budget is approximately $5 million, and 90% of our staff have a PSW background.

Our programs include: an independence training centre for persons with physical disabilities; a post-stroke transitional program; supportive housing for adults with physical disabilities; enhanced congregate care for persons who have been deemed ALC in hospital; outreach attendant care services for persons with physical disabilities; and assisted living for high-risk seniors.

The local health integration network was created in 2006 with a mandate to plan, fund and integrate health care services for more efficient care in their regions. As with any major change, when the North East LHIN was introduced, it created a lot of uncertainty for health service providers. With a name that included the word "integration," there was a lot of fear that the LHINs were created to integrate, merge and amalgamate smaller agencies like ICAN. This fear created a lot of mistrust within the health care sector and a lot of turf protection.

Over the past eight years, the North East LHIN has worked very hard to create a health care system built on partnerships and collaboration, always with the needs of clients in mind. ICAN has always been supportive of the reasons why the LHINs were created. Having local planning and accountability is a solid idea. I think it is especially important in northeastern Ontario, where our population and demographics are much different than in southern Ontario. Having northeastern Ontarians planning for northeastern Ontarians just makes sense.

There are some who would support the dissolution of the LHINs. This would not improve the health system right now and will distract from the more immediate issues relating to the delivery of home and community care.

ICAN has always had a very positive and supportive relationship with our LHIN. Our LHIN has recognized that community support service agencies like ICAN are part of the solution to our health care issues. Our LHIN has recognized that ICAN has a huge part to play in this.

Since its inception, the LHIN has funded many new programs and expansions of programs at ICAN. The LHIN funded the expansion of our supportive housing program into a second location. It funded the expansion of our outreach attendant care program into Sudbury west. It funded our enhanced congregate care program and our post-stroke transitional program. It included ICAN in the rollout of the new assisted-living program for seniors.

We have received outstanding support from the LHIN officer assigned to our agency. She is very knowledgeable about our sector and has been very supportive. She makes herself available whenever questions are raised and provides honest and transparent answers.

Generally, agencies like ICAN are struggling with recruitment and retention of our front-line workers who are mostly PSWs. A few years ago, our LHIN undertook a study and produced a report about the health human resource issues. There were several recommendations in the report. However, these recommendations were never implemented. This is a major issue for the community

support sector, and we would appreciate more support from the LHIN and the government on this.

Consumers of community support services are growing frustrated with turnover and the number of support workers being sent to their homes. The constant costs of recruitment and training new employees is immense.

We understand that retention isn't always about dollars and cents, and ICAN has made a point to strive for staff retention and staff satisfaction through various human resource means. However, offering a competitive wage is imperative to keeping quality staff with community support service agencies.

We are also struggling with the 0% increases to base budgets. For the past two years, the government has announced increases of 4% or 5% to community support services. Agencies like ICAN welcomed that news, only to learn that those increases were for new programming only, with the bulk of money going to the CCACs.

Community support service agencies are recognized as a solution to the health care issues, and we are being asked to support more and more people within the community. But we are being asked to do this on a crumbling foundation. This is no different than building new roads while leaving the existing ones to disintegrate.

The community needs more workers, but the community cannot pay our workers what they're worth. This results in high turnover and related expense as our workers move on to long-term-care homes and hospitals which, on average, pay their workers about $5 an hour more.

I would ask everyone to consider this question: Do you think $16 an hour is enough to pay for someone to look after your loved one? Do you think you could support your family on $16 an hour? We look to the LHIN to support us in talks with the ministry by advocating for our need for additional base funding.

The North East LHIN has had its share of growing pains. It is not perfect, but it continues to evolve and improve. Some of the LHIN funding decisions have been hard to manage. The original funding for the new assisted-living program for high-risk seniors is not sufficient. The consumers are crying out for more services, and because of the funding formula, our hands are tied.

Until recently, any new funding did not allow for any administrative expenses. This is becoming overwhelming for some smaller agencies. Reporting requirements have grown to include the ministry, the LHIN and, in some cases, the CCAC. A new provincial standardized client assessment tool has been implemented, with no additional funding to cover the ongoing cost of doing these assessments. Our LHIN has heard our concerns regarding these funding inequities and is working hard to address them.

Communication between the North East LHIN and service providers has also been challenging at times. Considering the huge geographic area and the diversity, this is not unexpected. For example, the North East LHIN has increased its engagement with providers, but with it comes more meetings, more committees and more resources to take part, especially when there's travel involved.

The LHIN has also become much more responsive to questions. However, there's still room for improvement. As I reported earlier, our officer is very quick to respond to emails or phone calls. However, others at the LHIN are very slow to respond or do not respond at all.

As already mentioned several years ago, a health human resource report was developed by the LHIN with several initiatives to address the ongoing PSW crisis. ICAN is still awaiting word on the next steps.

The LHIN's staff seems to keep growing, with new positions being posted on a regular basis. There have been times when the same question has been asked of different staff at the LHIN and we have received different answers. This causes confusion and uncertainty.

The LHIN implemented the expanded role of the CCAC, which included managing some of the community support service wait-lists. Some providers felt forced into these changes without a lot of input.

The LHIN is also working hard at improving communication throughout the sector. It's very nice to know and recognize the LHIN representatives at meetings and within the community. It is also very beneficial to be able to have frank and earnest discussions with the LHIN regarding our issues.

Is our LHIN perfect? No. Is our LHIN getting better? Yes. Is there room for improvement? Always. Does the LHIN recognize this? Yes. Does ICAN support the LHIN? Yes. Is our health care system headed in the right direction? Yes.

In closing, the North East LHIN understands the health care system, which includes hospitals, the CCAC and the community. It understands our diverse region. The LHIN promotes partnerships and understandings between all of the stakeholders in the health care system. The North East LHIN is committed to improving our health care system and sees the importance of keeping people living independently in their own homes. It recognizes the need to invest in home and community care, which will free up hospital beds and the emergency department and will decrease long-term-care placement. ICAN supports the North East LHIN and would not want to see it replaced with something else that does not have local control or input.

Although it may seem that the LHIN has been in place for a long time, transforming a whole health care system takes a lot of work and a lot of time. I ask that you give the LHINs the time they need to continue this important work.

Thank you for the opportunity to speak.

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

We have four and a half minutes left. With that, we will start with the government. Try to keep it within a minute or a minute and a quarter. Ms. Jaczek.

**Ms. Helena Jaczek:** Thank you so much for coming. We've certainly heard the PSW piece that you have articulated. We heard that in southwestern Ontario also.

I'm sure that our government will take a very strong look at that.

You talked about an officer from the LHIN who is assigned to you. Are you involved in any other sort of committee or council? We heard from the South West LHIN about something they've developed: the Health System Leadership Council. Is there any kind of forum like that that you might be a part of up here?

**Ms. Marie Leon:** For the community service sector, we do have a regional committee, which I sit on, and there's a representative from the LHIN on that committee. We also have a local committee, which is also well represented by the LHIN. So yes, they do sit on various committees throughout the northeast.

**Ms. Helena Jaczek:** So you're able to—

**The Chair (Mr. Ernie Hardeman):** Thank you. The official opposition.

**0920**

**Mrs. Jane McKenna:** Thank you so much for coming. It was a wonderful presentation.

I have a question. You had mentioned about the expansion and the monies that you had received from the LHINs to do that. I'm just curious: How do you measure the outcomes of what you've been given the monies for—if it has worked, if it has been put in the right place—because sometimes just giving money doesn't mean it was the right place to put it. So where was the strategy behind that?

**Ms. Marie Leon:** The new money that I was talking about for assisted living for frail seniors—we were the first to pilot it in Sudbury, and it was a new program, so in all fairness we were all learning. When we got the funding, it was based on us taking on 15 clients, with an average of two hours of service. Through key performance indicators, it has become clear that clients in that program need an average of four hours a day. So we're hearing from the clients.

The LHIN has actually set up, through a committee, some key performance indicators that we're measuring, including hospital emergency visits. So there's a lot of data to support that. It has been presented back to the LHIN, and they're recognizing that there has to be a tweak to some of that. Instead of holding us to 15 clients, they're now saying that it's based on hours of service. So instead of giving everybody two hours of service, we're able to give someone who needs six hours of service what they need. The LHIN has come through on that, and we're getting there.

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

**M^me^ France Gélinas:** I don't know if you are able to give us a bit of a comparison. You've explained some of the challenges with recruitment and retention issues because of salaries and others. You've explained some of the challenges with meeting the growing needs of the population you serve. Can you balance the fact that you're able to work with LHINs versus had you had to work with the regional office of the Ministry of Health? How has that relationship changed to try to solve the issues that you're struggling with right now?

**Ms. Marie Leon:** As I said, in communication with the local officer, they get it. They know our demographic. They see it; they hear it from everyone.

**M^me^ France Gélinas:** Do they visit your agency?

**Ms. Marie Leon:** Yes, absolutely. From the senior officer right up to the chief executive officer, they have visited; they've toured. They've met with some of the clients. They're definitely engaged and plugged into our sector.

**M^me^ France Gélinas:** Do you feel that because they're more hands-on and are located in the north, a solution will come, as opposed to what we had before with the regional office?

**Ms. Marie Leon:** I'm hoping. I still hold out hope that the initiatives identified in that report will be followed through on. I think it goes up to the ministry level and the funding level: Are the LHIN's hands tied in addressing this as well?

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

## NORTH EAST LOCAL HEALTH INTEGRATION NETWORK

**The Chair (Mr. Ernie Hardeman):** Our next presentation is the North East Local Health Integration Network: Louise Paquette, chief executive officer. I understand that we're going to have a PowerPoint presentation, some of which is in French.

**Ms. Louise Paquette:** Oui. Yes.

**The Chair (Mr. Ernie Hardeman):** So I just remind the committee that you have your translation devices on the table, if you wish to partake of that.

Thank you very much for being here. As with the previous presenter, 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 and it's more than four minutes, we will divide it equally among the three caucuses. If it's less than four minutes, it will be one caucus that gets the opportunity to ask a question. With that, the next 15 minutes are yours. Thank you.

**Ms. Louise Paquette:** Thank you. Bonjour. Hello. Aanii. My name is Louise Paquette and I'm the CEO of the North East LHIN.

What can I tell you today that will help you in your review of the LHSIA legislation as you consider the scope of responsibilities and authorities of the LHINs? I appreciate the opportunity to provide a northern perspective, and I would like to begin by introducing you to one of our elders: 109 years young, Marguerite Wabano. Born into the Attawapiskat First Nation, she is not only the oldest residential school survivor but one of the oldest seniors whom we, as a LHIN, are supporting at home.

I first met Granny Wabano, as she is affectionately known, in the Weeneebayko area hospital in Moose Factory. She had just showered and was getting ready to go home. The last time I saw her, she was playing bingo

at the Elders Gathering Place in Moosonee, where I met up with the Red Cross workers.

As a LHIN, we work closely with the Red Cross, and having supported the gathering place, I wanted to see the results of our collected efforts myself. On my most recent visit to the coast, I was accompanied by three geriatricians: Dr. Samir Sinha, the provincial Seniors Strategy lead; Dr. Jo-Anne Clarke, the clinical lead for the North East Specialized Geriatric Services; and Dr. Janet McElhaney, the medical lead for seniors' care at Health Sciences North. We visited five coastal communities, talked to health service providers and listened to elders. Here's a copy of the report.

As a result of this visit, the North East LHIN responded with very tangible items, like more foot care funding—coastal communities have one of the highest rates of diabetes in Ontario; a wheelchair for the health centre in Peawanuck; and two vans to help transport elders in Kashechewan and Attawapiskat.

More recently, two weeks ago, these same geriatricians, accompanied by a team of allied health professionals, returned to Fort Albany to do clinical work. They developed a geriatric assessment tool specifically for aboriginal people and individualized care plans that local workers will implement with ongoing support through telemedicine. To ensure proper follow-up, the North East LHIN has worked with the Red Cross to provide personal support worker training. Today, 24 students—many of them women with children—are receiving training in their community. As you can imagine, given the shortage of health care professionals, this grow-your-own program is filling a gap and providing both education and jobs in an area with low employment. You see, there are no long-term-care homes on the coast, so building a system of care that is culturally sensitive and acceptable to the people who live in these coastal communities requires a regional model that promotes flexibility and an understanding of local circumstances. That is why our 12-member Local Aboriginal Health Committee, with regional representation, is a critical sounding board in our decision-making process.

Recognizing that a community's health needs are best understood by the people who live there, community engagement is the cornerstone of the LHIN model. During the development of the North East LHIN's most recent Integrated Health Service Plan, we engaged with over 4,000 northerners, including patients, providers and the general public. Because of our huge geography and the importance of being accessible, the North East LHIN has staff in Sudbury, Timmins, North Bay and Sault Ste. Marie, and we engage across communities on an ongoing basis, actively participating in community events, Rotary and other service club meetings, annual meetings and public forums. Every day, LHINs work to break down traditional silos, bring people together and connect health service providers.

Here at the North East LHIN, we are blessed with exceptional health care workers who provide care to the 565,000 people who live in this vast geography that extends from Peawanuck to Parry Sound and from Mattawa to Hornepayne and all points in between. While geography is a particular challenge in our LHIN, so too are the facts that people are living longer with more complex conditions and our population is declining, particularly in our remote communities. Our job at the North East LHIN is to work with our 148 health service providers, including 25 hospitals, 41 long-term-care homes, 48 community mental health and addiction agencies, 63 community support services, six community health centres and our North East CCAC. Together, we are rethinking how care is delivered. For the most part, these organizations operate independently of each other and do not assume responsibility for transitions of care, particularly when a patient moves from hospital to community.

Comme planificateur du système local, le RLISS du Nord-Est se penche sur les transitions entre les milieux de soins axées sur les besoins des patients et non des organismes afin d'offrir aux gens du Nord l'accès aux soins appropriés au bon endroit et, comme l'a bien dit l'un de mes concitoyens francophones, « dans la langue de mon choix. » Étant donné que les francophones représentent 23 % de la population de notre région, le RLISS du Nord-Est travaille étroitement avec l'entité de planification des services en français, le Réseaux du mieux-être francophone du Nord de l'Ontario; maintient le dialogue avec les francophones; et collabore avec les pourvoyeurs afin qu'ils obtiennent leur désignation indiquant qu'ils offrent des services de qualité en français.

Notre RLISS a multiplié les services de soutien communautaire, les programmes de jour et l'aide aux transports pour les personnes âgées francophones, particulièrement dans les régions de Nipissing Ouest, Chapleau, Témiscamingue et l'est de Sudbury.

J'aimerais vous présenter Elizabeth Lamirande : femme avant-garde, elle a été la première femme à conduire un autobus pour la compagnie Sudbury Transit. M$^{me}$ Lamirande était une patiente en attente d'un autre niveau de soins depuis neuf mois à l'ancien site de Sudbury Memorial avant d'être admise aux soins de longue durée. Sa santé s'est améliorée grâce aux soins qu'elle a reçus au Manoir des pionniers. Il ne lui manquait que son autonomie.

**0930**

Today, Elizabeth lives in an assisted-living apartment in Sudbury, at Finlandia Village, which the North East LHIN recently provided with additional funding. In fact, we have added close to 230 new assisted-living clients to the system over the past two years. From acute care to long-term care to assisted living—this is a good example of how a person can move across and through the system, considering that being discharged from long-term care was virtually unheard of in the past.

But for LHINs to provide the much-needed service of assisted living, there needs to be infrastructure in the form of housing. This is where the cross-ministerial, jurisdictional and community conversations are crucial.

The LHIN is a system planner, not a provider. I trust our providers because I have great faith in people, but with trust must come transparency and accountability. That is why all of the LHIN funding is provided to health service providers through accountability agreements with specific deliverables, metrics and performance indicators.

We work closely with our providers because individual performance often has a ripple effect on system performance. For example, when I started as CEO of the North East LHIN four years ago, the rate of alternate-level-of-care patients in our regional hospital, at Health Sciences North, was hovering around 40%. With this high ALC rate, surgeries were being cancelled regularly, wait times in the emergency department were unacceptable and there was gridlock in the hospital.

The North East LHIN brought community and municipal leaders, physicians and health care partners together to develop a plan, targeted community investments and commissioned a peer review of Health Sciences North.

We also successfully worked with the ministry to overturn the commissioners' decision to close the Memorial site, which has now become the Sudbury Outpatient Centre. Sudbury needed this outpatient clinic capacity to address the chronic conditions of its aging population.

In addition, last year the North East LHIN brought together the Canadian Mental Health Association, the Greater Sudbury Police Service and the hospital to address the needs of a special population. A strong health care system is not built by those working in health care alone. Healthy communities are safe communities, and the North East LHIN sees our local police departments as vital partners.

This is Arvind Jagessar, a consumer who was at the launch of the community crisis centre in Sudbury in the fall of 2012. Arvind talked to me about not wanting to be around a lot of people in crisis, especially in the emergency department. He felt this new model, which relocated all crisis intervention services from the hospital to a calmer environment in the downtown core, would help people suffering from mental health issues.

Since the centre opened, not only has there been an 18% decrease in the number of people with mental health issues going to the emergency department, but people are getting the right care at the right place.

With the police officers receiving new training, there has been a marked decrease in the number of apprehensions under the Mental Health Act, and less time spent by officers in the emergency department, with an estimated two more hours a day devoted to front-line policing.

While it's still a work in progress, the average ALC rate at HSN is now fluctuating around 20%. There has been improvement in ER wait times, better discharge planning and improved transitions of care.

In June 2010, we commissioned a peer review of the Sault Area Hospital, which, at the time, held the second-worst deficit in the province of Ontario, at $12 million. Today, not only is the hospital budget balanced, it is achieving a surplus. In fact, today, all four of our large hospitals have balanced budgets.

As we move from global funding to a model where funding follows the needs of the patient, the North East LHIN is completing a clinical services review of all 25 hospitals in order to better understand the impact of these changes on northerners and develop a plan to support the transition.

Understanding northern Ontario's economy and our history are an integral part of the health care conversation. As the producers of mineral wealth and lumber for Ontario, over time, northern Ontario responded to the needs of miners and lumberjacks by building local, small hospitals and providing the best treatment available at the time.

Take, for example, Sensenbrenner Hospital, built in 1929 by the Spruce Falls Pulp and Paper Co., and consider that Mattawa General Hospital was built in 1878, when the average life expectancy was just over 40 years of age. Today, the CEO of Mattawa Hospital is also the administrator of the Algonquin Nursing Home, an innovative approach to managing the health care needs of people living in this small northern community.

Back in the day, health care was hospital care. Our 21 small hospitals play a pivotal role in northern Ontario. We as a LHIN recognize their importance and are working with them to better respond to the needs of our aging population.

Many of these seniors are the pioneers of northern Ontario and live in communities where the population has seen double-digit decline. They live on their own, with little to no immediate family close by. The LHINs understand because they listen.

The North East LHIN understands the importance of helping people with dementia and their caregivers by providing specialized training to 5,500 front-line health care workers. This means that people like Violet Babcock can enjoy the music of Phil Collins when she's having a bad day at her long-term-care home.

The North East LHIN understands people like Rina Clark, who cares for her husband, David, a physics teacher who was diagnosed with Alzheimer's in his early sixties. She asked the LHIN to enhance the hours of the local adult day program, which was only offered three days a week. Today, this program is available six days a week.

The North East LHIN understands that when people are in excruciating hip pain, they need to get to the next available surgeon. That's why we created five joint assessment centres, where people are assessed by an advanced practice physiotherapist. Since starting these centres, we've found that 64% of patients don't need surgery but some other form of treatment.

The North East LHIN works with providers to improve transitions of care, because we understand the importance of helping seniors return safely from hospital. That's why we started a program called PATH, where a care worker from the Red Cross accompanies high-risk seniors home, picks up their medications, makes sure that

there's bread and milk in the fridge and that they are comfortably settled, with home care services in place.

Decentralized decision-making allows us to target our funding to meet local needs. I'm sure it comes as no surprise that in our community engagements, transportation is often an issue, given that we have hundreds of communities with no local public transit. So, in 2012, the North East LHIN responded by providing vans to support seniors in the Cochrane area, helping people maintain their independence and access care.

Sometimes, though, it's not about buying vehicles. Two years ago, we supported the creation of a mobile adult day program that travels to different communities on Manitoulin Island, and we are just finishing a study on non-urgent patient transportation that will truly be a made-in-the-north solution to that vexing dilemma of how to do non-urgent inter-facility transfers. Being a leader in health care today means having the courage to call into question the way things have been done in the past. That's what LHINs do.

I hope I have provided you with a northern perspective of the value of LHINs. Being one of the 14 networks, the North East LHIN benefits from the experience and best practices of others, and has the flexibility to adopt or adapt a good idea to better suit local needs and local priorities. We need to stay this course.

As a born-and-raised northerner, I understand the challenges, the fear of loss and the territorial behaviour of some providers. I know that small hospitals are often the heart and soul of their communities, but I have also heard northerners tell us loud and clear that the status quo is not an option.

Prior to joining the LHIN, I spent 25 years working in northern communities, delivering community economic development programs as the ADM for the provincial government and as the director general for the federal economic development agency.

I believe that the North East LHIN is key to helping fellow northerners develop a solution to ultimately answer the question, "How do you provide quality care to 565,000 people in a geography bigger than Germany, so that northerners can remain as independent as they want and receive as much care as they need?" Because, to put it bluntly, we don't want decisions about the delivery of our health care made by people who don't live here. As a LHIN, we listen and respond to people like Granny Wabano, Rina Clark and Arvind Jagessar.

Meegwetch. Thank you. Merci.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. We have slightly exceeded the 15 minutes, so all of your time is consumed. Thank you very much for being here.

**Ms. Louise Paquette:** Thank you.

## NORTH EAST COMMUNITY CARE ACCESS CENTRE

**The Chair (Mr. Ernie Hardeman):** Next is the North East Community Care Access Centre: Richard C. Joly, chief executive officer, and Ann Matte, senior director of quality and information services. Welcome.

Thank you very much for coming in this morning and sharing your time. As with the other delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. At the end of the presentation, if there's sufficient time, we will have questions from the caucuses.

With that, the next 15 minutes are yours.

**0940**

**Mr. Richard Joly:** Thank you very much, Mr. Chair. Good morning to committee members. Bonjour, tout le monde.

Welcome to the heart of the province. My name is Richard Joly. I'm the CEO of the North East Community Care Access Centre. With me today is my colleague Ann Matte, senior director of quality and information services. Both Ann and I are registered nurses by profession, and we have worked in the health care field for a combined 50-plus years. We also bring a unique perspective this morning because at one point in our careers, we have each held senior positions with the North East LHIN.

From what we've seen this morning, we know that committee members have a busy agenda and are hearing from a number of presenters today, so let's begin.

First, I'm happy to report that the North East CCAC has a very solid relationship with the local LHIN. We support their system planning role. This includes bringing partners across the system to the table and engaging with patients and communities. This collaborative role is a critical component of any high-functioning health care system.

On balance, we believe that the Local Health System Integration Act works well and sets out a strong framework for local health system planning, funding and accountability. Our comments and suggestions this morning are intended to strengthen the current framework.

I'd like to take a few moments to clarify our respective roles within the health care system and then highlight a few examples of how we have worked together to improve health care services across the northeast.

Our mutual goal, of course, is to achieve a fully integrated, patient-centred health care system where the right care is offered in the right place at the right time and, of course, at the right cost. Although we share the same boundaries, the North East LHIN and the North East CCAC have very distinct roles within our health care system. Simply put, the LHIN is responsible for planning and funding the delivery of regional health services, monitoring health system performance and holding health service providers like the CCAC accountable for the quality and value of the care we provide.

As one of the largest health service providers in the North East, our CCAC plays a vital, critical role within the health care system as a whole. We are the coordinator of care for patients transitioning from hospital to home or from home to an alternate venue of care like assisted living, a retirement home or a long-term-care home. We provide in-home nursing, rehabilitative care and personal

support services to individuals who wish to live and age safely in their homes or recover after a stay in hospital. We also work with medically fragile children and individuals at end of life. Care coordination is our core service. It is not administration. It is patient care, and it is essential to any well-functioning system.

Ann will now share one of our patient's stories with you.

**Ms. Ann Matte:** Conrad was a fiercely independent, hard-working miner, self-employed construction worker and former service station owner, but then a series of medical setbacks set his life on a different course. In 1998, Conrad suffered a broken hip in an accident, and it was during his recovery that his multiple sclerosis was diagnosed. By the time he was 58, he found himself needing full-time care, with his mobility limited to a wheelchair.

Fortunately for Conrad, his wife of 46 years and his three adult children have been by his side every step along his health journey. But there are many heroes in this home, who came together to help Conrad maintain his independence and enjoy a happy and productive life.

First, a CCAC care coordinator worked with the family to develop a comprehensive care plan. Conrad currently receives therapy, assistance with activities of daily living and a monthly nursing visit. His personal support workers help him with his personal care and the daily exercises prescribed by his therapist. They are also able to monitor Conrad's MS and alert the nurse if they notice any new symptoms.

The care coordinator also provided the family with information about available community support services, and the couple now receives financial aid from the MS Society to help with many of the equipment costs associated with Conrad's illnesses.

Imagine one family trying to research, access and coordinate this level of care for a loved one, especially during a stressful time. As Conrad's wife herself writes, "Without CCAC services, I wouldn't be able to take care of my husband at home. It would be too much for me mentally, emotionally, and especially physically, even with the lifts."

CCAC care coordinators are often referred to as silo busters as they work with all health care partners—hospitals, primary care providers, long-term-care homes, community health centres and clinics, family health teams, hospices and more—to provide patients with seamless transitions from one health care destination to another, and to develop and coordinate care plans to meet individual needs. And we do it within a geography that covers 415,000 square kilometres, or approximately 42% of the province.

On any given day, we help over 16,000 individuals and families across our vast region, serving roughly 34,000 people each year. Each month, we help over 1,000 people come home from hospital with specialized services and support 200 seniors transition to long-term care, as you heard from Louise earlier. Our care coordinators work with all 25 hospitals and emergency departments in the North East. In Sudbury alone, we have 25 staff working on-site at Health Sciences North every day, 365 days a year. We work with more than 550 family physicians in the North East. We work with every school, every community agency and every long-term-care home.

As you can imagine, there are many unique challenges related to health care provision in northeastern Ontario. Residents often drive long distances to visit loved ones in hospitals or long-term-care homes, and home care workers themselves often drive long distances to provide services to patients. Specialized professional services are difficult to coordinate in rural areas, and wait times reflect these issues in both the acute and community settings. Yet, within this environment lies unique opportunity through technology and innovation, through leadership and integration, through the three big Cs: collaboration, coordination and communication.

Richard, would you like to continue?

**Mr. Richard Joly:** Thanks, Ann. The following are examples of current collaboration activities that have occurred in the North East, with the leadership and support of the North East LHIN. These activities have demonstrated and will continue to demonstrate efficiencies and improvements to the health care journey of people living in our region.

Just a few years ago, there were hundreds of patients in the wrong place: too many people in hospital beds, who no longer required acute care; and too many people in long-term-care homes, who could be better served with community supports like home care, adult day programs and assisted living.

Over the past several years, the North East LHIN has partnered with the North East CCAC and other health service providers to implement many system-level changes, including the very successful Home First philosophy; integrated discharge planning within our hospitals; new nursing programs in the community, like rapid response nursing; Telehomecare; and the province-wide physiotherapy reform.

With these changes, many service improvements have been realized, such as—you heard this morning—a decrease in the number of alternate-level-of-care patients in hospital, from 41% to 22%; increased complexity of patients to long-term-care homes, from 72% to 84%; a decrease in length of stay in long-term-care homes, from 3.5 years to three years; and a significant decrease in our placement wait-list.

As we discussed earlier, the North East CCAC's vast land mass can be a challenge to health care delivery, but it has also served as the perfect incubator for developing successful technological tools to bring health care to the patient.

Working collaboratively with its health service providers, the North East LHIN has developed a comprehensive technology strategic plan which has enabled and promoted innovation within our health care system.

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Here are just a few projects supported by the LHIN's strategic plan and led by our CCAC:

Last fiscal year, the LHIN provided funding to support a pilot e-notification project in Sudbury. The technology allowed the CCAC care coordinator working on-site at Health Sciences North to be notified electronically as soon as a CCAC patient presented themselves in the emergency department. The care coordinator would then meet with the patient and the family, before being admitted, to determine if the patient could return home with enhanced services. Due to the success of the pilot, which wrapped up just last month, eHealth Ontario has agreed to fund the expansion to 37 hospitals, through the North East and North West LHINs. Led by the North East CCAC, this work is scheduled to be complete by March 2015.

Another successful project is the Community Health Portal. The North East CCAC was the first to roll out the Community Health Portal—a secure website that allows health professionals outside of the CCAC to access a summary of patient information—to primary care providers. What began as a LHIN-funded pilot project with only three hospitals and three family health teams, the rollout will now expand to 74 health service providers, in coordination with both the North East and North West LHINs.

In conclusion, let me restate the obvious. Our population is aging. Our health care system is in the midst of a significant transformation to prepare for the future needs of our patients and our communities. We believe that LHINs and LHSIA provide the right foundation to support this transformation. Ultimately, regardless of structure, a common vision focused on the people we serve and a strong collaborative relationship are the key ingredients in making the health care system work.

The vast majority of people have good experiences with the care that they receive, but we know that the system doesn't work well for everyone and we can always do better. For example, there are hundreds of health service providers across the North East, each with their own administrative structures. Through back office integration and other shared service opportunities, efficiencies could be found and reinvested in patient care. LHIN and service providers should continue to explore opportunities for administrative efficiencies between service providers.

We also feel the delivery of health care in Ontario could be improved by a renewed focus on strategic regional health system capacity planning. Sections 15 and 16 of LHSIA require LHINs to engage their local communities and develop an Integrated Health Service Plan that sets out the vision, priorities and strategic direction for the local health system and strategies to integrate. We only need to look back at the significant disruption caused by the recent strike by personal support workers in the province to realize that planning for current and future human resource needs must be part of the capacity plan.

Here in the North East, we are walking the walk. Given the system-level changes that have been introduced to meet the care needs of the aging population and to maintain the gains made in our ALC rates across the region, we are working with the North East LHIN to initiate a third-party collaborative capacity analysis of our adult home care services. The goal of the analysis is to develop a multi-year plan to meet the home care needs of our population in the North East, while ensuring long-term financial sustainability.

Finally, I'd like to thank you for the opportunity of adding our voice to this important dialogue. The North East CCAC is proud of our role to deliver preventive, healing and palliative care in-home and in-community for the residents of our region. We will continue to recognize and support the North East LHIN's mandate in planning, funding and fostering collaboration between all our partners, to continuously improve our health care system. Thank you. Merci.

**The Chair (Mr. Ernie Hardeman):** Thank you both very much for your presentation—very informative—and we thank you for taking the time to present it. The time has been consumed, so with that, thank you again.

