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Lundi 10 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

Monday 10 February 2014

Lundi 10 février 2014

The committee met at 0900 in the Vankleek Hill Community Centre, Vankleek Hill.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Good morning. Welcome to the social policy meeting in Vankleek Hill. It's great to be here. We're doing the public consultation 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. This is our seventh day and the eighth city to be in. This may not be the largest of the cities we've visited, but in fact it is one of the most populated when it comes to people who want to present to our hearing, so we want to thank the Champlain township people for having that distinction. Thank you very much for being here. It may also be one of the least large cities I've ever had a public committee come to to hold a meeting, and we very much appreciate doing that. I come from a village smaller than this one, so it's nice to be here.

DR. ROBERT CUSHMAN

The Chair (Mr. Ernie Hardeman): Our first presentation is from Robert Cushman, the former CEO of the Champlain LHIN. Dr. Cushman, thank you very much for being here and taking the time to come and talk to us. You will have 15 minutes to make your presentation. You can use all or any of that for the presentation. If there's any time left, we'll have questions from the committee. With that, the next 15 minutes are yours.

Dr. Robert Cushman: Thank you, Chair Hardeman. Bonjour tout le monde. Thanks for having me. It's an honour to be here as the inaugural CEO of this particular LHIN. I came at it with a passion, and I saw what this LHIN did, and I'm very proud to have been part of that enterprise. But I did see some of the shortcomings in terms of what needs to be done with respect to the sustainability and the quality of health care in the province of Ontario.

To me, the first question is, is regionalization important? Ontario stretches from Kenora to Hawkesbury, which is not far from here. Mr. Chair, you alluded to the fact that this is a small town. Ontario is extremely big, but really, when it comes to health care, we are very Toronto-centric. Stephen Leacock said a hundred years ago that Toronto had electricity and the rest of us get coal. I would say to you that it's very similar in health care. I'm delighted to see that most of you are not from downtown Toronto.

That's my principal point: Ontario really defies its size and population. It's not really the place to deliver and monitor health care services. Certainly, the rules of the game can be made from downtown Toronto—the standards set, the resource distribution thought about.

I'll just give you a few examples. When the LHINs started, the downtown Toronto LHIN had the same travel budget as the North East LHIN. The subway LHIN had the same travel budget as the North East and North West LHINs, where you had to take a long flight to Toronto, where you needed Twin Otter planes and snowmobiles to get to some of the villages. It's very interesting.

The Toronto Central LHIN, when I last looked, had about 40% to 50% more of the CCAC budget than the Champlain LHIN, even though we serve the same number of people. As you look around today and you think about Renfrew county and eastern counties, it's pretty clear to me that a lot of time is lost when you go to serve people, just in terms of your travel.

I just make those points to say that it underscores how Toronto-centric health care services are in Ontario, and that we really need regionalization. Decisions need to be made at the regional and local levels and by the people whose lives are affected. I think it's a key principle. Someone drew the lines on the map over a hundred years ago, for Ontario, and that's what we have and it's wonderful, but in terms of delivering services, to have that local autonomy, obviously, within the greater game plan, which you folks decide on, is very important.

Then we get to the question of, what's too much bureaucracy? I would say that the Ministry of Health, unfortunately, does not have the expertise, does not have the confidence of folks in the field, province-wide, and certainly does not have the knowledge. There's a sad fact about the Ministry of Health when you're in the health care business: It's competing with the health care organizations in Toronto, so in terms of status, money and excitement of employment, I don't think it really gets the best of breed compared to UHN or Toronto SickKids in terms of health care administrators—a fact, probably one we don't like, but the truth. This is why we really need to have regionalization. As I said before, the allocations, all

these things—there are some decisions that should be made.

The Brits have a concept: They say to decentralize when you can, at all possibility, and centralize when absolutely normal. This also applies to Ontario.

We here in the Champlain LHIN are about 98% sufficient in terms of our health care services, so you wouldn't expect lung transplants or sophisticated services that Toronto SickKids can offer to be done here. On the other hand, we also have an import business here. We serve the two neighbouring LHINs. We serve the north, and we serve Quebec. So we are very, very self-sufficient.

The Champlain LHIN, in fact, makes sense. If you compared the Champlain LHIN to the other provinces in Canada in terms of population and resources and quality and sophistication of health care services, I think we would be the fifth province, which is very telling, very interesting. Again, that speaks to the size of Ontario.

There's a lot of talk about added bureaucracy. If you're really looking for bureaucratic savings—I'm very impressed by the LHIN, frankly. I'm now working with Health Canada. I've looked at hospital administration. I'm very impressed by value for money from the LHIN. If you're really looking for health care savings, I would suggest you start at the Hepburn Block. I would also suggest that you look at hospital administration—if you compare what people are being paid there and some of the activities that are going on. I have some very close family members who work at some of the larger hospitals in the area, and in terms of value for money, if you really want to trim bureaucracy, the LHIN is not the place to start.

The second issue is, what kind of governance is needed? We were told right from the start that the LHINs would have an uphill struggle if the boards were not dealt with. The true regional health authorities got rid of the organizational boards, and we were told that we would have trouble.

I turn back to the biography of the late Fraser Mustard, a pioneer in health and early child care. In 1974, in the final report of his Health Planning Task Force, he found that the hospital boards all "wanted to protect their turf and did not want to integrate with others, and hospital doctors had no interest in integrating with family doctors." He learned that "highly intelligent people do not find it easy to plan something that entails the loss of their prima donna status." Fraser Mustard always called it the way it was, and what he said—I guess that was 40 years ago, in 1974.

In the Champlain LHIN, we have over 200 boards. As Jack Kitts has said himself, when the Ottawa Hospital wants to ignore the LHIN board—maybe not on meeting wait times, something that's prescribed by the ministry and the government, but in terms of deciding whether they should have two centres for delivering babies and whether the children's hospital should do the delivery piece, along with the neonatal piece—they can get in the way if they want to. Jack is a great guy and is very honest about this. So this is something we have to look at.

These big boards—I hate to use the word—can be bullies if they want to and the small boards are absolutely tribal in terms of how small they are and where they want to go. Integrating two very small organizations is often as challenging as integrating two very large organizations.

0910

Again, I would say to you, what kind of governance do you want? I think we need to go to a regional health authority, but I am very concerned about having nine LHIN board members being responsible for this vast area from Hawkesbury up to Deep River with a budget of over $2 billion and 1.1 million people. I think we need population-based boards, not institution-based boards. You would actually have not only the Champlain board, but you would also have a district board—for example, in this area of eastern Ontario north of the highway you took to get here—so that you drill down to the district level. These people are not responsible for their local hospital, but they in fact are responsible for the 50,000 or 100,000 people who live there, so a population-based board as a foundation under the regional board. Again, I think governance is very important, and I think to really come to the level of a regional health authority, you have some major challenges ahead of you in terms of dealing with that.

I would say that I do sit on a hospital board. In terms of CEO searches, out west, they get their HR department to handle all but one or two of the top positions. Here we have headhunters do it. It adds an inflationary cost because we can't involve the HR department of the various hospitals or institutions. There would be major savings there.

So much of what goes on at a board is board education. One of the priorities of a board is invariably real estate, yet in the United States today, they're closing hospitals regularly because there's a big question in front of you, and that is, what needs to be done at a hospital in 2014? I would argue that if you're not on a ventilator, you may not need a hospital, which is very interesting. Yet we concentrate all of our resources in hospitals. Physicians—and I'm a physician—love it. Let me tell you, it's great. But in terms of having a patient-centred system, dealing with people—parking is very pricey, very difficult for people who are frail and pushing walkers around on the sixth floor of a parking lot in a snowbank because the final floor is exposed to the elements. This is a big issue.

My fourth point is hospitals, and I touched on that briefly: If you think about the Canadian health care system, we first started funding hospitals, and secondly we started funding physicians. We're actually in trouble because that's a World War II model. It was wonderful, but if you think of how health care has shifted into the community and how we need other resources, unfortunately in this zero-sum budget era that we live in, we're having trouble making the transfers. Again, what needs to be done at a hospital? That is a key question. As I said

earlier, experts in the field say that, really, if you're not on a ventilator, chances are it could be done someplace else, which is very interesting. Furthermore, you have these smaller hospitals when you may actually be better off in an ambulance on your way to a more sophisticated centre.

This brings me to the primary care issue in terms of urgent care, access and open hours beyond 9 to 5 business hours. Again, what's interesting is we're trying to transform primary care, yet we have more and more people going to emergency. One of the problems is physicians in their clinic don't have access to the tools they need to deliver after-hours care. When I used to go to my clinic, I used to have to press the alarm to get in. I would line up some patients. I was a robust, fairly healthy individual, but I would fear for a young woman trying to do the same thing, or even my wife. Who knows? Maybe I should have feared for myself in terms of an inner-city neighbourhood and going in to see three or four patients in an afternoon where you had to turn on the lights and deal with the alarms and open up the rooms. As one of my colleagues has said, what you actually need is a mezzanine service for these urgent care clinics, but you have to provide physicians with the material to do their work. To give five stitches, you probably need to go to a place with a big H in front of its parking lot, that type of thing; to get some basic laboratory or X-ray information—that's a clash there. You notice I said we don't need as many hospitals as we have, but from the primary care sector, we have to get some infrastructure. Whether you expropriate some of the hospital infrastructure for these after-hours urgent care centres or whether you set up some additional structures depends on where you are and what's available.

As for physicians, I said earlier that I'm one, so I tend to know my tribe pretty well; my wife is one. We tend to know the tribe. Physicians have done very well in Ontario of recent, but as I said, the primary care physicians need more access to the infrastructure. I would actually challenge you that the in-hospital specialists are doing very well these days and yet when you think about it, all the infrastructure, all the physical equipment, all the capital equipment they need is provided to them. At the university hospitals, sure, we devote time between research and teaching and service, but, still, the basic infrastructure is provided.

Just to draw an analogy, can you imagine Air Canada pilots having that amount of autonomy in terms of when they take off and where they land? This is another real issue you have to think about: that in the community, physicians are paying 30% overhead. The question is, how does that relate to hospitals? That's a tough question but it needs to be asked and you're not going to make people happy when you ask it. I may have trouble with my peer group when I leave, but I think it's something that's worth asking.

I'd just wrap up and say that I think Ontario is too big to deliver all but the basic principles and outline and funding of health care and that regionalization makes an inordinate amount of sense. Interestingly enough, it failed in Alberta because Calgary and Edmonton had fierce competition not only in football and hockey but also in health care. Frankly, both cities thought they were as big as Vancouver or Toronto. That's what happened in Alberta. But if you look at Alberta Health Services, now they don't have regions; they have zones. Very quickly and quietly, they're realizing that there's a better way to organize health care than on the basis of that large province.

I'm a big fan of regionalization. In order to keep health care sustainable and effective in Ontario, there are a number of things you have to do, which I've outlined. It's interesting—I'll just close. I have this piece here: the nine key factors for a successful health care system. The two "A"s: accessibility and affordability. I think regions can improve accessibility. The three "E"s: effective, efficient and equity. Again, I think a region can do that. Patient-centred and integration—

The Chair (Mr. Ernie Hardeman): I hate to have to stop you there. You do have a printed presentation?

Dr. Robert Cushman: I don't, actually, but I can leave you those nine—

The Chair (Mr. Ernie Hardeman): Yes, okay, and then the committee can finish reading them. I do have to stop it right on the 15 minutes.

Dr. Robert Cushman: I'm sorry I went over a few seconds; my apologies.

The Chair (Mr. Ernie Hardeman): It's a very informative presentation, and we really do want to thank you for making it to us this morning.

Dr. Robert Cushman: My pleasure. Good luck to you. You have a big challenge.

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

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presenter is Champlain Local Health Integration Network: Chantale LeClerc, chief executive officer.

Ms. Chantale LeClerc: Good morning.

The Chair (Mr. Ernie Hardeman): Thank you very much for coming in and sharing your time with us this morning. As with the previous presenter, you will have 15 minutes to make your presentation. You can use any or all of your time, but, as you noticed, not more.

Ms. Chantale LeClerc: Got it.

The Chair (Mr. Ernie Hardeman): If there's any time left over at the end, we'll have some questions and comments from the panel. With that, your 15 minutes starts now.

Ms. Chantale LeClerc: Perfect. Thank you very much, and good morning, Mr. Chair and honourable members.

It's my pleasure to welcome you today to the township of Champlain in the very big region of Champlain. I'd like to thank you for providing me with this opportunity to tell you a little bit more about what the Champlain

Local Health Integration Network's role is in creating a person-centred, quality health care system—that's what we're all about—and how the Local Health System Integration Act does enable that role.

Monsieur le Président, mesdames et messieurs les députés, bienvenue dans la région de Champlain. Je vais m'adresser au comité aujourd'hui principalement en anglais, mais il me fera certainement plaisir de prendre vos questions en français à la fin de mes propos. Je vais certainement laisser des copies de mes propos ainsi que d'autres documents, et ce matériel est disponible dans les deux langues.

Although I'm the CEO of the Champlain LHIN and I've been with the organization for close to six years now, my comments today are also informed by the fact that I'm a registered nurse. Over the course of close to two decades, or more than two decades now, of working in the health care system in this province, I've had the opportunity to work in very different roles across most of the health care sectors. So my comments are informed by that foundation, which gives me some context.

0920

The Local Health System Integration Act established health networks to plan, fund and integrate health care services at the local level, and I thought that the best way to illustrate for you the power of that unique legislative mandate would be to provide you with a single example of a real live person. In this instance, it is a senior. I know that you've likely heard similar stories as you've travelled around and met with different people, but this is the fastest-growing segment of our population. It is a population that we all look after. If we get health care right for seniors, there's a very good chance we will get it right for many other people as well.

I'm going to talk to you about Mrs. Smith, but you can think of an older person that you know—it could be your mother, your father or a next-door neighbour—and I'm quite convinced that their story would be very similar to hers. I've summarized Mrs. Smith's stories in the documents that I'll leave behind for you, and I've provided much more detail, but let me summarize by saying that she's an 87-year-old lady who lives alone in her own home; she has been managing very well, thank you very much, with the help of a housekeeper and a personal support worker that she gets through the community care access centre. She manages her daily activities. She's able to socialize with her friends. She gets out of the house using our transportation system, and she is visited by her daughter. But, lately, she has been becoming increasingly confused. She is incontinent of urine all of a sudden, and she ends up visiting the emergency department because she's dehydrated and she's no longer managing. It's a story you've all heard many times before.