## CANADIAN MENTAL HEALTH ASSOCIATION-SUDBURY/MANITOULIN

**The Chair (Mr. Ernie Hardeman):** We'll get on to our next presenter. The next presenter is the Canadian Mental Health Association-Sudbury/Manitoulin branch: Marion Quigley, chief executive officer. Thank you very much for being here this morning. We thank you for the time you took to come here. We have 15 minutes for each presenter. You can use any or all of that time for your presentation. If there's time left, we'll have questions from caucus.

With that, the next 15 minutes are yours.

**Ms. Marion Quigley:** Thank you, and good morning, everyone. I won't go into details about the Canadian Mental Health Association; I've provided you a package of information.

I am Marion Quigley. I'm the CEO of the local branch here.

Warren Bennis, one of our time's greatest authorities on leadership, is quoted as saying: "Leadership is the capacity to translate vision into reality."

At least one in three residents in northeastern Ontario experiences a mental health issue in their lifetime. Based on nationwide estimates in 2012 population figures, the annual economic cost of mental illness in the northeast is $730 million.

In 2007, when the North East Local Health Integration Network began to lead the transformation of our deeply divided health care system, some of us working at the front line were doubtful and had many concerns. Would this transformation be focused on finances, or would quality and accountability be addressed to help our governance teams and staff in ways that mattered to real people? I can only speak for the Canadian Mental Health

Association's Sudbury/Manitoulin branch when I say that, though there remain many areas desperately needing change, the benefits of leadership being provided by the North East LHIN are making a significant difference in the lives of the clients we serve.

One of the many examples I could give, which directly relates to the increasing collaboration our branch is involved in, with the support or leadership from the North East LHIN, is the Moonlight residence story. In a relatively short period of time, as vision to reality goes in the world of project management, we were able to partner with the North Bay Regional Health Centre, the Northern Initiative for Social Action and Health Sciences North to open an eight-bed recovery home. The home provides sustainable, permanent housing to individuals previously living in hospital. This is not just a bricks-and-mortar story. It's a story of lives transformed. Without this collaboration, these eight people may have still been living in a hospital bed today.

There is much which remains to be addressed, however, in the transformation of our health care system. For the clients we see on a day-to-day basis, the remaining challenges can frequently be traced back to our still-in-silos system and the cumbersome processes many clients experience in order to access service. We still see individuals in the Sudbury-Manitoulin area who are struggling, often desperately, or completely unable to access services they require. This reality ranges from clients without access to counselling, to service gaps in affordable housing, to suicide prevention, and multiple other gaps in service. We in the sector must learn and be supported to combine our resources so that in that moment, for that individual considering that choice, hope wins over despair and we are there to prevent the results of a tragic and irreversible decision.

There are many areas where the momentum being built for a better system in the northeast needs to be supported. You will find those we feel need to be highlighted for the northeast in the handout we've prepared. To mention a few, they include the changes we need and would support, such as more investment in affordable housing; multi-year funding; increased investments to the community mental health and addictions sector; and increased authority for the North East LHIN in areas such as housing, public health and primary care.

As well, when mental health and addiction funding is given to a community agency to provide supports in the community sector, clients benefit. However, we must not forget that the community agency also needs to see increases in their infrastructure so the organizations can sustain services such as reception, secretarial, heat, hydro, rent, and remain viable organizations.

System planning and leadership, such as that being provided by the North East LHIN, is exactly what our clients need to continue the work which has begun. The CMHA Sudbury/Manitoulin has been, and is, working collaboratively with the North East LHIN and our community mental health and addiction partners on many initiatives.

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One key element we see contributing to the success of these collaborations is the accountability and quality piece. Since the LHINs began planning and funding, any new financing is attached to the requirement to show results. By collaborating, we have been able to meet our commitments in getting results with new funding.

One example is our successful partnership on the crisis program in downtown Sudbury that Louise mentioned. The program benefits from a mobile crisis component and a client navigator situated in the emergency room waiting area of the hospital. We heard from our clients, understood their needs, and partnered with Health Sciences North and the Greater Sudbury Police at the front lines. We are getting excellent results with better, more efficient access to urgent care for our clients living through serious mental health challenges.

With any newly proposed initiative, organizations are now challenged with the requirement to answer questions such as: "Is this the best place for the funding?" If this cannot be shown, then the North East LHIN explores how we can make sure that individuals needing services will get them. More often now, the result is that new funding is going to the community sector, to the street, to homes, where people actually live day to day. We are helping individuals navigate through the health, housing and justice systems, among others, and obtain services that meet their needs close to home whenever possible.

We are seeing increased equity in the focus for health care across our region. The emphasis is not just on urban areas. We're seeing it in our rural areas—Manitoulin and Espanola, in particular, where we only have one CMHA staff member in each community. They work in collaboration with staff from other organizations, collaborating together. The client, being seen for mental health and addiction services, doesn't even realize who the staff member helping him or her actually works for. It's truly a team with a client-centred approach. All the client cares about is getting help. The client doesn't care about the name of the organization or who's funding it.

Seventy-five per cent of mental health care happens outside the formal health system. The 2012 Commission on the Reform of Ontario's Public Services, the Drummond report, supports higher levels of funding for mental health and addictions to address what it terms as a "historic gap." The government of Ontario has highlighted the importance of enhancing mental health and addictions in the action plan for health care and the 10-year mental health and addictions strategy.

CMHA Ontario is calling for a further increase of 4% in the sector to address client needs.

Expert planning and leadership for collaboration is needed to effectively manage funding and ensure better outcomes for our clients.

The Ministry of Health and Long-Term Care cannot address the needs of northeastern Ontario persons with lived experience, as a stand-alone agency. The arrival of the LHINs heralds a more client-centred, needs-based approach. The North East LHIN's vision is "Quality

health care, when you need it." It is the CHMA Sudbury/Manitoulin's mission to continually improve community-based mental health supports to facilitate the well-being of all people. We know that the synergies of our two organizations are bearing fruit.

The North East LHIN is hearing the voices of our clients and providing the leadership required to further transform the Sudbury-Manitoulin area's health care system. There is much left to do. The benefits of the leadership being provided by the North East LHIN are making a significant difference in the lives of the clients we serve.

On behalf of our clients and the board, the staff of the CMHA Sudbury/Manitoulin looks forward to a continued partnership with the North East LHIN in this historic transformation.

"Leadership is the capacity to translate vision into reality." Thank you.

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

We have two minutes for each caucus, starting with the official opposition. Ms. Elliott?

**Mrs. Christine Elliott:** Thank you very much, Ms. Quigley, for your presentation and for the great work that you do in our communities. I certainly agree with you that there is still much work to be done to have mental health being recognized as being equally as important as physical health, but we're making some progress.

You mentioned that there was still a lot of work to be done, that you are working collaboratively with the LHINs. Can you tell us what you'd like to see as a next step in that process?

**Ms. Marion Quigley:** I think for us as an organization, personally, it's to give the LHIN the authority to manage the housing portfolio, from the Ministry of Health and Long-Term Care. Sometimes it's difficult to work with two organizations, because they take care of the bricks and mortar, and the LHIN takes care of the people and the health care portion.

**Mrs. Christine Elliott:** So it's more of the integration of the housing and social services piece into the work that the LHIN does. We have heard that from other deputants in other locations.

**Ms. Marion Quigley:** I'm sure. It is difficult to manage.

**Mrs. Christine Elliott:** Yes. Thank you.

**The Chair (Mr. Ernie Hardeman):** Ms. Gélinas?

**M^me^ France Gélinas:** Thank you for coming. If you think province-wide, there are areas of the province where, historically, mental health services have been better funded. I will give you the example of Ottawa and eastern Ontario. If you look at the money that goes into that area for mental health, it is way higher than what we get in the north.

How do we reconcile the fact that we're now planning solely for the northeast? The northeast has been historically underfunded for mental health, but yet we're now stuck planning within this. How do you reconcile this in the wonderful step forward that you want to take?

**Ms. Marion Quigley:** I think you have to show what the evidence is to have the new programs and the funding in the northeast. It's just working on developing a mental health and addictions strategy in our community and working with the regional addictions mental health committee that the LHIN has set up to look at: Where are the gaps in service?

I think one of the things that we've really benefited from is that the LHIN has brought forward other examples of programs and services that are happening in other parts of the province. We've done the same. An example is the crisis program. So I think it's just continuing to move forward and look at: Where are the gaps and where is the funding that's needed?

**M^me^ France Gélinas:** Would you say that because we have a LHIN, because we now are collecting data and planning for filling up those gaps, we are in a better position to advocate for a better balance between the different regions of the province?

**Ms. Marion Quigley:** Definitely. I think that we look at population base, but we also look at need. The biggest thing that I see is that they are listening to what people who have lived experience need and want in their communities.

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

**Ms. Helena Jaczek:** Thank you so much for coming. I'm very interested in your Crisis System Navigator pilot project that you've outlined in your annual report. How is the LHIN involved in that, or were they involved?

**Ms. Marion Quigley:** The LHIN brought organizations together in the beginning and said, "The crisis program is not working. You need to fix it." So they gave the problem back to us, as community providers. We brought together all of the players. The police, as Louise mentioned, were a great partner because they were the ones who were really frustrated with the wait times.

We looked at where the needs were. We developed a community crisis steering committee that was made up of individuals with lived experience, family members, partners within the addictions mental health system, the police and the hospital. From there, we came up with a plan.

One of the strategies was the pilot project to see—moving a program out of a hospital and moving it into the community, as you might all know, has significant challenges. First of all, when you're sick, you go to the hospital. That's the same with mental health. So we needed to redirect people back to the community supports where they are.

The navigator was there to give people choice. People can still go to the emergency department for crisis services, but now they have a choice. And most people are making the choice to go downtown to the crisis program, and the navigator is helping with that. And so—

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

**Ms. Marion Quigley:** I gave you a booklet in your package with all the outcomes.

**The Chair (Mr. Ernie Hardeman):** Right on the second. Thank you very much for making your presentation. We very much appreciate it.

**Ms. Marion Quigley:** Thank you.

## CHIEFS OF ONTARIO

**The Chair (Mr. Ernie Hardeman):** Our next deputation is the Chiefs of Ontario: Patrick Madahbee. He's grand chief of the Union of Ontario Indians. Thank you very much, Chief, for being here this morning. I guess it is still morning. Thank you very much for being here and taking your time to come and present to us.

You will have 15 minutes to make your presentation. You can use any or all of that for your presentation. If there's any time left, we will have questions from caucuses, hopefully fairly distributed, even though sometimes we hear someone question my timekeeper next to me.

With that, thank you very much, and your 15 minutes starts right now.

**1010**

**Grand Council Chief Patrick Madahbee:** Good morning, Chair and honourable members of the Standing Committee on Social Policy. My name is Patrick Madahbee. I'm the Grand Council Chief of the Anishinabek Nation. I also hold the health portfolio with the Chiefs of Ontario, and it's in that capacity, as the portfolio lead, that I'm here today to present to you.

To provide some context to my remarks today, I will first provide you with some brief background on the Chiefs of Ontario organization. The Chiefs of Ontario is the coordinating body for 133 First Nation communities located within the boundaries of the province of Ontario. Its primary purpose is to enable First Nations political leadership to discuss regional, provincial and national priorities affecting First Nations people in Ontario and to provide a unified voice on these matters. Within this system, the chiefs and assembly have mandated the Ontario Chiefs' Committee on Health to monitor and oversee issues affecting First Nations in Ontario with respect to health policy, planning and delivery.

However, in all cases, the ultimate rights-holders are the First Nation governments and citizens, as the treaty signatories. An example of this is the treaty approaches to health that Grand Council Treaty 3 and Nishnawbe-Aski are pursuing with the federal and provincial governments, which have resulted in direct meetings with the minister.

This presentation represents the First Nations in Ontario regional response as part of the review of the Local Health System Integration Act and is without prejudice to the submissions which may be provided by individual First Nations or First Nations provincial and territorial organizations in relation to the review of the Local Health System Integration Act.

I first want to discuss the general First Nation position towards the Local Health System Integration Act. When this act was first introduced, the First Nations in Ontario immediately expressed concern that it was developed unilaterally and without meaningful involvement of the First Nations. The bottom line is, we were not consulted on this legislation. Unfortunately, the way the act was developed and the lack of consultation with First Nations immediately put First Nations and the provincial government on the wrong path.

The 133 First Nations in Ontario are part of the Anishinabek, Mushkegowuk, Onkwehonwe and Lenape nations. Ontario was created through the formalization of treaties between indigenous and crown governments. These treaties and the trust-like relationship that evolved have created a unique relationship between indigenous nations and governments. As a result, the First Nations of this land are not simply another stakeholder or special interest group. We have unique collective rights that were recognized and affirmed in section 35 of the Canadian Constitution of 1982. By unilaterally developing and imposing the LHSIA on the First Nations in Ontario, the provincial government has failed to meet its legal duty to consult First Nations. The duty to consult has been reaffirmed in numerous Supreme Court of Canada decisions, yet successive governments continue to neglect what is a clear legal obligation.

The preamble in the LHSIA states:

"The people of Ontario and their government … recognize the role of First Nations and aboriginal peoples in the planning and delivery of health services in their communities."

This is a nice-sounding statement; however, it is meaningless, as we have no real role in health planning for our communities under the LHSIA and the local health integration network structure. The First Nations in Ontario did try to improve the LHSIA once it was introduced, through submissions in response to a request for feedback on proposed draft regulations, specifically draft regulations pertaining to subsections 14(2) and 16(4) of the LHSIA. The recommendations that the First Nations proposed with regard to these draft regulations were not responded to. In fact, these regulations have never been enacted to date.

We've tried to work with what we believe to be flawed legislation. The LHSIA does not recognize the jurisdiction and status of First Nation governments, and the current structure of the local health integration network system provides no accountability back to First Nation governments. As things stand, the province appoints representatives to the LHIN's board. It's our protocol at First Nation governments to determine how they want to be represented and who will represent them. We believe in accountability to our citizens. The current structure established by the LHSIA does not provide this, and we have found that this conversation is a one-way street only. We get directives and instructions on how things will work and what has been decided. This is unacceptable and all too often does not align with the challenges and needs in our communities.

Sure, there may be a few pockets where our LHIN's board and the local First Nations communities have good

working relationships. There are good people working in the system. We have an example down in the Curve Lake area, where things seem to be working quite well because the First Nations are being listened to very well there. But even in situations where a good working relationship exists, there remains the problem of a one-way conversation and the lack of a real role for First Nations in health planning for their citizens.

It's not enough for the LHSIA to state that our role is recognized. This means nothing if it's just an empty statement. Section 16 of the LHSIA mandates every LHIN to engage the aboriginal and First Nations health planning entity in their geographic region; then it leaves it up to the LHIN to determine and define the entity. The 2011 draft regulation that attempted to define such an entity purported to create aboriginal/First Nation health planning entities through committees appointed by each LHIN and whose members were deemed to represent the diversity of aboriginal and First Nations peoples and communities in the geographic area of the network.

From a First Nations perspective, this proposed regulation has many flaws, including that the province, through the LHINs, would create committtees and unilaterally determine who it felt was representative of the aboriginal/First Nations people and communities. It's our view that such committees would have no accountability to First Nation governments and would simply be a construct of the LHIN created to comply with the requirement to engage the First Nations/aboriginal population.

A draft regulation was also proposed to implement the section of the act that mandates the creation of an aboriginal and First Nations health council. From the outset, First Nations have made it clear that a First Nations-specific council or table is required to meet with the minister to share information and develop health plans that will prove effective for our communities and our population. We do not need to reinvent the wheel here. First Nations already have mechanisms and structures in place that can easily function as a First Nations health council.

The First Nations in Ontario insist on a "First Nations"-specific council. We are not aboriginal; we are First Nations, the indigenous peoples of this land. "Aboriginal" is a catch-all term used by governments in reference to First Nation, Métis and Inuit.

I just want to comment here. I was directly involved in the Constitution patriation in 1982. At that time, the term "aboriginal" was used because they were looking for—we said things at that time: "How are we going to phrase ourselves in this Constitution? We're not native—that's a generic term." We even found the term "aboriginal" offensive because we're original, we're not aboriginal. That's like saying "normal" and "abnormal." An elderly lady from Saskatchewan said that the preamble of the Canadian Constitution says that the First Nations in Canada were the English and French. She said, "Don't these people know that we were the first nations in this land?" That's why you started seeing people start to use the terminology of "First Nations."

We are Anishinabek, Mushkegowuk, Onkwehonwe and Lenape. We have a distinct name for our people. This generic term is insulting. There are three distinct groups with diverse and unique needs, priorities and legal status. Continually lumping us together is wrong and ineffective.

Chair and members of this committee, the bottom line here is that the LHSIA is flawed legislation. The provincial government failed to meet their legal duty to consult with indigenous nations in this province before introducing this legislation, and then they passed it anyway, despite our objections and repeated requests to meet and discuss how things could be done more effectively in a manner that respects our aboriginal treaty rights. As I pointed out earlier, specific regulations were developed that were never enacted in respect of First Nations and the aboriginal people in Ontario. We believe that there is some recognition in governments that there are sections of the act that must be amended in order for them to work and be more acceptable to the people they will impact.

Again, the bottom line is that the LHSIA does not provide the LHINs with the necessary measures and structures to make good decisions about First Nations health. There are ad hoc arrangements that have been established between a few LHINs and the neighbouring First Nations that hold promise and can possibly be used as models to implement in other areas of the province. I suggest that First Nations and the Ministry of Health and Long-Term Care meet to identify potential good practices that exist and to consider using them more broadly. The fact of the matter is that the majority of First Nations have no real voice in the health planning within their LHINs, and this needs to change.

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The First Nations in Ontario believe that this review of the LHSIA provides a good opportunity for the provincial government to engage in a dialogue with us about what needs to be changed and what measures will result in improved health services and health outcomes for our people. Continuing to impose unilaterally developed strategies on First Nations will not work. One only has to look at the federal government's track record with First Nations, which shows that what they think is best for us hasn't worked. So the province should not be copying that failure. First Nations must be full partners in health planning and decision-making in order to achieve the positive outcomes that all parties are seeking.

Mr. Chair and members of the committee, thank you for the opportunity to present to you today. The Chiefs of Ontario has also provided a written submission on these matters, and I encourage you to review it and give it serious consideration. Meegwetch and thank you.

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

We have just under four minutes, so the questions will come from the third party. Mr. Mantha.

**Mr. Michael Mantha:** One of the questions that I have is in regard to what I've been hearing when I'm going into many of the First Nation communities: that it's hard for them to build their capacity; it's hard for them to retain their capacity; it's hard for them to provide the services that they absolutely need within their community. From your point of view, what are the most challenging reasons why that is happening?

**Grand Council Chief Patrick Madahbee:** There are two things, in my opinion. First of all, not having the control: When you're totally being dictated to on how things should operate and you don't have a say in what goes on, it causes problems. Then, there's the issue of resourcing. We're always asked to do a thousand-dollar job with about $200.

I'm going to ask Tony and Bernadette to chime in here if they want to add anything. They work more on the front line of this issue than I do.

**Mr. Tony Jocko:** One fundamental problem that exists is that unless you have a contribution or financial relationship with the LHINs, you cannot access funding. Many of our First Nation communities do not have that arrangement in place.

The very population statistics that have been utilized by the LHINs, despite our assertions to the opposite, come from census Canada. Many of our people do not partake in the census. We have lobbied and informed the local LHINs that they should be using the INAC, or the new misnomer, for the Indian registration population. The federal government has those accurate statistics for all our First Nations, but the LHINs continue to utilize the flawed, inappropriate population stats. When it comes to funding formularies, they determine that First Nations in each LHIN comprise a certain percentage of the population. Sadly, that's often the way the funding is flowed to different interest groups, in terms of population.

Any time you have legislation where the minister has the right to amalgamate or disband and also controls the purse strings, you have a serious compromise in terms of local. Local becomes an oxymoron. It's not truly locally controlled—and we all know that that would be the best scenario. Moving the solution of any problem further away from our people has never served us well.

The political insistence—and we were encouraged by that—that there would be an advisory committee to the minister fell off the rails. It has never transpired.

These types of challenges continue to plague our people every day. When we try to have a relationship with the LHINs, the failure to consult and develop a real relationship—if we had a buffalo nickel for every time we were asked by a provincial body, "How do we engage First Nations?" They fail miserably at that. They don't know how to engage. Given the MOH's funding cycle, the decisions are often made internally without any true consultation, and then it's rolled out and we're told, "This is what we're going to do for you," or there's no money left.

There are some fundamental flaws in the whole process, and this is what really has us on the outside looking in.

We've heard for years that an Ontarian is an Ontarian is an Ontarian. It seems to be that way except when it comes to Ontario's First Nations.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation this morning. We very much appreciate your coming in and speaking to us.

That does conclude the time for your presentation.

**Mr. Tony Jocko:** Thank you.

## CAPREOL LONG-TERM AND SUPPORTIVE HOUSING

**The Chair (Mr. Ernie Hardeman):** Our next presentation is the Capreol Long-Term and Supportive Housing: Tullio Ricci.

**Ms. Tina Junkala:** Good morning.

**The Chair (Mr. Ernie Hardeman):** —and Tina Junkala.

**Ms. Tina Junkala:** Thanks.

**The Chair (Mr. Ernie Hardeman):** The fundraising chair, and Mr. President, sir. Thank you very much for coming in. You have, as all the presenters have, 15 minutes to use as you see fit. You can use any or all of that time. If there's any time left over, 10 to 15 minutes, we'll have questions from caucuses.

Thank you very much for being here, and we look forward to your presentation.

**Ms. Tina Junkala:** Thank you very much for having us here. We really look forward to the opportunity to share our project with you. It's an exciting one.

I just want to take a minute to introduce our president. Tullio Ricci is a pillar in our community, in Capreol, a true visionary and a true going concern. He has really done some amazing things for us out in Capreol.

Tullio served as city councillor for the town of Capreol for 17 years, and while in politics, he consistently sought for the development of housing services in the Capreol community.

Tullio was the driving force behind the development of Capreol Non-Profit Housing phase 1 and Capreol Non-Profit Housing phase 2, which consist of 40 units for seniors, with rent-geared-to-income and affordable housing. Tullio continues to work closely with the management of these two complexes to ensure the ongoing sustained viability, and he is the president of both those boards as well.

Tullio has resided in Capreol for 58 years and, for 40 years, was employed by the Canadian National Railway in various management capacities.

For 10 years, Tullio was chief of the fire prevention bureau, president of the Sudbury mutual aid firefighters' association, and also deputy fire chief. For 12 years, Tullio served our community as fire chief and coordinator of the first-response team. Tullio was involved in the rewriting of the Ontario fire code and the Ontario building code, which is still in effect today.

Tullio has been retired for the past 20 years from the railway but is still very much involved in our community.

Tullio served with the Lions Club, Knights of Columbus, Red Cross, Heart and Stroke Foundation, Canadian Cancer Foundation and many others.

It is with great pride I present to you Tullio Ricci.

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

**Mr. Tullio Ricci:** Thank you very much, Mr. Chairman.

**The Chair (Mr. Ernie Hardeman):** It will start itself.

**Mr. Tullio Ricci:** Oh, that is off? Okay, thank you very much. You'll have to put up with me, because these are new glasses and I forgot the reading glasses at home. You know me, France.

**M^me^ France Gélinas:** Yes, I do.

**Mr. Tullio Ricci:** I don't know where these come from, but I'm trying to read it to you.

As Tina said, I've been involved with the community, but that's only part of it. There's a lot more than that on the labour front. I was also with the CLC.

LHINs: an opportunity for supportive housing and social housing.

The local health integration networks have a history of working with supportive housing. The recognition that many tenants not living in supportive housing need support to maintain their housing has led some LHIN agencies to begin new partnerships with other housing providers.

Since their creation in 2006, Ontario's 14 local health integration networks have assumed the Ministry of Health and Long-Term Care's role in funding community-based support services.

In addition to their role in the supportive housing sector, some LHINs have begun to fund support services for tenants living in non-supportive for-profit housing. This is a new and promising frontier.

Generally, LHINs remain tentative about getting involved in non-supportive housing, which falls outside the narrow definition of health policy.

**1030**

Non-profit housing providers are increasingly concerned about the number of tenants with unmet support needs. The results of the absence of support have frequently reached the front page, from fires to hoarding to poor housekeeping to terrible outcomes for vulnerable seniors unable to live alone in the absence of assistance.

At present, there are many cases of seniors' housing providers, such as Capreol, served by multiple community care access centre case managers—responsible for referrals to support services—and various community agencies, that continue to have unsupported tenants with unidentified needs. This is because access to support services is largely driven by referral instead of outreach. This model clearly does not work for seniors who lack sufficient social supports to make the connections happen.

LHINs should be partners with assisted housing corporations and encourage new development to address health challenges in a comprehensive way. Instead of waiting for individuals to arrive in a hospital for costly emergency procedures, the LHIN has the opportunity to deliver preventive services efficiently to our disabled population, who require support.

On the northeast side of our city, the need for supportive housing is very high on the radar, especially with seniors facing daily challenges with mental health and addiction issues that are undetected. It ultimately places a substantial burden on the health system. Mental health professionals are expecting that mental health will double in the next decade.

We, as housing providers, look forward to working with the LHIN to address many challenges to our people in need in their daily chores, and there are many. I understand that the LHIN has started to fund outreach-based services directly, to reach seniors in non-profit housing—for example, Ottawa Community Housing.

As the president of the Capreol non-profit housing corporation, representing seniors on RGI and affordable housing, I strongly recommend the committee to encourage the LHIN to expand their role and increase funding required for this agency to continue the work they are doing with the seniors population.

As president of Capreol Long-Term and Supportive Housing, which I have created in the hopes of bringing forward these facilities in our community, for the people in the northeast of the city of Greater Sudbury, which has a population of 34,222—this population covers Capreol, Ironside, Wahnapitae First Nation, Skead, Garson, Hanmer, Val Thérèse and Post Creek.

The board consists of volunteers, who are professionals in their fields, such as doctors, pharmacists, registered nurses, business owners, financial managers, advisers and domestic engineers. We are, as a board, well aware of what the LHIN is doing in the region. Therefore, we are pleased with the work and results accomplished by the local health integration network. This agency is very essential to this region.

We are also aware of the many negative complaints toward this agency by some members of the public in general. Of the complaints that have been filed, none have been proven to have neglected any health policy sent out by the minister's office.

We must also focus on human error. We are human, and as a species of humanity, we make mistakes. Therefore, as we move ahead, we learn from these mistakes and find the proper solution, to improve with other agencies providing health care for our seniors.

The LHIN is an integral part of northern Ontario. People in the north are able to connect one-on-one and discuss many problems that arise on a daily basis, either personally or with community development. This makes this agency more connected to the needs of the population. I must stress to the committee the LHIN is doing all of that and more.

Personally, I have nothing but praise for this agency. I have had the privilege to work with the Sudbury-Manitoulin health council, with Ms. Paquette, and during

that time, we also developed a document called The Next 10 Years. This document became an important, valuable document when the commission was created by Mr. Harris's government and led by Mr. George Lund, commissioner, to amalgamate the three hospitals into one.

The document called for an increase in hospital beds, but only 328 were built. Therefore, much of the problem does not lay with the LHIN, but rather with the government—the blue book revolution leader, Mr. Harris. As well, the Ministry of Health's staff estimated the cost of amalgamation to be a substantial amount of money and not what was presented to the public.

The LHIN has also been accused of not responding to the public in a timely fashion to the public's complaints. Maybe this is a lack of staff in the office, or maybe a lack of funding to operate this agency. Whatever it is, we must find the funding to make this agency operational.

There is $110 million at the Northern Ontario Heritage Fund under the Ministry of Northern Development and Mines' file. Perhaps some of this money should be shared with the LHIN for community development so that citizens with physical disabilities not ready to be institutionalized in the long term could be housed in supportive housing complexes at much less cost to the health budget.

Many MPPs from the opposition are demanding to scrap this agency. Maybe they are not aware what kind of work this agency is doing, especially trying to please everyone in the large geographical area of the north, in some cases with no roads for transportation for many isolated pockets of villages in the region. As the president of Capreol Non-Profit Housing Corp., representing over 100 seniors with multiple physical disabilities, unable to function properly, I would hate to see the LHIN move out of our region.

I have been involved with seniors and health providers in the community for the past 33 years. I was the one who organized the first-response team as an instructor with St. John Ambulance first aid. I had the opportunity to instruct my volunteer firefighters on a weekly basis. Also, we were the first community in Greater Sudbury to purchase a defibrillator at the cost of $6,529.43. We, as volunteers, raised that money to purchase that equipment for the community. The Royal Canadian Legion Ontario Provincial Command also purchased one for us with a cardiovascular tape reading for the doctor on duty at ER.

As a fire chief and coordinator of first response, I worked very closely with the community services agency in reducing the response time for land ambulance from one hour and 45 minutes to 19 minutes and brought air ambulance service to our community, which is still in order today.

As we move forward, we'd like to see that the LHIN remain in the north to look after the vast area that they are covering and bring health care closer to the people who need it in our remote towns and villages.

At the present time, our board is working with the LHIN to erect 44 units of supportive housing projects to accommodate our frail, disabled seniors who are not ready to be admitted to long-term care but need assistance. Our seniors need three nutritious meals a day on a daily basis to keep them out of the hospital and out of the expensive institutions. We need the LHIN in the north to work with us and bring health care costs down.

**1040**

We are aware that the cost in a hospital is about $750 daily. We are also aware that private long-term-care institutions range from $350 to $500 daily. Non-profit organizations are able to give the same care to seniors at much cheaper costs to the system and the seniors are able to stay at home in their communities where they raised their families.

I personally have been involved with the LHIN and CCAC for many years. At no time have these organizations turned me down. They are always able to meet with me on my time to discuss situations that arise from time to time and come up with solutions to give better service to the community.

As president of Capreol Long-Term and Supportive Housing, I would like to recommend to the committee that the LHIN have access to funding from the Northern Ontario Heritage Fund to help small communities in the north to build new facilities for our disabled seniors who are no longer able to stay at home and are not ready to be admitted to long-term-care facilities. I trust that this committee will make proper recommendations on the legislation and keep the LHIN in the north.

I also feel that the LHIN should be operating in Sudbury, which is the centre of the north, with the school of medicine at the university and the research department at Health Sciences North. Sudbury is also central to major cities like Sault Ste. Marie, Timmins and North Bay.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. We have expired our time by a minute already. Thank you very much for your presentation. I can assure you that the committee will read everything that was in the presentation in their review.