She does get admitted to hospital, and while she's there, her condition continues to deteriorate. Now she has become alternate-level-of-care. Her acute phase of hospitalization is now complete and she needs to be transitioned to a different setting. Everybody—her health care providers, her daughter—now thinks that because she continues to be confused, it's in her best interest to apply for a long-term-care home. So papers are put in, and she will likely sit in the hospital waiting for several months, with her condition continuing to deteriorate, for that placement in the long-term-care home.

When the LHINs arrived on the scene, in this region, 15.8% of all hospital days were occupied by people like Mrs. Smith. More than half of those individuals were en route to a long-term-care home; in fact, two thirds of all admissions to long-term-care homes in this region were via the hospital and not the community, where they should be from. We had 3,000 people on the waiting list for long-term-care homes. People were waiting close to 37 hours in emergency departments, waiting for a bed on a unit when they needed to be admitted. Elective surgeries were being cancelled on a routine basis. This was very much a system in crisis, and this was a symptom of what was going wrong with the health care system.

Today, if you fast-forward a few years, because of the work of the Champlain LHIN and our many partners, the story is very, very different. I'm extremely proud to say that we've been moving a whole system, because ALC is a symptom; it's not the cause.

Today, Mrs. Smith would benefit from a whole host of new initiatives and different ways—we've actually transformed the way services are being delivered for seniors. So she would have access to services that would have kept her healthy in her community in the first place, which would have intervened quickly when things started to go wrong. Someone would have diagnosed a urinary tract infection as the cause of her change in behaviour, and that would have been treated. She would have been helped to avoid a visit to the emergency department or an admission to hospital. Then, if she did need to be admitted, she would have been transitioned home with appropriate services much more quickly.

Today, 13% of hospital beds, compared to 15.8%, are occupied by people like Mrs. Smith. What's more, these individuals are transitioned back to their community 11 days sooner. That's the equivalent of opening up 65 more acute care beds in our region, and that has made a huge difference. Roughly now 10% of people who are in hospital are going to long-term-care homes as opposed to the 53% that it was several years ago. That is incredibly significant in terms of a change.

Wait times in emergency rooms for people who are waiting for a bed on the unit have been reduced by 11.7 days, so that's a 32% improvement, and we rarely hear now about elective surgeries being cancelled because there isn't a bed for a person post-operatively. So the data is showing that we're making a difference, and we know we are making a difference because we're hearing about it. We do know that the situation is dramatically different and we've been able to reverse a worrisome trend that was occurring. We know that things are working much more seamlessly for people like Mrs. Smith. I know that this would not have been possible without the LHIN's interventions and I know this because health service

providers, hospitals, regional offices of the Ministry of Health and Long-Term Care, district health councils—many others were at this long before us, and no one had been successful up until now at producing the kind of health care system that provides the right care at the right time at the right place for the right cost.

In Champlain, how did we accomplish this? We looked at data. We started with evidence and we brought that evidence to the table so that people could be working from a fact-based platform and not from anecdotes, but we also spoke to many people. We spoke to health service providers. We spoke to seniors, more importantly, and we spoke to many other partners about what was working well and what wasn't. We brought people together to develop solutions. We mobilized champions to produce the kind of change we were looking for in this region. We broke down silos, but always, we kept Mrs. Smith's story first and at the very front and centre. We used our local knowledge to make strategic investments. We know where to place the investments to make the biggest difference. We actually cancelled programs that weren't producing results and we reinvested the funds in those that were. We held providers accountable for the kind of results that seniors were expecting. We leveraged technology to help provide or share information and to bring innovation solutions like video conferencing, so people didn't have to travel to appointments. We actually worked with other LHINs in the province to leverage their best practices and initiatives that they had tested so that we didn't have to reinvent the wheel 14 times across the province, and we ensured that initiatives we were implementing were responsive to the needs of the very different kinds of seniors.

If Mrs. Smith was Madame Tremblay, we worked with our health planning entity to make sure that she could get services in French, and you'll hear more about that later. We also made sure that if Mrs. Smith was Mrs. Whiteduck, we were working with our Aboriginal Health Circle Forum to make sure that her services would be culturally appropriate.

I think this example has highlighted the role that the LHIN plays in transforming the system. We really are the only actor that has this very powerful role. It is enabled by the Local Health System Integration Act and its commitment to local governance, local planning, local decision-making, and, really, the local ability to act. We can be quite responsive to the kinds of issues we're seeing and actually take action.

While we have had, as LHINs collectively, a positive impact at moving this system forward, there are some opportunities to strengthen our roles through the legislation. You've heard about bringing primary care more closely under the purview of the LHINs. For someone like Mrs. Smith, that might have meant quicker access to her health care provider, or more ability to monitor her condition or take action before things went wrong.

Also, giving the LHINs more flexibility when it comes to funding would allow us to prevent delays in implementing initiatives and would give us some of the tools we need to push the system forward. For Mrs. Smith, this could have meant having a new program that would have met her needs up and running much more quickly.

Finally, making sure that health service providers and their boards share in the responsibility for ensuring a high-performing system would absolutely help accelerate health system change. For someone like Mrs. Smith, this would have meant every one of the providers she interacted with feeling a collective sense of accountability to transition her home as quickly as possible, whereas sometimes we are seeing that people do not always share in that common goal.

Alors, membres honorables, merci beaucoup pour votre attention et pour la chance d'informer votre travail important. Il me fera plaisir de prendre vos questions dans la langue de votre choix.

Thank you very much for your attention. I've left some time for questions, I believe.

The Chair (Mr. Ernie Hardeman): Thank you very much. We do have just under four minutes, and we will give that to the third party. Ms. Gélinas?

M^me^ France Gélinas: Bonjour, Chantale. Comment ça va?

M^me^ Chantale LeClerc: Ça va bien, merci.

M^me^ France Gélinas: J'ai été surtout intéressée—à la toute fin de ta présentation, tu nous parles de l'intégration des soins primaires sous le rôle de ton RLISS. Dans d'autres régions, il y a beaucoup, beaucoup de réticence à faire ça, surtout à cause des joueurs locaux.

0930

Est-ce que tu penses que dans Champlain, il y a une ouverture à faire ça?

M^me^ Chantale LeClerc: Je pense que oui. On a une très bonne relation de travail avec les pourvoyeurs de santé primaire. On était capable de faire des initiatives ici qui sont très, très intéressantes.

Par exemple, j'ai des rencontres avec les équipes de santé familiale. On en a 21 dans cette région, et elles cherchent beaucoup à se rapprocher de nous. Elles voient comment on pourrait travailler ensemble pour mettre sur pied des solutions intéressantes et innovatrices dans la région. Alors, il y a certainement un peu de réticence toujours, un peu d'inquiétude quant à l'inconnu, mais il y a une ouverture à voir ce dont ça pourrait avoir l'air.

M^me^ France Gélinas: L'autre service qu'on parle parfois à amener sous la gouverne des « LHIN », c'est les bureaux de santé publique. Est-ce que c'est quelque chose que vous considéreriez?

M^me^ Chantale LeClerc: Je sais qu'il faut absolument qu'on travaille en partenariat avec les bureaux de santé publique. Dans cette région, on a des beaux exemples où on travaille très étroitement ensemble, même au niveau du partage des données; on a des initiatives conjointes.

Ça va? Est-ce que ça devrait faire partie du RLISS? C'est peut-être un peu plus compliqué, étant donné leur structure et le fait qu'ils sont aussi gouvernés par les municipalités. Alors, je ne pense pas que c'est aussi simple que la santé primaire, mais c'est quelque chose

qui mérite d'être exploré. Par contre, qu'ils soient sous nous ou non, il demeure qu'on doit travailler ensemble.

M^me^ France Gélinas: Puis le dernier, c'est au niveau des centres d'accès aux soins communautaires. On a des agences communautaires qui nous disent pour nos—maybe I'll do this one in English.

Community support services comes to us and says, "For our homemaking services, for our community services, we get funded by the LHINs, but for our home care services, we get funded by CCAC, although we serve the same person with the same goal, the same care plan. Why is it that for our community services we get funded by the LHINs, but for our home care, our professional services, we get funded by CCAC?"

Any ideas as to whether this is a good system, or should we look at something different?

Ms. Chantale LeClerc: I think it does work. In this region certainly it does work. We've been actually working very closely with the community agencies and the CCAC and the LHIN to look at how we better distinguish and differentiate roles.

I think what it comes down to is not so much on the distinction between services; it's about population. The community support service agencies are more and more looking after the least complex individuals, and the CCAC is increasingly looking after people who have much more complex needs and need care coordination and need assistance with bringing in other services to form their care plan. So I think we will see over time much less overlap between who is doing what with the same individuals. I think you'll see that the type of clients will be better oriented towards one or the other.

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

Ms. Chantale LeClerc: Thank you.

CHAMPLAIN COMMUNITY CARE ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Our next presenter is Champlain Community Care Access Centre, Gilles Lanteigne, chief executive officer. Hansard will record it the right way, as opposed to the way I pronounce it. Thank you.

Dr. Gilles Lanteigne: Bonjour, Mr. Chair and honourable members of the Standing Committee on Social Policy.

Mon nom est Gilles Lanteigne, et je suis directeur général du Centre d'accès aux soins communautaires de Champlain. J'aimerais vous remercier de m'accorder cette occasion de présenter au comité permanent.

I joined the Champlain CCAC as CEO in September 2010. Over the past 30 years, I have held leadership positions in a variety of health care settings, and I've had the opportunity to work with numerous health care organizations in all provinces across Canada. I also have extensive international experience. I believe that my diverse background provides me with a unique vantage point for identifying key challenges and opportunities.

My presentation will focus on four key questions that I believe are central to evaluating the current legislative framework in review by the standing committee:

—Are regional health planning entities such as the LHINs needed?

—Are local health integration networks meeting the obligations under the Local Health System Integration Act?

—Should the CCACs and the LHINs be merged?

—What opportunities exist for continuing to drive efficiencies in the health system?

To learn more about the Champlain CCAC and the important role of care coordination in the health system, I refer you to the supplemental information that is attached in my presentation.

I will now address the four questions.

Are regional health planning entities such as the LHINs needed? Regional health entities responsible for planning, funding and accountability have been in place in all provinces for many years. Regional planning models vary in each province, depending on the population, geography and other factors. When you consider that a region such as Champlain is larger than many Canadian provinces, with a population of close to 1.3 million and over 200 health care organizations, a LHIN, or other type of regional planning entity, is vital to meeting the local needs.

A high-functioning and sustainable health system depends on working together. To meet the needs of our clients today and in the future, all health care providers must continue working in close partnerships. The LHIN plays a vital role in fostering collaboration among providers across the health system. As such, we must reinforce the LHIN's mandate to support the critical role of long-term planning, resource allocation, capital funding and increasing collaboration among all players in the health system.

Cross-sector collaboration, supported by the LHIN, is yielding some exciting successes. Home First is just one example of how our partnership is producing important shifts in our health system's ability to ensure the right care, at the right place, at the right time.

Home First was introduced in Champlain region in 2010. At that time, the number of alternate-level-of-care—ALC—patients in the region was too high. Far too many seniors were waiting in hospital for long-term-care beds to become available. We knew there had to be a better way of meeting the needs of these patients.

Home First represents an evolution in health care thinking, and Ontario is leading the way. The philosophy is focused on keeping high-needs seniors safe in their homes for as long as possible with CCAC care and other community services. Working with the LHIN and our hospital partners, Home First has been rolled out successfully in the region. While the LHIN financially supported Home First and helped bring the partners

together, the CCAC took the lead in making it happen at the patient level—an important distinction in our roles.

From my experience in health care, Home First would have been next to impossible without the partnership with the LHIN. Indeed, results in the region are impressive. A different data point than was presented in the earlier presentation, but Home First—one data point is taken here: 55% of placements to long-term-care homes were from hospital; today, that's less than 30%. That means that, from the community, there's more than 70% of people accessing long-term care. This has freed beds: in 2013, close to 41,000 hospital days. ALC numbers have dramatically decreased. Of the patients supported to go home, 86% of these remained in the community after 90 days. Estimated conservatively, net annual savings are over $10 million a year.

The second question: Are local health integration networks meeting their obligation under the Local Health System Integration Act? Overall, the current legislative framework is working well, and the LHIN itself is meeting the needs of our diverse communities. The LHSIA's purpose is to mandate the LHIN to provide for an integrated health system that offers quality care, effective and efficient health services for Ontarians. We know that the health care system is rapidly changing and that managing our health dollars and the planning and accountability of health service providers is more critical than ever. Services that had been offered in one part of the health system 10 years ago are now being delivered elsewhere.

In the home and community care sector, we've seen this transformation first-hand as we support more people at home with higher care needs. In Champlain, we've seen a 37% increase in chronic patients in a single year. And we're caring for more MAPLe 4 and 5 clients—that is, people with needs comparable to those in long-term-care facilities—at home. Consider this: Champlain CCAC is now caring for 6,000 higher-needs clients at home. That's the equivalent of 50 long-term-care facilities.

The scope of in-home service offerings has also expanded dramatically. Today, we're delivering services such as chemotherapy, wound care and intravenous therapy at home, all services traditionally provided in the hospital. Under the current framework, we are well positioned to continue expanding this range of services we can offer. Delivering more home care at home is not only significantly more cost-effective, it is what people want.

0940

Third, should the LHINs and the CCACs be merged? There has been some suggestion that merging LHINs and CCACs would yield efficiencies. To date, we have not seen any evidence to support this. There are many factors that must be analyzed in undertaking a structural change of this scale. I would like to offer a brief perspective based on economics, impact on services, compatibility of functions and, finally, timing and context.

First, it is important to consider the very different roles played by the LHINs and the CCACs. The LHINs plan and fund the health system, while the CCACs deliver care to patients. Merging the LHINs and the CCACs would result in a hybrid organization unlike anything that currently exists. New expertise would need to be developed, and conflicting functions such as funding allocation and accountability frameworks versus providing direct care to clients would need to be defined.

Logic might suggest that a merger would result in significant and immediate savings, at least on overhead and administrative costs. Most provinces in Canada have experimented in this area, with mixed results. Evidence demonstrates that synergy and, thus, savings are created in horizontal mergers—similar organizations, such as long-term-care home with long-term-care home, or hospital with hospital. But this isn't the case with vertical-integration mergers—organizations with different mandates.

More important than this question of cost savings is whether such a merger would improve care to patients. Again, there is no evidence for this, and in fact, we know from experience that disruption from health care restructuring can negatively impact patient care until the system is restabilized.

For these reasons, I believe that merging LHINs and CCACs would generate marginal benefits, with significant potential savings lost because of the complexity inherent in such a vertical merger. Greater efficiencies can be obtained by strengthening the LHINs and continuing to fund efficiencies through strategic partnerships, local solutions and leveraging technology.