**Mr. Tullio Ricci:** Thank you. Sorry about my voice. I was sick for a week.

## COMMUNITY COUNSELLING CENTRE OF NIPISSING

**The Chair (Mr. Ernie Hardeman):** Our next presenter is the Community Counselling Centre of Nipissing: Alan McQuarrie, executive director. Thank you very much for being here this morning to make a presentation. We appreciate you putting in your time. You will have 15 minutes to make your presentation. If there's any time left for questioning, we will have questions from caucuses. With that, thank you very much.

**Mr. Alan McQuarrie:** Thank you. Mr. Hardeman, Chair, committee members, I'm Alan McQuarrie, the executive director of the Community Counselling Centre of Nipissing and co-chair of the Nipissing mental health and addictions system table.

I want to start by thanking you for the opportunity to speak to your review of the Local Health System Integration Act and the regulations made under it.

I've been an executive director for two organizations receiving funding for health care since 2003. When I first began my work under the guidance of the local district health councils and the Ministry of Health, I was working in a system that was characterized by divisions and a lack of communication. As a service system, there was very little innovation. Instead, we sought resources for our siloed agencies to do more of what we were already doing. Due to the reality of life in northern Ontario and the vast geography here, we rarely met our program supervisors from the Ministry of Health, and when programs were rolled out from Toronto, they tended to be a one-size-fits-all format. New initiatives rarely took into account the demographics and socio-economic realities of the north.

The few projects of integration that I was involved in at the time were usually because we knew our fellow service providers as neighbours, a function of small-town northern life and not really any kind of organized integration. When the North East Local Health Integration Network arrived, we finally felt that we had a regional presence for the planning and funding of health care. The North East LHIN was the voice of northerners, identifying northern needs and priorities.

The arrival of the LHIN was the first time in my career that serious thought was put into identifying the unique health care needs of our northern population. Through numerous consultations with stakeholders from all corners of our region, the North East LHIN put in place four priorities for health care:

—increasing primary care coordination;

—enhancing care coordination and transitions to enhance patient experience;

—targeting the needs of culturally diverse population groups; and

—making mental health and substance abuse services more accessible.

As a health care provider in the north in the community mental health and addictions sector, my work falls under the fourth priority of the North East LHIN. Since the arrival of the LHIN, we now have a local program consultant who meets with us face to face. We now have a process for our local mental health and addictions system table to communicate our realities and to plan together to improve access to health care.

In Nipissing, we have a network of nine community-based agencies working to provide housing, peer support, counselling, addictions treatment, and community integration. Guided by the North East Local Health Integration Network, these agencies touch the lives of thousands of people in the district of Nipissing alone.

Keeping people healthy starts in the community, and community organizations are strategically placed to connect with people before they need the hospital. However, a frequent stereotype of community, provincially funded programs is that there are too many; that these organizations don't work well together; that these organizations have administrations that are expensive and redundant; and that diversity in the social services field is synonymous with inefficiency, duplication and too many wrong doors or difficult access. The truth, however, is very different. The innovations of our community service partners are not always well known; however, they are serving our populations in new and creative ways, increasing the health of our citizens like never before. Under the guidance of the North East LHIN, our system table now has a process to innovate, to plan, to coordinate, and to implement new and exciting health supports for our communities.

I'd like to share some of the accomplishments of our mental health and addictions system in Nipissing with you this morning.

In 2012, People for Equal Partnership, a local agency, began a unique program in conjunction with the North Bay Regional Health Centre, putting a peer support worker in the hospital emergency room. Now people with a mental illness have an advocate and an ally when they arrive at the hospital. Often, the peer advocate can improve the quality of care and redirect people to community resources instead of repeat, expensive hospital visits.

The Common Referral program is a joint initiative of many agencies that coordinates addictions and mental health referrals each month. These are triaged and in many cases are fast-tracked to community services, where they receive support outside the emergency room.

The community counselling centre that I represent has implemented a walk-in clinic since mid-September, and statistics are showing that 18% of the 76 respondents completing the surveys would have used the hospital or the doctor if the walk-in was not available. A walk-in clinic is a creative way to eliminate barriers to access such as wait-lists.

The Canadian Mental Health Association in Nipissing, Nipissing Mental Health Housing and Support Services, People for Equal Partnership, and the North Bay Regional Health Centre have been attending the gateway hub community mobilization meetings, which provide quick intervention and wraparound services to high-risk clients, thereby reducing the need to attend the ER.

CMHA Nipissing and the North Bay Regional Health Centre work together to provide housing and support to 20 people who now have a supported community destination when they leave the wards of the hospital.

The North Bay Recovery Home continues to provide an ongoing aftercare program that supports the continuum of care. They also follow the No Wrong Door procedure that enables cross-referrals for the overall health and wellness of heavy users and recurring users of the addictions and mental health system. The recovery home is co-chairing the North Bay and Area Drug Strategy Committee and is developing a local protocol for the return of used fentanyl patches—you may have heard that on CBC Radio; there was an interview recently—thereby reducing the medical emergencies that might arise from misuse.

The Alliance Centre participated with two other non-health-funded agencies during Addictions Awareness Week to present community education in the area of trauma and mental health and addictions. The events were well attended and resulted in increased awareness of community services.

This year, North Bay Regional hospital hosted a PhotoVoice event to promote mental health and to highlight community mental health services as a diversion from the ER.

Nipissing Mental Health Housing and Support Services has a shared memorandum of understanding with the crisis intervention services of the North Bay Police Service and the OPP, which allows for shared, facilitated interventions and consistent follow-up to prevent recurrent presentations to the hospital ER.

Nipissing Mental Health has established a respite unit as part of its Percy Place residence, offering clients brief respite from their current living arrangements, who may be temporarily without housing supports. Supports accompany the client to ensure successful tenancy in the unit.

**1050**

Teaming up with West Nipissing General Hospital's emergency department, the Alliance Centre is currently looking at strategies to reduce repeat ER visits for mental health and addictions clients. To do this, they have implemented a community wellness program and are participating in several committees, including the Nipissing drug strategy committee, the suicide prevention task force and the Common Referral table. They're also partnering with several agencies to provide community education, awareness and promotion in the areas of trauma, mental health, suicide prevention and addictions.

416 Lakeshore is a partnership of the Canadian Mental Health Association and the North Bay Regional hospital. The 416 Lakeshore property houses 20 people who do not have anywhere else to live. Many of these people are dealing with mental health issues and addictions, social isolation and traumatic life events, and have difficulty accessing many of the supports that most of us take for granted. The 416 Lakeshore property is more than housing: It provides a community of care and support, and it also provides people with the means to live independently and to achieve their goals.

This is just a list of some of the many joint interventions that are currently or recently were in the works. A closer look at the community mental health and addictions system shows a network or an ecosystem of dynamic, creative agencies working together to find a new and better way to improve the health of our citizens.

Through the support of the North East LHIN, we have found ways to improve access to mental health and addictions through creativity, innovation and integration of our shared resources. We're grateful to the LHIN for guiding and supporting local initiatives that are tailored to the needs of our local populations. By fostering strong community health care programs, we are improving access to health care in the clinical areas of addictions and mental health.

Speaking as a table chair, the North East LHIN is our LHIN; but speaking as a citizen and a patient, the North East LHIN is my LHIN. It's a voice for northerners for better health care. Thank you.

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

We have about two minutes for each party, starting with the government side. Mr. Colle.

**Mr. Mike Colle:** Thank you very much. I'm most interested in this 416 Lakeshore project. This seems to be an ongoing theme across the province. I know even in my own riding in Toronto, I've got the local police superintendent saying that more and more police time is being used dealing with people with addictions and mental health challenges. They just don't know where to take people for help, so they spend hours in hospital waiting rooms, ERs, so it's clogging up the ERs, plus it's clogging up police time. How did you ever get this up and running?

**Mr. Alan McQuarrie:** The 416 Lakeshore project was really a project of the Canadian Mental Health Association. It's difficult for me to talk at length about what was the start of that, but I know they were approached with some housing dollars, and then they approached our system table, saying, "Look, we can't make this work on our own. We can provide a building, we've got infrastructure, but we're going to need some support to make this work for people, because they're being discharged into the community from the hospital, let's say, and the chances of things breaking down are fairly high."

Through collaboration of the local system partners, we were able to find the resources to staff a person during the day at the 416 Lakeshore site. It's just providing that little bit of support that people need to be able to function effectively in the community. We believe it has really reduced some of the pressure on the hospital system.

Something you may be interested in is the gateway hub model of community policing that is coming to North Bay. I just mention it briefly here. Some of our system providers are involved in that. It's an initiative that provides wraparound services, with the police involved, and we identify high-risk people and provide services to them.

**The Chair (Mr. Ernie Hardeman):** Thank you. Ms. McKenna.

**Mrs. Jane McKenna:** Thank you so much for coming in with your presentation. I have a couple of questions. How does the LHIN coordinate the program that you mentioned here on the first page—a program consultant who meets face to face?

**Mr. Alan McQuarrie:** Yes. Our program consultant with the North East LHIN meets with our system table at our monthly meetings. We also connect with her regarding our MSAA, our service agreements. We have much more of a relationship now with our health funder than we ever had in the past.

**Mrs. Jane McKenna:** But how did that come to fruition? How did that program come to fruition?

**Mr. Alan McQuarrie:** I believe the LHINs set that up as part of their process, the renewal of funding. At the system table—the LHINs have the resources now to attend the system table meetings on a monthly basis.

**Mrs. Jane McKenna:** We hear over and over again that people are exhausted from panels and round tables and discussions. What is actually implemented after all of these discussions that you have?

**Mr. Alan McQuarrie:** I could probably point to most of the innovations that I've read in my paper today as coming from discussions of the system table. The LHIN being part of that has helped us to move that forward.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. The third party: Mr. Mantha.

**Mr. Michael Mantha:** A question with regard to your community counselling centre that started up the walk-in clinic: Can you just give me a little bit of the background on how that got generated and how it's actually operating? I see some of the benefits here, but can you elaborate on that?

**Mr. Alan McQuarrie:** We became aware of a pilot project in Thunder Bay. It was identified in a document on excellence in health care that I believe came from the LHINs, or at least the Ministry of Health. We contacted the Thunder Bay agency. It's a partnership between children's mental health and adult mental health. Through discussions with our provincial association, Family Service Ontario, we started a pilot project of our walk-in program. We've allocated existing funding dollars to service our walk-in clinic, and, as a multiservice agency, we're able to pretty well see whoever comes in off the street.

**Mr. Michael Mantha:** Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. It's much appreciated, you taking the time to come and talk to us.

**Mr. Alan McQuarrie:** Thank you.

## NORTHERN ONTARIO SCHOOL OF MEDICINE

**The Chair (Mr. Ernie Hardeman):** Our next presenter is the Northern Ontario School of Medicine: Roger Strasser, the CEO. Thank you very much for your attendance this morning to help us out with our information-gathering sessions. You will have 15 minutes to make a presentation. You can use any or all of that time with your presentation. If there is sufficient time left, we'll have questions from caucuses. The 15 minutes are yours, sir.

**Dr. Roger Strasser:** Thank you very much for the opportunity to come and meet with you this morning and talk about my observations and experience in relation to the Local Health System Integration Act. As you said, I'm from the Northern Ontario School of Medicine. My name is Roger Strasser. I'm the dean and, as you said, the CEO of the school. The remarks I'm going to make are really about the whole of northern Ontario. I understand that you're also spending some time in Thunder Bay. It just worked, from my calendar perspective, to meet with you here rather than in Thunder Bay.

What I'm going to do is talk about the Northern Ontario School of Medicine and give you a sense of the perspective that I bring in looking at the local health integration networks, talk about the concept of the LHIN and then talk about the experience in the north of the LHINs that we have in the north.

The Northern Ontario School of Medicine came into existence as the result of a widespread community movement which said that if we're ever going to turn around the shortage of doctors and other health professionals in northern Ontario, if we're ever going to improve the health status of the people of northern Ontario, we need to have our own stand-alone northern Ontario school of medicine. That was the background. I imagine that some of you were even involved in this movement back in 2000-01. That was the background to the Ontario government deciding to establish the Northern Ontario School of Medicine.

The school has a social accountability mandate. That's a commitment to be responsive to the needs of the people and the communities of northern Ontario, with a focus on improving the health of the people of northern Ontario.

The school serves as the faculty of medicine of Laurentian University here in Sudbury and of Lakehead University in Thunder Bay. We see the whole of northern Ontario as a campus of the Northern Ontario School of Medicine.

We've developed what we call distributed community-engaged learning as our distinctive model of medical education and health research for the Northern Ontario School of Medicine. There are three key elements of distributed community-engaged learning: distributed—that is, the teaching, learning, research and academic activities occur in multiple locations. We have over 70 sites across northern Ontario where our students, residents and faculty members may be involved. In order to have this kind of distribution, we place heavy reliance on electronic communications to facilitate this distributed learning. We have an extensive digital library service, which means that our learners, faculty members and community members have the same access to educational resources wherever they are, if they're on the Internet, as if they were in the big city, like in a teaching hospital.

**1100**

The third component is community engagement. This is interdependent partnerships between the school and the community, so working in close collaboration with the communities of northern Ontario. That's the rural communities, the large population centres, as well as the populations of special interest: the aboriginal people and communities and the francophone people and communities.

So that's the Northern Ontario School of Medicine and how we go about things. You have some handouts and the opportunity for you to look at those closely. I think it

is fair to say that already the school has surpassed its expectations. We had the official opening in 2005 and the first graduation from the MD program in 2009, so we've had five groups graduate. We do have our own graduates now providing health care in northern Ontario, so the outcomes are certainly very positive. First of all, our graduates compare favourably with graduates of other medical schools in terms of matching to residency programs and in terms of their academic performance in the Medical Council of Canada. But what's probably of most importance to people in northern Ontario is that 62% of our graduates have chosen family medicine, mostly rural family medicine, as their career pathway. That's double the national average for Canada. Thirty-three per cent have chosen other general specialties, the kind of specialists we need in northern Ontario—and just 5% subspecialties like dermatology, plastic surgery and radiation oncology. So there are signs of success for the school.

We also undertook a socio-economic impact study of the school some years ago now, and we showed that the school has had a positive impact in terms of the economy of northern Ontario. The year that was studied, the budget—taxpayers' money—was $37 million; the level of new economic activity in that year was between $67 and $82 million, so more than a two-for-one multiplier effect. There was economic growth—that's new jobs and economic development—and new job categories that we wouldn't have in northern Ontario without a Northern Ontario School of Medicine.

Probably more interesting was the social impact. Yes, the universities reported improvement in retention and recruitment of faculty members and students. Yes, the health services reported improvement in recruitment and retention of health care providers. But what was really interesting was the communities themselves. This research was done in 2009, just after the global financial crisis. As you know, the northern Ontario region is very much a resource-based economy, so things were looking pretty bleak for the communities in northern Ontario in 2009, and yet the people who were interviewed as part of this research actually were optimistic about the future. They linked that to the Northern Ontario School of Medicine. It wasn't just about more doctors and access to health care; there was a sense of empowerment. These people had been part of that community movement, and they had been involved in advocating for having a Northern Ontario School of Medicine. So there's a sense of, "Well, if we can do a successful medicine school, we can do anything." I think it is fair to say that now Lakehead University has a law school, Laurentian University has an architecture school, and the idea of those sorts of professional schools at those universities would not really have gained much traction without the success of the Northern Ontario School of Medicine to point to.

So I've given you a snapshot of the Northern Ontario School of Medicine and the perspective that I bring now to look at the idea of having local health integration networks in Ontario, and I must say I think it's a good idea. I think the basic principle of developing and implementing health services through collaborative processes involving all of the key players is a very positive way to go, as compared with the straight regional health authority model, which is really a central-control model. Generally speaking—and in one way or another I've seen many other jurisdictions, not only in this country, but other countries as well—the sense in the small communities is that they are the losers when you have a regional health authority type of model. So I think it's a good idea. To be successful, it's essential to strike the right balance between the local needs and advocating for health care that meets local needs and in the communities of the region with the province-wide priorities and initiatives. That's a constant tension, I think, for the local health integration network and for the idea of local health integration networks. I think that, in the way that that they've been set up in Ontario, there are some limitations, in particular that there are aspects of service and health care that are not included: in particular, public health, and also the whole issue of the way in which physicians are funded to deliver health services.

That's a snapshot of observations about the concept of local health integration networks.

The experience of the LHINs here in northern Ontario: I must say, when the decision was made to have a North West LHIN and a North East LHIN, I said to anyone who listened, "Isn't government funny? They set up one Northern Ontario School of Medicine for the whole of northern Ontario at a time when there was one north region office for the Ministry of Health and Long-Term Care, and now there are two local health integration networks."

The approach that we took with the Northern Ontario School of Medicine was to say that we are keen and, in fact, very committed to working in collaboration with the local health integration networks, and that our preference is to work with them together, rather than separately. We have collaboration agreements with both the North West LHIN and the North East LHIN; we meet on a regular basis with a joint relations committee, where we keep each other up to date with what we're doing. We look for opportunities to collaborate with the two LHINs and the school of medicine together.

It took some years for the LHINs to get on their feet; I must say that it took some years for the Northern Ontario School of Medicine, as an organization, to get on its feet, so I can see that that would take a while. Now that the LHINs are well established, I think there are some real opportunities for working together.

One of the issues, though, is that it's important that the LHINs really have supportive, collaborative relationships with all of the health service agencies across the north. At times I think that there are some real tensions, particularly between the regional hospitals and the LHINs. To some extent, that's built into the system—you might say as a floor in the system, because, with the requirements of the Canada Health Act, hospitals have to accept all comers, and other agencies in the system don't have that

same requirement. Then we have this situation of people getting stuck in hospital and not being able to move on to other forms of care if they're not able to go home—the so-called alternate-level-of-care or ALC issue.

But I do see some real opportunities, as I mentioned, for the Northern Ontario School of Medicine. Community engagement is really central to everything that we do, and I see some potential for the LHINs and the school of medicine to work more closely together in terms of community engagement and developing innovative approaches to health care delivery, really improving health care and, ultimately, the health status of people in northern Ontario.

Just to wrap up my brief presentation: I've introduced you to the Northern Ontario School of Medicine, I've talked about the concept of local health integration networks, and then given some observations about the implementation of local health integration networks here in northern Ontario—that's the North West and the North East.

In conclusion, I would say that I see the LHINs as a positive initiative with great potential for further integration of health service development and delivery, including through collaboration with the Northern Ontario School of Medicine. Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. We just have time for one party's questioning. Mr. Dhillon?

**Mr. Vic Dhillon:** Thank you very much for your presentation. As an alumnus of Lakehead University, I'm very happy to see that finally the school of medicine is up and running. I know that when I graduated, it was a thing that the university executive was talking about. The town and the university were very excited.

I just wanted to know: What percentage of students who graduate go to serve underserviced communities in northern Ontario?

**Dr. Roger Strasser:** It's too early for us to give you hard and fast figures on that. As I said, we've only had five groups graduate from the MD program. After the MD, they then move into residency, and residency is a minimum of two years for family medicine—often three years—so it's early days yet to be able to have enough experience to give you numbers for that.

I can certainly give you some examples of stories. For example, in the northwest, in Dryden, there's a community that was struggling to maintain medical services, and now they're full of graduates from the Northern Ontario School of Medicine.

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Here in the northeast, the standout story is Chapleau. Chapleau went for nearly seven years without a permanent doctor. Since July 2012, they have three home-grown physicians. "Home-grown" means the three of them grew up in Chapleau. They did their MD degree with NOSM. They did their family medicine residency with us. As I say, since July 2012, they've been practising together, providing health care in Chapleau. One of those physicians is First Nations, and she's serving her own Brunswick House First Nation.

**Mr. Vic Dhillon:** Thank you.

**The Chair (Mr. Ernie Hardeman):** No further—

**Ms. Helena Jaczek:** Is there still time?

**The Chair (Mr. Ernie Hardeman):** Ms. Jaczek, yes. We have less than two minutes left.

**Ms. Helena Jaczek:** You said it was a little strange that there are two LHINs in the north.

**Dr. Roger Strasser:** Yes.

**Ms. Helena Jaczek:** Would you advocate for any sort of amalgamation at this point?

**Dr. Roger Strasser:** Well, yes. I would advocate—and I'm talking about northern Ontario—to look at the whole of northern Ontario, I'd say the northwest and the northeast. Clearly, there are differences and distinctions between them, but they have more in common than divides them. And then, in terms of population, you have a critical mass of around 800,000, which then provides opportunities that we've managed to make the most of with the school of medicine, and I would say in terms of health service delivery the same.

The reality for living and working in the north is that most of the time, the key decision-makers like yourselves are in Toronto, and there's little attention paid to the north. So the more critical mass of collaboration that we can have across the north working together—the Northern Ontario School of Medicine was very much a made-in-northern-Ontario initiative. Encouraging local initiative across the north and networking across the north I think would be of benefit to the north and to the whole province.

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

## NORTHERN INITIATIVE FOR SOCIAL ACTION

**The Chair (Mr. Ernie Hardeman):** Our next is Northern Initiative for Social Action: Shana Calixte, executive director. Thank you very much for being here this morning and sharing your time with us. You will have 15 minutes to make your presentation. You can use any or all of that time as you see fit. If there's time left over at the end of your presentation, we will have some questions from the committee.

With that, starting now, the next 15 minutes are yours.

**Ms. Shana Calixte:** Thank you very much. Thank you, everyone. My name is Shana Calixte, and I am currently the executive director of a mental health organization named NISA. I am pleased to be here today to talk to you briefly about our organization, the over 200 members who rely on our services, and the support we've received from the North East LHIN in this regard.

The Northern Initiative for Social Action, or NISA, as we call it, is a growing grassroots organization located here in Sudbury. We're a very unique organization with a very interesting point of view on the realities of living with mental illness.

At NISA, all of the employees within our team have lived experience with mental illness, myself included, either personally or through a family member. This uniqueness means that all of our staff members have a very special lens on mental illness and mental health and provide a very important bond with those who use our services. We've been there, and many of our members profit from sharing their stories from those who can relate.

NISA runs programs and services that focus on the recovery of the individual, a process that we describe as more of a journey rather than a destination. Our work centres in four areas: building occupational and vocational skills, providing spaces for creative engagements, one-to-one peer support, and general resources for mental health recovery.

NISA was a very small organization when I first joined four years ago. We had five staff members, about 30 active members, a small budget and one tiny location here on the grounds of the current psychiatric hospital. Over the past four years, we have grown to 35 employees; a much larger budget; two locations, soon to be merged into one larger and more spacious home; and over 200 active members. We see at least 50 people come through our doors every day looking for a space to engage with others and to develop practical and useful strategies for living within the city as people who use mental health services.

These changes have been supported and encouraged by the North East LHIN, who have been very clear that they are interested in making sure that people who use services in our city, specifically mental health services, should be heard first and foremost about changes within their care.

Over the course of the five years I have been with NISA, representatives from the North East LHIN have proven to be open to suggestions, available for discussion, and eagerly interested in hearing about the needs of those who access mental health services. When it comes to mental health care, engaging those who use the services has been one of their priorities, and they have expanded resources that support those who are most marginalized. This includes supporting an organization like ours, which sees these marginalized people every day and facilitates discussions to discover their needs and translate them into programs and services.

As a result the LHIN has supported us in providing occupational programs for members in our city. It has funded a regional, nightly, pre-crisis warm line service, which you have a brochure about there, which fields over 5,000 calls every six months. And it has fostered a collaborate relationship between mental health partners to build and staff an eight-person transitional home which has provided housing for those who would be better suited to live in the community rather than in the hospital.

Building community partnerships is important, specifically in the field of health care, which has a habit of working in silos and not necessarily communicating in open and streamlined ways. The LHIN has not only worked to build partnerships between those working in mental health care in our city, but representatives have been available to talk directly to the service users in their spaces and on their terms. In this way, the North East LHIN has taken actions in line with some of the recommendations of the Drummond report: firstly, by improving service integration, and to produce a more efficient system by providing support that is firmly rooted in the community it serves.

The North East LHIN has clearly indicated how important it is to truly work on engagement. With diverse communities due to race and culture, rural and urban geographical areas, and various income levels, the North East LHIN has had to be accountable to many voices, working to meld the needs and concerns of all within this vast space of northeastern Ontario.

They have made a commitment to enhance community services in the mental health sector, placing trust in the work that happens on the ground and at the grassroots to make fundamental changes to our mental health system.

An example: It was a wet and miserable day when Mike O'Shea from the North East LHIN came to visit NISA to get feedback to help craft their multi-year Integrated Health Service Plan. The room was full, and more and more people kept streaming in to give their take on the needs of those living with mental illness. It was almost a two-hour discussion, where members gave frank opinions on things that were working and what they thought was not. Some words were tough and angry, but all were accepted with openness. When the plan was crafted, a very clear focus on peer support—which is the unique work that NISA does; where those who have lived experience with mental illness are employed to provide support with those with similar experiences—was present in that report. Many members still speak about that day, most specifically about how empowering it felt to be heard by and have access to those who have a hand in making direct decisions about funding. They look forward to more opportunities to engage with the LHIN in more one-on-one sessions.

In my estimation, I have found the North East LHIN to have been quite accountable to the needs of those who are direct service recipients for mental health care. Their attention to the specific needs of the geographic region, the interest in collaboration and encouraging service providers to work together and break down silos, and the attention to the service recipient—indeed, to focus on client-centred care—have all been ways, I believe, that the North East LHIN has been fundamental in the ongoing support of mental health care in northeastern Ontario. Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. We do have almost nine minutes left. We start this one with the official opposition. Ms. Elliott?

**Mrs. Christine Elliott:** Thank you very much for your presentation this morning, and thank you for the great work that you're doing in the community. Many

members of this committee also served on the committee for addictions and mental health some years ago—Ms. Gélinas, Ms. Jaczek and I—and we certainly understand the importance of peer support. It really can't be stated strongly enough how important that is.

Your agency started, it looks like, in 1997.

**Ms. Shana Calixte:** Yes.

**Mrs. Christine Elliott:** So you would have been working under the old system and then transitioning into the situation with the LHINs. Can you tell us how things were before and how they've changed since the LHINs have come into existence?

**Ms. Shana Calixte:** I'm not quite sure I could comment on that; I've only been with the organization for four or five years. The LHIN has always been present in terms of my own experience. However, I can speak to going from a very small organization. Just to explain a little bit, we have a relationship with the local CMHA here, which actually is our flow-through funder. We don't actually have a direct relationship with the LHIN, although we've always wanted to, but we have realized over the past few years that it's important to work more collaboratively.

What I've found over the past five years I've been with NISA is that we've been able to have much more discussion, I would say, and many more people at the table to discuss how services can be improved. And because our organization has gone from a small one to a large one, we've had to really prove why that was important. We've used the relationship with CMHA in order to do that and also in order to access some more feedback from the LHIN.

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When I first started, I didn't often speak to any members within the region about our services. As we've grown, I've been able to report back how we've done, what kind of improvements we've had. I've been very well supported by having direct conversation with members of the LHIN. That's how I've seen it change in terms of the fact that I've been able to have more ready access to people who have a very important stake in how our service has changed.

**Mrs. Christine Elliott:** Can I just ask a follow-up?

**The Chair (Mr. Ernie Hardeman):** Really short.

**Mrs. Christine Elliott:** You mentioned that you would rather have a more direct relationship rather than being a flow-through. Can you tell us what you think you would get from that that you're not getting now?

**Ms. Shana Calixte:** We had wanted it, and so our understanding was that it would mean that we'd have more ability to increase our service and increase our funding. What has happened, actually, is by working in partnership with other mental health organizations, we've seen how collaboration is the best way to be supported. I would say that I'd actually rather have this kind of organization, mainly because it means we don't duplicate services, number one, and number two, we can actually work in collaboration with other service providers in the city who are trying to work for that end goal, which is to support—

**The Chair (Mr. Ernie Hardeman):** Thank you very much. The next question is Ms. Gélinas.

**M^me^ France Gélinas:** If you are to think about the greatest needs of the population you serve and relate this back to the fact that we have the North East Local Health Integration Network, we have the North East LHIN, how do they connect? First, what are the greatest needs for the population you serve right now?

**Ms. Shana Calixte:** The greatest needs? It would be focusing on the issues around lower income and poverty. I would say that would be the most important, and also to reduce isolation, so having more services that provide day-to-day support for people to get them out of their homes. One is to combine that with more financial support.

What we see are people who are struggling to access housing, to access food specifically, and then something to do during the day. That's where I would see the needs are the most.

The second part of your question was?

**M^me^ France Gélinas:** Basically, when you talk about poverty, you talk about isolation; you talk about housing. All of those fall more or less outside of the mandate of the LHINs. So my question is, how does having a LHIN here help your clients?

**Ms. Shana Calixte:** How does it help our clients? Well, for us, it's talking about what kinds of services we can provide with the funding that we're provided. For us, the LHIN has decided that they want to see what kind of impact they can have for the amount of money they provide, and for us, it is about translating those needs—housing, income, those kinds of needs—into direct care. That has been one of the ways we've seen that the LHIN has supported us. That's how we see it.

**M^me^ France Gélinas:** Could you see a day where the LHINs would advocate for better income for your clients?

**Ms. Shana Calixte:** I would hope so, yes.

**M^me^ France Gélinas:** You would hope so.

**Ms. Shana Calixte:** I would hope so.

**M^me^ France Gélinas:** So really look at them as advocating for the needs of the population they serve, no matter if it falls within or outside their mandate?

**Ms. Shana Calixte:** Yes, and supporting organizations that do that kind of work.

**M^me^ France Gélinas:** Thank you.

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

**Ms. Helena Jaczek:** Thank you so much for coming in; just a great program. As Ms. Elliott said, what we heard on the Select Committee on Mental Health and Addictions was the need for the peer support, and so it's great to see this happening right here.

One of the potential criticisms of so many agencies involved in the mental health and addictions field—and it was articulated by Mr. McQuarrie from Nipissing—is that perhaps there's duplication in terms of administrative

costs. Has your agency looked at some of these back-office functions perhaps being merged in some way so that you could provide more to the front line?

**Ms. Shana Calixte:** We haven't, and mainly it's because we've gone from such a small organization of five people to now 35. Many of our positions are quite rooted in having that lived experience. For our specific example, we haven't looked at melding with other organizations because we don't want to lose that very important lens on saying that we've been there, we've had that experience, and peer support is really rooted in that. From the person who does admin to the person who does the janitorial work—every single one of us has that lens. For us, it hasn't been something we've looked at. Further down the road, it could be, specifically introducing or thinking about how lived experience of mental illness could be a part or could be introduced in every workplace. It could be something that we could see happening in the future.

**Ms. Helena Jaczek:** Thank you.

**The Chair (Mr. Ernie Hardeman):** Mr. Fraser?

**Mr. John Fraser:** How much time do we have?

**The Chair (Mr. Ernie Hardeman):** You have about a minute and a quarter.

**Mr. John Fraser:** Thank you very much for what you do, and thank you very much for your presentation. I wanted to ask you about the genesis of that eight-bed transitional unit, because it sounds like it's an example of collaboration. Can you tell us a little bit about how that came to be, who drove that and who the partners are?