Last, what opportunities exist for continuing to drive efficiencies in the health system? As the population ages and the complexity of care increases, we must continuously look at ways to drive efficiencies. There are a number of opportunities for maximizing health care dollars and continuing to advance quality of care.

One exciting opportunity unfolding across our region relates to technology. In partnership with the LHIN, electronic information sharing is now in place between Champlain CCAC and 165 LHIN-funded programs across 140 agencies. The power of technology is one of the most transformational elements for enabling a more effective health care system.

Another example: Our CCAC is working with Bruyère Continuing Care and leveraging our existing electronic tools to provide a single point of access to a range of palliative services. More end-of-life patients are able to die in their place of choice in Champlain than in any other region in Ontario. Similar collaboration with other partners, such as family physicians, offers numerous possibilities for realizing efficiencies.

We have made great progress in reducing the number of people waiting for a long-term-care home and increasing the number of people going to long-term care from the community instead of hospitals. We expect this trend to continue as we deepen our collaboration with the community support sector in implementing information

sharing in real time, developing joint care plans and sharing assessments.

A program introduced with paramedics in Renfrew county is a compelling example of a local solution that is both enhancing patient care and yielding cost savings. The model is simple, yet the impact is significant. When paramedics receive a call from a senior, they screen that person to determine if they're at risk for loss of independence. People at risk are referred to the CCAC for ongoing support. This dose of preventative medicine means more seniors can remain at home. Costly 911 calls from anxious seniors have been cut in half, and emergency department visits have declined. Collaboration is key in developing innovative local solutions with existing resources.

On balance, our system is responsive and meeting the needs of people in the Champlain region. Last year, our CCAC patient survey showed that over 93% reported a positive care experience. The current legislative framework allows for flexibility and supports innovation, key ingredients in any person-centred, high-functioning system of care.

Looking ahead, I'm excited by the opportunity for increasing the connection between the CCAC and primary care, optimizing best and promising clinical practices, expanding the delivery of services in the home, and continuing to unlock the technological solutions that make it easier for our clients to get the care they need close to home.

There is still much to be done, and we continue to work with our partners in advancing our vision. However, I believe that we have the right foundation for a stronger health system.

Merci, et je suis heureux de répondre à vos questions, soit en français ou en anglais.

The Chair (Mr. Ernie Hardeman): Well, thank you very much for your presentation. We have about three or three and a half minutes left, and we'll go to the government side.

Ms. Helena Jaczek: Thank you very much, Monsieur Lanteigne, for coming today, and thank you for addressing kind of the crux of the matter, what we are hearing across the province: the issue of some sort of integration between the LHIN and the CCAC.

One of the things that you said in your presentation is that the CCACs deliver care to patients. I guess that, from many people's perspective, what you actually do is you contract with other agencies to deliver care. Your employees are care coordinators, but we certainly get complaints within our constituency offices that these individuals do not do any hands-on care. They don't look at the wound when they do the assessment.

We've also heard, certainly in the North East LHIN, that some hospitals still have a position called a discharge planner.

So could you just explain yet again how the CCAC delivers direct care to patients?

Dr. Gilles Lanteigne: Well, CCACs provide direct care to patients through assessment, through care coordination, through working in collaboration with primary health care physicians in doing those assessments and ensuring that the care is provided.

Now, what is not really known is that CCACs do also provide direct care. All of the care coordinators are professionals. Most of them are nurses, physiotherapists, occupational therapists or social workers. This function is—in the literature, you will see that it is considered direct care to clients.

We also have other programs; what you would call "hands-on," as you term it, is provided by CCACs. So I'm glad that you're bringing that myth out as a question, because care coordination is recognized as bringing value, direct patient care, and is considered in the literature and in other systems as direct care.

Ms. Helena Jaczek: Do—

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

DR. WILBERT KEON

The Chair (Mr. Ernie Hardeman): Our next presenter is Wilbert Keon.

Dr. Wilbert Keon: Thank you very much.

The Chair (Mr. Ernie Hardeman): I should say "Dr. Keon."

Dr. Wilbert Keon: Whatever.

The Chair (Mr. Ernie Hardeman): Thank you very much. I understand that you also hold other titles, but we'll leave that all to you. I was just given the introduction as Dr. Keon.

Welcome. You will have 15 minutes to make your presentation. You can use any or all of it for your presentation. If there are any questions or comments, we will have some questions from the committee. With that, your 15 minutes starts now.

Dr. Wilbert Keon: Okay. Thank you, honourable Chairman and honourable members. I'm delighted to be here. I am chair of the board of the LHIN, as you know, but I was asked this morning to slant my comments in a general context as an individual, and I'll try to do that. I have prepared notes that may be a little bit biased, but I'll try to be as objective as I can. I'm hoping I can make a useful contribution to your deliberations, and I will be raising a few issues that are a bit different.

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For many years, I've been a great enthusiast of regional health services and a true supporter of local governance. While the LHIN model isn't perfect yet, it's pretty close to ideal. Its strength lies in its local emphasis. The letter L in the LHIN acronym is what I plan to focus on in my remarks. We have local partnerships, local service delivery, local decision-making and, perhaps most important of all, local governance.

There's a definite need for central decision-making, of course, in health care: for overall planning, governance, coordination and capital planning. Pandemics, for example, can only be handled by centralized planning and

indeed by federal-provincial planning. But central planning must work in concert with regionalized programs. It's not an either/or situation. It's very important that the LHIN planning be in sync with Ontario's Action Plan.

The 50/50 split of finance and responsibilities seems to work for the time being, until something better comes along. Programs are divided equally: six from the LHINs and six from the province. That seems to work fairly well. There has been a tremendous amount of experimenting across the country over the past 40 years. Having been active in my career during some of that, I was distressed to observe the wheel-spinning that went on, the reinvention of the wheel, the loss of time for everybody concerned and the loss of the patients in the system, so we have to be careful not to go there. I'm a great believer in evolution and change, but we have to be careful not to just throw the baby out with the bathwater.

The great advantage of local health care governance, if we get it right, is that it helps us build healthy, productive communities. I spent a good deal of time thinking and talking about healthy, productive communities. Many of you know that, as a Canadian senator, I was privileged, in 2009, to chair the committee that examined population health and produced a report on what a healthy, productive Canada means. The report concluded that Canada is generally perceived as one of the greatest countries in the world in which to live. When it comes to health, however, we unfortunately have serious disparities.

While researching the report, we travelled to healthy communities and to unhealthy communities, noting the difference between the two. There will be a baby born tonight in the Champlain LHIN with a life expectancy of about 50. That baby will have poor health because he or she was born into a family that had poor health. Another baby born tonight to a different family will live for 100 years or more and likely be far more productive. Those are the kinds of disparities we are faced with, and we must start to think on a much broader scale than we've been doing.

The fact is, health services account for only about 25% of health outcomes. The rest is determined by the determinants of health, such as housing, education, income, transportation, etc. It is clear we are not spending enough time on the 75%. We've become preoccupied with the repair shops—and I've built a deluxe one myself along the road—of the health care system, instead of focusing on preventing disease and diminishing the need for these repairs.

What does all of this have to do with the LHIN? Without a doubt, the LHIN has all the levers necessary to enact meaningful change, not just change in the way that home care and hospitals work, but I would argue that the LHIN has the instruments in place to affect all the issues that impact on health outcomes, working in concert with other relevant players.

Health outcomes improve when seniors can enroll in falls prevention, when those with severe addictions can have proper counselling and a key to an apartment, when people with diabetes can have foot care close to home, and when a community health care centre expands in an underserved neighbourhood. For instance, the launch of a satellite community health centre in Beachburg in Renfrew county has reduced the number of emergency room visits at Pembroke Regional Hospital.

It is important to note that the local lens is also alive and well in the work of the board of directors of this LHIN. LHIN governance is done by local members who have interests in the broader social system. We, as board members, are very much aware of the importance of developing health care in the context of the overall well-being of our citizens. Every year, in the spring, summer and fall, the Champlain board travels to various regions. Last year, we had public meetings in West Carleton, Pakenham, Cornwall, Eganville, Deep River, Chute-à-Blondeau and Ottawa. We know that each of these areas has special needs, and the citizens of these areas have an opportunity to talk to the board members and tell them how they think things can be improved for them.

Another example here is the non-urgent transportation program which the LHIN has instituted. With a combination of volunteers and LHIN-funded vans, the rides for residents were increased by 20,000 last year. You can just imagine what this does for a person who is incapacitated during an ice storm or something like that—or just to get to the grocery store.

We also have problems in the LHIN with wait times, and they have to be solved. Last year, Champlain LHIN CEO Chantale LeClerc and I met with the board chairs and the CEOs of the 20 hospitals. We said, "We have to do something. These wait times are not satisfactory. Let's look at MRI. Let's do something about it." The Ottawa Hospital stepped up and said, "We can help." They have helped, and MRI wait times have been reduced by 50% over the last year. And there are other examples where local initiatives and local governance can work.

Where do we go from here? For one thing, we need to stay the course with a regionalized health system that operates in concert with the central system. I'm pleased that health links are in concert with that philosophy and concept, and I believe they will improve things considerably.

Some people have asked me whether the LHINs should have more authority. People wonder whether the LHINs should have jurisdiction over primary care, public health and home care, and the CCAC. My answer to that question is that ownership doesn't matter. It doesn't matter who owns it. The important thing is to work together. Integration is not ownership. Instead, we can strengthen the structural framework that allows people to work together and do the best for the patients. We need to emphasize connectivity and give the front-line workers an opportunity to work together.

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You'll note I have not addressed proposed legislative changes. Your committee will receive a document suggesting 15 changes that has been prepared by the LHIN collective. I'm sure you already know that. You should

get that document today or tomorrow. I think it's in the final stages, so I'll not comment on that.

I think I have a few minutes for questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation. We do have three minutes for questions. The official opposition: Ms. Elliott.

Mrs. Christine Elliott: All right. Thank you very much, Chair, and thank you very much, Dr. Keon, for being here today. We greatly appreciate your insights. I would say—I can probably speak for the rest of the committee—that we share your concern that some of the other determinants, other than just the health services that are being provided, are important to be integrated to produce a system that's going to be focused more on wellness, on health promotion.

I'm wondering if you could give us a little bit more insight into how you would propose to do that, how you're working here in the Champlain LHIN and what else we need to do to be able to integrate that so we really have a system that's focused on healthy, productive communities.

Dr. Wilbert Keon: Right. Well, that's a very, very important concept and it's one we really must be dedicated to. I have asked our board members to involve themselves in the community, to work with the council, to work with various other agencies and so forth and see where some of the deficiencies are.

It's incredible when I mention that life expectancy—one of the fundamental indices of good health—is not the same across our LHIN. At both ends of the LHIN, we have people with very, very low life expectancies, so we've got to get out. That's why we travel as a board. The board members have to get out. I ask them, "If you're going to serve on this board, will you get out there and work at community engagement so the communities can tell us what they need, whether it's better housing, a clean water supply, clean air, whatever, to eliminate some of these things that are causing such poor health?"

Mrs. Christine Elliott: So would it be fair to say, then, that you're looking beyond traditional LHIN service providers and health groups that you would expect to be working with you and looking to the broader community, to other areas? For example, we've had several chiefs of police come to speak to us about some of the issues that they're facing, particularly with respect to mental health and addictions issues. Is that what you're looking at as well in this LHIN?

Dr. Wilbert Keon: Absolutely. And I met with the police when I was doing the Senate report. I met with the police across the country—in Vancouver, in Ottawa, in Toronto—and said, "How can the system help you with the problems you have picking up addicted people in the middle of the night and so forth?"

I believe my time is up. The Chairman has turned on his red light, and I have to run.

Mrs. Christine Elliott: Thank you very much, Dr. Keon.

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

Dr. Wilbert Keon: Thank you.

HÔPITAL GÉNÉRAL DE HAWKESBURY AND DISTRICT GENERAL HOSPITAL INC.

The Chair (Mr. Ernie Hardeman): We now have—the next one is not coming, and then the following one is on their way, I believe. We will go to the Hawkesbury and District General Hospital, Sébastien Racine, president. He is here, so we will replace the other ones as they come in when we can.

With that, thank you very much for being here and being heard just a tad early this morning. As with all the presentations, you will have 15 minutes to make your presentation. You can use any or all of that time for the presentation. If there's sufficient time left at the end, we will have some questions and comments from the committee. With that, the next 15 minutes are yours.

Mr. Sébastien Racine: All right. Thank you.

Bonjour. Mon nom est Sébastien Racine. Je suis résidant de Casselman, Ontario, et architecte de profession. Je suis ici à titre de président du conseil d'administration de l'Hôpital Général de Hawkesbury et District.

In my presentation today, I will first focus on the leadership that HGH has assumed in health care integration at the local level and highlight some of the positive outcomes in Prescott-Russell. I will conclude with some reflections on the LHIN's mandate and offer considerations.

First, HGH's role as a health system partner in Prescott-Russell: The board of HGH has, for the past five years, been strongly committed to aligning the hospital's programs and services with the provincial and regional directions. The board has been engaged with other hospitals and with the LHIN to create a positive environment to build collaboration among local providers and fix the significant service gaps in Prescott-Russell. More specifically, the following hospital-led projects and initiatives demonstrate this commitment to integration.

First, our HGH redevelopment project: Our hospital infrastructure renewal and expansion project has been developed and planned in close collaboration with the LHIN, the Ottawa Hospital, our tertiary-care referral centre and other local partners, including primary care physicians. The construction of our expanded and renovated facility will start this summer. The new HGH will offer care closer to home and meet the needs of the community for the next 15 years.

Another initiative is becoming a rural teaching site. HGH became a teaching site for the faculty of medicine of the University of Ottawa in 2011 and for La Cité collégiale in 2012. In 2013 alone, we provided training to over 40 medical students and residents, who now have a positive exposure to medical practice in a rural setting. This will greatly facilitate future medical recruitment.

Another initiative is the Prescott-Russell health care hub. HGH is pursuing a unique model to create a regional health care hub. The concept consists of a network of facilities in Casselman, Hawkesbury and Rockland that will allow consolidation of primary and community care in line with the health links strategy of the government.

Our business model is not dependent on government capital funding. We are currently at the planning stage. However, the first of our four proposed buildings will be ready in late 2014. Our hub concept will be an enabler for the Prescott-Russell Health Link, which was the first to be approved in the Champlain region.

Let's talk about local integration in Prescott-Russell. In 2009, the Champlain LHIN, in collaboration with the four hospitals in the eastern counties, launched a major review of the distribution of clinical services across all counties. The process, which included broad community consultation, extended over a two-year period. Through this exercise, significant gaps in core program areas were identified in Prescott-Russell.

Through this planning exercise, the LHIN provided extensive population-needs data and substantive planning reports. The LHIN, in collaboration with stakeholders, came up with a set of key recommendations. However, at the end of the day, it was left to the stakeholder groups to consider any future steps. As a board, we decided that HGH should exercise leadership at the local level and drive an agenda of change in collaboration with other committed health partners.

Starting in 2011, our board earmarked some internal funds—close to $2 million—to pursue the priorities identified together with the LHIN. Some of these include geriatrics. We joined the CCAC in actively pursuing a Home First strategy for discharged patients. With LHIN funding, we have implemented an assisted-living program where patients are discharged earlier to their home, with supportive care in the home provided by hospital staff. We've been able to maintain our ALC ratio at less than 10% during the past three years, one of the best ratios in the Champlain region.

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Another recommendation that we took action upon is mental health and addictions. Over the past three years, HGH assumed an ongoing leadership effort to repatriate programs from Ottawa hospitals, consolidate services, and build a regional community of practice. Thanks to the endorsement of the local providers and local community support, we were able to pull it through. Our foundation just completed a $250,000 fundraising effort to support the program. Prescott-Russell went from being the poor relative in Champlain in terms of mental health and addictions, and now benefits from having a comprehensive, integrated regional program. In 2012, HGH won a national prize for its innovative undertakings in mental health and addictions.

These specific examples I've given illustrate that a new reality is emerging in Prescott-Russell. We are building a more integrated, more cost-effective system at a local level.

The LHIN's role in local/regional integration: Our experience with the LHIN has been positive because, as the major health care institution in Prescott-Russell, we accepted to assume a leadership role that went beyond the traditional mission and mandate of the hospital. The board understood two important elements in the area of integration. First, the LHIN has resources, expertise and a broad mandate. However, it has been clear from the beginning of the planning work for the eastern counties in 2009 that the LHIN would not direct or lead integration. It had to occur based on strict goodwill on the part of the providers.

Secondly, our region has a number of local health care providers such as the family health team, the CCAC local office and the health unit. However, the hospital, with administration and financial resources, was the best positioned to be the catalyst of change and integration, and this role was certainly expected of us.

The stated principle underlying the creation of the LHINs was that health care services are best managed at the local level. LHINs were seen to be a mechanism for overcoming existing health care silos and improving integration and coordination of services that would hopefully lead to a more patient-focused, results-driven, integrated system.

In Prescott-Russell, the LHIN has provided enabling support, and HGH has leveraged its position in the community and among partners to pursue and implement integration at the local level. The benefits for Prescott-Russell are: the interconnection of health services has been improved; there's now more equitable access to services compared to other sub-regions of the Champlain LHIN; creativity and innovation has occurred at the local level.

When looking back at the Champlain region's accomplishments over the past six years, and in particular at the accomplishments most directly related to the local health system in Prescott-Russell, we know that we still have a significant way to go to achieve integration. Why? Well, quite simply, we feel that more meaningful integrated planning and partnerships should be in place to provide patients, clients and communities with a truly person-centred health system versus a provider focus. I think that the slow start of the health initiative in the Champlain region illustrates the point. HGH, like other health service providers, needs to seriously question the extent to which it has truly achieved the integration, as stated in the law. Our guess is, not entirely, and it has depended on whether or not we and our partners were willing to put the needs of the region ahead of our own agenda. In this answer lies a possible reason for some of the LHIN's limitations, lack of collaborative leadership between providers, and lack of a clear leadership role by the LHIN. This reality continues to inhibit progress, although opportunities exist now to achieve a higher level of integration.

Now some key considerations: Given the importance attributed to the province-wide health links strategy, the

health link is now the major project under way for health care integration in Prescott-Russell.

The 12 partners of the Prescott-Russell Health Link, including the hospital, have developed draft values and guiding principles. Why? Very simply, because they have come to realize that it is their engagement to the health link and to each other that will bring success. These values are collective trust and respect, collaboration, and being truly client-centred. Our decisions and actions must, first and foremost, consider the needs and interests of the client before our own.

In closing, my colleagues and I on the board of the HGH believe that the time has come for the Ministry of Health and Long-Term Care, the LHINs and the health care service providers to take a step back and evaluate the extent to which we are individually and collectively aligned with the directions and objectives that were set through the act.

We should accept that a new version of the law must inevitably strengthen the accountability of the LHINs and the service providers, creating the right conditions for a more integrated, cost-effective and client-centred system at the regional/local level. In other words, we need to put the patient and the region first. Integration is about filling the gaps and connecting the dots.

Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We'll have questions from the third party. Ms. Gélinas?

M^me^ France Gélinas: Une petite question facile avant de commencer. Tu as dit que les patients en attente des « ALC », en attente de placements—ce sont les employés de l'hôpital qui les suivent à la maison?

M. Sébastien Racine: Je ne peux pas aller dans les détails moi-même mais il y a eu beaucoup de travail de fait en partenariat avec le « CCAC ». Il y avait de ce travail-là qui était fait par l'hôpital avant et maintenant c'est fait conjointement. Je ne pourrais pas vous dire techniquement le rôle de chaque personne.

M^me^ France Gélinas: Est-ce que—

M. Sébastien Racine: M^me^ Heuvelmans, la vice-présidente de l'hôpital, pourrait répondre à cette question, si vous voulez.

M^me^ France Gélinas: Je vais aller la voir après.

M. Sébastien Racine: OK.

M^me^ France Gélinas: Est-ce que, donc, dans votre région, l'hôpital offre également des soins primaires?

M. Sébastien Racine: On est un modèle d'hôpital basé sur les « general practitioners ». Donc, ça tient les médecins de famille et les « family health teams ». On a un très bon « family health team » dans la région, très près de l'opération. On a de très belles collaborations. Le projet de « health links » renforce ces liens-là, puis notre projet de travailler sur un « hub » renforce aussi cette proximité avec les médecins. Donc, il y a une très grande collaboration parce qu'on travaille de très près.

M^me^ France Gélinas: Tu as entendu ce qui a été présenté ce matin; j'ai vu que tu étais là. Puis, l'idée d'avoir un conseil d'administration ou un conseil régional qui serait le conseil d'administration pour l'hôpital, pour l'équipe de santé familiale et pour tous les joueurs dans une région, comme il a été mentionné, est-ce que c'est quelque chose qui vous intéresse?

M. Sébastien Racine: Je ne sais pas si ça c'est la formule, mais je pense, comme le D^r^ Keon l'a mentionné, que les conseils d'administration ont un rôle à jouer. Nous, on a fait notre planification stratégique et elle est enlignée sur celle du RLISS et sur celle du plan d'action. Ensuite, il devrait y avoir plus de discussions inter-conseils d'administration et entre les différents organismes. Un peu comme le D^r^ Keon l'a mentionné, ce n'est pas qui détient le pouvoir, mais de s'assurer qu'on travaille vraiment ensemble.

Si c'est une formule qui—je ne peux pas me prononcer à ce moment-ci.

M^me^ France Gélinas: Non, ça va, ça va. Donc, ce que tu nous racontes, ce qui s'est passé ici, dépendait beaucoup de la bonne volonté de votre conseil d'administration. Si votre conseil d'administration avait dit non, rien de ça ne se serait passé?

M. Sébastien Racine: La bonne volonté du conseil d'administration, puis, comme de raison, tout au niveau des administrations—quand les administrations sont appuyées par leur conseil d'administration et qu'il y a beaucoup de discussions avec les autres « providers », ça va créer des opportunités.

Au contraire, oui, ça pourrait arriver que si les gens ne collaborent pas à tous les niveaux administratifs ou au niveau de la gouvernance, il peut y avoir des blocages.

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

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RÉSEAU DES SERVICES DE SANTÉ EN FRANÇAIS DE L'EST DE L'ONTARIO

The Chair (Mr. Ernie Hardeman): Our next presenter is from the francophone services of eastern Ontario: Lucien Bradet, president, and Jacinthe Desaulniers.

Interjections.

The Chair (Mr. Ernie Hardeman): You can introduce yourself to the Hansard as we're proceeding, and that will save me embarrassing myself even more.

Thank you very much for being here this morning. As with the other delegations, 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 at the end, we will have some questions or comments from the committee. With that, your 15 minutes starts right now.

M. Lucien Bradet: Merci beaucoup. I will speak in French. I think that you have the facilities.

Mon nom est Lucien Bradet. Je suis le président du Réseau des services de santé en français de l'Est de l'Ontario. Je suis en compagnie de Jacinthe Desaulniers, qui est notre directrice générale.

D'entrée de jeu, nos constats sont positifs. Nous adresserons au comité une recommandation de modification du règlement dans le but de consolider les avancées du système de santé pour ce qui est des services de santé en français.

Le réseau a été nommé entité de planification des services de santé en français par la ministre de la Santé et des Soins de longue durée en 2010, conformément au règlement 515/09 sur l'engagement de la collectivité francophone. Nos principaux partenaires sont les RLISS de Champlain et du Sud-Est, avec qui nous avons signé une entente de responsabilisation.

Le réseau compte près de 400 membres individuels, soit des résidants de l'Est ontarien qui ont à coeur la santé en français. Nous avons aussi 67 membres corporatifs—on a parlé tout à l'heure de 200 à travers la région, mais 60 membres de ces 200-là sont corporatifs—c'est-à-dire, des organismes qui offrent des services de santé en français dans les régions de Champlain et du Sud-Est. La population francophone de Champlain et du Sud-Est s'élève à près de 258 000 personnes, ce qui représente 42,2 % de la population francophone de l'Ontario.

Mesdames et messieurs, il y a exactement sept ans, notre réseau comparaissait devant le comité de la politique sociale qui se penchait sur le projet de loi 36 sur l'intégration du système de santé local. Alors et encore aujourd'hui, nous sommes favorables aux fondements d'un système intégré basé sur les principes d'imputabilité, de qualité et de soins centrés sur le patient.

Depuis, la loi de 2006 tient compte des francophones de différentes façons :

—la référence à la Loi sur les services en français en préambule;

—un conseil consultatif pour conseiller la ministre ou le ministre;

—l'engagement de l'entité de planification par le RLISS; et finalement

—un règlement sur l'engagement de la collectivité francophone.

Ce règlement a été bien accueilli par notre communauté. Par l'entremise de l'entité, la communauté a une voix au chapitre de la planification du système de santé local. Ces avancées sont significatives pour la communauté francophone dans le domaine de la santé. Localement, les trois dernières années ont été marquées par la collaboration entre le réseau et les RLISS. Je vais demander à la directrice générale de nous en dire quelques mots, et avec des exemples précis.

M^me^ Jacinthe Desaulniers: Bonjour. Je vais identifier deux exemples d'actions conjointes qui ont une portée structurante sur le système de santé local. La première, c'est les solutions qui ont été développées pour répondre à l'absence de données probantes sur la santé des francophones. Le deuxième exemple, c'est la systématisation du processus de désignation, dont l'appui aux fournisseurs de services de santé, l'analyse régionale de la capacité d'offre de services de santé en français et les recommandations de désignation qui ont été faites auprès du ministère. Ce sont là des exemples directement reliés à la planification, la responsabilisation et l'amélioration de l'offre de services de santé en français dans la région.

Le réseau a aussi émis aux RLISS une série de recommandations sur des initiatives et processus reliés au système de santé afin d'assurer l'inclusion de la perspective francophone dans la planification du système. L'an passé, 91 % de ces recommandations ont fait l'objet d'une action par les RLISS en partie ou complètement conforme à nos recommandations. Nous sommes fiers de ce résultat qui illustre la pertinence de nos analyses, le degré d'interaction entre nos instances régionales, et l'ouverture des RLISS à ce partenariat. Nous sommes aussi sûrs qu'à terme, les mesures recommandées et mises en place auront une incidence sur l'offre et qualité des services offerts aux francophones.

Maintenant, à l'échelle de la province, l'expérience des trois dernières années a permis d'identifier un enjeu fondamental dans l'application de la loi et du règlement : celui de l'absence d'un cadre d'imputabilité clair, transparent et complet pour les services de santé en français en Ontario. À l'heure actuelle, la loi et le règlement favorisent des actions et des mesures régionales d'engagement et de planification des services offerts aux francophones.

Nous vous soumettons que le système de sante peut faire mieux. Nous avons besoin d'une véritable cascade d'imputabilité, c'est-à-dire un enchaînement logique des responsabilités et obligations reliées aux services de santé en français en province.

En effet, nous faisons le constat qu'il y a absence de clarté, de transparence et de rigueur dans la responsabilisation sur les services de santé en français. Donc, il y a absence entre le ministère et les RLISS, entre le ministère et les entités, entre les RLISS et les entités, et entre les RLISS et les fournisseurs de soins.

Je vais vous donner quelques exemples. Il n'y a pas de référence aux obligations à l'égard des services de santé en français dans l'entente entre le ministère et les RLISS. Il n'y a pas de lien de responsabilisation entre le ministère et les entités. La forme actuelle de l'entente entre les RLISS et les entités fait qu'il est parfois difficile pour une entité d'assumer pleinement son rôle-conseil dans la dynamique de redevabilité au RLISS. La présence et la teneur de conditions locales à l'intention des fournisseurs de services de santé par rapport aux services en français varient considérablement d'une région à l'autre. Finalement, comme dernier exemple, on ne retrouve aucune mesure des services en français dans les indicateurs de performance pour le système.

À vous, monsieur le président.

M. Lucien Bradet: Nous sommes d'avis que l'atteinte de résultats tangibles quant à l'offre active de services de santé en français dépend d'une articulation de chacune des dimensions du système de santé : systémique, organisationnelle, professionnelle et individuelle.

Nous témoignons aujourd'hui pour signaler l'impact positif qu'ont eu la loi et le règlement sur les services pour les francophones et pour encourager la province à continuer d'exercer son leadership à l'égard des services de santé en français.

Nous pensons qu'il est possible de poursuivre dans la voie d'une meilleure efficacité du système local à l'égard des services de santé en français par un changement soit du règlement ou de la loi. Par conséquent, nous recommandons que la province de l'Ontario bonifie le règlement ou la loi en y ajoutant un cadre de responsabilisation pour les services en français : complet, à tous les niveaux et explicite sur les rôles et responsabilités de chacune des parties.

Dans ce cadre, nos recommandations :

(1) L'intégration de la perspective francophone dès le début et tout au long du développement de politiques et programmes provinciaux;

(2) Le développement et l'instauration d'indicateurs de performance à l'égard des services en français pour les RLISS, pour les entités et pour les fournisseurs de services; et

(3) L'établissement d'un mécanisme de concertation sur les enjeux liés à la santé des francophones et aux services de santé en français, qui implique le ministère, les entités et les RLISS.