**Ms. Shana Calixte:** Sure thing. It was the North East LHIN, along with the North Bay Regional Health Centre and CMHA. We have a couple of other partners who are also involved, and NISA. What had happened was, it was looking at the ALC crisis and thinking, "How can we move people out of the hospital and into community services?" This is really people who have high needs.

One thing that happened was, we came together to say, "First of all, where could they be placed and who could support them?" One place that they said that needed support mostly was through the staffing, so looking at who could provide that support through staffing.

We were asked to provide peer-support-directed staffing, so not just people who would be there to help people clean and cook, but really to focus on their recovery, so getting people out of the house, getting people learning skills—occupational skills and ADL skills, or activities-of-daily-living skills. So that's how it come to be.

It has been a really great partnership. It opened in June. It's very similar to Percy Place, which you heard a little bit about, that's happening in North Bay. It really has proven a really effective model, to have the peer support workers there to support people in their housing.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. We very much appreciate the time you took.

## CANADIAN RED CROSS, ONTARIO ZONE

**The Chair (Mr. Ernie Hardeman):** Our next presentation is the Canadian Red Cross, Ontario Zone: Heather Cranney, system navigator. Good morning.

**Ms. Heather Cranney:** Good morning. I'd like to thank you for allowing me this opportunity to speak. I originally looked at—

**The Chair (Mr. Ernie Hardeman):** Just before you start, I should advise you of the rules of the game, shall we say. Thank you very much for coming. You do have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's sufficient time afterwards, we will have questions from the committee, but you don't have to leave time for that. Thank you very much for being here. Your 15 minutes start now.

**Ms. Heather Cranney:** Okay. My name is Heather Cranney. I've been with the Canadian Red Cross for 10 years now and was originally a southern Ontario soul, like many of you. I grew up at Steeles and 48 and transitioned to northern Ontario in 1987. Officially they'll be changing my passport to reflect that after five more years.

I just want you to know that it really means a lot to me to consider this local part of our LHIN—it is very localized—and to say that they understand northern Ontario. That part is very important to me.

I started thinking about doing a presentation with charts and providing you a lot of information, but given the recent storms in northern Ontario, you have the gist of who Red Cross is in one part of our agency, which is our disaster management side, but to let you know, throughout Ontario, we have a lot of health care and community services.

Specifically in the North East LHIN, the Canadian Red Cross is funded for a variety of services, which include—I'll run them off real fast; don't take notes: transportation, home maintenance, friendly visiting, congregate dining, adult day, assisted living and meals on wheels, which we've been doing for many a year.

As well, in the last year, we've started into what we call a priority assistance to transition home—not transfer, because that just implies the ride. The transition is actually connecting community to hospital and a hospital-based service where Red Cross staff will travel home from hospital with a client and settle them in and make sure there's a report back to indicate: What was this first view of the home on the client's return? Were they safe to return home? Was there food in the house? Were there medications?

All of these things have now rolled out through the North East LHIN to Red Cross in all of our hubs. As you know, northern Ontario has four major hubs. We think that part is pretty exciting. We're really looking forward to impacting on the hospital ALC rate and discharge planning by connecting community to hospital.

My role as the system navigator is another, I think, stellar investment of the North East LHIN, because it

showed mostly that they were listening. We were gathered in a meeting in May 2011, the first time we really got the community support agencies in a room together. It came out loud and clear: We really don't have one voice. We really aren't telling each other what we're doing on a day-to-day basis in our operations. We saw a way to build, through the support of the North East LHIN, the system navigator positions, which have accomplished the support of a regional community support network, as well as localized community support networks, which have us talking, which is the true window to integration. I think that, in itself, is a real coup for the LHIN, to say that now they have a voice for the community and they are very strong, and we'll be knocking at their door often to say that this is what we collectively see as efficiencies to be developed in northern Ontario to better serve our clients.

**1130**

When I first started going to different tables, people spoke in the room with their cards held close to their chest. Now I find after the many, many LHIN committees I've sat on, we have our cards out there. You can see my hand is open to you, that we are actually looking at sharing information. We are looking at relationships I didn't see possible. When I see someone putting in a proposal that's very similar to something I might have worked on two years ago, I send them my stuff: "Here are things I've collected over the years," or I'll give them a heads-up that "I think this might be an opportunity for your agency." These weren't conversations, I think, that occurred five or six years ago. That's because the LHINs fostered this trust within our agencies. I truly believe that we're connected more than we ever were.

I look at really good decisions they've made, and besides the system navigation, some of them are that quick phone call when I have surplus funding at the end of the year. It's the Red Cross manager from Timmins getting rethermalization units for Meals on Wheels put in the remote locations, because our LHIN officer understands how hard it is to serve the town of Mattice in this community—that we wanted Meals on Wheels, but it couldn't be done. So we got a way to have frozen Meals on Wheels served warm to clients. We made them happy. What was even cooler was that we managed to get one of those units up in Moosonee, because in that community a lot of the elders were sending someone to the local store to get a burger and fries, and that was a consistent dietary staple. We ended up being able to use that to better serve the community.

Right now, my role is in a period of transition because the LHIN has recognized some of the needs of the First Nations communities to bring education, such as personal support worker training, to try to make it more able to serve their needs. They've actually called on me. That's my history with the LHIN: Sometimes they pick up the phone and ask my opinion. That's pretty flattering. They do it to everyone, not just me. They listen. Sometimes when I see something happen I can say, "That might have come out of a conversation I had." So I feel a connection as a person and as a member of the Red Cross, and as a member of our community support network. I didn't see that in my earlier years. I've been in health care since my 20s, so it has been a long road, but I really see that the North East LHIN listens to me.

I see a personal connection to the officers of the LHIN—I sometimes say I know that Steve Belanger is trying to learn piano in Sault Ste. Marie, even though his family doesn't think he should. These other things that I know—they talk to me. I'm not just a person delivering a program; I'm an actual person. I like that I can walk into a room and that Louise Paquette knows who I am. She knows that I'm committed; I'm passionate. Someone from the LHIN told me, "It's infectious"—my commitment to the people we serve. I think the relationship is that I know that I can pick up the phone and say, "This isn't going to fly," or "Darn it, I want this for this community, so please listen," and I know that that will happen.

I really respect the work they're doing in First Nations now—the outreach—that they're doing. They've always understood.

When I worked more in Timmins, the challenge is that we have to be respectful of our francophone population—it's not just a language; it's a culture. I really had great experiences there in support with the LHIN to make sure the Red Cross was responsive and to make sure that we were able to serve those communities, as well.

I think that's enough. That was my passion for today. I'll take questions.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. We have about eight minutes left. We'll start with the third party. Ms. Gélinas?

**M^me^ France Gélinas:** It's nice to see you, Heather. Thank you for coming.

I will start with the tough questions that we read in the media. We hear people say that there are too many system navigators; there are not enough people actually delivering the care. Can you put that issue to bed for us?

**Ms. Heather Cranney:** I guess it's the definition of "system navigator"— a lot of the people who have the title "system navigator" are actually navigating the patient journey. In our system navigator role, we're looking at where the system didn't work. We're having tough questions at the hospital. At the CCAC, we're sitting at tables together. We're looking at CSS: "Why didn't you respond to that request?" We're not looking at Mrs. Smith's journey to and from. We're looking at why the system is letting her down, and not so much the actual people. Why did the system not work? We're trying to effect systemic change.

A lot of the other positions really are more patient-focused—like, say, they're diagnosis-specific or whatever. We're looking at the bigger system and things—in scope, out of scope. We see where housing failed. We see what needs to be rebuilt in transportation. We're looking at the system, and it's different.

There are four of us, so that's not a lot, to serve the incredible amount of geography that the North East LHIN serves. If you look at the map, it's big, just big.

**M^me^ France Gélinas:** The same question I've asked the other providers is: Right now, what is the greatest need of the people you serve?

**Ms. Heather Cranney:** Well, I'm prejudiced: It's the community. It's things that have gone by the wayside, that you used to have 10 years ago: home maintenance and supports to stay in your home.

Are we prepared for what's going to happen with low-acuity personal support? I don't see, maybe, the communication. That's at the Ministry of Health level right now, but that's going to be a very big change in how things are done. We don't know how it's going to flow. Are we ready for that?

I'd say, personal support and things that keep people in their homes. The health human-resources crisis—I've been involved at that level when the regional table—I don't say it's not something that we can solve. I just think we need a lot to put at that one.

As long as you consistently are funding, for example, personal support workers—the funding envelope and the way that it flows out, and the quality of care that we want to provide for our patients makes it very hard to maintain a workforce, and I think that's a really big challenge.

**The Chair (Mr. Ernie Hardeman):** Thank you. The government side: Mr. Colle.

**Mr. Mike Colle:** Thank you, Heather, for your personal presentation. I think that's really helpful in terms of getting the real human side of how these organizations work and how you basically work on a daily basis with them. I thought it was very helpful.

The question I had for you is, from your on-the-ground approach—we've heard a lot of comments as we've gone across Ontario about the need to get doctors, primary care providers, into the LHIN system. Because as you know, right now, they're basically still outside, except for the doctors who are at the community health centres. Do you ever run across any challenges with dealing with physicians and how to get them under the same tent?

**Ms. Heather Cranney:** I was just on what was considered a rock-star tour with Dr. Samir Sinha and the geriatricians from the North East LHIN. I got to observe their trip to Fort Albany and the First Nations community to deliver care and to create a very individualized plan of care for 27 members of the community, that had to be set up in such a way that the lack of, say, the rotating physicians and the lack of access to primary health—that when they came to the community, they were told very clearly that the next doctor who comes in here, who may not see this patient again ever, even, has to be able to say that you need to follow the directions that this stellar rock-star team of geriatricians has set forth for this client. They had to do this.

It was a great investment of the LHIN, but it was the idea that people are not getting primary health care. They can only get seven minutes with a doctor. You might have five concerns; pick one. I see that often.

I do want to know a way—I don't have a solution—to have physicians that are very interested in working in especially the more remote areas of northern Ontario.

**Mr. Mike Colle:** What about a greater role, maybe, for these family health teams—I don't know how many you run across—or the nurse practitioners?

**The Chair (Mr. Ernie Hardeman):** Time. Go ahead—short answer.

**Ms. Heather Cranney:** Okay. I have been working with the health links in Temiskaming. I was on that committee—an opportunity for one of the early adopters.

I do see that the family health teams—I've watched their development. I sat on their board in Timmins and watched the development of them and as they expand, and they're having such a multidisciplinary team. Not everything in the world has to be done by a physician. My care was for 10 years with a nurse practitioner. I only met my doctor once in 10 years.

I do think there are a lot of models out there, and we need to pursue all of them. I do think a—

**The Chair (Mr. Ernie Hardeman):** Thank you. Now the questions go to the official opposition: Ms. Elliott.

**1140**

**Mrs. Christine Elliott:** Thank you very much for your presentation today, Ms. Cranney. It's great to see someone who's so passionate about her work. I applaud the great work that you're doing in the region. It sounds like there have been some great collaborations.

My only question would be, where do you see things going from here? What would you like to see as a next step in your evolving relationship with the LHIN? Are there things that you could see that could be improved, perhaps, or changed, or added on to?

**Ms. Heather Cranney:** I don't know. Sometimes it's hard to see. Sometimes, because we have cross-borders, like the North East LHIN onto the northwest Red Cross—it crosses into there and crosses into North Simcoe Muskoka. Sometimes, I find that it would be nice if a day came where there was a little more similarity in some processes, but I don't want to lose the uniqueness.

North East is completely different from North West, with different issues, so I would like some similarities across LHINs and some ways to transfer, but while maintaining my unique North East LHIN.

**Mrs. Christine Elliott:** Some deputants have indicated to us that it would be helpful to have a clear vision from the Ministry of Health, with some predetermined priorities that can then be implemented in more local situations. Would you agree with that, or do you think it would take away from the autonomy that exists here?

**Ms. Heather Cranney:** I always try to find my nice words. Some things which are excellent concepts at the Ministry of Health—I personally think of health links as an excellent idea, but I felt like it rolled out in such a pressurized fashion. I really, truly felt like it was handed down from the Ministry of Health to the LHIN—"Make this happen by Monday."

I do think the Ministry of Health needs to maybe be more aware of what's on the plate at the LHIN. They're about to launch this, but all of a sudden you've got a really quick RFP for the change in the physiotherapy and rehab. I don't know if they realize—they were kind of busy that day. You can't really write an RFP and have it out in two days. Sometimes, I—

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your answer, and thank you very much for making your presentation today.

**Ms. Heather Cranney:** Thank you very much.

## SAULT AREA HOSPITAL

**The Chair (Mr. Ernie Hardeman):** Our next presentation is the Sault Area Hospital: Ron Gagnon, president and chief executive officer. Good morning, sir.

**Mr. Ron Gagnon:** Good morning.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for coming in to share your time with us this morning. With that, you have 15 minutes to make your presentation. You can use any or all of that. If you have time left, we'll have some questions from caucus, to answer any questions they may have about your presentation. The next 15 minutes are yours, sir.

**Mr. Ron Gagnon:** Thank you very much, and good morning to all of you. As you heard, my name is Ron Gagnon. I'm the president and CEO of the Sault Area Hospital, which is about a three-and-a-half-hour drive to the west of here.

It's my pleasure to be here today to share my thoughts and observations as they pertain to the review of the Local Health System Integration Act. I share these from the perspective of a hospital CEO, someone who's been a hospital investigator and, more importantly, as a son, father and taxpayer.

My thoughts can be really summed up in two key areas or themes, the first being clarifying authority, accountability and roles of the different players in the health care system, and, secondly, facilitating integration and one true system for the person who is accessing it.

Let me start with accountability, authority and roles. Although LHSIA attempts to address these areas, I think it's fair to say that we're still experiencing growing pains. As a result, decisions and actions are slower than they need to be and, in some cases, are being made centrally as opposed to locally.

I would suggest that the ministry should be able to rightly focus on the provincial strategy for health and health care, and the needed provincial policy and programs to execute against this strategy. It should then be for the LHINs to work within those frameworks to deliver results on a local basis, by organizing the delivery of services in a way that best meets the needs of the populations they are accountable for and one that delivers the best value for the spending of taxpayer dollars.

LHINs need to be accountable for results—I'd suggest that they can do that through their accountability agreement with the ministry—and they should have the authority to structure health care at the local level in order to deliver these results. They should not have to check each individual decision with the ministry, and they should not be left out of decisions that impact the delivery of services in their LHIN.

I have a couple of examples that will illustrate my point. First, a number of years ago, we worked very closely in our community with our community partners and with the LHIN to secure funding to help reduce the amount of alternate-level-of-care patients in hospital. The early part of this strategy included utilizing some beds that were freed up at one of our vacated hospitals. As we implemented strengthened programming in the community, the LHIN, the partners and the hospital all worked very closely together on these. We had established targets and we were working towards those targets.

In early 2013, the ministry directed that those beds were to close. However, the services in the community were not yet up and running. In some cases, those services weren't in place because of other LHSIA implycations, and I'll touch on that a little bit later. In addition, each individual component of that original plan required ministry approval. As a result, the solution was not truly local, and individual programs were much slower in getting off the ground. This impacts the people who need the right service in the right place and who are now in hospital when they should be at home with the appropriate amount of supportive care, in a supportive housing bed or in a long-term-care bed, not to mention the added expense to the taxpayer as a result.

My second example has to do with ministry discussions or negotiations with primary care providers. We heard a question about that earlier. I've seen instances where the LHIN has not been part of these discussions at the local level until after something goes wrong or needs to be managed. Had the LHIN had some of the important information, different decisions may have been made and matters that escalated may have been managed differently. My comments should not be taken as a condemnation or a criticism of the Ministry of Health; they're not. My comments are examples, and examples are to illustrate the importance of clarity as it applies to accountability, authorities and rules. My comments are also to illustrate that the geographies and needs of the population in different parts of this province are different, and that those differences need to be able to be reflected in the structure and delivery of health services. I would say to you that one size definitely does not fit all.

Turning to integration, it's my belief that every one of us, every user of our health care system, wants and expects a true system, where all the players are focused on one thing: what's best for the person they are serving. The health system consists of many great people, all trying as hard as they can to do what's right. Unfortunately, our efforts are not always aligned and, as a result, we have siloed care as opposed to one systematic care system.

I'd also observe that there are opportunities to align the key parts of the system and I would recommend to

the committee that its deliberations seriously look at how to better align the providers in the system through alignment or their accountabilities, incentives or disincentives, and potentially through oversight of the LHIN. Legislation such as LHSIA and policy needs to lead to the partners in the system all making the decisions that are best for the patient.

I'll give you a small example of how our current system functions. Many family health teams are negated, or they get money taken away from them, if one of their rostered patients goes to another family health team or clinic. However, if that same patient goes to an emergency room for that low-acuity visit—a sore throat, or something that could really be seen in a primary care physician's office—there is no negation. Essentially, what we're doing is incenting people to direct patients to the highest-cost place in the health care system and adding to an already overburdened system of hospital emergency departments.

LHINs need to have a significant ability to align the health care system at the local level. This does not mean that provincial negotiations, policies or programs are not required. What it means is that the LHINs have the authority for the oversight of all key health care players so that the users of the health care system benefit from a system of coordinated care that is getting better value for the taxpayers' investment. How primary care is better aligned in such a system was one of the recommendations of the Drummond report and, I would suggest, should rightly be part of your committee's deliberations and recommendations. I'd also recommend that finding a way to include ambulance services and public health as part of the overall health care delivery system on a local basis be part of your recommendations.

Labour legislation is a major consideration with regard to health system integration and restructuring. LHSIA explicitly applies labour frameworks, such as the public sector labour relations act, to health care integrations. The applicability of PSLRTA to health care restructuring, or more specificity around when it does apply, should be considered.

**1150**

I can think of at least two examples where the fear of the costs associated with the application of PSLRTA have resulted in strategies that would have been better for system users and patients, and for the taxpayer, but have not proceeded. I can also think of at least one example where the fear of PSLRTA implications almost stopped an integration that was the right one for users of the system.

Amending the LHSIA to remove barriers for integration found in labour legislation will facilitate the changes necessary to improve the alignment and quality of patient care and reduce the cost of its delivery.

The last area I'll touch on is with regard to how facilitating an integrated system has to do with the powers of the LHIN to direct integration of organizations. Although many would believe—including myself until probably about 12 months ago—that LHINs have the authority to direct the integration of organizations. In reviewing the legislation, it would appear that they do not.

They do have the authority to direct the integration of services, though most of that has been through voluntary integrations at this point. But they do not have the authority to direct the integration of organizations. At times, that may be what's necessary for a better and more cost-effective system of care delivery and health.

As the population of the province ages and the demands and needs for health and health care grow, a truly integrated system is needed so that it is easy to access high-quality care regardless of where you live, and it requires a system that is responsive to the needs of the people who live in the area being served. What it does not need is a one-size-fits-all approach.

In completing its work, I ask that the committee place emphasis on clarifying accountability, authority and roles of the different players in the health care system, and, secondly, facilitating integration and one system for the person who is accessing it.

I ask that, in the true spirit of continuous improvement, you build on what is working well to address what is not so that our parents, loved ones, children and grandchildren have a system they can depend on, not just for today but into the future.

Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. We have about two minutes for each caucus, and we start with the government side: Ms. Jaczek.

**Ms. Helena Jaczek:** Thank you so much for coming today and giving us a lot to think about and a lot of suggestions.

I'll pick up on just one area, and I'll display my bias: I am a former medical officer of health. We've heard divided opinions as they relate to public health. In your comments, were you implying that there should be some sort of structural integration with public health into the LHIN as a sort of core responsibility of the LHIN?

**Mr. Ron Gagnon:** I think that possibility exists. It would be up for more deliberations and review by the committee. However, when I look at—and I heard one of the questions earlier: What are those key needs? There are a lot of, I would say, housing and social needs that maybe municipalities and public health could take on. Prevention is one of those key pieces of health that, I would argue, still hasn't gotten enough—

**Ms. Helena Jaczek:** We've heard very divided opinions on this, clearly, from the municipal sector, very much emphasizing that that particular municipality was very conscious of the determinants of health, and they felt that public health was a key role. Of course, there's the funding consideration for both public health and land ambulance.

On the flip side, do you have a relationship with your medical officer of health in Algoma?

**Mr. Ron Gagnon:** Yes, we do have a relationship with the medical officer of health. Actually, in Algoma, she's new. She started about six months ago, I'm going to say. We're building partnerships there.

**The Chair (Mr. Ernie Hardeman):** Okay, hold that thought. Ms. Elliott?

**Ms. Christine Elliott:** Thank you, Mr. Gagnon, for an excellent presentation. I was really interested with respect to your comments about the Ministry of Health and achieving alignment. You brought up the example of the family health teams and people being directed into the emergency department. What do you think should be done, from the Ministry of Health's perspective, in order to allow the LHINs to achieve their integration locally?

**Mr. Ron Gagnon:** The first thing, I think, is the strategy for the province: What is the vision of health and health care for the province—that is rightly the ministry's accountability—and then letting the LHINs work within that framework to deliver the key results that are being expected, as opposed to having to improve every individual program or initiative? I think if you want a true local solution, you have to give them some freedom.

**Mrs. Christine Elliott:** So it has to start with a vision that currently you're not seeing necessarily as a—

**Mr. Ron Gagnon:** I think the minister has done a pretty good job of articulating what she sees for people in Ontario; however, maybe we need to move that to a next step. When we look out 10, 15, 20 years, which is going to be a pretty big demand for health care in Ontario, where do we see our focus?

**Mrs. Christine Elliott:** Thank you.

**The Chair (Mr. Ernie Hardeman):** Ms. Gélinas?

**M^me^ France Gélinas:** I was curious. When you first opened, you talked about the work that you did to bring the ALC population under control within your hospital, and then you mentioned that every step of the plan was delayed because the LHIN could not give you approval; you still had to go to the Ministry of Health for approval. Can you give me some ideas as to where it would have made sense for that decision-making to be with the LHIN rather than with the ministry?

**Mr. Ron Gagnon:** I would say the entire plan. We had key results that were agreed to; we had funding that was agreed to. Once you have those in place, it should then be up to the LHIN and the local community to deliver against those objectives. You shouldn't have to be checking every individual action plan. I realize that that means mistakes will be made, but if we want an innovative health care delivery system, we have to be ready to accept mistakes. The only way you get better is by making mistakes.

**M^me^ France Gélinas:** Could you give me a specific example of something where you had to wait for ministry approval before going forward—a piece of your plan?

**Mr. Ron Gagnon:** The operation of interim beds. We're still 18 months behind.

**M^me^ France Gélinas:** Really? Okay. You had the money—

**Mr. Ron Gagnon:** We have the money; we have the facilities; we have somebody ready and able to deliver the service in the community.

**M^me^ France Gélinas:** But you don't have the okay. I can see your frustration, and I see Louise smiling, kind of. I think she would be willing to move in that direction also.

**Mr. Ron Gagnon:** I think she would as well.

**M^me^ France Gélinas:** Thank you.

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

Just before I hit the gavel for lunch, lunch for the committee will be in the Courtview West room. With that, see you at 1 o'clock.

*The committee recessed from 1200 to 1300.*

**The Chair (Mr. Ernie Hardeman):** I call the committee back to order. All present and accounted for, and no turkey for lunch, so we won't be falling asleep.

## MR. DAN WATERS

**The Chair (Mr. Ernie Hardeman):** Our first presenter is Dan Waters. Is Dan here? Here comes Dan. Thank you very much for being here.

**Mr. Dan Waters:** Thank you for having me.

**The Chair (Mr. Ernie Hardeman):** As with all delegations, you'll have 15 minutes in which to make your presentation, and you can use any or all of it. If you don't use it all, if there's less than four minutes, we'll have just one caucus with questions, and if there's more than four minutes, we'll divide it equally among the three caucuses and use up all your time. Your 15 minutes starts now.

**Mr. Dan Waters:** I'm a bit long-winded, so here's hoping I have some time left.

We're here today to determine whether the LHINs are fulfilling their mandate. In a nutshell, the organizations within the scope of the LHIN would work beautifully together if it weren't for the inconvenience of patients. Don't get me wrong. The caring, trained, front-line staff who attend to people in the health care environment are top-notch. It's the hierarchy of the organizations that becomes troublesome.

A local health integration network in our area, first of all, isn't really in our area. Our area is Parry Sound–Muskoka, but our LHINs are the North Simcoe Muskoka LHIN, based out of Barrie, and of course the North East LHIN. It isn't really a problem that is isolated to health care or to the LHINs.

There is a town, actually, in central Ontario that is served by three LHINs. Rather than having three sets of ears to hear their health care needs, they have no ears to hear their health care needs. Each of the respective LHINs believes the health care needs are covered by the next LHIN.

When there is only so much money to go around, it's easy to see why one LHIN would want to pass costs on to another LHIN. How do we fix that? Is the answer to get another management team to watch over the LHINs? Where does this stop?

What we have is an umbrella organization that passes our health care dollars to other umbrella organizations. We have a LHIN that distributes funding to, in our case, seven hospitals, 26 long-term-care centres, one commun-

ity care access centre—that once again does not supply service; it's just an umbrella—three community health centres, 29 community support services and nine community mental health centres.

The North Simcoe Muskoka LHIN is responsible for $815 million in funding, which is allocated to our 75 individual health care provider organizations. Each of the organizations operates within a service accountability agreement that details their funding, along with the performance targets and other requirements they are expected to meet. Some organizations provide more than one service. There are approximately 35 employees with the North Simcoe LHIN, and that's not counting the directors. If my memory serves me correctly, there are about six or eight who are on the sunshine list. And then, of course, the CCAC has people on the sunshine list as well—still no service to the individual.

Then we have the CCAC, which is another umbrella group. As mentioned in the opening of this presentation, this group would work beautifully together if it wasn't for the inconvenience of patients. The CCAC is a management group under the management group of the LHIN.

It has been said by the health care providers that if you become ill or need support during banker's hours, it's great; but if you are a human being who gets sick and needs support outside of banker's hours, you are a victim of the management groups.

These two groups allocate funding to hire services to the feet on the ground. The groups they hire also have management, of course. The problem is that by the time you get to the feet on the ground, the home care people, there isn't much money left, and they are paid poorly. In order to work in our area, they need to have a decent car and must travel a good portion of the day in order to see the excessive number of patients that they see. They don't get paid while they travel—which can be somewhere between half an hour to 45 minutes or longer—between patients. They get paid only for their patient care time.

According to the board chair at MAHC, which is Muskoka Algonquin Healthcare, our CEO also spends half of her time travelling, but, of course, she gets paid, and she does that to satisfy the LHIN. The highest-paid staffer is spending half of her time driving—a pretty high-paid driver, isn't she? It isn't just her; it's all of the smaller hospitals' CEOs. We need her at work in our hospital, not driving because she was summoned by the LHIN.

I'm not taking a shot here. Our highest-paid staff in our hospitals—and we have two under Muskoka Algonquin—need to be running our hospitals, not driving around central Ontario. In the case of North Simcoe Muskoka, an analogy used many years ago by Pierre Trudeau about living next to the USA was where he stated that it's like sleeping with an elephant: The elephant rolls over, and you're crushed.

It's the same thing with Parry Sound–Muskoka. The elephant is Barrie and RVH and Sudbury Regional Hospital, which are our two big hospitals. As much as we love the two hospitals, the bigger they grow, the bigger their communities grow around them. The smaller communities between them lose services, and they don't grow. Then the LHIN needs to rationalize our services and make our community health care more efficient by reorganizing it in such a way as to dispense with the unnecessary personnel or equipment. What they really mean is to cut front-line staff and services. That's the reality of it.

Here's an example. We closed beds at South Muskoka Memorial Hospital, so they laid off staff due to the closed beds. To this day, the community supports are not in place to cover the needs, so the people who need care end up in an over-census bed in the hospital. "Over-census bed" means closed beds. There isn't enough staff to care for the patient load because of the over-census beds. There is a problem here because, in the current funding model, the hospital doesn't get paid for over-census beds, so they sink deeper into deficit. Now they need to cut more, and around we go, spiralling downward.

I live in Bracebridge. I have an autoimmune disease that, in my case, has affected several organs in my body, mainly my lungs—you wouldn't know by the way I talk. My specialist is in Toronto, and he teaches all over the world. If I were travelling to another centre to get advice on my condition, why would I travel one hour instead of two? Why do we put all our eggs in RVH?

Let me ask the question simply: Why do we have a new cancer care centre in Barrie, in the north part of Simcoe, and another one in Newmarket, which is just south of the Simcoe boundary, both of them serving Simcoe county? At the same time, they're stopping chemotherapy in Bracebridge because, according to the CEO of the local hospital, the LHIN and Cancer Care Ontario want chemotherapy only in one hospital in Muskoka, so it's going to the Huntsville hospital.

We need chemotherapy in both Muskoka hospitals. The chemo treatments exhaust patients, and they become nauseated. We need to remember that the function of health care is to care for people. These people travel for up to an hour or more to get to Bracebridge, and you're now forcing them to travel another hour round-trip to Huntsville.

If patients live in rural Ontario, there is no transportation service to help them get to their appointments, no matter where their appointments are. These people who need to travel have incomes that are not supplemented by any plan outside of CPP and OAS. Most of the people in Muskoka work seasonally and in minimum wage jobs.

Women who are homemakers have no extra support. As an aside, we have another little problem with health care; I didn't know about this until my mother passed away. Because she hadn't worked for seven years because she was disabled and was on compensation for the majority of her life from about 70 on—those people are not even eligible for CPP death benefits. When you've got low-income families, they rely on that to help bury their loved ones, and they don't even get that, even though she was on compensation all of those years. I

have an aunt who owned a business, and because back then you couldn't pay into CPP, she'll get nothing. She doesn't even get any CPP now.

**1310**

We need to remember the function of the health—I'm sorry. I digressed here.

The cancer society in our area requires $100 up front to drive patients. The ambulances cost $45 each way. There's no guarantee they will make an appointment because emergency transfer comes first. Transportation is a big problem in rural Ontario and for our small hospitals.

As we eliminate services in our small hospitals, more and more patients are required to travel. In Parry Sound, they use the air ambulance, actually, to move people to Sudbury for tests. In Muskoka, those people who have appointments in Barrie often miss them because the ambulance has exhausted its ability to cover both transfers and emergency calls. There are some private transfer services, but they drain the patient care budget from the hospital exponentially. The financial cost of running transport services, both air and ground, may be greater than leaving the services in the hospitals in the first place.

Add to that that the funding model pays hospitals for services that they provide. So if the patients are sent to Barrie for services they would have received in the past in the Muskoka hospitals, Barrie gets the funding for the service and the stat for using the hospital, and it becomes a self-fulfilling prophecy. The small hospitals, again, take a hit.