Nous vous remercions, et nous sommes ouverts à toutes questions. We are open to any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We do have six minutes left, so we'll have two minutes from each party. We start with the official opposition: Ms. Elliott.

Mrs. Christine Elliott: Merci. Thank you very much for coming today and for presenting your perspective. I understand that there seem to be great discrepancies in various parts of the province with respect to the provision of French-language services. So the framework that you're suggesting will ensure that there's equal access across the province. Is that—okay.

How do you think we could go about doing that? Is it greater representation on the LHIN board itself? What would be the best way to directly ensure that the francophone communities across the province are being served?

Mr. Lucien Bradet: My personal view, and Jacinthe can add to that, is that the leadership must come from the province first. We've said, as francophones over the last 100 years, that the province is the authority that can give real leadership when it comes to French-language services in terms of legal framework and rules, and so forth. I think that the province should dictate or should be clearer with the RLISS on the representation. In Ottawa, we have two out of nine, and we are pleased with that. It's not in the law. It's the goodwill of the chair and the province. Goodwill is good, but it's not enough to firm up our rights and the roles that we have.

1030

Ms. Jacinthe Desaulniers: Thank you for the question. It gives us an opportunity to expand on what we mean by a "cascade of accountability." Really, what it means is looking at the roles, the obligation, and then the performance indicators of everybody involved in the system. We start at the provincial level with the ministry, then we look regionally at the LHINs and the entities, and we go all the way down to the suppliers of services who are first on the ground. So really making sure that we understand the responsibilities, the obligation and the performance indicators so that that cascade of accountability can occur.

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

M^me^ France Gélinas: Merci beaucoup pour votre présentation. J'ai trouvé très intéressant la façon dont vous mettez de l'avant une nouvelle relation qui ne serait plus basée sur une relation hiérarchique où le RLISS vous finance et vous dirige au travers du cadre d'imputabilité. Mais là, ce que vous proposez c'est vraiment une hiérarchie plate où vous collaboreriez avec le RLISS pour son mandat de services en français. Est-ce que j'ai bien compris?

M. Lucien Bradet: Je pense que oui. Je pense que la question de services en français pour nous—on pense qu'on a une responsabilité première et on pense que, lorsque le gouvernement a établi les entités, c'est ça qu'il avait en tête. Le RLISS avait besoin de conseils; on en donne. On devrait être considéré comme des partenaires. La question monétaire, par exemple, qui est passée via les RLISS : le gouvernement avait dit, « Bon, on va vous financer. Les entités vont être financées. »

Il y a parfois des moments où on pense qu'on est juste une autre agence, mais on n'est pas juste une autre agence. On est, à mon avis, légalement responsable d'aller plus loin pour les services en français.

Je ne sais pas si ça—

M^me^ Jacinthe Desaulniers: Peut-être juste une note historique : dans Champlain, la collaboration, comme on l'a décrite, va très bien. Je pense que c'est parce que notre collaboration pré-date cette entente-là avec les RLISS. On avait une entente de collaboration, donc cette histoire-là de travailler ensemble en partenariat pour l'amélioration de l'offre de services de santé en français, ça a déjà été fait dans le passé.

M^me^ France Gélinas: Donc—

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

Mr. John Fraser: Merci pour votre présentation. Je parle français un peu et je pose ma question en anglais in the interest of time. What do you mean by "cascade of responsibility"?

Mr. Lucien Bradet: Cascade: We have the government, the LHINs, les entités, le réseau et les « providers ». On pense que chacun de ces niveaux-là, each of those levels has a responsibility towards more French services, because that was the intent of the Parliament or of the Legislature. So we would like to know who is responsible for what, how it's going to be judged and what the indicators of performance are. At this point in time, there's only a statement of principle

that we should give more. It leaves us too much in a quandary of who is responsible for what, and so forth.

We had a meeting on the 17th of January in Toronto. We asked the department about the role and responsibility; it was the first item on the agenda. They didn't say a word about it—not a word. We were very surprised. We asked the question. We said, "What about the role and responsibility?" "Well, next question." We are concerned by that.

Mr. John Fraser: Merci.

The Chair (Mr. Ernie Hardeman): Anything further? If not—

Mr. John Fraser: Do I have time?

The Chair (Mr. Ernie Hardeman): Yes, you have a little bit more time.

Mr. John Fraser: Why do you think it's important to have a provincial consultation?

Ms. Jacinthe Desaulniers: Because over the last three years, we have realized that the issues are common. Many of the francophone issues are common across the 14 LHINs so it does make sense that we don't duplicate efforts and that we work collaboratively because it's the right thing to do. We've done it. The entities have regrouped, and we've tried to collaborate. Chantale LeClerc, who was here today, is actually the representative for the LHINs for francophones, with Madame Paquette, but there's no formal structure in place. We've done it, although there is an obstacle for us doing it. So we're just saying, let's formalize it. We really need to do this. There are some unique needs, but there are some that are common.

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

Our next presenter is Arnprior Regional Health: Eric Hanna. I believe they may not be here yet. We are slightly ahead of time, because we did have two cancellations, so I think we will just break for a health break.

The committee recessed from 1035 to 1044.

ARNPRIOR REGIONAL HEALTH

The Chair (Mr. Ernie Hardeman): This is the same challenge I have at every event I go to—when it's the start of the event and they ask the dignitaries to speak, they always say, "Ladies and gentlemen, if I could have your attention. We just have a few things we want to clear up, and then you can go back to enjoying yourselves." We do have a few things to clear up, and our next delegation is here, so I think we'll start doing that, and then as the day wears on, we can get back to enjoying ourselves.

Our next presenter is Arnprior Regional Health: Eric Hanna, president and chief executive officer. Welcome to our committee. 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 over, we'll have some questions from the committee. With that, the next 15 minutes are yours.

Mr. Eric Hanna: Thank you very much for the opportunity to give you a presentation. I've given an awful lot of thought to what I can include in this presentation.

This reminds me of the first time I was doing some hospital restructuring back in Kincardine about 15 years ago and I came to an arena like this, and we were recommending looking at some amalgamation of hospitals. We were supposed to meet in a room like this, but by the time we got ready to go, we moved down into the arena, and we had 7,000 people in the arena—not quite what I was expecting, and similar for this one, I must admit. But I'm very pleased to be here.

I've been in health care now for close to 30 years. I've worked for hospitals. I've worked for a national consulting firm. I worked for one year in the Ministry of Health. So when I put this together, I reflected upon an awful lot of my experiences, and based upon that, I tried to suggest what I thought was working well and areas where I thought there were some opportunities for improvement.

For those of you who are wondering where I may be coming from, from a particular bias, I'm from Arnprior, which is located about 45 minutes on the other side of Ottawa, so about two and a half hours away from here. I'm bringing in the perspective of an already integrated organization. I think that's one of the key opportunities that the LHIN has: to continue to foster integration. You can see our organization has a hospital, a long-term-care facility, an adult day program, assisted living services. So when you see some of the observations that I have, you can see that that's because of that perspective that I'm bringing to you.

We also serve a mix of urban and rural geography. Our catchment area is about 30,000 people, so it's not all that large, but it's large enough to give us the diversity of having about 30% of our population over the age of 75, and we have about 30% of our population of seniors living alone as well.

The outline of my presentation will include SWOT—the strengths, weaknesses, opportunities of the LHIN—some recommendations and then your questions.

From a point of view of the strengths, one of the things that I was most pleased to see with the LHIN is their ability to take the policy direction of the Ministry of Health and then translate it down to the local area, and the most significant example of that is the reduction in alternate-level-of-care patients in the Champlain LHIN. We have made significant strides in this, taking a provincial objective and then driving it down to the local area.

1050

Working with the LHIN staff, we've come up with an awful lot of innovative ideas that are unique to our communities, and I think that's one of the benefits that we get. This is not about taking a made-in-Toronto solution and then trying to make it fit in our area.

I know you have a presentation going on later about support for integration, and you're going to have a presentation later on from somebody from the Eastern Ontario Regional Laboratory Association. For those of you

who aren't familiar, EORLA, the Eastern Ontario Regional Laboratory Association, took about nine years to formulate, but it was a voluntary integration. Now, in eastern Ontario, we have 16 hospitals with one lab company, if you will, but it was a voluntary integration and supported by the LHIN.

The LHIN staff are very passionate as well. I know you see this in an awful lot of strengths of organizations, but I would say this even if I did not know that the CEO and the chair were here from the LHIN.

We have the LHIN CEO and the board chair come up to our board meetings on numerous occasions and talk about what the system transformation is like. They're very passionate about what it is, and they encourage us, as organizations, to continue to move forward. The LHIN is very, very strong and very, very advocating, I guess I would call it, in terms of the health system transformation.

Where we see some of the weaknesses, then—and I think this one comes down to just trying to find this balance. In our organization, what I suggest is that we use the phrase "change used to be episodic"; i.e., every couple of months, there would be a change, and then you'd wait, and a little bit later there would be another change and another change. Now I use the phrase "change is constant now." We're always changing.

One of the things that I think the LHIN needs to do, then, is be able to be in that mindset of saying, "You know what? You may not have everything completely studied, but you're going to have to move ahead and do it anyway."

In my case—and I've had this discussion with the LHIN here before—our LHIN didn't have an earlier adopter for health links. We studied it and we studied it. I think we could have been quicker. We need to be more adaptive. When things start coming down, we need to start to be able to do those things in a quicker fashion. It means, then, you need to have a culture of risk taking and, I think, for the LHIN, will there be a balance in terms of how much risk they can take, not having studied everything?

There is another opportunity in terms of the LHINs lacking the consistency in the way they implement things. Policy comes down from the Ministry of Health for small hospitals, for example, and says, "You've got $20 million to start to work on the transformation of small hospitals." It's great that we come up with local solutions, but I think that we can develop processes for everybody to implement things in a similar manner. There was not the same consistency from one LHIN to another LHIN to another LHIN. I think it utilized an awful lot of resources of the LHIN that didn't need to be used.

We want to develop local solutions, but we can have common processes across all the LHINs. I've given a couple of other examples that are up there as well, where I think that might be the case.

Opportunities: As the saying goes, "Noses in, fingers out." This is one, then, just to say, where is that balance again of having oversight and managing accountability agreements and managing some of the detailed operations versus supporting full system transformation?

What I would like to suggest on the first two that are up there, about saying that the LHIN, in my mind, again, because of the rapid change that's going on right now—less time focusing on individual performance of the individual institutions and more on the system performance. We have an awful lot of that happening at the CEO group right now, but I think there could be more of that focusing on overall system performance and driving those types of dialogue as opposed to individual ones.

Community engagement is another one where I think there's an opportunity to improve as well—and I don't want to suggest here that I'm being perfect. In our organization, community engagement is always a struggle. As I mentioned before, using that example in Kincardine where we had 7,000 people out because we said we were going to take down the blue H signs, people will come out for community engagement then. If you just say we're going to talk about what the future could look like, and nothing substantial is going to change, it's tough to get people out. I don't have the right answer for it, but I would like to suggest respectfully to the LHIN that we've got to find a better way of getting more people engaged in what is happening.

I think the last bit, under "Other opportunities," is matching the skills to the tasks at hand. Some of the people who are in the LHIN offices right now do not necessarily have experiences in the health services provider area. I was fortunate; I was seconded into the Ministry of Health for a year and worked on an awful lot of projects. I brought the hospital experience into the Ministry of Health. There are an awful lot of very well-intentioned individuals in the LHIN right now, but they don't have that practicality of working in a health service provider to be able to bring and oversee certain practical solutions. What happens then is that sometimes the LHIN loses credibility with the health service providers when you're trying to engage them, and I know our LHIN is aware of that.

Threats: We have an integrated health services organization right now, as I suggested before. The LHIN would love to say, "Eric, we could move money from the hospital over into long-term care or move money from the hospital into community-based services." You can't do that now. I go to some national conferences and talk to my colleagues out in British Columbia, and they say, "We're making a better health care system." It meant the vice-president of patient care on the hospital side talked to the vice-president of community-based services, they shook hands and said, "We're going to move a half a million dollars from here over to here," and it was done. So we may have the best intentions as a LHIN and as health service providers, that we want to integrate and actually move money from one organization to another one, but we can't do that in the way that things are organized now because of the siloed funding. The same

type of thing happens down on another one that I'll talk about later, under health service arrangements. I haven't seen this one as much, in terms of not having the primary care physicians under the LHIN or having the emergency health services. I've heard it from other colleagues, saying, "We're trying to develop better solutions, but we need to make sure that emergency services are at the table, and the LHIN needs to be able to direct that."

The other part that's on the last of the threats is one that talks about the appointment of new board members. Again, I'm speaking as a CEO in our organization. I know what it's like in our organization if I'm missing two or three board members for a long period of time. I'm missing that skill mix. I'm missing that geographic representation. I think the same thing happens here in our Champlain LHIN. I know there have been times when there hasn't been a board member on there for many months, and, as a result, where I am in Renfrew county, there may not be any representation or that skill set. I'm not here suggesting that the order in council is wrong; it just needs to get done in a much more expeditious fashion.

Recommendations: As I said before, we need to constantly evaluate how we're delivering the LHIN services, especially now, recognizing that change is much more rapid. When I look at recommendations, then, I'm going to give you a couple under the areas of structure, culture and skills.

Under structures, I talk about the first one: Looking at a different type of process to expedite the appointment of board members to the LHIN, to ensure that they always have a full complement of governance leadership. Support the LHIN administrative processes by streamlining for an integrated health services agreement, i.e., one accountability agreement. As I said before, I have a nursing home, we have assisted living services and we have a hospital. I have three accountability agreements, and my board is pulling out their hair and asking, "Why do we need to have three of these types of things?" Not only is it my time that's required for this, it's also the LHIN's time. So if you're going to really ask for an integrated health delivery system, create the structures that are going to allow that to happen, one being a multi-service accountability agreement that will allow us to have just one with all the different parameters.

Find mechanisms to consistently roll out Ministry of Health policy across the LHINs. If you have a strategy that the ministry wants to have, roll it out. One of the things that I found that's a little bit different—when we used to have the area teams in the Ministry of Health, they would be decentralized out here. I found there was more consistency in the way that the policy was being implemented in the various geographic areas than there is right now. What has happened now is there's a strategy being developed in Toronto, if you will, that's asked to be implemented by all the LHINs, but there's too much variation. I sit on a couple of provincial committees where I'm actually starting to see this now. I'm chairing a committee for small hospitals, and I'm hearing what one LHIN is doing versus another LHIN versus another one in trying to achieve the same objective. We're trying to organize our efforts to be effective, and saying, "Well, in this LHIN you're going to have to do it this way because they have a different process; in this LHIN they're doing it this way; in this one they're doing it that way." Everybody is trying to achieve the same goal, which is great, but I still think you can have local solutions with a common process.

Skills: I would talk about the skills of the LHIN staff to have community engagement. I think that's very important. There are some people who are learning those skills. In our own organization, we're trying to build that skill set as well.

Additional expertise in health service providers or the LHIN staff: Whether or not it's a secondment into a health service provider or whether it's just trying to hire people out of hospitals or community-based services etc., we can look at that.

As well, we need to make sure that the staff complement is moving away from people who are detail-oriented, looking at micro initiatives at individual sites, into a larger system transformation. Again, it's a different skill set, as the role of the LHINs have changed and the tasks have changed.

1100

The last one I think that's there is similar to what I've been stressing all along. I have it up here as being rebalanced. I'm not too sure if it's a rebalance or just greater emphasis. Again, I myself, as a health service provider, want to view the LHIN as being a strategic partner, helping me to transform the health care system—and not thinking that when I get the call from the LHIN, it's going to be, "Well, line 6.2 on your accountability agreement is off by 10%." I don't want to feel that that's the way it is. I can tell you that with the CEO and the chair, that's not the way it is. But some of the staff—I think they honestly believe that's what they're there for: to monitor the performance as opposed to leading the change. And there are many of us in the field who want to do that. That's just that culture of the organization. That's one part of your function, to monitor performance, but your other part is to support transformation.

The Chair (Mr. Ernie Hardeman): Thank you very much for a very-well-thought-out and worked-out presentation. You have, at that moment, finished 15 minutes, so thank you.

Mr. Eric Hanna: My technical glitches.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It is much appreciated, and it will be greatly helpful to our committee as we pursue our report.

CHAMPLAIN COMMUNITY HEALTH CENTRE EXECUTIVE DIRECTORS' NETWORK

The Chair (Mr. Ernie Hardeman): Our next presentation is from the Champlain Community Health

Centre Executive Directors' Network: Jack McCarthy, executive director of Somerset West Community Health Centre, and Simone Thibault, executive director of Centretown Community Health Centre.

So everybody can give full attention to the presentation, we'll just wait a minute.

We want to thank you for coming in this morning to speak 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 over at the end, we'll have some questions and comments from the committee. With that, your 15 minutes starts right now.

Mr. Jack McCarthy: Thank you, Mr. Chair. Good morning, ladies and gentlemen. It's a pleasure to be here. It's a pleasure to be with a former colleague, France Gélinas. As fellow executive directors, we worked on some of the issues of advancing primary health care in this province. It's nice to see France again, in a different capacity, here at the committee.

My name is Jack McCarthy, and I am the executive director of the Somerset West Community Health Centre in downtown Ottawa. I'm joined by my colleague Simone Thibault, who is the executive director of the Centretown Community Health Centre. We work very closely on many issues, as we do with many of our other partners. We're here today speaking on behalf of the Champlain Community Health Centre Network, of course, to you folks, as part of your review of the Local Health System Integration Act.

In case you may not know, community health centres are a community-based model of care that provide comprehensive primary health care services, in combination with health promotion and illness-prevention services to people who typically have barriers to accessing health care.

A quick primer: There are currently 75 CHCs in Ontario, 11 of which are located in the Champlain LHIN. They are: Carlington CHC, Centretown CHC, Pinecrest-Queensway CHC, Sandy Hill CHC, Somerset West CHC, South-East Ottawa CHC, in Ottawa; in Cornwall, Centre de santé communautaire de l'Estrie as well as Seaway Valley Community Health Centre; Lanark Health and Community Services in Lanark; and in Killaloe, the Rainbow Valley CHC. In addition, our CHCs in the Champlain LHIN also operate a number of satellite sites to expand access to those in need of primary care services.

Our goal today is to highlight the strength of the Champlain LHIN, as experienced by CHCs, while also making some concrete recommendations on which ways we think the LHIN can function better.

We have four main points to address: the role of the LHINs in supporting local collaborations between stakeholders, the scope of the LHINs with respect to primary health care, and the authority and decision-making of LHINs; finally, the fourth point we'll go into is the relationship between better data management and accountability.

First, local collaborations have increased. First of all, we believe that our LHIN has been largely successful in accomplishing a key aspect of its mandate: that of coordinating health care within the local system. We're fans; it's working well.

The fact that the Champlain LHIN's board and staff are located close to the communities they serve allows for a better understanding of the specific realities that are faced by the communities that we're here to serve. This has meant that our LHIN has enthusiastically supported discussions between local stakeholders that have led to greater collaboration within the health sector. For example, the Champlain LHIN has ensured that important networks, reflective of the diversity of our populations, have been strong partners involved in identifying specific needs within the local health sector and improving the system. These networks include the aboriginal health access centres, or AHACs; the French Language Health Services Network of Eastern Ontario; and the Ottawa Local Immigration Partnership. Reflecting the needs of these networks in our discussions and decisions has been key.

In this regard, our LHIN has demonstrated strong leadership in promoting dialogue between health service providers in the home care sector, the acute care sector, and in primary health care. For example, in the past year, senior staff at CHCs and the CCAC have met to explore ways to identify how to serve mutual clients with complex care on a neighbourhood basis. Another example is our primary care outreach program, led by South-East Ottawa CHC and integrated within each Ottawa CHC. This program, made up of a tag team of a nurse and a community health worker, targets the frail elderly and has developed a strong partnership with area hospitals, city emergency services, the CCAC, home support programs and others to support improved navigation of a particularly vulnerable population. CHCs have also been active participants in the development of health links.

M^me^ Simone Thibault: Alors, Jack vous mentionne que oui, on a des éloges pour le RLISS de Champlain, mais on va vous parler du mandat des RLISS et comment on verrait que ça pourrait être élargi.

Alors vraiment, on croit fermement que le mandat en matière de soins de santé primaires pour le RLISS devrait être élargi. Bien que le RLISS aide déjà à faciliter le dialogue en santé, comme Jack l'a mentionné, nous croyons qu'il faudrait élargir son mandat en soins de santé primaires.

Nous aimerions voir le gouvernement de l'Ontario travailler à la création d'un système de santé primaire plus robuste qui se préoccupe des déterminants sociaux de la santé, ainsi que des services de promotion de la santé, de prévention, et de santé mentale et de toxicomanie. Selon nous, le meilleur moyen pour ce faire est d'étendre et d'élargir le mandat du RLISS en matière de soins de santé primaires.

Les centres de santé communautaire sont les seuls fournisseurs de soins de santé communautaires qui

relèvent du RLISS. Le mandat du RLISS exclut donc les équipes de santé familiale et d'autres modèles. II est essentiel de créer un environnement où tous les organismes de soins de santé primaires relèvent de la même autorité et rendent des comptes au même organisme de la région. Par conséquent, le fait d'élargir le mandat du RLISS renforcerait le système de santé en améliorant le dialogue et la planification des services de santé à l'échelle locale. Pour qu'il soit possible de coordonner les soins dans le cadre de maillons santé, tous les modèles de prestation de soins primaires devraient relever du RLISS, qui serait alors capable de faciliter l'intégration des différents organismes de soins de santé primaires.

While the role of the LHINs as managers of health services is necessary, it is not sufficient in itself to ensure solid and sustainable local health systems. Expanding the legislative scope of the LHINs to include all primary health care models under the purview of the same local planning structure that CHCs are under will create a more robust and responsive health system. The emphasis of the LHINs must shift to focus on keeping people well, not just treating them when they get sick. This means ensuring effective primary care, which we all know is the foundation to our health care system.

Our third point: We strongly believe that the LHIN has to expand its primary health care mandate.

Nous souhaitons que le RLISS ait une plus grande autorité. Bien que nous soyons d'accord avec le fait de conserver des structures régionales dans le cas des autorités sanitaires et de la planification locale, nous pensons que ces structures devraient avoir davantage de pouvoir sur les décisions de financement. À l'heure actuelle, la capacité des RLISS à accorder et à réallouer des fonds est restreinte, ce qui retarde les efforts d'intégration locale.

Nous avons observé plusieurs cas, mais on a deux cas qu'on aimerait mentionner avec vous où le fait d'accorder une plus grande liberté au RLISS pour l'attribution du financement aurait des effets positifs sur la communauté. Le RLISS doit avoir un meilleur contrôle sur la réallocation des surplus du financement aux médecins et davantage de pouvoir sur le financement des projets d'immobilisations. Pour nous, il n'est pas très logique que ces décisions soient prises à Queen's Park.

Par exemple, les centres de santé communautaire dans la région de Champlain, on collabore ensemble et on a élaboré ensemble une proposition de programme de services de physiothérapie à l'échelle du RLISS en réponse à un appel de propositions. Nous avons soumis notre proposition en juillet 2013, puis les représentants du RLISS nous ont bien avisés que leur examen était terminé quelques semaines plus tard et que la décision serait prise par le ministère de la Santé et des Soins de longue durée. Huit mois plus tard, nous n'avons toujours reçu aucune nouvelle. Notre exercice financier se termine dans sept semaines. Pourquoi cette décision ne peut-elle pas être prise localement par le RLISS?

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Giving the LHINs greater authority over key funding areas would remove a number of significant barriers that we have noticed to the integration and implementation of community-based services.

Mr. Jack McCarthy: Our fourth and final point: data management and accountability. There is a real need for more integrative data-sharing practices among health service providers at all levels of the health system, and the LHIN has a key role to play in enabling this exchange. What we care most about is accessing and sharing useful local data that is comparable and relevant across sectors.

Data-sharing needs to be transparent, so that all members of the health system have access to the information they need. We simply cannot be held accountable for data that we don't generate or don't have access to. What we need is a better way of tracking relevant data to improve the flow of people through the health system. In that respect, improved data-sharing goes hand in hand with reporting meaningful accountability measures.

In our experience, data-sharing among CHCs in Ottawa has led to great improvements in the ability of providers to collaborate and work together to improve outcomes. Simply put, if you show people relevant and useful data, they will work to improve the gaps in the system.

As we move to expand health links in Ontario, we need to ensure that all members who are held accountable for improving care coordination have the ability to access relevant, transparent and comparable shared local data. This will put HSPs, or health service providers, in a better position to reasonably measure their progress towards meeting accountability indicators set by the LHIN and the ministry.

We believe that LHINs are in a unique position to act as an enabler of good data-sharing practices among sectors within local communities. LHINs would benefit from taking a greater leadership role with respect to enabling wider data-sharing among health service providers. Without more integrative data management, it will continue to be difficult to adequately measure progress.

In conclusion, the Champlain LHIN is to be commended for facilitating local planning and developing the Integrated Health Service Plan. A local plan that we can all have input into makes sense. As a consequence, this planning has brought different health system providers together in a common dialogue on the needs of clients and patients in the Champlain LHIN.

Secondly, expanding the mandate of the LHINs to include family health teams and possibly other primary care providers will only serve to strengthen the focus on keeping people well.

Thirdly, bringing decision-making closer to communities that are affected by those decisions is very much the right thing to do. For our sector, being able to meet with LHIN staff on a regular monthly basis is far superior to dealing with Ministry of Health staff based in Toronto. We have developed effective and productive working relationships.

The Ministry of Health has to devolve more authority to the LHIN. If our emerging economic realities require our health care system to do more, better, for less, then the question becomes, who is best positioned to decide on the allocation of health care resources locally? A strengthened, better-resourced and community-led LHIN is better than dealing with the Ministry of Health in each of its fragmented ministry silos.

Lastly, we strongly believe that the LHIN has to play a key role in promoting data-sharing agreements among health service providers, so that we all have comparable data to work with and accountability measures that fit appropriately for each group of health service providers. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about two and a half minutes left. The third party: Ms. Gélinas.

M^me^ France Gélinas: I know that you did not talk about this directly, but I will bring it up, because we hear it everywhere we go: this idea that primary care should coordinate care for the people needing home care. In other words, some of the coordinating functions that are being done by CCACs right now could be better done by primary care providers. Although we're reviewing the LHINs, it comes up often. You haven't touched on it. Are you comfortable sharing your thoughts?

Ms. Simone Thibault: We value the relationship of working hand in hand with the CCAC, but I think there is also a role for primary health care in terms of coordination of that, because we do it, and we do it with very limited funds. I think it's worth looking at to see how best we could build on what's centralized versus decentralized and working more closely with the primary health care sector to make that happen. It's often about relationships on the ground, and really, home support services have to be highly linked with primary care to make it work.

Mr. Jack McCarthy: Just to add to that, I think there's a role for both to work really effectively well. So for us—and we've started this dialogue with the CCAC—in a particular catchment area of our community health centre, say it's Somerset West, let's identify mutual clients so that we're wrapping services around them effectively. We've got work to do on that. I think there's a lot of informal collaboration and formal collaboration that is good, but I think there's a viable role for both.

M^me^ France Gélinas: When you say "bring primary care under the LHINs," you focus on family health teams. Do you purposely exclude fee-for-services physicians?

Mr. Jack McCarthy: No. Practically speaking, I think it would be easier to start off with family health teams, who we are starting, as CHCs to collaborate more with, in terms of the evolution of these health links. But, absolutely, my own belief here is that family physicians and primary care providers within a geographical area should all be under the purview.

How do we plan for H1N1, God forbid there's a pandemic? We have to work closely with all family physicians and primary care providers locally to mount an effective population health response to a crisis as a starting-off point.

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

CHAMPLAIN COMMUNITY SUPPORT NETWORK

The Chair (Mr. Ernie Hardeman): Our next delegation—I understand Alex McDonald is not here at the present time, but the next one, the Champlain Community Support Network: Valerie Bishop de Young, chair, is here. She's agreed to present ahead of Alex McDonald.

Thank you very much for being here and we thank you very much for taking the time to come and talk to us this morning. As with all of the delegations, you'll have 15 minutes in which to make your presentation. You can use any or all of that for your presentation. If there's any time left, we'll have some questions and comments from the committee members. With that, the next 15 minutes are yours.

Ms. Valerie Bishop de Young: Thank you very much, and thank you for the opportunity to present today. I very much appreciate it.

Community support services are sort of the unsung components of the health system. We all know community supports when we need them, and we don't know about them very often until then: Meals on Wheels, for example; adult day programs for frail seniors, seniors and others with dementia; personal care and home support services; attendant care outreach and supportive housing services—these are for people with permanent physical disabilities. The spinal cord injury that is the result of the diving accident this summer is going to be our client in the next nine months.