There are good things, though, happening, one of them being with the local fracture clinics, where the initial visit with a surgeon or a specialist in any of the bigger centres is followed up by appointments that happen right in our ambulatory care area of our local hospitals. We just need to expand on it.

We are here today to determine if the LHINs are fulfilling their mandate. In a nutshell, the organizations within the scope of the LHINs—and I'll repeat—would work beautifully together if it wasn't for the inconvenience of patients.

It appears to me that there are so many levels of management that siphon off front-line health care dollars out of the system, we are in a spiral downwards. The hospital is the hub of health care in our communities. We need to bring the services and management services back to our hospitals.

As a person who used to sit around this table when this outreach home care first came out in the early 1990s—the idea then was that in small-town Ontario, as you took the services out of the hospitals, you would bring up the community health care services into the hospitals. It would give them the funding to meet our needs of a hospital in our community there. It would also allow for service in the community. I think that you have to look at it.

I know that we need the LHIN, because before that we had regional health care centres. There will always be a LHIN. What I'm worried about is the levels of management that are below the LHIN that really aren't performing any front-line service. They're not coordinating things.

I had a doctor talk to me last week. She had a patient come in on the Friday. She phoned the CCAC: "Sorry. We can't do anything until Monday. We just can't help them. We have no way to do that." Guess what? That patient stayed in the hospital for three days before they moved that patient out, instead of saying, "The doctor said they can go home. They need support. Here's the support." Those things are not happening.

I thank you for your time.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. We have exactly one minute, and it goes to the opposition. Ms. Elliott?

**Mrs. Christine Elliott:** Thank you very much for your presentation today. You've raised a lot of concerns that other people have raised to us as well about not having enough front-line services available—too much being taken up in administration and bureaucracy.

You may be aware that the Registered Nurses' Association of Ontario has made a presentation and is recommending that CCACs be disbanded and that the function that they perform be brought into what the LHINs do. Would you support that as a way of eliminating layers of administration?

**Mr. Dan Waters:** As long as the bureaucracy doesn't—it has a tendency to, in government, grow. Within the LHIN, I look at how some of these things happen. We were encouraged to have Muskoka Algonquin Healthcare instead of Huntsville and South Muskoka hospitals as two boards and two managements. Really, we have just as much management and probably more ineffective management than what we had before.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. It's much appreciated. We thank you for taking time to come here to tell us about your concerns.

**Mr. Dan Waters:** Okay. Thank you.

## MS. MARY ELLEN SZADKOWSKI

**The Chair (Mr. Ernie Hardeman):** With that, our next delegation is Mary Ellen Szadkowski.

**Ms. Mary Ellen Szadkowski:** I'm a delegation of one.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for taking the time to come in to speak to us this afternoon. As with the other delegations, you'll have 15 minutes to make your presentation. You can use any or all of that time. If there's any time left over, if there are less than four minutes, it will go to one caucus. If it's more than four minutes, we will divide it equally among the three. With that, starting now, it's your 15 minutes.

**Ms. Mary Ellen Szadkowski:** Mr. Chair, members of the committee, thank you for this opportunity to meet with you today and share some views from the front line, if you will. My name is Mary Ellen Szadkowski. I'm a registered nurse, retired. I have spent a number of years

in the health care system and have worked at many levels, including community nursing with the VON. I worked in nursing education; I worked in acute care. I spent some time with the Algoma District Health Council a number of years ago and worked with them as a health planner in mental health services. I've also worked in primary care and public health—I had a little stint in public health as well.

More recently, I started a consulting business. In that capacity, I had the opportunity to assist a family health team and two nurse practitioners get started, so developing their business plans and helping them to get launched.

That's the professional perspective that I have, but I'm here today mostly as a caregiver, as a family member of elderly relatives who have had experiences in the health system.

I just wanted to do a couple of things today. One would be to share some of their stories and perhaps make some suggestions based on the recent experience of family members, and then also reflect on my experience with the district health council compared to the LHIN today, how it's different and the strengths of it.

I'll begin with the story of some of my relatives. On two occasions, we've waited in the emergency room with frail, elderly relatives who sat for up to eight hours, waiting to be seen by a nurse. They were told during that time, "Oh, we're very busy." "Yes, we haven't forgotten you. We have other priorities right now." "No, we can't tell you how much longer it's going to be because there might be an ambulance case that comes through the door." In these cases, both of these patients left the emergency room without being seen. They had to sign papers to release themselves, but nobody seemed to care, and they left.

In another situation, the triage nurse was very quick to respond to symptoms of fever, nausea, vomiting and shortness of breath. This was followed up by a hospital admission of four weeks. The care that was received during that time ranged from considerate and respectful to dismissive and threatening at times. As a registered nurse, I was embarrassed by the behaviour of some nurses. I was asked by my relative not to complain. I said, "Come on; we have to do something about this." She said, "No, I don't want to do anything because it might affect the care that I receive. They might take it out on me," as it were. That concerned me as a health professional, that that was a perception that was there.

Although these experiences were quite upsetting, we are hopeful that with the Ontario Seniors Strategy and Dr. Sinha's report and recommendations—and recently, the LHIN had been facilitating discussions with the hospital to develop senior-friendly hospitals—we believe that these initiatives will be positive and will lead to some positive outcomes in the care that patients receive in hospital.

Following discharge from hospital, my 83-year-old aunt, with at least seven chronic diseases, who lives alone, received three baths a week from community care access. After a couple of weeks, a coordinator came in to visit her, completed an assessment form and abruptly told her that her baths were being cancelled, even though she was still quite weak and unable to get to the bathroom and was unable to arrange all of the appliances in the bathroom to allow her to have a bath; it was very difficult. I acted as her advocate in that case. I requested the manager to review the situation, and after some discussion, she agreed to have an occupational therapist come in and do the assessment to determine if my aunt needed a bath. In the meantime, because that assessment was going to take a couple of months, she agreed to one bath a week. So at least we have one bath a week, but it was a bit of a challenge having to go through those hoops to make that happen.

**1320**

As I've heard today, with CCACs it seems that the focus is not so much on patient-centred care but on completing paperwork and reducing services. It also seems that there are ever-increasing numbers of case coordinators whose roles seem to be minimizing costs and eliminating services. I'm sure that's not correct, but it's a perception that I have at the front line. In the meantime, patients who are experiencing health challenges are often left at risk in the community.

The growing number of seniors in our community places a heavy burden on the system that was designed for a much earlier time, when home care and CCACs were introduced. Things were different in those days.

The cost of care at home, we know, is less than the cost to keep patients in acute care, yet when the services are cut, it leads to the revolving door that brings patients right back to the hospital emergency room.

The Canada Health Act identified five principles for health care, and two of these are comprehensiveness, which means that all necessary health services must be ensured, and accessibility, which means that all insured persons have reasonable access to health care. Canadians have come to expect to receive appropriate health care as an insured service. The delivery of health care services at home needs to be reassessed, with a strong focus on services in the home that are comprehensive and accessible.

In spite of the negative situations I've just described, there were two very positive things that happened for my aunt.

Before she was discharged from hospital, she contacted the Algoma diabetes education centre, where she has been a patient for 10 years. They had copies of her lab results and were quite concerned that throughout her hospital stay her blood sugar levels were three to four times higher than normal. Over the telephone, the nurse advised her how to adjust the insulin dosages. Within a couple of days, her blood sugar levels were back to normal. The nurses and dietitians in this program are the community experts in managing diabetes, and it's unfortunate that they could not have more influence in the management of diabetes among hospitalized patients.

Immediately after discharge, a registered nurse from the congestive heart failure program came to visit my

aunt at home, and through her interventions, other medications were adjusted and her symptoms were relieved. This nurse has been a critical part of the last 10 years of my aunt's stay at home and allowed her to stay there and be more independent than she would have been otherwise.

These two ministry-funded programs provide effective and efficient services that have had positive impacts on the health of their patients. Although they are accessible to everyone in the community, since the Group Health Centre manages them, many people think that they are restricted to only those people rostered at the Group Health Centre. The Group Health Centre is a primary care centre that is unique in the province, with an alternative funding agreement with the Ministry of Health. It's not a family health team or a family health group or a family health organization or a community health centre. It's a multi-specialty ambulatory care organization of independent physicians. More than 60 family physicians and a number of specialists work out of this centre. The Group Health Centre has more than 60,000 of the approximately 75,000 people in Sault Ste. Marie who are rostered members. Many of the non-physician services such as the anti-coagulation clinic are only available to members of the Group Health Centre. I think this has contributed to the perception that the diabetes and the congestive heart failure programs are only limited to people who belong to the Group Health Centre.

In addition to the Group Health Centre, primary care in Sault Ste. Marie is available through the family health team, the nurse practitioner-led clinic and a few family physicians in private practice. The family health team and the nurse practitioner clinics are required to participate in quality initiatives of the ministry and are accountable for the services they provide. However, because the Group Health Centre has a unique funding model with the ministry, it is not required to participate in quality initiatives and not required to provide information on any of their performance indicators, such as wait times for appointments, services provided, health promotion and education initiatives.

In order to ensure consistency, quality and public accounting of expenditures and outcomes, all primary care services should be included, along with the community health centres, hospitals and long-term-care homes, as health service providers under the act.

Over the past few years, the LHINs have had significant influence in moving to patient-centred care and away from provider-centred care. Many providers have begun to incorporate patient satisfaction surveys. While these scores are an important measure, they must be balanced with quality outcomes. On one hand, the staff may demonstrate care, understanding and hospitality to the patient and the family, which makes them feel satisfied; however, if the care has been substandard or does not follow accepted professional guidelines and has resulted in errors, the quality scores could be quite low.

Many resources are now available through Health Quality Ontario to assist providers to develop appropriate tools and their processes for monitoring and improving their services. Requiring that health care providers use these will provide assurance that the methods used are valid and reliable, and will reduce the risk that providers have good answers but to the wrong questions.

In the early 1990s, I worked as the health planner for the Algoma District Health Council. We recruited many local residents to provide input and advice on health system issues, and we developed many plans to meet local needs. The DHCs were limited in their ability to effect change because all of the funding decisions were made at Queen's Park. There were times when we developed community-based plans and made recommendations that we were quite proud of, but they were not approved by the Ministry of Health. In some cases—and this my belief, my opinion—this was due to lobbying efforts on the part of local providers to have decisions made in their favour regardless of what the planning efforts had.

One of the major weaknesses of the district health council model was the lack of authority and the ability to hold providers accountable for meeting the goals or targets within the budgets provided.

The DHCs were excellent planners, and we had a wide range of data available. In the LHINs, this service has been enhanced through technology and the ability to provide a wide range of data quickly to assist others in health planning.

The Local Health System Integration Act decentralized decision-making on health system issues, and the new LHINs were given the power to make decisions based on evidence and input from local communities. While the LHINs have been given the authority and planning in the delivery of health care, confusion still remains because some community-based health services funded by the ministry are not required to report through the LHINs. Primary care, paramedics and public health are examples of organizations that have significant impact at the local level but are not included under the act.

In my experience, the LHINs listen, validate and take action to improve health care. They have led health care providers in moving to a patient focus. Back in the early days, it was uncommon to have patients or consumers at the planning tables for decision-making, but it's just standard and expected procedure these days under the LHINs.

A real strength of the LHIN, in my opinion, is the demonstration of transparency. All of us have access to information. We're allowed to attend meetings either in person or by electronics. We're always being asked to contribute ideas and suggestions. Accountability agreements between the LHIN and the health provider agencies are available and we can see what the results are.

The LHIN has made efforts to introduce innovative programs. One example of this is a pilot project in Sault Ste. Marie, where we don't have too many psychiatrists. It's done with the LHIN and the Ontario Telemedicine Network. When a primary care provider wants to have a patient seen by a psychiatrist, they could be seen through

the Ontario Telemedicine Network. A videotape is made and sent to a psychiatrist, who reviews the patient's history, renders a diagnosis and refers a treatment plan to the primary care provider, so that the care has some continuity. I think this is an example of how the LHIN has really supported us to be innovative and creative.

They also have taken major steps to help us become familiar with new education opportunities. They've led conferences of share planning between the district.

**1330**

In my opinion, the local health system integration network has been effective in improving our access to health services, improving coordination among local providers, increasing participation of citizens in health planning, and improving accountability and transparency in the delivery of these services. This review, I expect—with some additions that will be made, I'm sure—will help to make that even stronger.

I have three suggestions for you that I've discussed briefly: One is that home health care services be reassessed, with a focus on comprehensiveness and accessibility; that primary health care services be included as one of the health providers under the act; and that all health care providers be required, or at least encouraged, to use Health Quality Ontario tools to ensure their quality of service.

Thank you very much for your time.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. It's much appreciated. All the time has been consumed, so thank you again for being here and assisting us in our endeavours.

## SUPERIOR FAMILY HEALTH TEAM

**The Chair (Mr. Ernie Hardeman):** Our next presenter is the Superior Family Health Team: Alan McLean, family physician. Thank you very much for coming in and sharing your time with us this afternoon. As with the other delegations, you'll have 15 minutes in which to present your presentation. You can use any or all of the time, but if there's time left, if it's less than four minutes, it will be just one caucus getting questions. If it's more than four minutes, we will split it equally three ways. All that is somewhat irrelevant from here on. The next 15 minutes is yours.

**Dr. Alan McLean:** God bless you guys for sitting here all day like this, listening to people like me. I'm impressed.

I'll talk a little bit about why I decided to come here. I am a family doctor. I've worked in several different organizations. I started out fee-for-service. I've worked in the group health that Mary Ellen talked about. I've worked in a family health group, and I'm now working with the Superior Family Health Team and a family health organization. The other things I've done: I backed into a job as chief of staff at the Sault Area Hospital about eight years ago, so I was intimately aware of the relationship with the hospital and the LHIN from the beginning. I have a number of experiences around that, and I thought I'd like to bring those to share about what the LHIN has accomplished going forward.

The other thing that I do is that I have become the primary care provincial LHIN lead for LHIN 13. It is an important role in terms of trying to get primary care integrated into the system. It also gives me the opportunity to go and talk to all the other LHIN leads and see what's happening elsewhere in the province. I do think it underlines the need for local decision-making processes in terms of health care. Downtown Toronto does actually have just as many challenges as we do in the north. They're very different challenges; they have to do with the diversity of population and huge density of population as opposed to huge distances. So to think that you could make the same thing work there as works here, I think, is somewhat crazy-making. But we do still learn from each other. There are still similarities, and I think it's important for us all to work together at the solutions and to learn from each other and steal solutions from other groups when it's possible.

Health care in Ontario is an incredibly complex system, as I'm sure you're all aware. There are multiple facets and a huge amount of bureaucracy, as I've heard a couple of the speakers speak to. But there are huge expectations in delivery. A lot of services are delivered to a lot of people, and it is difficult to pare down the bureaucracy when you're delivering that kind of care and the amount of costs that it includes. A little bit less bureaucracy in some cases would certainly be helpful, I think.

In terms of even the LHINs' function, I think local decision-making is important. Often, they get their hands tied by higher-ups in terms of limits in what they can do, and certainly, as Mary Ellen mentioned earlier, the fact that it's hard to integrate and coordinate when all the services aren't under their purview—the public health units, primary care. Anytime you're looking at doing a program to improve care and get everyone working together, we can ask them to participate, but there certainly is no accountability where we can ensure that they participate in programs going forward.

In terms of what I've seen in the last eight years, I think—I see Richard back there from CCAC, and I feel bad for him because my example comes from CCAC as well, but it is around an improvement, actually. About eight years ago, when I was chief of staff, the CCAC ran out of money in February. From February until April 1, the new fiscal year, they would take no referrals from the hospital. There would be absolutely zero patients getting services, coming from the hospital, at home. That, of course, left many patients stuck in the hospital, which is where your most expensive care was. That was crazy. That would never happen today, albeit they are looking at cutting services because of costs and because of the immense amount of services that they have to provide, especially with our aging population. But there is much more coordination.

Certainly, the ideal—and it would be difficult to know how to do this—would be to have the money follow the patient, so if there's funding for a patient, and they move

from the hospital into CCAC, the funding follows them, rather than this siloed approach of funding each organization separately. I'm not actually proposing that you blow the whole thing up and start over again, because I think that would take several steps back. In fact, in looking at that, going to the different leadership conferences for physicians across the country, it was a number of years ago that Alberta went from—well, first they were provincial, then they went to local and then they went back to provincial. There was such anger amongst the physician leaders and front-line staff when they were flipping back and forth. They lost a lot of leverage, they lost a lot of good people who went elsewhere, and they lost a lot of forward momentum in terms of switching back and forth.

I do think we had problems with the LHIN in the beginning changing direction, and frequent changes of CEOs as well. I think that has come around somewhat. There is a lot more patient contact and interacting with patients to figure out the mission of the LHIN and following that direction. I think they're just starting to fire on all cylinders a lot better, looking at integration, getting people working together. I think it's difficult to review them at this point. I know it's timely to do that; however, I think it needs another few years. I think if we start blowing up the system and going to another one, we'll go back five steps and then have to go forward all over again.

I think I had other things written down here but—you guys must get bored. No, I said all those.

I would also like to—

**M^me^ France Gélinas:** We have questions if you're desperate.

**Dr. Alan McLean:** Never desperate. In terms of my suggestions—we'll look for questions afterwards—I do think we should look at, overall, the better integration. I'm not sure the LHIN has the capacity right now to expand, but the ideal situation would be funding pots that are more totally controlled by a single organization, less siloed budgeting and more aspects where the money actually follows the patient. There certainly has been a proposal that—in terms of quality improvement, I think aligning quality improvement plans amongst all the different organizations would be helpful so that we can actually achieve—so you don't have different organizations fighting against each other. I think there would be a certain aspect of quality improvement leading to money savings, being able to reinvest those money savings in the community. I think that would lead to higher-quality cost savings and better quality of care for the patients. I do think that's why you folks are here and I think why most of the people in the audience are here. At the end of the day, it's about better care for the patients. I think we all need to remember that.

With that, I'd be happy to have any questions.

**The Chair (Mr. Ernie Hardeman):** Okay. With that, we have about nine minutes left, so the first question—we'll divide the nine minutes up three apiece, and it starts with the official opposition. Ms. McKenna.

**1340**

**Mrs. Jane McKenna:** Thank you so much for coming today and giving us your presentation. Obviously, you know the reason that we're having these is not for a Kumbaya session for everybody to come and tell us how great it is, but it's to get recommendations of how we can actually make it better. Besides your one—blowing up the whole system and having the money—

**Dr. Alan McLean:** That wasn't a recommendation.

*Laughter.*

**Mrs. Jane McKenna:** Yes, I know.

We would really just like to get some concrete recommendations of what to actually move forward with. So if you could tell us one thing, with all the expertise that you have and all the positions that you've had, that would actually make it flow better for the patient, what would that be?

**Dr. Alan McLean:** If I could have two, one would be the continuing engagement of the patients. I think you have to hear their stories and know what they're going through, and I think that needs to be the focus in terms of determining where your policies and processes go.

I think the thing we haven't done as much is engagement of the front-line workers. They have all kinds of ideas about what's happening, what makes them crazy in terms of things they're doing that is wasted time, and in terms of how to get the care to the patients. I think engaging them would help direct the system to lose all kinds of waste and benefit the patients at the same time.

**Mrs. Jane McKenna:** You're saying that the front-line people are the ones who have the frustrations and probably most of the answers about how some of the system can be fixed. Who are they actually giving that information to?

**Dr. Alan McLean:** Sometimes they feed it up the line. They often complain to physicians about it. Let me throw an example out there, just for fun. There are care coordinators in our hospital whose responsibility it is to get patients out of the hospital, to the appropriate place. Right now, our number of people going to nursing homes is too big. They will sometimes go in and see patients who are clearly not able to go home, no matter what services you put in, but they are required to go back to those patients to reassess them to see if they can go home, because our number is too big. Listening to them about the individual patients, they're spending a lot of time that they know is wasted, being required to do that, which is a bit of a problem. That's one that they expressed to me. I'm pretty sure they've expressed it up the line at their own organization. Again, the focus is on the big number.

If I could throw another one in there, too, in terms of—

**The Chair (Mr. Ernie Hardeman):** Thank you very much for the answer.

Ms. Gélinas.

**M^me^ France Gélinas:** Coming back to primary care, a lot of people have said they're quite satisfied with the work that the LHIN has been doing, and they're looking at expansion. Some of them talk about how public health

units should be planned and financed by the LHINs. Some of them have talked about primary care, which has to do with your line of work. Do you see value in having the LHINs decide where the next family health team is going to be; where the next community health centre is going to be; where the next nurse practitioner-led clinic will be; where the next aboriginal health access centre will be? All of those decisions are made by the ministry right now. Should they be made by the LHINs?

**Dr. Alan McLean:** Yes.

**M^me^ France Gélinas:** Why?

**Dr. Alan McLean:** I think they have a better idea of where the needs are, a better analysis of not only where the orphan patients are—the patients without physicians—and where special-needs groups are, so areas where there are huge rates of diabetes, or areas where there are certain groups of people who can't currently access care. I think they would be able to possibly place the chess pieces a little bit better, looking at it on a more local level than provincial.

**The Chair (Mr. Ernie Hardeman):** Mr. Fraser.

**Mr. John Fraser:** Thanks very much for your presentation. It was very thoughtful.

My question is about primary care as well, as you're the primary care lead. I want to come at it from a different point of view. I know you spoke about care coordinators in terms of hospital discharge, but from the primary physician point of view in terms of a patient coming from the community, how do you see what you're doing right now as a primary care lead—what do you see as a solution to, sometimes, a lack of connectedness and cohesion that exists in the family health practice as it relates to the rest of the health system?

**Dr. Alan McLean:** There's a few different ways we're looking at doing that, and that is the focus of our primary care group at the LHIN. One of our focuses has been collaboration and co-operating with the CCAC. I think there has been a lack of communication both ways, from primary care to the CCAC and back, and we have formed a subcommittee to work with the CCAC on that.

The other big way we're looking at trying to get primary care in the loop is with the health links proposals that have come up. Health links involves getting all the different organizations—and primary care is required to be involved in that—to provide care plans for the neediest patients. I think that will get primary care working with all the other organizations—the hospitals, the CCAC, mental health, even nursing homes—and I think there will be ripple effects from that. They'll get to know the other organizations and will be talking about other patients too. I do think that we'll benefit from that. So that has been the focus of our primary care group as well, trying to move the health links system forward.

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

## NORTH BAY REGIONAL HEALTH CENTRE

**The Chair (Mr. Ernie Hardeman):** Our next presenter is the North Bay Regional Health Centre: Nancy Jacko, vice-president, planning, partnership, professional practice and chief nursing executive. That must be the whole administration of the health centre.

**Ms. Nancy Jacko:** Yes.

**The Chair (Mr. Ernie Hardeman):** Very good. Thank you very much for being here. As with the previous delegation, you have 15 minutes to make your presentation. You can use any or all of that time for that presentation. If there's time left over, we'll have some questions from the caucuses.

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

**Ms. Nancy Jacko:** Thank you very much. As you know, my name is Nancy Jacko and I have that long, long title, and I think I get paid if I can say it right in a day.

I also have with me Mr. Phil Geden. Phil is the chair of our board. Also in the audience is Monica Bretzlaff, who is our regional manager of Behavioural Supports Ontario-North East.

Thank you for this opportunity to present to the Standing Committee on Social Policy, reviewing the LHINs' governing legislation, the Local Health System Integration Act, 2006.

Having the LHIN oversee our sector of health care in our LHIN 13 over the past eight years has allowed our organization to reflect on the impact of this oversight change. It is clear that it has taken a few years for the LHIN to establish processes and relationships with the varied care providers under their mandate in this vast geographical territory. As with any change, it took all of us time to understand their role and the accountability requirements. It now seems like the relationship has developed, and the benefits of local solutions have begun to provide positive opportunities for collaboration across the northeast.

You may not be aware that the North Bay Regional Health Centre is the product of three amalgamation processes spanning 19 years, the most recent one being North Bay General Hospital and the Northeast Mental Health Centre in April 2011. Prior to the decision to amalgamate, we had been ordered by the health restructuring commission of the late 1990s to integrate as many services as possible, as we planned to build and move into a new facility still being two corporate entities.

To integrate services, significant numbers of service level agreements were required to define relationships between the two organizations. This consumed a great deal of time for leaders in the organizations, and significant legal costs were incurred. Neither of these activities—I mean the time spent by leaders and the significant legal costs—enhanced patient care in any way.

Finally, the boards and senior leaders at both organizations came to the conclusion that a corporate amal-

gamation would allow us to dedicate our limited financial and human resources to providing the best care for the patient, both mind and body.

This amalgamation was complex, merging a regional mental health facility with a district general hospital. The LHIN, due to the restrictions to its powers, was unable to authorize an amalgamation. We, along with the LHIN, were required to follow many steps to seek the required approvals through the Ministry of Health to implement this positive change. Once again, this resulted in significant manpower and legal costs.

**1350**

There are many opportunities amongst the numerous health care providers with whom the LHIN has accountability agreements. Integration processes, in many cases, will be both resource-intensive and may not fully realize the quality of service and efficiencies that amalgamation would.

To achieve the truly best results that the LHINs are accountable for and the people of the province expect, they must have the authority to execute the required system changes with local stakeholder input. Collaborative opportunities orchestrated by the LHIN have brought both hospitals and community providers together in joint planning and projects. Transparency of shared data amongst the organizations has created the ability to establish and share best practices, resulting in improvements to care and the patient experience across the northeast.

For example, following the development and implementation of our North East Behavioural Supports Ontario initiative, we have been witness to impactful system transformation. Through the LHIN's leadership, we've experienced a renewed focus on inter-sectoral collaboration, which has helped dissolve historic barriers and enabled the implementation of collective best practices. The end result is a program that was built on stakeholder input and addresses the unique needs of our region.

To truly improve system navigation, transitions in care, wait times, costs, staff and patient safety, and quality of care, the entire continuum of care must be accountable to one another. Currently, primary care, composed of family physicians and nurse practitioners, as well as public health units, are not under the authority of the LHIN. Their impact on the other health service providers that are accountable to the LHIN leads to fragmentation in the provision of care and subsequent inefficiency. For example, the initiation of a health link in our area has required a separate process to engage physicians when most of the other key providers are at the table at the call of the LHIN. Ideas to improve care, such as health links, are very innovative. However, implementation may become onerous when prime partners must be rallied to participate and have the option to decline.

To sustain and improve the current standard of health care, system transformation must occur at an accelerated rate. Optional integrations will not occur quickly enough. Radical changes made in isolation to balance budgets may have unintended consequences for the entire system, eroding the quality of care. LHINs must have the breadth of authority to implement these changes at a local level with stakeholder input and measurable outcomes to ensure the best use of resources and, ultimately, the best quality of patient care.

In summary, the North Bay Regional Health Centre believes that in order to get the very best quality and safety in patient care, accompanied by the best use of limited resources, we recommend the following:

The LHIN's breadth of responsibility should be augmented to oversee at least primary care and preferably public health and other health care organizations within the LHIN.

The LHIN should have the authority to initiate and approve integration or amalgamation of services within its area.

The terms of reference for such integrations or amalgamations must allow local solutions to occur, taking advantage of particular best practices within each area of the LHIN.

The terms of reference should mandate local consultation before any implementation occurs, but the final authority should rest with the LHIN.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. We have about eight minutes, so we will each have two and three-quarter minutes. We start with the New Democratic Party, the third party: Ms. Gélinas.

**M^me^ France Gélinas:** Okay. I think you were in the room when I asked the previous presenter, Dr. McLean, about bringing some funding and decision-making authority to the LHINs. You have it as one of your key recommendations for primary care. Could you explain to me the breadth of primary care that you would like rolled into the LHINs? Or, as you say, the responsibility should be augmented to oversee at least primary care. What size of the primary care pie are we talking about?

**Ms. Nancy Jacko:** We're speaking about all our primary care in the way of physicians and our nurse practitioners; those are the two that I was thinking of, that have the most impact in our relationship in the community.

**M^me^ France Gélinas:** So that would include all of your solo fee-for-practice etc.?

**Ms. Nancy Jacko:** Yes.

**M^me^ France Gélinas:** Okay. Do you know if that idea has support within your realm of influence, with the people you know?

**Ms. Nancy Jacko:** I would say, certainly, with some of our—do you mean physicians or do you mean other health care providers?

**M^me^ France Gélinas:** Everybody you know.

**Ms. Nancy Jacko:** I think that you would certainly see it with many other health care providers, because we all have our ability to meet together, but there's a different relationship with primary care.

From a physician perspective, those who have probably embraced more modern practices, like your family health teams, would probably be more amenable, because

they also see the connections in the systems. It might be a little bit more challenging with your independent practitioners, because they've stayed that way because it's the way they like to operate.

**M^me^ France Gélinas:** You said "preferably public health."

**Ms. Nancy Jacko:** Yes.

**M^me^ France Gélinas:** So you would like public health to also be under the responsibility of the LHIN?

**Ms. Nancy Jacko:** Yes. We increasingly see such a connection with the hospitals, with all the things with infection control measures, the outbreaks with long-term-care homes. They have a great deal of work with all of us across the whole sector.

**M^me^ France Gélinas:** The second one, I don't really get: "The LHIN should have the authority to initiate and approve integration or amalgamation of services...." They already do.

**Ms. Nancy Jacko:** Integrate, but not amalgamate. In the case of boards, they can't order boards to make decisions, and with us—

**M^me^ France Gélinas:** That's what you mean by "amalgamation"?

**Ms. Nancy Jacko:** Yes.

**M^me^ France Gélinas:** It's amalgamations of agencies. Because they can already do integration of services, now it would be amalgamations of agencies.

**Ms. Nancy Jacko:** Yes.

**M^me^ France Gélinas:** Okay. That would be not only the agencies themselves but their boards, their letters of patent, the whole thing?

**Ms. Nancy Jacko:** Yes.

**M^me^ France Gélinas:** Okay. You don't see any downside into losing boards of directors?

Maybe I'll ask this to you. A board of directors brings the governance. They are usually not-paid volunteers who give you the long-range planning for your agency. Do you see any risk in losing those?

**Mr. Phil Geden:** I suppose it's just the fact that people are going to feel threatened, I guess, to a certain extent, but so what? I mean, it has got to happen. It's all on the basis of the best patient care. It's as simple as that. So I don't think so, no.

**M^me^ France Gélinas:** Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. That concludes the time there. Ms. Jaczek?

**Ms. Helena Jaczek:** Thank you so much for coming in. As MPPs, probably one of the biggest complaints we get from our constituents is patients being discharged from hospital and that transition, whether it be to long-term care or whether it be to the home, is problematic for many people. I'm looking at this from the patient's point of view. At the North Bay Regional Health Centre, do you still have a position called "discharge planner"?