In Champlain, there are 60 community support services throughout the geographic area, 11 here in the eastern counties, 24 in Ottawa, and Renfrew and county has 17. We are in pretty much every community across the province of Ontario. You may or may not have heard about us but we're very much alive and well in your constituency.

We serve thousands of people every week. Many of us have wait-lists for additional services and people who need it. We are members of the Ontario Community Support Association, OCSA. You may know us in your local community as Carefor, King's Daughters Dinner Wagon, Meals on Wheels, Rural Ottawa South Support Services, or le centre Guigues. The organization that I work for is VHA Health and Home Support.

I've provided you with a copy of a presentation. That's your take-away to think about. I recognize that I'm the last presenter and I'm the challenge between you

and lunch, but let's go through what community supports can offer you.

We believe that home and community supports work because they offer flexible, local solutions. That's what a progressive, modern health care system needs. You have to be responsive. People want to live and age in their own homes, not institutions. They certainly can't and don't want to be in the hospital any longer than they have to be. Hospitals are for acute care; let's keep them for acute care. Keeping people living independently in the community is cost-effective. It's efficient. Very little overhead goes into a community support organization. We help decrease emergency hospital admissions. We decrease long-term-care-home placements and long stays, and we do so at a lower cost to the health care system.

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The demographic horizon: What haven't you heard about it? We don't have to look to 2025 or to 2031 to know what the reality is. By the time we hit a year from now, 2015, there are going to be more seniors proportionally than children. From a taxpayer base, you've got to find the best way to make the biggest bang for the taxpayer dollar. As a taxpayer, I want to see you do that—and as somebody who is familiar with community supports, both because I work in the sector and also because I have aging parents. I'm sandwich generation: My parents are linked up with community supports so that at 83 and 86, they're able to stay in their own home.

Community is key. We work in the community support sector. We feel very much that LHSIA's foundational principles are strong and still stand: local planning and local accountability that respects regional differences. I'll give you some local examples of that. Across Champlain, there is one-stop access to attendant services for people with physical disabilities and for supportive housing. There is one point of access for adult day program providers, but that doesn't mean you can't go to the individual agency and say, "I need that help." Every door offers service. The Champlain transportation network helps people get to medical appointments so that they're not avoiding those medical appointments that are so important. We see increased collaboration—health links are a perfect example of that—and community supports are at that table.

All that is to say that LHSIA, the LHIN, has enabled community supports to be at the decision-making table, and we have not had that luxury before. Hospitals are there and long-term care is there, but as we age in this demographic, we're going to need people to be at their own home. You're going to need community supports. The LHIN legislation allows us to do that. This LHIN has been very supportive of having community support at the table. We're very grateful; it's the first time.

LHINs are not perfect—I'd be hard-pressed to identify any piece of legislation per se that is perfect—but we do not feel this is the time for change. Dissolution will cost money and it will cost time, and we have no better alternative identified as yet. Any review of local health care has to acknowledge the interconnected structural challenges that are required to be overcome to develop and maintain a healthy population within the public budget.

Stability of the current structure is key. LHINs are increasingly responsive and, more so, engaged. LHIN strategies reflect local area interests and needs, and the LHIN responds to local taxpayer interests.

What, if any, improvements can be made? We can always improve. Improve coordination between LHINs and community care access centres. Improve coordination among LHINs, all of the LHINs, 14 of them in the province. Sharing information: What's the best recipe for a problem, a common situation? What are the wins? Engage and evolve primary care. Invest in community support services.

We don't believe that the challenge today is in restructuring existing legislation; rather, it's about supporting the needs that are greatest in our communities, in your communities. I listened with interest to the Arnprior hospital CEO, and I know him by reputation to be very involved and very community-focused. I would suggest that his desire to shift legislation so that the hospital can reallocate money into the community or elsewhere is probably unique. I just want to plant that bug, if I may.

There. I don't want to take up a whole lot of your time. We don't believe that there's reason to change the legislation, but there is reason to keep community support services alive and well and at the decision-making table. This legislation allows us to do that. This LHIN is very responsive in that regard.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have about seven minutes left, so we'll split that evenly—as evenly as I can. We start with the New Democratic Party: Ms. Gélinas.

M^me^ France Gélinas: Thank you so much for coming. I would say that the comments from the community support sectors have been very much in line with what you said. You're at the table; you're taken seriously. The valuable asset that you bring to community care is being recognized, and that has been a very good thing. We've heard that throughout the province, so—

Ms. Valerie Bishop de Young: Good to know we're consistent.

M^me^ France Gélinas: Yes, you are. My first question is this: There's some suggestion that we do away with local boards, so that the Meals on Wheels doesn't have its own board anymore, and the home support doesn't have its own board anymore, but moves either to a regional or a sub-regional board. Have you given that any thought?

Ms. Valerie Bishop de Young: We've watched with interest as Alberta moved to a fully regional board—in fact, a pan-provincial board—and are now devolving from that, going back to the regional boards. That sense of local flavour is unique. The GTA and Toronto cannot reflect what's happening in Ottawa, although they're large urban centres. Here in Champlain, we have the unique French component and a large rural component.

I'm not sure that regional boards can possibly be as sensitive as they need to.

Where the current boards of directors and those very committed volunteers have great value is in their willingness to reach out and talk to the LHIN boards and the LHIN staff and make those presentations and have discussions about regional needs.

Community supports are unique in that many of them specialize in certain services, so there's a special local interest and local flavour. I can certainly attest to the fact that many of those board members are very passionate about their community and what their service brings to them. A pan-regional or a regional body may be able to provide some of that, but the current structure doesn't cost you anything.

M^me^ France Gélinas: My second question is: A lot of the service you provide has a copayment attached to it. If you get Meals on Wheels, you have to pay seven bucks or whatever it is in your area. Is this well accepted by the people you serve: that people have to pay to access your services?

Ms. Valerie Bishop de Young: It is a barrier to accessing services for some, and some organizations have been very good about finding ways to fundraise to work with that. Our challenge is that the co-pay is different from organization to organization. It is not the same for Meals on Wheels here as it is in Thunder Bay or somewhere else.

The Chair (Mr. Ernie Hardeman): We'll have to cut it off there. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair, and thank you, Ms. Bishop de Young, for your presentation. Just to understand a little bit more about the Champlain Community Support Network: You have, as your network, all these individual service provider organizations.

Ms. Valerie Bishop de Young: That's correct.

Ms. Helena Jaczek: And then do you have your own board and you have reps from them on your board? I'm just trying to get a picture.

Ms. Valerie Bishop de Young: No. We are member agencies. We work for local agencies. We come together to collaborate, to share opportunities and to discuss where there are opportunities to improve services. There is no local board for the network. There are boards of directors for each of those organizations.

Ms. Helena Jaczek: And if a client phones one of you and the service may not be delivered by that agency, you can quickly—

Ms. Valerie Bishop de Young: Soft transfer.

Ms. Helena Jaczek: Okay.

How has the LHIN engaged your network in a formal sense? We've heard from one LHIN that they've created something called a health service provider council. Is there any structure like that here?

Ms. Valerie Bishop de Young: Very similar. I would say that the CCSN is very much like a council of community support agencies for the LHIN. The LHIN sits regularly at our meetings. We meet once a month. The LHIN provides input into discussions—very active. I think the LHIN has actually enabled the community support network.

Ms. Helena Jaczek: And then do they bring you together with acute care facilities or other providers within the LHIN?

Ms. Valerie Bishop de Young: That is not their role at CCSN, but I think many of the organizations I know of that are in the community support network—we're all uniquely connected to our own primary care networks as we need to, as physicians and nurse practitioners want to be involved—community health centres, hospitals. The Going Home project in Ottawa is a perfect example of interconnectedness. The Champlain LHIN funds the Going Home project. It's run by a community support organization led by Carefor. Many of us are contracted partners or partners in it—

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

Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Ms. Bishop de Young, for your presentation today—very informative. I'm interested in your recommendations, particularly the one about improving coordination among the LHINs. It seems to me that there is a large role for the Ministry of Health to play there, and there have been some presentations that have been made that suggest that the lack of an overall vision by the ministry is causing some consternation at the LHIN level in not knowing what the priorities are and what should be focused on in each individual LHIN.

I wonder if you could comment on that, and perhaps give us an example of where that is problematic.

Ms. Valerie Bishop de Young: I wouldn't want to speak to the vision. I think that on a practical basis, in a very pragmatic way, the LHINs are functioning quite well, as far as I've heard. Certainly I can attest to that here in Champlain. It seems to be working extremely well for community support services, and that's what I can speak to.

In terms of connectedness, I think there are opportunities to share our recipes for wins, as I call it. Integration is an example. I think there are a lot of opportunities where different community support organizations, community health centres, even hospitals, are coming together and looking at how we can work together. Integration is a mass of shades of grey along that spectrum. How do you do that? So we know that the Toronto Central LHIN has a huge cache of information about integration, and we're often cross-referred to get that. It seems to me that there's an opportunity, with all that expertise at each LHIN, to create a bank of resources. I'm speaking very pragmatically about the expertise that's available from across the province. How can we share that so that we can ramp up integration and opportunities for coordination a little bit better?

Mrs. Christine Elliott: So it's really about sharing best practices—

Ms. Valerie Bishop de Young: Yes, exactly.

Mrs. Christine Elliott: And allowing everyone else the opportunity to participate.

Ms. Valerie Bishop de Young: 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 and talk to us.

Ms. Valerie Bishop de Young: Thank you very much.

The Chair (Mr. Ernie Hardeman): Our next presentation, I believe, is still not here. It's Alex McDonald. I didn't realize, when I mentioned last time that he was not here yet, that it wasn't time for him to be here yet. We had worked reasonably well forward with people who were here ahead of time. We have now passed the time that his delegation was to be here.

Mr. McDonald is not here yet? Well, then, that's the last of them before lunch, so I guess we'll stop there and adjourn for lunch. If he should happen by, maybe we can find some way to fit him in.

With that, we stand adjourned. The committee will have lunch here in this room.

The committee recessed from 1133 to 1327.

The Chair (Mr. Ernie Hardeman): Good afternoon, ladies and gentlemen. I think we're a minute or two from the starting time, but that makes up for all the times I've been late in my life, just once in a while being a little early. We thank you all again for being here this afternoon.

ONTARIO COUNCIL OF HOSPITAL UNIONS/CUPE

The Chair (Mr. Ernie Hardeman): Our next presenter is the Ontario Council of Hospital Unions/CUPE: Doug Allan, research representative for CUPE. Thank you very much, Mr. Allan, for coming in this afternoon, presenting to us and helping us with our deliberations as we're looking at the LHIN review. You will have 15 minutes to make your presentation. You can use any or all of that for your presentation. If you have any time left at the end of it, we'll have some questions from our committee. With that, the next 15 minutes are yours.

Mr. Doug Allan: Perfect. It's a pleasure to be in Vankleek Hill. I didn't expect to be here, but this is nice. I hope to present for about 10 minutes and to leave five minutes for questions.

The Ontario Council of Hospital Unions, OCHU, represents 30,000 hospital workers and long-term-care workers at 65 hospitals around Ontario. When the LHINs were first raised, we forecasted that there would be some difficulties; unfortunately, we feel that this has proven to be correct.

A number of problems have arisen, but two in particular stand out. First, they have been charged—quietly, perhaps—with centralizing, privatizing and cutting local hospital services; and second, they have distanced elected government officials from decisions to reduce, privatize or centralize local health care services. In other words, they have allowed governments to avoid full responsibility for one of the most basic political issues, especially on a provincial level: access to health care, an issue that should be fully subject, in our view, to the democratic political process.

In this way, LHINs are like the Health Services Restructuring Commission of the 1990s. The HSRC took the flak for unpopular decisions to cut and centralize hospital services. That process, in our view, was very weak on public input, underestimated need, centralized services and resulted in bad outcomes, but did at least attempt to assess capacity and create some clear public plans for hospital restructuring.

With the LHINs, the planning process, to the extent it exists, is less clear and less consistent. There appears to be no consistent public attempt to assess capacity and need, or a plan to meet identified needs with adequate capacity. While capacity planning is weak, the changes we observe do certainly tend to follow certain very specific directions: centralization of services, the narrowing of hospital services, cutbacks, privatization, and the closure of smaller hospitals. Indeed, we believe there is a particular threat to hospital services in smaller communities.

The restructuring process used by the government and implemented by the LHINs is, in our view, more subtle and in some ways less transparent than the HSRC process. The LHINs have significant powers, it is true, and these were well noted when LHINs began to restructure health care, but they're seldom used, unlike the HSRC—that is quite a contrast—where the HSRC had very clear directions specifically set out, a lot of process involved in those decisions.

Unfortunately, it appears to us that the lesson learned from the HSRC experience was to keep the process out of public debate as much as possible. Instead, funding is the main tool that is driving the restructuring that we are currently seeing.

On the face of it, LHINs make major funding decisions for hospitals, long-term care, home care and other providers. However, the reality is different. Their room to manoeuvre is extremely modest. The 2013 budget indicates that funding for the LHINs actually increased by $5.6 million. That is a 0.02% increase—two one hundredths of 1%. Indeed, over the last two years, there has actually been a $310-million decrease in funding for the LHINs—a significant decrease, a 1.3% decrease. We sometimes call the LHINs the Dr. No of health care.

This is the major way that the government has driven the sorts of changes we fear. Rather than go through the process of public hearings, a public commission and public directions, the government has simply established regional arm's-length bodies which present health care providers with untenable budgets. The response, naturally enough, is to force regionalization and centralization and to abandon and cut health care services. Apparently—respectfully, we would say—it appears to us that it is more expedient to force the providers to do this and let them take the blame. Even when troubles do travel up

beyond the providers, the health care employers, they are often diverted—this is a constant discussion among health coalition people and union activists—on to the shoulders of the LHINs, which, frankly, we believe, have little room to manoeuvre.

Now we have significant restructuring with little public input and debate, and the pace of restructuring is quickening as we've gone through the last few years of very significant cuts to health care funding—real cuts. We've seen the removal of acute care services from smaller hospitals like Fort Erie and Port Colborne; the proposed or complete shutdown of smaller hospitals in the Niagara Peninsula, Shelburne and Burk's Falls; large cuts in smaller hospitals like Perth, Smiths Falls, Arnprior, Renfrew and Wallaceburg; the merger of the West Lincoln and Hamilton Health Sciences hospitals; the merger of the Rouge Valley Health System and Scarborough Hospital; and the merger of Credit Valley and Trillium hospitals all in process.