**Ms. Nancy Jacko:** We have a very strong discharge-planning process in our hospital. Actually, our ALC rates in that are very, very good. We work very well with our community partners.

**Ms. Helena Jaczek:** You also have a care coordinator from the CCAC.

**Ms. Nancy Jacko:** We do.

**Ms. Helena Jaczek:** So there are two individuals planning on the process. Is that how it works?

**Ms. Nancy Jacko:** Yes, and they plan together. Actually, we co-locate them in the same office so that there is a duplication of processes, so that they each cover their own area that needs to be covered, and it works very well.

**Ms. Helena Jaczek:** I guess we've heard a lot of concern about over-administrative practices with the CCAC, that the CCAC essentially just brokers direct patient care. Do you subscribe to any of that, from your observations?

**Ms. Nancy Jacko:** It's all in how your relationships work. If you keep the patient at the centre, you're not going to be duplicating services. What you're going to be ensuring is that the patient has the safest discharge, and that's what we aim to do.

Of course, there are always restrictions of funding and those other things that we can't change, but we try and work together, bringing in all of those services and working together to achieve the best transition for that patient.

**Ms. Helena Jaczek:** Thank you.

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

**Mrs. Christine Elliott:** Thank you very much for your presentation. I'd just like to follow on from Ms. Jaczek's questions. Just to understand, what is the responsibility of your discharge planner, and what's the responsibility of the CCAC care coordinator? How is it they don't overlap?

**Ms. Nancy Jacko:** One of the things is, you can't bring in your care coordinator without a referral. What our discharge planners do is look at high-risk patients who come in. They see almost each and every one, because we have them assigned to the different areas. They help navigate that patient's course to discharge.

If, at some point in time, CCAC services are required, the CCAC is brought in, but sometimes those services aren't required. They work with families. If families are going to take the patient home, maybe the CCAC isn't required. Maybe a community support service will do the role, so a CCAC may not be involved. There are different patient groups that could be dealt with, strictly with the discharge partners; other times, the CCAC is required to be brought in for the complexity of that patient.

**Mrs. Christine Elliott:** Thank you.

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

**Ms. Nancy Jacko:** Thank you.

**1400**

## PEOPLE FOR EQUAL PARTNERSHIP IN MENTAL HEALTH

**The Chair (Mr. Ernie Hardeman):** Our next presentation is People for Equal Partnership in Mental Health: Joel Johnson, family program manager.

**Mr. Joel Johnson:** Good afternoon.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for being here, and good afternoon. We thank you very much for coming in and sharing your time with us. You will have 15 minutes to make your presentation, and you can use any or all of that time for your presentation. If there's time left over, if it's less than four minutes, we will have just one party ask questions; if it's more than four minutes, we'll try and divide as equally as I can to all of the three parties.

I just wanted to question, before you start your time: All day, we've been moving farther down the table. I think you're the first one that's looking for the door.

**Mr. Joel Johnson:** Where have we started?

**The Chair (Mr. Ernie Hardeman):** On that side, but it's okay. No, it's okay. I say that in jest. You can take any—

**Mr. Joel Johnson:** Not at all. Actually, I could just slip up front with you there, and we could work it as a television opportunity.

**The Chair (Mr. Ernie Hardeman):** There you go. With that, I'd better start your time. The next 15 minutes is yours.

**Mr. Joel Johnson:** Thank you very much. I'd like to say thank you for bringing the select committee together and for taking a close look at this, because I think that this is a very opportune time in the development—especially of the provincial strategic plan, especially around mental health—for bringing a little bit of a check mark into place and taking a look at where we're at and where we can go from here.

We have a couple of facts that we'd put on the table. First of all, we have an aging population. The demographics are such that, in the northeast region, the largest segment of the population are aging. We call ourselves the baby boomers, and we require and demand good, solid health care and equal, equitable access for all of the citizens in our region. It's one of the things we demand as citizens of our province.

We're a big province. I sat as the president of the Ontario Peer Development Initiative, which is the provincial voice, if you will, of consumer-survivor initiatives, community mental health agencies that deal with peer support and consumer-survivors. I sat there for six years and worked with the ministry and some of the LHINs, both down in Toronto and up in the north here, and one of the things that struck me is that the LHINs are as varied as the population, and the solutions are as varied as the population as well.

I wanted to set that as the baseline for some of the things that I'd like to say next, because I really want to look at this perhaps a little more philosophically. Although the devil is in the details most of the time, it has to come from the right value system, and it has to come from the right strategic plan.

With the consideration that we look at our citizenry from a physical and mental health perspective—both those living in the heart, if you will, of downtown Sudbury and on the coast of James Bay—we look at them with the same lens and the same service paradigm in mind. We have to start considering what the LHIN has brought into the system by coming down to a regional level.

I'm going to speak specifically of our district, which is the Nipissing district—and North Bay particularly, because that's where I serve—but I have to look at the differences between how we worked with the ministry prior to the LHIN and how we've been working with the LHIN.

It's been a long, long road, but one of the things that I discussed with my team before I came here is, I asked them to give me a definition or to draw a line between the words "revolution" or "evolution" of a system. To a member, around the table, we decided that, from an evolutionary point of view, there is sustainable growth and sustainable movement towards patient-centred care and towards enhanced value for what we provide. That can sometimes mean that we provide more, as community agencies, as hospitals, as CCACs. It can often mean we provide more, or often it can mean that we have built efficiencies into the system.

One has to, of course, look to what has facilitated that. I have found and our team has found that over the years now, as the LHIN has come into its own, if you will, the process in our district has been descriptive as opposed to prescriptive. Through that descriptive process of engaging with our senior policy analysts or what have you and having them attend our district tables where we make decisions for community services in our district, they bring to the table with them an understanding of what the LHIN has available, what the region has available, the movement in the various aspects of their top three priorities or what have you. They bring that to the table and then discuss with us, each and every one of us at the table—we have all of our agencies represented at our district table, as well as a consumer representative, a family representative, and we have a discussion with our LHIN representative as to our next steps forward.

We have built a partnership with our LHIN, and the partnership looks an awful lot like we're an advisory body, and then other days it looks an awful lot like we have a need and the LHIN is our advisory. But at the end of the day, not any of it has been prescriptive. There have been things that have had to be done and we've all had to come to consensus on it. Sometimes that consensus is difficult. It calls to mind, of course, the silos, which I'm sure you've heard lots of throughout the day today. But from a strength-based point of view, I can honestly say that I haven't met a person in our system who has anything but the good of the patient, the good of the client, the good of the member, the good of the citizen at heart. We're all doing our job to the best of our ability, and sometimes that has required a whole lot more. It's difficult to hold and retain highly qualified staff sometimes with, of course, the freezes on salaries and so on, but the LHIN always manages to find a way to assist us in the process of moving the system forward, sometimes collaborating with each other, sometimes just offering

some of their expertise around how other districts have managed or dealt with a situation that we may be dealing with at the time. So I find them a phenomenal education resource as well.

The main driving point for us—and this is a bit of a feel-good story, yes. If you're looking for recommendations from me as to what I would change, that's coming.

Our perspective, and I'm here representing a number of us in our district, especially around peer support—peer support has been a phenomenal opportunity in the district and we're starting to realize gains in it. But another thing we're starting to realize: I'm only one step removed from the grass itself. My feet still hit the grass, so I understand what people are saying because they're saying it to me too. I manage a process, I manage some staff, but I'm right in there with them, with sleeves rolled up. As a matter of fact, I wanted to make a point here.

What I'm looking at is I'm looking at the LHIN and our policy analysts and our integration analysts from Sudbury, from North Bay, what have you, providing us with facilitation. They don't stipulate; they facilitate—strongly worded suggestions at times, out of necessity, always with a ready explanation, and sometimes the explanations don't always add up at the end of the day either, but that is evolution, isn't it? That is what we do when we evolve a system as opposed to radically altering or changing to meet the political will of that particular decade.

It struck me as odd—amusing but odd—the research department in Toronto that I was working with said their expectation was that results would be forthcoming in 12 to 15 years. My comment was, "Gee, I really hope I'm alive, because I want to know how this works out. I hope I make it that long." But that is evolution, and that's what it takes sometimes.

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It's a complex system, as has been said, I'm sure, numerous times. It's a complex system with very complex needs and demands, with an ever-burgeoning population with the requirement—and not always the funds available that would address that; the same dollar-per-person value that we've perhaps enjoyed in the past. So that's where we're at right now.

From the perspective of the LHIN, then, our team finds, not just as a partner, but as a funder, that they have been fostering change and assisting with change management in ways that only a local understanding of the system—again, I'm speaking more from a mental health, community agency perspective at this point. Only a local understanding of the system could bring forth the change management that has been required over the past couple of years, as the LHIN has truly come into its own.

The one very strong recommendation that I would put forward—and this is consensual, from all of the team members I spoke with before I came today: We ask that they stay the course. For crying out loud, don't change too much now, because we're on a roll. Thank you.

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

We have enough for the circulation, about two and a half minutes each. We'll start with the government side. Mr. Fraser.

**Mr. John Fraser:** Thanks very much for your presentation. It was very thoughtful. I appreciate the fact that you talked with your team before you came and that you had a discussion about this. Obviously, there was a lot of collaboration.

I understand your recommendation, but I want to ask you, in terms of your organization, what role do you play? You're a family program manager. Just for my own edification, what does that mean?

**Mr. Joel Johnson:** Interestingly enough, in the realm of peer support in mental health, we basically have two groups. We have consumers and consumer managers—those are managers of staff who work with consumer-survivors, or consumers, as you will. On the other side, we have family programming, with family staff. Each and every one of us, especially at People for Equal Partnership in Mental Health, are either consumers of mental health services who are employed by PEP, or consumers or family members working in the family program, also at PEP, who have lived experience with family. I have a brother who has a serious and persistent mental illness, so I am a family member. I deal with it on a regular basis, and therefore I can come at it from that perspective.

Did that come close to what you were looking for?

**Mr. John Fraser:** Yes.

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

**Mrs. Christine Elliott:** Thank you very much for your presentation, Mr. Johnson. It's very encouraging to see so many groups involved with mental health that have come forward to present to us.

We still hear, though, that the system is still very fragmented, and I'd be interested in hearing from you about what the LHIN is specifically doing in the mental health area to create more of a unified system to make sure that no one falls through the cracks.

**Mr. Joel Johnson:** That's a good question.

**Mrs. Christine Elliott:** Thank you.

**Mr. Joel Johnson:** I come from a background of lecturing at universities, which is why I think they sent me. Nonetheless, to keep it short, I would have to say that what the LHIN does is they move into our district, they come into our tables, they talk with us and they bring forward where we need to go.

I'm going to talk about "integration" here, because I happen to think it's a great word—it's right in there with "collaboration." "Okay, we need to do this. We need to bring some of you together. We need to help you to partner." That's what they do. They come in and they facilitate the partnerships that are required, without directing us specifically as to how to do that.

**Mrs. Christine Elliott:** Thank you.

**The Chair (Mr. Ernie Hardeman):** The third party? Ms. Gélinas.

**M^me^ France Gélinas:** I will start my questioning the way I did with most others. What would you say are the top needs priority for the clients you serve?

**Mr. Joel Johnson:** Continuous access as they require—

**M^me^ France Gélinas:** Access to?

**Mr. Joel Johnson:** Access to services. I don't want to get too specific, but I'll say, from a mental health perspective, access to mental health services when they require it and in a way that they can access it freely—"freely" meaning, of course, that the time and the place is to their advantage, not disadvantage.

**M^me^ France Gélinas:** Okay. So problems with access, as in, the services are not accessible when they need it or where they need it?

**Mr. Joel Johnson:** Accessibility is directly linked to capacity.

**M^me^ France Gélinas:** Wait-lists, you're talking about?

**Mr. Joel Johnson:** That could be one of them, yes.

**M^me^ France Gélinas:** Okay. So that's your number one. What would be number two?

**Mr. Joel Johnson:** You know, when I said, "stay the course," ma'am, what I was really saying is that I think a number of my issues are being addressed and the issues of the system are being addressed as an evolution. My number two issue, of course, is the ability to train people from all of the different perspectives that the client requires or that our member requires. For instance, if it's peer support, I want trained peer support workers; if it's case management, I want trained case management people available, and I want them on the ground and reaching out—not waiting; reaching out. But that requires capacity, as well.

I promised myself I wasn't going to hammer on the capacity issue but, at the end of the day, my issues revolve around the ability to enhance or increase capacity in a smart way that doesn't continually bloat the system but serves the paradigm that's being developed right now, which is a care paradigm unseen in the past, quite frankly.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. That concludes the time allotted, so we thank you very much for your presentation, and maybe we'll start the flow again.

**Mr. Joel Johnson:** Thank you all.

## FINLANDIA VILLAGE

**The Chair (Mr. Ernie Hardeman):** The next presenter is Finlandia Village: David J. Munch, executive director. Good afternoon. Welcome and thank you for coming in today. You will have 15 minutes in which to make your presentation. You can use any or all of that time for your presentation. If there's time left over, we'll have questions and comments from caucus. With that, your 15 minutes starts right now.

**Mr. David Munch:** Excellent. Good afternoon, Mr. Chair, and everyone here today. Thank you for allowing me to present. My name is David Munch and I am the executive director of Finlandia Village, and have worked in the seniors' housing and health care sector for the past 18 years. I'm here to speak to you today about Finlandia Village and how the North East LHIN supports a northern Ontario community.

Finlandia Village, for those of you who don't know, is an aging-in-place, or what we refer to as a continuum of care, for seniors. I'll give you some quick facts about what Finlandia Village is all about. We're located here in Sudbury. We were founded in 1982 by the Finns of Sudbury as a charitable non-profit group. Currently, on site, we have over 400 residents with about 250 staff and over 100 volunteers strong. We have a 99.7% occupancy and we are accredited through Accreditation Canada. We have agreements with the North East LHIN with our, what's referred to as an M-SAA, which is referred to for the community side of our assisted living, and with an L-SAA operating agreement which is for our long-term-care side of our organization.

It all started at Finlandia Village with affordable housing. Back in 1985, we constructed and built 90 apartment units and offered support services to aging seniors. Over the last 30 years, we've been able to build six projects on site, offering that continuum of care in the form of 30 life-lease townhouses, 218 apartments made up of one- and two-bedroom units, eight shared seniors accommodations and 110 long-term-care beds.

Finlandia Village's experience with the LHIN has been excellent in many different areas, but today I will focus on just one that is its most recent, which is assisted-living services for older adults—not just assisted-living services for older adults, but affordable assisted living, which means any senior in the province of Ontario who is on a minimum or modest pension of anywhere from $1,300 to $2,500 a month can afford to live there. That means they can pay their rent and get assisted-living services provided to them to help them live as independently as possible.

I think the name of the LHIN says it all: north east, local and integration. Developing solutions for our community in our latest Lepokoti apartment development, the North East LHIN provided integration support to bring together various forms of the government, namely the Ministry of Municipal Affairs and Housing, the Ministry of Health and Long-Term Care, the North East CCAC, Canada Mortgage and Housing, and our municipal government. I think you've heard the term earlier; it's breaking down silos. We had all these forms of government working towards this project.

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This project was 82 apartment units of self-contained apartments of one and two bedrooms, with rents as low as $600 a month. That's affordable for a senior on a minimum pension. What did the North East LHIN do to support this project? They provided funding for personal care, with 24/7 PSW staffing on-site to care for the 50-plus residents who needed assisted living.

Another thing they did which was unique and creative was that before this building was rented up, we identified people in our community who lived in long-term care and didn't need to live there anymore. I ask the question: Who do you know that's moved into long-term care and has moved out back into an apartment, into the community? Long-term care does an excellent job caring for our residents, bringing them back up to health, giving them physio services and proper medication services. We identified a handful of residents in our community to move out of long-term care into assisted living, into this building, thereby getting people in for the right care at the right time, which is part of our focus.

As well, the LHIN supported senior-friendly design: How about building an apartment building with a congregate dining room? How about a multi-purpose space for residents to be able to have their activities in? How about designing fully accessible shower units and toilets: not doing it after the fact, but putting in those grab bars during the construction process, putting in those raised toilets during the construction process, to allow people to move in—maybe independently, maybe at full service—as they age in place, in their home, in their apartment, and can be cared for?

I am convinced that without having the North East LHIN provide a leadership role in the development of this project, it wouldn't have happened. I probably would be sitting with you here today rhyming off a list of excuses of why this didn't happen. I would tell you that the housing forum of the government doesn't fund health care. I'd probably be telling you that health care told me they don't fund housing. The municipal government would be caught in the middle. CMHC—Canada Mortgage and Housing—and the North East CCAC would be waiting for something to happen, because they know the demand that's out there for this type of housing in assisted living. The most important part is that seniors would be waiting in our community for a place to move, to call Finlandia Village their home.

So that's what has happened in the last couple of years. What I'd like to look forward to, with this group, are the next steps.

Working with the North East Local Health Integration Network to enable our continuum of care to transition residents who call Finlandia Village home, we would like to look at opportunities to internally transfer from one level of care to another, so taking the opportunity as a continuum-of-care organization to have somebody in assisted living move into the long-term care on-site to stay in their home, or quite possibly those living in the long-term-care home who don't need those services anymore being able to transition on our site to our assisted living project. Right now there are certain barriers to entry on these areas, and we'd like to continue to work with the North East LHIN to challenge the legislation, with the challenges that we have in this area to move forward.

I hope the 14 LHINs in Ontario continue to be supported by the government and that their role in the communities is maintained and expanded. Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. We have about eight minutes left, so I think we start this round with the official opposition. Ms. McKenna?

**Mrs. Jane McKenna:** I just put a candy in my mouth, so I apologize. Anyway, thank you so much for coming in.

I'm just curious. You started in 1982, correct?

**Mr. David Munch:** Yes, that's correct.

**Mrs. Jane McKenna:** What did you do prior to that, considering the LHINs started in 2006?

**Mr. David Munch:** We were funded through the Ministry of Health and Long-Term Care in some cases. But over the 30-year history, we were able to construct new buildings. In the original parts, the early years, it was more independent housing. But what our society noticed was that people moved in back in the 1980s when they were in their 60s. Now, 20 and 30 years later, they are in their 80s and 90s, and we need to provide assisted living services to them.

The other key ingredient was that the apartment buildings that were designed back in the 1980s and 1990s weren't designed to have people live in them into their 80s or 90s, so bathrooms were smaller and kitchens were bigger in those times. Under our new design criteria, we're designing smaller kitchens and bigger bathrooms to allow people to age in place.

So we have been working with the health care establishment for the last 20 years.

**Mrs. Jane McKenna:** What are your age demographics?

**Mr. David Munch:** It's age 65-plus. Each building differs, but, believe it or not, the average age in our assisted living is older than in our long-term-care home. The average age in our assisted living is, I believe, 84 years old on average, and in our long-term-care home, it's 82 years old.

**Mrs. Jane McKenna:** If you could think of just one thing that could make the system better, from what you're doing right now, what would that be?

**Mr. David Munch:** More affordable assisted living. Anybody can build apartments and charge $1,300 or $1,400 a month. Unfortunately, for seniors in Ontario over the age of 65, the minimum pension is $1,300. There are many people receiving only $1,300 to $2,000 a month. Where do they go? They can't afford a retirement home. They do a great job servicing the community. But they have no affordable place to go.

If you live in a house in certain parts of Sudbury, built in the 1940s or 1950s, there are physical limitations in that house: narrow hallways, narrow doorways, stairs to enter. What we've noticed at Finlandia Village, with aging seniors, is the mobility and the barriers to entry. You have to make things barrier-free and allow them to access the areas they need to access.

**Mrs. Jane McKenna:** Thank you.

**The Chair (Mr. Ernie Hardeman):** The third party: Ms. Gélinas.

**M^me^ France Gélinas:** I was very interested in the last comments that you made in your presentation, about how people within Finlandia Village should be allowed to go from one level of care to the next.

People love Finlandia. When I get a complaint about Finlandia, it's always the same thing: They were in your assisted living, in your apartment; they were admitted into the hospital, and they now need long-term care, and they get shipped to anywhere-but-Finlandia long-term-care beds. Do you have a solution for that? When you talk with the CCAC or with the LHINs—if you were the decider, what would you change?

**Mr. David Munch:** I've actually had discussions with the CEO of the North East LHIN and the CCAC. My issue was, change the legislation. That's one of the reasons why I'm here today. We need to add into the legislation for the CCAC to recognize continuum of cares, to allow these people to transition to the right care at the right time. I do agree that there are people in the greater community who need access to it as well. But when you've had somebody live on a site like Finlandia for 10 or 20 years—their friends are there; in some cases, their spouse is residing in the apartments for assisted living—we need to have a formal procedure to allow that to happen. I do think the CCAC try to do that as best they can, but it doesn't always work out, as you hear from your constituents.

**M^me^ France Gélinas:** So you would make it that if you've lived at Finlandia, although you may not be the highest on the priority list when one of your long-term-care beds opens, you should be allowed to go into one of those beds.

**Mr. David Munch:** That's correct.

**M^me^ France Gélinas:** Thank you.

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

**Ms. Helena Jaczek:** Following up on this barrier, as you've described it: Are each of your facilities independent corporations?

**Mr. David Munch:** No. They're one corporation.

**Ms. Helena Jaczek:** I'm just thinking ahead, as to how, if one wanted to amend the legislation—so they are currently a resident, as an example, in the assisted-living part, and they would like to get into the long-term care of the same corporate structure.

**Mr. David Munch:** Yes. One of the things we've identified is, assisted living goes to the person, not the apartment. Anybody can live in an apartment, but it's the age and the frailness of the senior that gets the assisted living. What we're looking for is, individuals in a continuum of care, like Finlandia, who are living in an apartment but getting high-level assisted-living services, and who no longer can live there safely, who need to transition to long-term care—allowing those individuals to transition into our long-term-care home when the availability comes up.

**Ms. Helena Jaczek:** Does the assisted-living piece of your corporation fall under some sort of retirement home legislation? We put forward retirement home legislation. Would you have to accord with that legislation?

**Mr. David Munch:** No, we don't. We fall under apartment legislation. We are building self-contained apartments with full kitchens, full bathrooms—one-bedroom units. These are apartments anybody can rent in our greater community. So we fall under that legislation, and then, because we receive funding from the North East LHIN, we fall under the Ministry of Health and Long-Term Care guidelines for assisted living.

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

**1430**

## MEALS ON WHEELS SUDBURY

**The Chair (Mr. Ernie Hardeman):** The next presentation is Meals on Wheels Sudbury: Kelly Zinger, executive director. Thank you very much for making the time to come and see us this afternoon. As with all delegations, 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, we'll have questions from the caucuses. With that, they're your 15 minutes.

**Ms. Kelly Zinger:** Good afternoon, Mr. Hardeman, Madame Gélinas, other members of the Standing Committee on Social Policy, Ms. Paquette and representatives from the North East LHIN, community agencies and guests. My name is Kelly Zinger and I am here today as a representative of Meals on Wheels Sudbury in my role as executive director.

Meals on Wheels Sudbury is a non-profit charitable organization with more than 40 years of history serving residents within the city of Greater Sudbury and its outlying areas. We are a community support health service provider that receives annualized funding dollars from the North East LHIN as a component of our annual revenues.

Meals on Wheels Sudbury offers nutritional meal programs to members of this community who are unable to manage or prepare meals on their own. Our clients represent a wide spectrum of people who live in and around Sudbury, including seniors who require support services in order to remain independent in their homes, convalescing individuals recently discharged from hospital with limitations to preparing healthy meals at home, persons with disabilities, persons dealing with mental illness, and caregivers of clients. Meals on Wheels Sudbury is a unique meal program provider as we operate our own social enterprise: Home of Our Own Catering. Our catering business, which also serves the catering needs of the public, is responsible for the contract that prepares all hot meals for Meals on Wheels Sudbury clients.

Last year, our agency supplied more than 34,000 meals to over 440 residents of the Sudbury area. These meals were delivered by a dedicated team of loyal volunteers. Although our volunteer numbers have decreased

over the last few years, our drivers continue to support our programs by logging more than 85,000 kilometres each year to ensure our meals are delivered daily to all clients.

Historically, Meals on Wheels Sudbury has been a leader in the community support services sector. We have a reputation for leading change and advocating local and provincial governments for reform and improvements in our sector. As such, we are represented on a variety of local and provincial networks, committees and associations. Two important collaborations of note are the Ontario Community Support Association and the Sudbury-Manitoulin Community Support Services Network.

At the provincial level, Meals on Wheels Sudbury has been a long-time member of the Ontario Community Support Association through participation on various committees and their board of directors. The OCSA plays an advocacy role for all CSS health service providers throughout the province and is a key player in legislation reform for the sector. The OCSA provides an avenue for CSS agencies in Ontario to share best practices in service delivery and support professional development, ensuring all Ontarians receive quality health care where it matters most: in their home.

Locally, the Sudbury-Manitoulin CSS Network is an assembly of 12 North-East-LHIN-funded CSS agencies that provide services to the area. We have a mandate to share and adopt best practices in the CSS sector to support the goals of the North East LHIN's integrated health service plans and to provide a method of communication amongst CSS providers, the North East LHIN, North East CCAC and Health Sciences North.

The network has received support from the North East LHIN through regular representation and attendance, which has contributed to opening the lines of communication between our sector and our funding arm. Additionally, regular representation from the North East CCAC, Canadian Mental Health Association and Health Sciences North has supported open dialogue and discussion between the CSS and other health care sectors.

The establishment of the LHINs province-wide in 2006 was born out of the idea that the provincial health care system needed, and Ontarians wanted, a localized approach to health care planning and allocating of government funds for health care service providers. Meals on Wheels Sudbury was incorporated into the North East LHIN and has since signed multiple agreements that align the agency with the North East LHIN's integrated health service plans and local priorities.

Over the past eight years, each of the 14 different LHINs have developed and transformed as appropriate to their local area. Although the Ministry of Health and Long-Term Care establishes and defines the key health priorities for the province, it has fallen to each individual LHIN to interpret and realize these priorities. Interpretation of Ontario's health priorities as they relate to specific communities offers localized solutions; that is, 14 different solutions to similar challenges.

The Local Health Integration Network Collaborative was created to collectively address the issues and concerns common to all LHINs and allow open communication between the 14 CEOs to share successes and challenges. At times, the LHIN Collaborative has missed opportunities to communicate the sharing of many experiences of the various LHIN projects, which has led to duplication of initiatives and some project failures in various LHINs. For example, implementation of the Great Plains financial software system through CCIM was mandated by some LHINs for all health service providers, yet only recommended for use in other areas of the province. Also, the experiences and trials of those who have transferred systems were not commonly shared; thus, we still do not have a system that ties all agencies and organizations together. Those health service providers currently in the process of transitioning to the GP software system have no insight from providers who successfully made the switch. In order to succeed as a system, we must remember that the sharing of ideas, achievements and experiences of one LHIN with the rest of the province will ultimately benefit all Ontarians.

Means on Wheels Sudbury is a partially funded health service provider of the North East LHIN and thus it is possible for me to speak directly to some of the successes and challenges of this particular LHIN. I wish to comment on a few key areas that Meals on Wheels Sudbury feels are reflective of positive system change with the evolution of the North East LHIN and where improvements can be made to improve the health service delivery to northerners.

The North East LHIN has taken many strides and achieved a great many successes for their part in the overhaul and reorganization of the funding processes and practices in northern Ontario. Chief among these successes is the local allocation of government funding dollars. For years, northerners wondered why southern-Ontario-based government representatives were given the authority to determine where our northern health care dollars were to be spent. Now, under the Local Health System Integration Act, 2006, monies are allocated to the health service providers based on needs determined by local North East LHIN representatives.

Additionally, advanced requirements for agencies to submit data and financial details on services provided have supplied the North East LHIN with the mechanisms to make evidence-based decisions when allocating funds. Although it is not yet a perfect science, the value of data collection and appropriate financial oversight is now emphasized and supports a more accountable and credible health system.

The focus of all LHINs has been to enhance and embrace community and home support services in order to decrease the public's reliance on acute care services. It is well known that the cost to the taxpayer is greatly reduced when people are supported in their own homes rather than in long-term-care and hospital settings.

I urge the North East LHIN to use the evidence from the financial and service reports they receive on a regular

basis from their health service partners when making decisions related to funding allocation. Increases to base funding in the community support sector is a necessity. The North East LHIN must recognize that the administrative and support costs of health service providers are constantly increasing. Although the North East LHIN has provided slight increases to funding through enhanced project funding, it must be recognized that the CSS sector went without increases to base funding for a great number of years. These increases have only allowed CSS health service providers to begin catching up to their health care sector counterparts.

The North East LHIN has greatly enhanced its visibility and communications with members of the health care community and the general public over the past few years. Through interactions with the local and regional media, rarely a day goes by without mention of the North East LHIN and their current activities and interactions.

The North East LHIN offers an informative and easy-to-navigate website for quick reference and topical updates within the regional health care sector. I would recommend that the North East LHIN utilize their media contact and website resources to share with the northeast community the unique successes and developments of other LHINs.

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Rather than working in a regional bubble, creating new and improved processes, health service providers in the north should be looking to other provincial programs and activities, to share innovative ideas and concepts. What has been tried and tested elsewhere may be applicable in some form to the northern health care community.

The North East LHIN has improved accessibility and contacts to government-level representatives for agencies such as Meals on Wheels Sudbury. Our agency has access to a local CSS representative who oversees our portfolio related to funding. This individual is available for regular meetings and discussions and has an intricate understanding of the specific operational needs of our agency. In addition, the North East LHIN has introduced the role of the CSS system navigator within each of the hub hospital areas in the northeast. These navigators allow for system issues to be addressed with the coordination of all health care sector partners. As a local CSS agency, it is encouraging to have a voice at the table where information is presented and decisions are made.

It would be easy for me to stand before this committee and narrate various difficulties encountered by small, local agencies like Meals on Wheels Sudbury over the years, since 2006. However, no new organization develops flawlessly. Instead, I would prefer to offer support and encouragement to the LHINs and the ministry as we continue on the path of developing a localized health care system. There are areas in which the LHINs and, more specifically, the North East LHIN can improve and become more effective in their processes. There is a need to promote the evolution of the LHINs. Much change has occurred over the past eight years, and I expect we will see more. Change takes time and investment. Both the government of the day, the health service providers and the general public need to realize that positive change will not happen in isolation or overnight, but as an open dialogue among all participants, in a constructive format.

I wish to thank the Standing Committee on Social Policy and the North East LHIN for the opportunity to present the opinions and thoughts of Meals on Wheels Sudbury. I look forward to reading the final report and to continuing my role in progressive change.

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

We have about three minutes left, so we'll go to the third party. Ms. Gélinas?

**M^me^ France Gélinas:** Thank you very much for coming, Ms. Zinger.

You mentioned the need for the administrative support of Meals on Wheels and other community support agencies and how there have been flat-lined budgets in your sector for a long time. Would you be able to elaborate a little bit more as to what you're looking for? When you speak to the LHINs, how does it go?

**Ms. Kelly Zinger:** What I was referring to was the cost of having properly trained individuals within our organization. The funding that we receive from the LHIN is not enough to support an adequate number of trained staff. We must fundraise and receive donations on top of that, and increase our client fees. What we're looking for is an increase to our base funding so that we can have these properly trained individuals on our staff to properly care for our clients. When I speak to the North East LHIN representatives, they hear what I have to say; they understand it. It's a matter of where we find the money. There isn't a lot of money out there to be spread around. There's no more money coming to us—we realize that—but it's how it's distributed amongst all the health care sectors.

**M^me^ France Gélinas:** You were not included in the 4% increases that were given?

**Ms. Kelly Zinger:** We only received a partial amount of that.

**M^me^ France Gélinas:** How much do your clients pay right now to receive Meals on Wheels?

**Ms. Kelly Zinger:** Our clients pay between $7 and $7.25 per meal.

**M^me^ France Gélinas:** What's the difference?

**Ms. Kelly Zinger:** If you're a diabetic client, you pay $7.25. Also, if you're receiving a frozen meal, it's $7.25.

**M^me^ France Gélinas:** You've talked about all of the community support services getting together. Is this supported by the LHINs?

**Ms. Kelly Zinger:** Yes, it is. We have regular representation on this committee. They attend all of them, and they relay our information back and forth.

**M^me^ France Gélinas:** And then, when you go to province-wide, you've talked about mistakes made in some parts that were repeated, that could have been—how do you see this working better?

**Ms. Kelly Zinger:** Better communication, sharing of ideas, and sharing of successes and challenges. How one agency may have implemented a new assessment tool in one area of the province should be shared. Whether it was a success or they incurred a challenge in that, it should be shared amongst all, so that we can learn from our experiences. For one agency to just—

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation, and thank you for taking the time.

## SHKAGAMIK-KWE HEALTH CENTRE

**The Chair (Mr. Ernie Hardeman):** Our next delegation is Shkagamik-Kwe Health Centre: Angela Recollet.

I just wanted to say to the delegation that it doesn't matter how I butcher the names; Hansard will report them perfectly as printed.

Thank you very much for coming in and meeting with us this afternoon. You do have 15 minutes to make your presentation. You can use any or all of that for your presentation. If there's time left over, we will have questions from our caucus. With that, the next 15 minutes are yours.

**Ms. Angela Recollet:** Perfect. Can you hear me okay? All right.

*Remarks in Ojibway.*

Bonjour. Je m'excuse; je ne parle pas français.

*Remarks in Ojibway.*

I've just introduced myself in our traditional language of Anishinaabemowin. This is the territory of the traditional people of the Anishinabek Nation. Je ne parle pas français, so I will provide my presentation in English, so that we can all understand what I'm here to share with you.

My English name is Angela Recollet, and I come to you in my role as the executive director of the Shkagamik-Kwe Health Centre. More importantly, I come to you as a daughter, a mother and a grandmother of three, with another binoojiins on the way, but for my presentation's sake I will present to you in my role as the executive director of the Shkagamik-Kwe Health Centre. Shkagamik-Kwe, in our language, means "Mother Earth," and this is the Mother Earth healing centre.

I want to give you a little bit of the history of the 10 aboriginal health access centres in Ontario. So, a little bit about the AHACs, as we'll refer to them—and I won't go word-by-word, verbatim, of the presentation. I'll just have an informal discussion with you about the history of the AHACs, what our current state is and where we would like to be, but more importantly to speak a little bit about first peoples in what you now call Ontario, and what primary care needs they have—or, if we could be honest and say, "What primary care for first peoples in what you now call Ontario?"

In Ontario, you have 10 aboriginal health access centres. The AHACs were created through the Aboriginal Healing and Wellness Strategy, the AHWS strategy, several moons ago, under the Ministry of Community and Social Services.

Shkagamik-Kwe is about 15 years old. We're going into our 16th year. In our lobbying efforts throughout the years, we made a transition to the Ministry of Health and Long-Term Care. This transition took place about four years ago, so now we are currently under the Ministry of Health and Long-Term Care.

It's quite a gem that the province has in the AHACs, because there is no other kind in what you call Canada. From coast to coast, these are a very unique health care system that is mirrored by the community health centres in Ontario. It really is a true gem in Ontario, providing the primary care that we are able to provide to first peoples, whether you're in an urban centre or you're coupled with First Nations communities.

All 10 are very common in our approach to healing and well-being, and that's coupling western practices of medicine with our traditional approaches to healing. That's the core foundation of how the AHACs have been created, and it really honours and sustains our cultural values and systems in how we care for our people in our communities.

As you know, history has not always been the kindest when it comes to first peoples in Canada, and that's no different here in Ontario. But we are a very strong people, and we take pride in ensuring that we continue that development of the seven generations.

**1450**

As I stated earlier, I am a grandmother. The decisions that we make here today are going to affect those babies who come tomorrow. We always need to be mindful of the things that we do with pen and paper and how that impacts our future.

A little bit about the AHACs: We are very unique but still similar in our approaches, as I stated. The geography in Ontario is quite vast, so you can appreciate the different locations of the 10 AHACs and the populations that they serve.

One of the unique qualities of the AHAC that differ across the province is the population. We have some in larger urban centres, such as Toronto—is an aboriginal CHC, which is very much like the AHACs as well, and hence where we were mirrored from within our creation. We have centres in Ottawa that serve a very high population of First Peoples, Métis and Inuit. This is simply because of the Eskimo project that took place many moons ago, that brought Inuit people into the large city of Ottawa.

We're very unique in our approaches, but still very common in our plight to ensure access to primary care.

Like our Association of Ontario Health Centres—our provincial association that the AHACs moved to, probably five years ago—we also see a future without systemic barriers that prevent people from reaching their full health potential, a future in which everyone can make choices that allow them to live a full life.

I'm not going to go into all of this. I'm not good at reading things. I'm really good at just visiting and telling a story.

If we could talk about the LHINs and some of the successes—as you know, you're here as a standing committee to look at the social standing of the LHINs in Ontario.

For us here in the north, our North East LHIN is fortunate to have three AHACs that are in the catchment area. There has been some dialogue over the past little while on whether we should be moving under the LHINs or whether we should be staying where we are within the Ministry of Health and Long-Term Care. Because we're a sector of 10, the AHACs have agreed that it's critical that we maintain our unity within our lobbying efforts within the ministry, to ensure that our voices are not getting lost in the system.

Although we have a phenomenal relationship with the North East LHIN and the administration here in the North East LHIN, our other counterpart AHACs do not have the same. So in order for us to move, we have to be considerate of not losing our values system and our core, fundamental approaches to our primary care, and respecting our traditional values.

That's one of the quick answers, how I respond, and I believe that my colleague AHAC EDs would respond in the same context: that we have solid relations with some of our LHINs, and we don't feel at this time that it would be appropriate to move into the LHINs' structures until we can look at some parity and some inequities that face the AHACs in our delivery of primary care within the ministry, and until the ministry identifies what a strategy could look like in Ontario for aboriginal primary health care.

Another piece with the LHINs: The mandate of the LHINs is too focused on the integration of the sickness system, and it doesn't have a health-and-well-being mandate. Culture is treatment, and that's the motto that the AHACs take with all of our service delivery. Because of the void in the psyche that our people have been faced with, with colonial practice and residential school truths, we need to ensure that we get back to the basics of our cultural fundamental values, and for us, that's healing and community. That's the core part of how we deliver our service. In everything that we do, culture is treatment. We treat wellness, as opposed to having to treat illness further down the line, although we are still in the midst of having to undo the intergenerational trauma impacts that history has imposed on us.

Second, the 10 AHACs across Ontario are in a position of serious underfunding. I'm not going to sit here in front of you and tell you about all the underfunding. I'm sure that you've heard this right across all of your deliberations, about the resources it takes to deliver so-and-so. It's not always about the financial resources. It's really about streamlining and utilizing the existing resources, and putting focus on the areas that are successful in delivering primary care services.

The final point: The LHINs need to institute a First Peoples population needs-based planning approach. We know about the poorer health outcomes of our people, yet there is no First Peoples health care plan for the province. Under the act, the ministry was required to establish an aboriginal and First Nations health council and aboriginal planning entities. Six years after the act was passed, neither has been established. This does not signal that the health outcomes of our people are a priority for the province or for the LHINs.

I'll speak to this point in a little bit more detail and talk about some of the political challenges that we face in what you now call Canada. You have federal governments, you have provincial governments, you have municipalities and then you have chiefs and councils. In all of these relationships, there's a fiduciary responsibility put to the feds and not to the province. So until we can get past this invisible border and look at all Ontarians or all peoples living in this vast territory and ensure that they have equal access to care, then we're not going to identify solutions to offer primary care to First Peoples.

In our North East LHIN, we have made substantial strides in addressing some of our coastal challenges, but if you've ever been to our fly-in communities—and how many of you have?—then you will know some of the disparities that our communities are faced with when it comes to simple health care, simple primary care. So that, in itself, is a huge challenge.

Until we can get past some of the political disputes around where the responsibility lies for the Nishnawbes, whether it's federal or provincial, we're not going to have equal access, because we too are people. We're not subhuman by any course. We've been here for a very long time, and we plan to be here for many, many moons to come.

I come to you in respect so that you can make some healthy decisions and look at the choices that we're moving forward so that all Ontarians, including the First Peoples, Métis, Inuit populations—and that we put aside some of these differences but still focus on the differences that have been laid out, not by us, in order to access primary care in Ontario. Meegwetch.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. It's much appreciated. We just have one caucus with questions. Mr. Colle.

**Mr. Mike Colle:** Meegwetch, and thank you for your very clear presentation. We've had a number of community health centres give presentations with this LHIN review. I know myself and others were very, very supportive of the community health centres because they really are hands-on in the community. There aren't all the layers of bureaucracy, and they really connect with people on the street. I guess the AHACs are really a First Nations version of that.

Do you employ primary care physicians or nurse practitioners? Who do you have on-site?

**Ms. Angela Recollet:** Absolutely. Okay, so I'll give you a quick overview of the complement of the practitioners that we have within our agencies, our organizations. So we couple primary care, western and traditional. At Shkagamik-Kwe, we have four NPs. We have a full-

time pediatrician, so that takes up one of our FTEs for our physician envelope. We have two part-time physicians who work with us. Remember, we're located here in Sudbury, so access to recruitment and retention initiatives for primary care western practitioners is sometimes easier than going into the rural areas or the First Nation communities for recruitment and retention of the physicians. We also have three traditional doctors—or, as some would call them, healers, but I look at them as our doctors as well—with their helpers. So to us, those two are treated equally as specialists in their respected fields.

Our core funding comes from the Ministry of Health and Long-Term Care in several different branches. We have our diabetes envelope, so we have a nurse dedicated to diabetes, a dietitian who is also a certified diabetes educator. We have another envelope from the Ministry of Children and Youth Services that funds our FASD initiatives, along with our healthy food for our kids, so our Healthy Choices Program; some of the admin—which is very limited, and therefore our resources are spread thin with our existing administrative support to deliver programs.

**1500**

We also have chiropody within the centre. We have health promotion. Our traditional component is a huge component to what we do at the centre because, again, everything at the core of what we do is culture treatment. So we do have a full complement of western practitioners who are employed at the centre on a full-time basis in a salaried capacity, and that, again, includes the four NPs and the two FTs for the physicians.

**Mr. Mike Colle:** I think you've made it very clear that you have a good relationship with the North East LHIN, but, on the other hand, you want to keep that strong, united voice of the 10 AHACs. Is there anything that can be done in the interim?

**Ms. Angela Recollet:** We've already taken action for the interim. Relationships are critical for me, and I believe that everything that we do is based on relationships: relationships with each other, within our human family, relationships with our plant life. We utilize all of the plants in our traditional approaches to healing; our animal kingdom, as well, because we believe good food is good medicine. We've taken the initiative to build relationships with Louise and her team and we've been having talks with the four of us. We've initiated that on our own accord, once we tried to start finding solutions.

Now, also note that all of the AHACs have MSAA agreements, so we all do access funding from our LHINs, but with our core funding coming through the Ministry of Health and Long-Term Care negotiations branch. I won't get into the politics of that today, but we do have MSAA agreements, and we do, I believe, within our LHINs, have a healthy relationship. I can tell you that the other AHACs do not. Other than our South West LHIN, that is the only other AHAC that has a very solid relationship because they happen to be in Deb Matthews's riding, so Deb has taken the time to build that relationship.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. That concludes your time, but I'm somewhat surprised by your last comment. I thought it was because it was in the Chair's riding.

**Ms. Angela Recollet:** There we go. That's probably it too.

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

## NORTH EAST SPECIALIZED GERIATRIC SERVICES

**The Chair (Mr. Ernie Hardeman):** Our next one is the North East Specialized Geriatric Services: Jo-Anne Clarke, leading geriatrician.

**Dr. Jo-Anne Clarke:** Hello. I'm not a health planner and I don't speak well from notes either, so we'll see what we get. I'm speaking on behalf of the North East Specialized Geriatric Services. I was recruited here in 2009. I think the story of our service speaks to the value of local health planning.

I was the first geriatrician to come to northeastern Ontario and remained the only geriatrician here until September of this year, when we were lucky enough to recruit another geriatrician. However, the planning for geriatrics started before that. The Regional Geriatric Programs of Ontario, at the time chaired by Michael Borrie, as well as Cal Martell, who were part of the regional planning group for geriatric programs, had made several visits when they learned that there was a northern school of medicine being founded in northern Ontario. They knew that funding for geriatrics and underfunding of geriatric specialties, as well as programs, was often a barrier to the development of geriatric programs and so started to plan, knowing that funding initially to create regional geriatric programs was tied to the medical school, saying, "Now that you have a medical school, how are you going to work to develop geriatric programs and potentially a regional geriatric program for northern Ontario?"

I also happened to be mentored by Dr. Borrie, who then told people not to recruit me, that I was from Sudbury and I was going to come back to Sudbury and we were going to develop geriatrics there. When I was graduating, I made a site visit to Sudbury and we met with all of the local groups, including the North East LHIN, the hospitals, the CCAC, as well as community supports to look at how we would develop geriatric programs for northern Ontario if you only had one geriatrician.

At the time, it was a challenge. The word was that the ministry was not going to be funding more regional geriatric programs, that that was not something they were going to do in that manner. The normal groups that would support geriatric programs at the time were not in a position to do that. I would have to say that the North East LHIN was very creative in creating the North East Specialized Geriatric Services to meet the local needs. We paired it with the aging-at-home funding which came

through, and the city of Greater Sudbury, which was a municipality, was selected as the host and led the way for developing the program. For the first five years of North East Specialized Geriatric Services, we were administrated by the city of Greater Sudbury through funding from aging-at-home dollars.

We were told quite clearly when we received this funding that we would be a regional program, so although we're going to be located in Sudbury, it was up to us to look at developing geriatric programming for all of northeastern Ontario.

We built our program reflective of the regional geriatric programs of Ontario. We focus on clinic service delivery for the frail, older adult. We look at capacity-building in education to develop best practices for geriatric care across northeastern Ontario. We also look to be responsive to the unique needs of northern Ontarians, be it francophone, First Nation communities, rural communities, and then, program evaluation.

We currently have one geriatrician and have been lucky enough to recruit a care-of-the-elderly-based physician. We have an executive director/manager; clerical positions. We have an occupational therapist, physiotherapist, three nurses and a nurse practitioner who all help with this programming.

We service all of northeastern Ontario. We go from Parry Sound to the James Bay coast, with most recently having visited the James Bay coast to deliver geriatric care in conjunction with our partners, as well as with Dr. Sinha and Dr. McElhaney, to do our first visit for the elders in Fort Albany.

We deliver our care both by travelling around northeastern Ontario, as well as by telemedicine. Everyone who sees us has a comprehensive geriatric assessment done by one of our allied health care teams or by one of the local teams on the ground who we work in partnership with. They are then seen by the geriatrician or care-of-the-elderly physician, and then we work on treatment care plans.

One thing you will probably note is that there is no shortage of assessment for frail elders. We know how to assess them. Our job is not to assess them but to then identify how we can modify the modifiable, treat the treatable, and then bubble-wrap the rest, as I like to say. Our job is to work with the variety of organizations out there to actually intervene to reduce functional decline, to prevent frailty, to prevent unnecessary admissions to hospital and premature admissions to long-term care.

Our job is to make people live in their homes for as long as possible. That is not easy. It requires partnerships; it requires collaboration; it requires freedom of information; it requires sharing that information; it requires flexibility; it requires using the resources that you have in a flexible manner to identify their very unique needs. It involves working with caregivers; it involves finding caregivers when they have none.

It has, I have to say, been quite an experience since I've been in northeastern Ontario, because there has been no shortage of organizations or people willing to work in that collaboration. I have seen us be enabled by the North East LHIN, by our CCAC partners and by our relationship with hospitals.

The barriers are a lack of consistent assessment tools, a lack of communication between providers, whether that's medical providers, community support systems, hospitals, our own program, physician groups. We all know what we want. We don't always know how to get it. We don't always know how to share it. An example is, we often, as physicians, will do a carpet-bomb approach to care, is what I like to say. You have a frail elder in front of you, so you refer to all these programs, whether it's community support services, my program, a psychiatry program, mental health. The elder will often go from having no one around to 17 assessments in the next two weeks—often the same assessment, often the same information gathered. In fact, I can guarantee you it is the same information gathered, just in a different tool. Mental health services will use the OCAN; CCAC will use the RAI; I'll do a comprehensive assessment; community support services will use a different version of the RAI—none of that information meets, and it's often the same information. So how we work together to integrate those assessments to create a single record that we can all work from and communicate is very important, I see, if we're going to care for frail elders, which is going to be an issue as we move on.

**1510**

What I have seen in terms of local solutions as well is the co-locating of CCAC case managers. In my own program, as well as in family health teams, caring for frail elders means we need to coordinate care. Oftentimes, the access to appropriate home care is a make-or-break solution as to whether people can live in their homes. That home care cannot be governed by rules necessarily, by tools necessarily. Oftentimes, there have to be unique assessments, unique considerations put in, and physicians need to be able to rely on the fact that that care plan that we put in is a reliable care plan. So access to reliable home care, to a coordinator whom we know we can talk with and communicate that care plan, who can modify the care plan based on ever-changing needs—and they can change quickly. A simple hospitalization, a simple fall, a simple change in medications can really change whatever is going on in that home from one minute to the next. How do we communicate with primary care? How do we communicate with hospitals? How do we communicate back to home care when these things change?

I have to tell you, the variety in home care services across northeastern Ontario is an ever-changing pattern as well. I know what I can get for a patient in Sudbury. I know what I can get for a patient in Parry Sound. I know what I can get for a patient in Timmins, but they're not always at all the same thing. We have one CCAC and one funding mechanism and one geriatric care, and it has nothing to do with anything other than human resources, often, or the ability to geographically deliver these services.

What I have seen is a willingness to discuss these issues, to meet with us, to work with us to deliver these services. I think that without a local flavour and a local appreciation for what the resources already are, that's next to impossible, especially for northeastern Ontario.

I'm not sure I have anything else to say. I'm more willing to talk about that, I think. What we've been able to accomplish: We've had almost 3,000 referrals to date since 2009. Since June of this year until now, we have done over 1,900 educational sessions. We have reached 1,900 providers since June of last year for capacity-building and education. I can't tell you what we've done every year in the last five years, but that's just since June of last year. We are an active program. We are actively reaching out to northeastern Ontario, to our care partners. We have a long way to go, but I don't think, for a region as geographically vast as northeastern Ontario, for a frail senior population who are incredibly unique, vulnerable—that cannot be done without a local solution.

**The Chair (Mr. Ernie Hardeman):** With that, we thank you very much for your presentation. The question will go to the opposition. Ms. Elliott.

**Mrs. Christine Elliott:** Yes. Thank you very much, Dr. Clarke, for your presentation. Congratulations on the success of your program so far. You indicated that there is a lack of consistent assessment tools, that different organizations require information presented in different formats. Is there a move afoot now to standardize the assessments into one standard assessment, or where does that stand at the present time?

**Dr. Jo-Anne Clarke:** I think the conversation is there; I'm not sure what the movement is. I think there are two issues. One is the assessment tool. So how do we choose these tools? Most of these tools are ministry-mandated, so CCAC uses one tool because this is what they're told to use. Seniors' mental health similarly use a different tool because that's what they're told to use. Clinicians use different tools. But we are all using the same—it's the same questions, just formatted differently. You're looking at talking with administrators, managers, health planners, physicians, hospitals, all of whom also don't like to share information because there are privacy issues. It's also an IT issue, so I think a lot of the information we gather could easily be shared if our EMRs connected, if our charts connected, if we simply charted.

I know there's an integration assessment record being created. I think that's a move to start to pool that information so that there would be a spot where all that information would lie. I think that's starting to happen, but I think what we need is better integration, because half the time, that assessor doesn't know that another assessor was there a week ago. That's what often—oh wait, I don't think I finished my thought on the carpet-bomb approach to referrals, which is that people will wait six months, 17 of us will go in, but as I walk in the door, they'll say, "Oh, Dr. Rivard was just here"—the geriatric psychiatrist—"yesterday," and I say, "Oh, shoot, you probably don't even need us anymore." CCAC just came in, and all those things that we were worried about have been implemented now.

The problem is, we all have wait-lists as well. I bet you our wait-lists would be a lot shorter if we didn't all have to pre-assess and do these assessments. Secondly, if we knew that someone else was going in and we shared that information, the care plan might be a lot shorter and quicker.

**Mrs. Christine Elliott:** The EMR would be essential in helping you get to that point.

**Dr. Jo-Anne Clarke:** Yes.

**Mrs. Christine Elliott:** Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. We very much appreciate you taking the time to come to talk to us today. Thank you.

## TG INNERSELVES

**The Chair (Mr. Ernie Hardeman):** Our next presenter is TG Innerselves: Rita O'Link, community relations, and Catherine Savarie, community facilitator.

**Ms. Catherine Savarie:** Thank you. Good afternoon. We are not an organization funded by the LHIN—

**The Chair (Mr. Ernie Hardeman):** Before we start—we haven't started your 15 minutes yet, but I should actually tell you about the 15 minutes.

Thank you very much for coming out today. You do have 15 minutes to make your presentation. If there's any time left, we'll have questions from caucus. With that, it's your 15 minutes to do with as you see fit.

**Ms. Catherine Savarie:** Thank you. As I had said earlier, we are not an organization that is currently funded—

**The Chair (Mr. Ernie Hardeman):** Since we have two making the presentation, could you introduce yourselves in the microphone for Hansard, for the record?

**Ms. Catherine Savarie:** I am Catherine Savarie and I am the community facilitator for TG Innerselves.

**Ms. Rita O'Link:** My name is Rita O'Link. I'm the community relations person for TG Innerselves.

**The Chair (Mr. Ernie Hardeman):** Thank you very much. Now your time has started.

**Ms. Catherine Savarie:** All right. The reason that we're here today is to bring a little bit of awareness around issues that face the transgender community, especially in the north. As I had said earlier, we are not an organization that is funded by the LHIN. Actually, we're not funded by any funding source whatsoever. We have just recently entered into dialogue with the North East LHIN, where they are consulting with our group with regard to the health care needs for the transgender community in northern Ontario.

The reason that TG Innerselves was formed was due to the fact that we felt that we needed to have a transgender-specific organization to assist people who identify with that community and essentially help them navigate the system. One of them very much is the health care system, because it is a fairly complex health care

need, so the transitioning process is one that is fairly lengthy. Most people here in northern Ontario have to access services in southern Ontario for that transitioning process, and that can be very, very difficult. So we wanted to approach the LHINs with regard to having that dialogue around what it is that we're looking for in the north.

Rita had actually booked this presentation, so when we came here, we wanted to essentially bring awareness—we're not looking for funding—and sort of look at the objectives of the North East LHIN and see how they fit. So we have a very brief presentation for you.

When we did look at it, we realized that 11 of the 14 LHINs have made mention of looking at diverse populations. The transgender community definitely falls underneath that category based on gender, geographic location and socio-economic status. I do stress socio-economic status, especially for individuals who are transgendered in the north, because that is something that definitely affects the community.

When we looked at the first objective, we feel that for the most part, the North East LHIN has accomplished that for mainstream health services. We feel that this is a good opportunity for a path forward based on the already-existing foundation, because as we've entered into dialogue, we've seen that a lot of northern Ontarians who identify with being transgender are travelling outside of their geographic location to access services or the health care that they need.

**1520**

To identify and plan for health services: This is one objective that the North East LHIN, at this current time, has not accomplished for the transgender community as far as health care. There isn't a comprehensive plan, and it is very, very specific. That is one thing that most individuals who are transgender will vocalize: that they can't get that in their own northern communities. What our focus is with the LHIN here is to promote that path forward for the delivery of health services.

The third objective was to engage community persons—absolutely. Has the North East LHIN done that? Yes. We are currently in dialogue with them.

To ensure the appropriate processes: I think that as of right now, that objective has been fulfilled, and the LHIN has been very effective in providing the community with information on the appropriate processes and educating us a little bit about how they operate.

On objective 5, we do believe that the LHIN has been very effective in their ability to monitor and report on local health care service needs. But we do feel that new metrics have to be developed to measure success rates with the transgender health care services, because of the very secretive nature of being transgender, and that is what makes this community very unique.

Objective 6: We feel that they have definitely achieved this objective with the development of provincial strategic plans, which we have been made aware of, and with the implementation of systems tables, both local and regional. We are really looking forward to being able to take our place at that table, to be able to participate fully as it moves forward.

For objective 7, we feel that, yes, they have achieved this objective, and they've built a very strong foundation to facilitate dialogue with an extremely diverse sector of the health care system.

Objective 8 definitely has been accomplished with the local health integration networks. We do feel that we do need access to high-quality health services for the transgender community. We know that it is a relatively new topic, so we want to utilize the framework with the LHIN to start establishing that.

As far as objective 9, with getting best practices and to promote knowledge transfer: Has the North East LHIN accomplished this objective? Yes. They have a very solid foundation to promote that. We believe once again here that there are new opportunities to be found in the north by expanding the role of the LHIN to work with front-line health providers. It's due to our geographic nature of the north that front-line health care workers take on additional duties in the delivery of health care that would be traditionally handled by other health care services.

For objective 10: Through recent discussions with the LHIN, it is the hope that health care services for the transgendered community will become more accessible, thereby increasing economic efficiencies within the health care system. Once again, we would like to utilize front-line health care service providers to be able to do this for the community.

Allocate funding: We feel that, through ongoing consultation with the LHIN, hopefully, funding will be allocated to the already existing health care services to provide health care services that are very specific to the community.

To enter into agreements: Once again, that is our hope, that they will be able to enter into agreements to provide the quality health care services that are needed very specifically for the northern trans community. Thank you very much.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. We have about eight and a half minutes left, so we start with the—

**Interjection:** The third party.

**The Chair (Mr. Ernie Hardeman):** That's what I thought. We start with the third party. Ms. Gélinas?

**M^me^ France Gélinas:** Always a pleasure to see you, Ms. O'Link, and a pleasure to meet you, Catherine.

**Ms. Catherine Savarie:** Thank you.

**M^me^ France Gélinas:** If you look at what you're trying to achieve, you're trying to have access to care in the northeast. If we take the first step, was the North East LHIN able to tell you who are the primary care providers who accept transgender people?

**Ms. Rita O'Link:** No. There is no information through the LHINs on who will provide us primary health care. One of the big things that we need is hormone replacement therapy. Very, very few physicians here in the north have any knowledge of that. They're

afraid to tackle it because they don't know, because there is no support.

Here's where we see opportunity with the LHIN structure: You are a network. We can utilize that network to get the information down to the front-line health care providers. They're the ones who can do it. We cover an immense geographic region. Travelling for any appointment is measured in terms of hours or days. If we can provide those services—and, by the way, they're not rocket science. They're well within the capability of a front-line physician. If we can get that information down to them—take care of it at home in the community, utilizing what is already there.

We don't have the population density to support centres. We're not looking for another bricks-and-mortar institution to say, "Okay. This is where you go." There's no reason why, through electronic means, all this cannot take place with the front-line health care provider in their communities. What we're hoping is, working with the LHINs, that that is where the money is going to be spent, and that is the direction we're going to go.

I'm a very conservative person fiscally. I want to get every mile per gallon I can out of a dollar. I don't want to see us building another institution; I want to see us make the ones that we have work efficiently, and we can do that.

**M^me^ France Gélinas:** Right now, would you say that there are areas within the northeast where transgender people are better served, or is it equally lousy no matter where you go?

**Ms. Rita O'Link:** As soon as you get north of Barrie, it's lousy. We're called a black hole up here, because, first of all, we're not supposed to exist, and second of all, if you want anything, the first thing the doctor does when he does manage to find it out is CAMH, and he sends you south. The waiting list just to go down there to meet with someone runs at something like six to eight months. Plus, now you've got the travel grants; you've got everything you've got to get in place. By the way, you've got to do that all on your own and you get reimbursed later.

**The Chair (Mr. Ernie Hardeman):** I'll have to stop you there, and we have to go to the government side. Mr. Colle?

**Mr. Mike Colle:** Thank you for coming. I think you're doing a good strategic thing by being here, because, as you said, you want to really introduce this need and make us aware of it and make the health service providers aware of it, too. So I think you're doing the right thing, really. You're taking a very good approach, because what you want to build, as someone said, is you want to build relationships.

**Ms. Rita O'Link:** Yes.

**Mr. Mike Colle:** And I think this is good. Have you had any discussion with anybody at the LHIN yet?

**Ms. Rita O'Link:** We've been very fortunate. We were invited by Mike O'Shea and his group to come and do a presentation for them. I'll say this about Mike—

**Mr. Mike Colle:** Who is that, by the way?

**Ms. Rita O'Link:** Mike O'Shea is the regional director here in the north.

**Mr. Mike Colle:** Okay.

**Ms. Rita O'Link:** He came to a presentation that we did in Sault Ste. Marie for the women's centre down there, because the Ontario human rights act was amended on June 19, 2012, to include gender identity and gender expression into the Ontario Human Rights Code. What we're trying to do is build the awareness that if we have those rights, then we need to come to the table and say, "Look, please, we need to be dealt with."

So we did that with Mike. Mike came to our presentations. He was very impressed. He asked us—and just this last week, we were able to meet with Mike here in Sudbury and his group, and give them a presentation on where we would like to go with things. So we're finally bringing this to the forefront. The co-operation with that group has been just marvellous. They're listening to us.

What we're coming to you for, and where I feel that you can really help, is we need to expand the role of the LHINs down to the front-line health care providers here in the north, because they are the ones who are there every day to take care of us. Until it's down to that level, it's going to be very difficult to service any of us.

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

**Mrs. Christine Elliott:** Thank you very much for being here today. I also think you're taking a really commendable approach by being here, talking to us about what's going on. You're trying to work with the LHINs, and I think that's great. We certainly are cognizant of the changes to the Human Rights Code, and all three parties supported that, as you probably know.

**1530**

It sounds to me like there's some concern with the primary care providers here, just making sure that they are knowledgeable about what needs to be done, but I think there's also some transportation issues. I think you were getting to that with Ms. Gélinas's question. Could you maybe just expand a little bit about some of the challenges that you face there as well?

**Ms. Catherine Savarie:** This kind of goes back to something that is a little bit outside of health care: 75% of people who identify as being trans have a post-secondary education of some sort. Out of that 75%, a very large number only make about between $7,000 to $15,000 a year. You're looking at a population that is exceptionally marginalized.

When you are living in the north and you have to travel to CAMH in Toronto for a 15-minute appointment, that costs money. That is a huge issue, and not everybody can access the northern travel grant, nor do they even know that the northern travel grant exists. Then you're looking, once again, at upfront costs before you can be reimbursed. It is just not feasible.

We're seeing a large number of especially young people who identify as being trans, because that is actually becoming more and more prevalent. You're starting to see a lot of them move down south because

down south is utopia. It's not. That's why we have a 47% suicide rate in the trans community, because there is that inaccessibility to service.

**Mrs. Christine Elliott:** Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation this afternoon, and we very much appreciate you taking the time to come in and present to us.

**Ms. Catherine Savarie:** Thank you very much for having us.

## NOOJMOWIN TEG HEALTH CENTRE

**The Chair (Mr. Ernie Hardeman):** Our next presentation is Noojmowin Teg Health Centre: Janet Fathers, registered nurse.

**Ms. Janet Fathers:** Thank you for inviting me. To start with, I'd like to introduce myself. My name is Janet Fathers and I am a registered nurse employed by Noojmowin Teg Health Centre. Any time you see two Os together in Ojibway, it's always pronounced "oh"—Noojmowin Teg, okay?

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

**Ms. Janet Fathers:** You're welcome.

Noojmowin Teg Health Centre is an aboriginal help access centre on Manitoulin Island providing services to seven First Nations communities of Manitoulin and to off-reserve clients.

My program, the Aging at Home Program, is for First Nations elders, 55 and older. The Aging at Home Liaison position was an initiative of the LHINs about four or five years ago. The goal of the program is to keep elders safe and as healthy as possible in their own homes and out of hospital.

The job description included, "liaising between health care organizations for the best interest of our elders; working with current services providers, caregivers, family and clients in the community to build capacity; and teaching the personal support workers continuing education." The role was new and had to be developed. I was glad for my previous experience as a case manager with the CCAC, and as a head nurse in a long-term-care home.

The Aging at Home Liaison job description also said to "fill in the gaps," so I went out to the different First Nations communities and followed nurses and personal support workers around in their daily work to learn from them. As a result, I have seen gaps and have worked toward filling these gaps, one of which has been to attend both sites of Manitoulin Health Centre three mornings per week in a discharge planning liaison role. This is where the North East LHIN comes in.

Sometimes, funding is requested and provided, and guidance is needed to benefit most from it. I would hear, "They just give us money but don't tell us how to do it"—the program or the initiative. So I've been working alongside, mentoring the First Nations nurse care coordinators in their role, and with new initiatives, such as facilitating nurses in improved skill with negative-pressure vac dressings; working toward a wound care protocol; working alongside staff with Heart and Stroke's Aboriginal Hypertension Management Program; mentoring each nurse in use the RAI assessment, the common assessment tool for use in community that you just heard about; and supporting the First Nation nurses as they gain confidence with intravenous therapy for long-term antibiotics in community. IV therapy in the community is a huge need. There have been many barriers to getting this program going, one of which has been funding challenges. The North East LHIN has provided funding for equipment and supplies for IV therapy.

Another goal has been to improve palliative care in the home for those who choose to die at home. We really want to focus on this this year.

Since I've been here four years, the North East LHIN has provided the mobile adult day program three days per week in three different communities on Manitoulin, two on-reserve and one off-reserve. The North East LHIN listened to our input when planning for this program.

They also listened when evaluating the assisted living program through VON for clients who need more hours of care daily than what our programs or CCAC can typically offer. One of the criteria for the assisted living program was that a client be within a 15-minute radius of the formal caregiver, the PSW, so that if the client had a fall, for example, the PSW could reach the client within a quick time frame. This 15 minutes may be reasonable if in the city, but Manitoulin Island is over 100 square miles, and there were many who desperately needed these hours of care but did not meet this criteria. So the LHIN really listened when that distance was extended to 30 minutes from 15 minutes, which, geographically, is much more possible here.

It was quickly apparent that we needed respite hours of care for caregivers of both palliative clients who needed 24-hour care and clients with dementia, who could not be left alone. The LHIN listened and provided funds for respite care over and above personal support hours of care for personal care. Now, for three years, when we've run out of funds for respite care, the North East LHIN has paid attention and has provided additional funding.

Noojmowin Teg Health Centre has an aging-at-home van, funded by the North East LHIN, which provides transportation for Manitoulin clients 55 and older to manage instrumental activities of daily living, such as getting groceries, banking and getting to medical appointments. This service, with the LHIN's permission, has been extended to non-First Nations, so it's used by both First Nation and non-First Nation clients 55 and up, mostly for medical trips to Sudbury, for example, to Health Sciences North. Again, this is used to its max, and the LHIN has provided additional funding at year's end, when requested.

For both of these programs, this year, a proposal was requested and approved in a very quick turnaround time, requiring only reasonable detail because of past and current well-documented need.

I've worked very closely with the First Nation care coordinators with complex cases, in family conferences and to assist as needed with advanced care planning and/or placement application to long-term care, short-stay or convalescent care programs. I made myself available, working along with and mentoring each nurse as she completes the CCAC's application package for the above programs.

Just recently, the North East LHIN has been quick to assist in problem-solving to facilitate a smooth transition from community or hospital to the above programs, both through collaborative meetings of all players and identifying challenges and working one-on-one to build capacity.

How is it that we are able to make ourselves be heard by the North East LHIN? We've had three LHIN representatives—outreach officers—since I started in this role. All three ladies have been accessible and approachable to us. They answer the phone, they take time to listen to our concerns and they attend our meetings, participating and providing helpful input and, again, hearing our concerns. The main meeting is the Manitoulin health links, where many health agencies of Manitoulin come together to network and share regarding common goals.

**1540**

Recently, the North East LHIN was hoping we would form a formal government health link or hub and work within its guidelines. When we voiced that we'd prefer to continue to work together as we have been, as what we've been doing has been working in our unique geographic, cultural and political situation, they listened again.

The RN care coordinators and I have attended annual events put on by the North East LHIN which have been a wealth of resources for our programs. The first, a day in Sudbury three years ago, was jam-packed with brief presentations of about eight new programs or initiatives funded by the North East LHIN, which are available to our clients. Without this, we might not have been aware or utilized these programs to their potential for the best interests of our clients.

All of these programs have been very helpful: for example, the Choices and Changes program, to empower clients to take responsibility and make changes in their lifestyle to benefit their health, and caregivers to make changes in their approach to clients, to maximize outcomes in their care; and the complex diabetes program in Sudbury, for the Sudbury/Manitoulin region, a wonderfully comprehensive program that many of our clients now attend—to name just a couple.

Other forums have been facilitated by the North East LHIN where we have come together to learn, to see how research aligns with real-life stories, to work on solutions to barriers and challenges, and to celebrate successes. Louise Paquette has been there, leading, her compassion and genuine concern evident.

The North East LHIN chose well in having Dr. Sinha, Ontario's senior care strategy lead, research and prepare his report Living Longer, Living Well. Again, we were invited to sessions with Dr. Sinha, to share experiences from our everyday work with clients and to voice concerns. He and Louise Paquette go with teams to various areas, even to the most northerly regions, to listen to clients' concerns, and to the programs to see and hear first-hand what the needs are.

I think it's always a challenge to ensure that bureaucracy, the people at the top, really know and understand, and can make changes which impact in a good way the problems of clients and those working most closely with them at a ground-roots level, whether family caregivers, or formal caregivers such as PSWs, nurses, physiotherapists, social workers etc.

The LHIN does require reports from us in order to plan and validate our need for programs and funds. Yes, they need numbers, but I love that the North East LHIN is interested in our stories about real people:

—frail, elderly couples, one perhaps with a cognitive deficit, and the other with physical deficits, the two barely managing as one;

—grandmothers who are caring for grandchildren more than for their own health concerns;

—exhausted caregivers;

—perhaps a gentleman living in isolation, newly grieving the loss of his wife of 60 years; and

—everyday people whose conditions may be chronic and draining, or whose lives have been suddenly interrupted by disease or accident, with all the effects—physical, emotional, social, financial and spiritual; real people, beautiful people, trying their best, some needing more of our assistance, and others, with our support, empowered in self-help to be responsible for their own health and care.

I can honestly say that the North East LHIN has listened and heard. They've paid attention in a way that has impacted our programs and care, to make a difference where it really counts: in the lives of our clients. Thank you.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. We have about three and a half minutes, so it's just one, and it's the third party. Ms. Gélinas?

**M^me^ France Gélinas:** Well, there you go. I thought it was going to be your turn.

I appreciate you, very much, coming here today.

**Ms. Janet Fathers:** Thank you.

**M^me^ France Gélinas:** I'll start my questioning like I did with many others; I know you listened in on some of them. Right now, what would you say are the highest needs of the people you serve?

**Ms. Janet Fathers:** Well, I did mention in one line here that palliative care is very near and dear to my heart. People are choosing more and more to pass at home. That's what they want, regardless of culture, regardless of First Nation or non-First Nation. We need the human resources for that, we need the education for that, we need the capacity-building and, yes, we need funds for that as well.

**M^me^ France Gélinas:** How do you see the LHINs being helpful in this versus what we had before, when you dealt with the regional office of the Ministry of Health? Well, you didn't, but somebody had before.

**Ms. Janet Fathers:** No. I can only speak from my experience in the last four years. I really, honestly feel that the LHINs do have their ear to the ground. They do listen. They are responding. When we say we have needs—I would expect that if we said, "We need more funding to develop palliative care programs to be better," they would hear us and provide the funding.

**Mr. Michael Mantha:** Just a quick question on the home care front. Fifteen minutes would be great if that was possible, and for some people it is possible; 30 minutes would be great. But you know the area as well as I do. I know that there are PSWs who are travelling in from Gore Bay all the way in to Spanish to bring that care, and that's a lot more than 30 minutes; that's almost two and a half hours. Is that something that you see regularly in your area in the field of home care? What can we do with the LHINs to really change that?

**Ms. Janet Fathers:** First, let me say that in the programs that I work with, most of the First Nation health centres have their own PSWs. The five smaller First Nations have PSWs who work for all five through Mnaamodzawin Health Services. So we actually have pretty good PSW hours of care. Our problem is that we need more PSWs, more actual human beings, so that they're not burning out.

Our PSWs do get paid for travel. I believe that PSWs who work for places like Bayshore and Red Cross and VON need to have their mileage paid. The PSWs across the province, whether they're working in long-term care or community for aboriginal health centres, Red Cross or any other agency—I really believe they need to have standardized salaries. They need to get paid equitably.

What's happening in community care is—

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

**Ms. Janet Fathers:** We're out?

**The Chair (Mr. Ernie Hardeman):** We have run out of time. We thank you very much for your presentation. Thank you for taking the time to come here.

**Ms. Janet Fathers:** Thank you.

## PERRY AND PERRY ARCHITECTS INC.

**The Chair (Mr. Ernie Hardeman):** Our next presenter is Perry and Perry Architects Inc.: Jeff Perry, president. Thank you very much for your attendance today. You have 15 minutes to make your presentation. You can use any or all of that for your presentation. If you leave any extra time at the end, we'll have some questions and comments from the committee as they relate to your presentation.

With that, the 15 minutes are yours.

**Mr. Jeff Perry:** First of all, can you hear me? Am I close enough to this? Okay.

Thank you very much for affording me the opportunity to address the board and review committee. Allow me to introduce myself. My name is Jeff Perry. I am president of Perry and Perry Architects locally here in Sudbury and, as well, president of Perry and Perry Developments locally here in Sudbury, who have recently been actively involved in the development of seniors' housing.

Although we come with 26 years of experience within this community, we've done work throughout northeastern Ontario and feel strongly that we can accurately reflect the needs as it comes to seniors' issues and, in particular, housing issues.

**1550**

Why am I here? I'm here basically to share our experiences and share an example of the relationship of the North East LHIN with respect to accessibility, collaboration, their partnering abilities, and the ability to address homegrown solutions and grassroots solutions in our community. We've had a very positive experience, and I'm also here to offer that perspective from the private sector.

But let me flash back a little bit—maybe a lot—at this point in time, back to 1944 in the city of Sudbury. Seventy years ago, post-World War II, the city is founded on a great base of nickel development and production. Things are booming and, of course, along with post-World War II, there are lots and lots of babies here. As we all know, and I'm sure we've heard many, many times before, this related population boom—of course, they're boomers—is in fact a strong influence in our community as well. In fact, during that time, between 1944—there was over a doubling of the population, approximately from 30,000 people to 90,000 people over a 10- to 15-year period. That's potentially 60,000 people who had to be addressed in terms of population growth. Their needs had to be addressed in terms of that population growth, including infrastructure requirements, schools, roads, retail requirements, of course housing requirements and, last but not least, their health care requirements.

The point to be made here is that at such time, those needs were built on the premise of a very young population—young in age, as I put it. As a result, those needs that had been addressed based on that young population were reflected accordingly in that development.

Now I'm going to fast-forward to today, which is 50 to 70 years later, and those babies that took place way back when are now that age: 50 to 70 years old. We, of course, are around this table today wondering how we can best address that, in particular the health care needs of that new society and that new reality. Over the most recent years, we've experienced a decade of change with respect to health care. We've invested in our hospitals. We've invested in our complex continuing cares. We've invested in our long-term cares. We are investing with a great deal of focus on our home care. We're also doing the math, we're counting the numbers, and we're coming

to the realization and determination that we basically can't afford it. We don't have the dollars, we don't have the capacity, and we don't have the workers. Our previous presenter already mentioned the fact that there are challenges with access to PSWs, nursing care, and, by simple demographics, we all know that there are fewer of the young ones and many more of the old ones.

Of course, we're all looking for alternative solutions. In particular, we're looking—in our case and in many cases across the province—for an ALC solution. Herein lies the challenge when we start to focus our efforts on home care. I divert back to the fact that in 1944, when this development was taking place in the city of Sudbury, there was the development of an infrastructure in the form of housing that took place that today houses those very seniors, in many cases. Although we've built complex continuing cares, long-term cares and enhanced our hospitals and have approached enhancement of our services for all, we still have a great deal of our aging population in inappropriate, small, high-maintenance houses in great need of repair, that we are trying to serve in the form of home care in an area of more than 3,200 square kilometres. So there are some obvious challenges with that, of course, in not only the practicality of being able to accomplish that but, as well, the reality of the costs of such service to be delivered to these areas.

With our efforts and with our collaboration and with our work with the stakeholders in the community, and in particular the North East LHIN, we've been able to focus on some opportunities that may result from a means of addressing this type of challenge.

Before you, I believe, there's a handout. I think everybody got one. In that handout is a very high-level reflection of what we have been working towards and what we have been evaluating with respect to what we call the affordability gap. As mentioned earlier, it's very difficult to afford, at $850 a day, a bed at Health Sciences North. Complex continuing care services are approaching $350 per day per bed; long-term-care costs are approaching $130 per day per bed. We're comparing that with, as mentioned, the home care approach. As you can see, the image depicted at the far left is of a single-family dwelling: two storeys, stairs outside, big yard, long driveway and so on. The point is, in terms of home care, what we're trying to accomplish with the current infrastructure of housing form that exists in our society—and this is a Sudbury reflection, but I'm sure it's the same story across many communities across northern Ontario. We're finding it very difficult to serve those individuals in that inappropriate housing form.

What we've been exploring and investigating and even testing is the opportunity to look at filling that gap with an assisted living form of housing where a hub of assisted living services can be placed and formed at multiple-family-unit dwellings appropriate to the needs and access of seniors and frail seniors in our community.

The point to be made, and to keep it brief, is that without the collaboration, the co-operation, the interest and insight that is shared by all community partners but, in particular, the North East LHIN, these types of projects, these types of stories and explorations, would not be feasible.

So I applaud the approach. I applaud the eagerness and the interest in working with all stakeholders, including the private sector, to look at opportunities to appease the challenges that we have in front of us with respect to seniors in our community.

With that, I'll leave it open for questions; I want to keep it brief. I'll leave you the floor.

**The Chair (Mr. Ernie Hardeman):** Yes, we have about six minutes, so we'll start with the government.

**Ms. Helena Jaczek:** Thank you very much for coming in. I think I probably speak for everyone on the committee: We're really enjoying some of the presentations made by the non-traditional health care providers, so thank you for this.

Maybe you could describe to us exactly—obviously, you've told us you're a builder and a developer and so on—how you have been involved with the LHIN. Did you voluntarily go to a LHIN board meeting? How did you become engaged in this whole issue?

**Mr. Jeff Perry:** Well, quite simply, I picked up the phone and contacted the LHIN in an effort to see if there's interest in this sort of thing, whether or not there are any synergies involved, and looking at opportunities to work together, whether it be simply by information dissemination or potential service funding for services for the elderly or some form of synergy that may make sense so that not only the LHIN but the seniors and all the stakeholders in the process of addressing this issue can all be successful in making that happen.

**1600**

**Ms. Helena Jaczek:** How have they engaged you subsequent to you picking up the phone?

**Mr. Jeff Perry:** Well, there have been several meetings, several interfaces, several discussions, several opportunities that have been explored, all resulting in a project that—in fact, there's an image of that very project in the middle, right above the affordability gap line there. That has, in fact, resulted in the development of an affordable housing for seniors' project. There are 32 units in that building. But as a private sector approaching that project on its own, it's not able to address all of the financial challenges that would keep it and make it affordable.

**The Chair (Mr. Ernie Hardeman):** I'll have to stop you there and go to the next question. Thank you very much. Ms. Elliott?

**Mrs. Christine Elliott:** Thank you very much, Mr. Perry, and perhaps you could just carry on with your thought on that. I'm very interested in how you would see this operating and what the challenges are.

**Mr. Jeff Perry:** Well, long story short, in order to build that building in today's dollars, you'd have to charge a minimum $1,500 a month for the unit that is developed. In partnership, in this case, with the Ministry of Housing and, in particular, the investment in affordable housing program, they offered capital to assist with

the overall capital cost of construction. As a result, we are able to offer the units at an agreed-upon affordable rate due to the influx of capital.

That's where it stopped, in terms of building bricks and mortar for affordable seniors. Therein lies the relationship with the North East LHIN, whereby the interest was to not only offer this to our seniors, but to supplement the bricks and mortar with a service within the four walls. So as a private sector, we couldn't afford it within the basis of an affordable scope. The opportunity is to have the LHIN—have those discussions, get the partners together and create the service environment that would allow and offer that service not only within that building, but as well to serve as a hub—

**The Chair (Mr. Ernie Hardeman):** We'll have to stop you again. The third party. Ms. Gélinas?

**M^me^ France Gélinas:** Sorry, just to follow on your train of thought, I'm becoming a little bit more picky in the answers as they go around. Is it better that the Ministry of Housing gives you capital up front so that you can offer a reasonable rent that you've agreed upon or the other model, where you have some units that go for market rents and the government subsidizes the people who cannot pay the full rent? What works better, in your thoughts?

**Mr. Jeff Perry:** From our perspective, it's six of one, half a dozen of the other. It's all about mathematics at that point. We know what it costs to build those four walls and that roof, and whether the money comes in the form of capital or whether it comes in the form of rent subsidy, it really doesn't matter. The results are the same; the affordability is available.

But the exciting piece of all of this is the collaboration and the joining of the community partners who have come to the same table and discussed this. I still think there's a long way to go, personally, from a private sector perspective. I think there are a lot of silos that have to come down. There has got to be a lot more synergy between those silos in terms of where the money comes from. I don't particularly care if it's from the Ministry of Housing or the Ministry of Health or if it's from some other ministry; it's all tax dollars. The net result is, hopefully, a better life for seniors.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. The time has expired. We do thank you very much for coming forward to make your presentation. I do have to say, it's one presentation that I haven't heard before in our travels so far. Thank you very much for bringing new information into the debate.

**Mr. Jeff Perry:** Thank you for having me.

## MINE MILL LOCAL 598/UNIFOR

**The Chair (Mr. Ernie Hardeman):** Our next one is Mine Mill Local 598/Unifor, Anne Marie MacInnis, president. Thank you very much for being here, and we thank you for taking the time to come and talk to us. You have 15 minutes to make your presentation. You can use all or any of that time for your presentation. If there's time left at the end of it, we'll have questions from the committee. With that, the floor is yours.

**Ms. Anne Marie MacInnis:** Thank you for the opportunity. Good afternoon, everyone. I'm here as the president, but I'm wearing my daughter cap today. I feel a little uncomfortable because I'm not one of the lobbyists here that are lobbying for the dollars, but I have to share my experience, and 10 years of it is going to be hard to complete in 15 minutes.

I just want to say that—a lot of things. In 2001, I lost my only child after going to a walk-in clinic four times and being told that I was overreacting and that he only had the flu. He dropped dead at home in a chair in front of my mom and I.

Then, in 2002, my father had his first heart attack. He went to the hospital and came home after that. He was still mobile, able to go out and socialize and able to bathe himself. He was still able to do all those things.

In 2004, he had another heart attack, and it was serious. What had happened was, at that time, he went into the hospital and he was allergic to a medication that they had given to him in the hospital. He was in restraints for two days—my background is in long-term care; I'm a PSW by trade, by career choice. What had happened then was, we went through the hospital system. He came home. Again, he had another bump in the road. He went back to the hospital, and it was very serious. He had developed many cognitive impairments and was losing bladder and bowel control.

Anyway, he was coming home again, so we knew that we had to have some help in the home. We knew that my mother was going to be the primary caregiver because I had to work. So we did have some folks come into the home. We were given a certain amount of time a day so they could bathe him. What had happened was, for three years, I slept on a couch because he was wandering at night and I needed to give my mother a break because she was deteriorating as well. So I slept on a couch so I could hear him. When he fell out of bed, I'd have to call my brother, my brother-in-law and family members to help me pick him up off the floor.

Then it increased again, and I was told that I only had so many hours in a day to have help to care for him to meet his basic needs. That meant, again, that my mother was the primary caregiver. When I got home, I took over. We all pitched in as a family because we loved my mom and dad. We loved them, so we did it.

Why didn't we place him in a nursing home, because I think at one point he could have been placed there? Because there's not enough time in a nursing home to care for a resident properly, and we knew that. Anyway, he went back into the hospital. He went through the rehab at CCC. He went back into the hospital again. He had to have a pig valve replacement. He made that decision with the doctor. I had asked to be involved in all those processes as a POA—he had a living will—and I was not.

In the hospital, he wasn't put on a toilet; he was told to go in a bedpan. There were all kinds of things that happened. He was a patient at the ALC for a while. He was

depressed at first, but then it picked up because he was given activities. They were involving him in things. He was actually enjoying it. I was able to go home and rest. It was nice.

In that time, though, my mother had died—at home; I found her on the floor. I took care of my dad for six months by myself. I couldn't do it anymore. I was told that I had four choices—I knew I didn't; I knew I could only choose one. I knew if I wanted to choose one, that's what I could do, but I knew that, right?

Anyway, we had him on a waiting list. I was told that if I paid for a private room he would be able to jump the queue. I didn't pay for a private room because it's about fairness and processes. I couldn't do that.

Then he was transferred back to the hospital because ALC closed—the Memorial site closed. He was brought back to the hospital. I had gotten a call 10 minutes before they were going to transport him in an ambulance. At this time, he's confused. He's scared. He doesn't know what's going on. I was told, "Well, you've got 10 minutes to get here." Guess what? I wasn't there and he was transferred.

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My dad ended up dying in the hospital on June 28, but before that happened, he had contracted C. diff. twice, he was in palliative care, taken out, then put back in palliative care because I demanded it. Even at the end—and I couldn't be at the hospital in ICU when my mom died because I was at home with my dad. I couldn't get help to be in there when my mom died. Everybody else was there; I wasn't. And I wasn't there when my dad died. Why? Because I was on the phone, dealing with the bureaucrats. I was getting hold of an advocate. I was calling Vale Hospice myself. I wanted him out of there to die with dignity and respect.

So, like I said, sorry. I really don't have anything positive at this time.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. There's a lot more to a presentation like that when you're talking about how we're looking at improving our health care system than what you would—

**Ms. Anne Marie MacInnis:** There is.

**The Chair (Mr. Ernie Hardeman):** We very much appreciate you coming in and sharing that with us.

We do have some time—about eight minutes—left for comments, if there are any questions from caucus. We start with the PC Party. Ms. Elliott.

**Mrs. Christine Elliott:** First of all, thank you very much, Ms. MacInnis, for coming in today and presenting to us on such obviously deeply personal issues. All I can say is, I'm sorry that you've had such a terrible time with the system.

I'm just wondering if you've communicated those concerns to the LHIN. Have you spoken with them about the care that both of your parents received particularly?

**Ms. Anne Marie MacInnis:** As I said, on the last day, when my dad died, everybody was there but me because I was on the phone with the bureaucrats. I believe that you try to work things out in the system, right? Truthfully, I was a little concerned because I saw that when I did say something, my dad would give me heck because he was treated differently. So when I did say something, I didn't want that to happen.

And the home care: I didn't even mention that. I kind of skipped over it, the missed appointments and people not coming out. At one point, we had to replace the bathroom because there was a flood in the bathroom. But that's okay; we put in the shower so he could get in and out more easily. But it's things like that. If there was a scheduling issue, my mother would have to contact the head office, which was in Thunder Bay. If we had somebody scheduled at 9 o'clock and we had plans for the afternoon to bring them out to enjoy life, we might have had to change them because they weren't going to be able to come in until a different time.

I want to say too that it was difficult, and I did see my mother deteriorate. She became depressed and anxious. That wasn't my mom. I can only imagine, to see your partner go through that and then know what's next—right? It was tough, but my God, she was a strong woman.

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

**M^me^ France Gélinas:** Thank you for coming, Ms. MacInnis.

**Ms. Anne Marie MacInnis:** Thanks, France.

**M^me^ France Gélinas:** If you looked back at what your family went through and you had to change the number one thing, if you were able to change anything, what would be the one thing that you would like changed? I know there would be many, but what would be your top one?

**Ms. Anne Marie MacInnis:** I think I was fortunate, France, to work in a unionized facility so I could take leaves of absence. A lot of the time was spent—I went off work in May to care for my dad. I'm fortunate to be able to take that time off without fear of termination and things like that.

So probably—I almost feel like I'm owed some money. Maybe my mother was owed some money. Maybe for folks who are in their homes, and you have a primary caregiver who is a family member, look at some kind of compensation for that.

**M^me^ France Gélinas:** So when we have a willing family who's willing to take somebody back home who is very high care, consider paying the family rather than a home care agency to help? Or both?

**Ms. Anne Marie MacInnis:** Both.

**M^me^ France Gélinas:** Both.

**Ms. Anne Marie MacInnis:** Because it's 24-hour care.

**M^me^ France Gélinas:** Because it's 24 hours. Okay, so that's number one. Do you have a number two?

**Ms. Anne Marie MacInnis:** A number two would have to be, honestly, that it continue being a public system, that we be careful when we start venturing into P3s

with the private sector, because if you and I were going to get into a business, it's to make a profit.

**M^me^ France Gélinas:** And is this what you saw? Was this your experience, where the people coming to help were for-profit businesses?

**Ms. Anne Marie MacInnis:** Yes.

**M^me^ France Gélinas:** And you feel that this has an impact on the quality of care, the retention of workers and—

**Ms. Anne Marie MacInnis:** Certainly, because there's no money left to pay the workers and other forms of pay—because, I mean, it's to make a profit. Somebody has to pay for it, and it's usually on the backs of the workers.

**M^me^ France Gélinas:** Do you know how much the PSWs that were coming to help your parents were making?

**Ms. Anne Marie MacInnis:** Yes, they were making a little over $13 an hour before they organized.

**M^me^ France Gélinas:** Has it gotten better since they were organized?

**Ms. Anne Marie MacInnis:** Not with the recent award. Long-term-care workers—we're on a freeze, right? People are asked to not get a raise for five years now.

**M^me^ France Gélinas:** That's a long time.

**Ms. Anne Marie MacInnis:** It's a long time, a very long time. And no COLA or things like that.

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

**Mr. John Fraser:** Thank you very much, Ms. MacInnis, for sharing your family's story. In our family, we're currently going through the same thing. We've been doing some couch-sleeping for about three or four months. I can't imagine doing it for three years.

**Ms. Anne Marie MacInnis:** Ten.

**Mr. John Fraser:** What's that?

**Ms. Anne Marie MacInnis:** Ten.

**Mr. John Fraser:** You did it for 10 years. I can't imagine doing that. That's a lot of sleeping on the couch and not always sleeping well.

I'd like to go further to Ms. Gélinas's line of questioning, but I'd like you to be a bit more specific in terms of your personal circumstance as to how the care could have connected to you better. You said that in the last day, you were trying to organize—you were going to the hospice yourself. So do you have any thoughts, comments or something that would have made it better in your situation?

**Ms. Anne Marie MacInnis:** I do. I know recently I've asked a couple of folks who are in the RN program, "What do you want to do?" And their comment is, "To be a boss." So I think that what's happening is that there's a lot of money that's being spent, and it's going to top management, and it's not trickling down.

We all want to work. We all have to work, right? But I think that there has to be, as the doctor had said before, some kind of coordination. There has to be standardization. There have to be those things so people aren't jumping through the hoops to get the care that they need.

**Mr. John Fraser:** Thank you very much.

**The Chair (Mr. Ernie Hardeman):** Thank you very much for your presentation. We very much appreciate you coming out and sharing that with us.

That, as I look on my list, was the last delegation. If there is no further business for the committee, the committee—

*Interjection.*

**The Chair (Mr. Ernie Hardeman):** We'll be leaving—in the lobby—at 4:40 p.m.

With that, thank you all for your attendance. I thank the audience for their attendance.

We have a hand up.

**M^me^ France Gélinas:** It's very mundane. I have to drive to the airport, so whoever wants a ride with me, you can save a cab and hop on.

**The Chair (Mr. Ernie Hardeman):** This committee stands adjourned until tomorrow morning at 9 o'clock in Thunder Bay.

*The committee adjourned at 1619.*

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