What have been the consequences of this funding policy for health care: a major reduction in complex community care and rehabilitation-weighted cases over the last two years. Ontario provides in-patient services to fewer than half the patients that other developed nations provide to their citizens. Tens of thousands of beds now have been cut over a long period of time—30 years. Bed occupancy is now at world-record levels. The English, for example, talk about a problem when it goes over 85% in terms of cancellation of surgeries, hospital superbugs and so forth. Ontario is significantly higher than that. There's some discrepancy over the figures, but the figures we've seen suggest about a 98% hospital bed occupancy level in 2010. Unfortunately, we sometimes hear from the minister that there will be more cuts of beds.

Ontario spends $281 less per capita than the rest of Canada combined, including Ontario—a significant difference in terms of hospital spending: 19% more for all of Canada. The result? Nursing service is one key example: 3.6 hours less nursing care per weighted case—that's a typical patient—than the Canadian average. That was in 2007-08. It has gotten worse: We've reduced it by a further 2.1 hours, while the rest of Canada has gone up, so now the gap is an astonishing 6.1 hours per weighted case.

Not surprisingly, this is driving very much higher what they call nursing-sensitive events—medical errors, essentially, on the nursing side—5.1% higher in Ontario. Well, it's not surprising. With 6.1 less hours of care, there are going to be more errors.

There's also a very significant move to shrink hospitals only to in-patient acute care services. People sometimes talk about this as the natural process of what hospitals do, but in-patient acute care services are actually a small part, a major but small part, of hospital services—a minority part, I should say. Some 37% of funding for hospitals goes to acute care services. Reducing back to that level will threaten the viability of hospitals around the province, especially in smaller communities.

There have been, in contrast, significant increases in other areas, notably OHIP, primarily covering doctors. In the 2013-14 budget estimates, OHIP went up 2.9%, to $13.3 billion. They got a 2.9% increase. The rest of the health care system, including LHINs, got, on average, a 0.3% increase, just over one tenth as much. Some $374 million of that increase, according to the budget estimates, went to OHIP, which primarily covers doctors, whereas the total health care increase was $486 million—three quarters of the increase. It's part of a long-term pattern. Ontario spends more per capita on doctors than the other provinces, and 6% more than the Canadian average, whereas we spend significantly less, as noted, on hospitals.

As an immediate step, the real cuts to public hospital funding need to stop. Funding should increase to the Canadian average. Over the longer term, the government, in conjunction with the regional health authorities, wherever they may be, should publicly develop capacity planning by identifying the current and future health care needs of local communities as well as the existing bed and service capacity in the hospitals, the long-term-care facilities and in home care. The identified health care needs should form the basis of capacity development to these health care subsectors and be part of the public debate on how to achieve that and what those levels should be.

Privatization: This is becoming a dramatically increasing role for local health integration networks in the period ahead. The government has identified that it wants, as part of these changes that we've talked about, to move more public hospital services out to private clinics; in particular, surgeries and key diagnostic work. Again, that's a significant threat to community hospitals, especially in smaller communities. Already, it is effectively closing down community hospitals by moving core work over to private specialty hospitals or specialty clinics. That threat has deepened. Such clinics will only seek to provide services where they can make money. Instead of being able to provide a range of services, community hospitals will see more and more of their services creamed off, leaving them with the most difficult and least profitable. This was an issue in America about a decade ago and led to a freezing of their work.

Quality: Operations can and do go wrong. The main response of the specialty clinics that we've seen so far is to call 911. They don't have emergency capacity to deal with this, typically. Will ambulances be able to move patients to hospitals when things go wrong? These are surgeries, after all. Indeed, private surgical clinics first came to the public's attention in Ontario when a patient died and the paramedics arrived to find the patient with no vital signs.

Is it appropriate to establish a system that inherently requires extra time to effectively treat patients who will fall into emergency situations? Inevitably they will. Will the hospital government establish a requirement that doctors be on site at all times? Will they require that specialty hospitals have emergency capacities beyond

calling 911? Will they require that private clinics disclose to patients the limitations they have on their ability to provide emergency services?

Oversight: The government has quickly passed the buck over to the College of Physicians and Surgeons. This, we find, is odd because it was the doctors who had actually lobbied for this development. They have provided only very limited information. Typically, their public review of the clinics is one word: "Pass." That's all we get.

User fees: The Ontario Health Coalition has revealed widespread extra billing by existing private clinics. There's little doubt that this will intensify with more private clinic delivery. Already, Ontario has a very high—the highest—amount of private payment for health care services in the country, about $100 more per person than the rest of the country, including Ontario, combined.

There have also been significant problems with questionable billings. The government just went through a very extensive fight with private physiotherapy clinics this past summer—a major struggle. The government reported that they did not have proper billings for most of their billings information. In Quebec, just across the border here, we had Rockland MD that was shut down because they were billing for things that weren't appropriate—a major concern for us.

OCHU, with the Ontario Health Coalition and others, will be going door to door to stop the transfer of services from public hospitals to private clinics. That will happen in the months ahead. We need to stop the transfer of hospital, surgical and diagnostic work from public hospitals to private clinics. LHINs should be forbidden from transferring work from public hospitals to private providers.

With that, thank you for your consideration. I hope I left a little bit of time for questions. I may have blathered on a bit too much.

The Chair (Mr. Ernie Hardeman): Actually, we're at 14 minutes and 14 seconds. So we have reached the end, and we don't have time for questions.

Mr. Doug Allan: I'm sorry; that was not my intention.

The Chair (Mr. Ernie Hardeman): We are here to hear you. Thank you very much for your presentation, but that does conclude the time.

Mr. Doug Allan: Thank you.

The Chair (Mr. Ernie Hardeman): The next presenter is Perley and Rideau Veterans' Health Centre: Akos Hoffer, chief executive officer.

United Way Centraide Ottawa: Michael Allen?

He's not here either yet, so we'd better take a break.

The committee recessed from 1343 to 1343.

PERLEY AND RIDEAU VETERANS' HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): We're reconvened.

We want to thank you for coming and even more so for being early for your appointment so we can hear you early. Secondly, it also provides me with the opportunity to lay out the ground rules without repeating myself. You haven't heard them before because you weren't in the audience as I've done it for others.

Mr. Akos Hoffer: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): I usually start off by saying, "As you've heard me say before," but you haven't. You will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's any time left over—more than a minute—then we will have questions or comments from the committee. With that, starting now, it's your 15 minutes.

Mr. Akos Hoffer: Thank you for having me here. I really appreciate the opportunity. And thank you for scheduling the hearing on such a beautiful day; it makes the commute a little easier.

I'm assuming you've had one person after another come here and recommend that you go to Beau's brewery, so I'm going to lend my voice to that recommendation.

Ms. Helena Jaczek: We've been.

Mr. Akos Hoffer: Oh, good, you've been there.

The Chair (Mr. Ernie Hardeman): They've been researching the topic.

Mr. Akos Hoffer: Good.

I didn't submit a CV, so maybe I'll start by introducing myself. I'm Akos Hoffer. I'm the CEO of Perley and Rideau Veterans' Health Centre, and I'll talk about who we are a little further in a minute. I'm also the co-chair of the Champlain Dementia Network steering committee, which is an organization that provides guidance to the Regional Geriatric Advisory Committee, which is one of the committees that advises the local health integration network on its work. I've been with Perley Rideau for about six years now and with the Champlain Dementia Network just this past year.

Who Perley Rideau is: I should talk about what our relationship is with the LHIN. Essentially I think of us as their client because they provide a great deal of our funding. Perley Rideau is a 450-bed long-term-care facility. We also have recently constructed 139 seniors' housing apartments and introduced some new programs such as the assisted living services for high-risk seniors program, many of those done in consultation and partnership with the local health integration network.

I would like to speak to integration, as that is one of the foremost responsibilities of the Champlain LHIN. Our orientation at Perley Rideau—again, because we have essentially a client relationship with the LHIN—is to think about how we can be most responsive and most valued by the LHIN and the citizens of Ottawa.

A lot of our work and a lot of our planning in the last year has led us to think about this: If you think 15, 20 years out, what are the trends that are really pushing the health care system and how can we be most responsive? In fact, our response has been to become more integrated

as an entity. Some of the things that we've been able to do are, for example, to expand our convalescent care program, which helps people return home from hospital rather than staying in the hospital. That's one of the benefits of that program. Another is, we rolled out an assisted living services program that is available to members of the community but also to seniors living in our new apartments. All of this work was done, again, in very close consultation with the LHIN. What they brought to the table, really, was high-level direction. A few years ago, we were developing our strategy and at the same time the province and the LHIN were developing the Aging at Home Strategy, so the two met and we set our own strategy going forward.

I would argue that it's very difficult to do this kind of work without some really strong local planning expertise. Certainly, I would say that that's where the LHIN has been able to help us—number one, through engagement. It's not just with the staff but also, for example, committees like the Champlain Dementia Network steering committee that really engage the local health care community and consumers of health care in trying to develop solutions to some problems. One obvious example is alternate-level-of-care, which is a very significant concern for hospitals; it has been for a while. If you go to the steering committee that deals with that issue, you will see some very highly engaged local health care leaders who are trying to find ways to solve a complex local systems issue. Certainly, the LHIN supports that process by chairing the meetings but also by providing good data and creating accountability with all the players around the table in various ways. I think that's classic performance management. That's something we try to do within our own organization and it's something that has certainly yielded results when it comes to alternate-level-of-care.

The other thing I would talk about is, if you think about the LHINs as venture capitalists or angel investors, they obviously are there to execute the strategic direction of the Ministry of Health and Long-Term Care, but clearly there's some latitude there and there's some judgment and decision-making that can take place at the local level.

I'd like to give an example of this. Recently—about a year ago—a group of us developed a study that came out with an integrated model of dementia care. What this strategy does is it really talks about a consumer of health care who is coping with dementia and their family—and the number of these people is going to increase in the years to come—and talks about how they access services for dementia care and how the care providers can coordinate their care, because it's quite complex, and especially if your cognition is impaired, it gets more and more difficult.

1350

This was a strategy that was funded by the LHIN in terms of the development. There was a mandate given to a small group of providers to develop that strategy. It was submitted to the LHIN; it was accepted. Now the planks of that strategy are being funded as well, so we're very pleased to see that. Part of that is an awareness campaign so that people can become more educated about the resources available to them. Others are changing the way clinicians provide care to persons with dementia. It's based on evidence and on leading practices throughout the province, so we've been very pleased to be part of that.

The other part that I'll mention is advocacy. I'm fairly new to my role—I've been in the CEO role for about six months now—but I can already see where there's the potential to work with the LHIN to help our local issues become known by the provincial Ministry of Health. This is important because the LHIN finds itself in a situation where it has latitude over some decisions, but not over others. Long-term-care funding is distinct from hospital funding, and some of the rates and per diems and funding levels are set centrally. For some of us, for an organization the size of Perley Rideau, that is going to cause some challenges fairly soon. What we see is an opportunity to work with the LHIN in partnership to gather data about local needs—so what will the need for long-term care and other types of care for seniors in the community be—and then try to determine whether the funding for that type of care is adequate and whether we can function within that funding envelope. If we can't, personally I see an opportunity to work with the LHIN to bring that forward and to work in partnership rather than going it alone, as it were, as an organization.

I'll end by just touching on one recommendation. I assume you're hearing lots of recommendations and possibly even some criticisms. The one recommendation I would have comes to planning. If you look at Perley Rideau, our own strategic plan started off by looking out 25 years. We ended up developing a plan that runs from 2010 to 2015, so it's a 15-year plan. This is fairly unusual in health care because of all the dynamics. Obviously, health care, health care funding, health care policy is subject to political influence, so there's uncertainty on a regular basis. Some providers are reluctant to look out on the horizon, but we have to. We really have to because the infrastructure and the planning take so long to get into place that what I'm worried about is that if we don't take a longer view, we're going to find ourselves responding or reacting rather than planning.

The LHIN has obviously a strategic plan; however, it is limited to three years. I would dearly love to support longer-range planning at a local level, even if we don't know the answers, even if we don't have certainty. It really has been very compelling for our organization to set a vision that's way out in the future, recognizing that some of the strategies and some of the plans may need to change as time goes by, but it's amazing how time flies. I'll end there.

The Chair (Mr. Ernie Hardeman): Thank you. We have about five minutes left, so we'll start with the government. Mr. Fraser.

Mr. John Fraser: Thanks, Akos, for your presentation. I'll have to say a little plug: Perley Rideau veterans

is in my riding of Ottawa South and they're a great organization.

I'm very interested in what you have said about long-term planning, and I think that's a very important point. But I want to go back to something we've been hearing. Primary care: Something we've been hearing throughout the hearings is in terms of the LHINs having more connection or impact or control over that. Can you speak to that in terms of your work with the dementia network, how you would see that?

Mr. Akos Hoffer: Sure. With the dementia network, some of the work in the integrated model for dementia care calls for a model that was developed by Dr. Linda Lee—I believe she's out of the Waterloo area—that is really backed up by evidence in terms of how clinicians—how family doctors, really—can better diagnose and provide care for persons with dementia. Right now, if you go to your family doctor and you are suffering from dementia, it's not as consistent as it could be. The knowledge is not as high as it should be.

But to me, it's a very low-cost way of improving the expertise of people who are already there. They already have a roster of patients, and there's a system that has been developed where you take these clinicians, you train them, you set aside time in their schedule to diagnose for dementia, and then that model can be sustained over time as well, and expertise can be developed.

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

Mrs. Christine Elliott: Thank you very much for appearing before the committee and for stepping up so quickly. We appreciate it.

Mr. Akos Hoffer: You're welcome.

Mrs. Christine Elliott: I'm also really interested in the concept of planning and the advocacy role as well. We have heard some presenters and some people who work in the fields of dementia—Alzheimer's and so on—talk about the tsunami of Alzheimer's that's about to overtake us, and what they perceive as being a lack of planning, frankly, on the part of the Ministry of Health, to really prepare for this.

What do you think the ministry could or should be doing now, working with the LHINs, in order to advance this planning?

Mr. Akos Hoffer: To be honest, I think they're doing it. The LHIN will say this—we can't put it all on the LHIN; I mean, there's a handful of people working there. What they will say to us is that it's the providers like Perley Rideau, the hospitals and other organizations that really have to do the heavy lifting. In fact, in our accountability agreements, we're held to account for planning for integration.

I think the challenge is there. The models, like the integrated model of dementia care, set it out. Now it's just funding it and really making it a priority. I think that's where the long-range planning will become really important, because we'll be able to see, if the seniors population is going to double in the next 15 or 20 years, really, what the capacity is that we're going to require for long-term-care beds versus convalescent care beds versus community support as well, which also needs to grow. Providing that kind of information to the community, to the people who are accountable to help integration happen, I think, would be very, very helpful.

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

M^me^ France Gélinas: You've touched on it, but very briefly. You've mentioned that you have 450 long-term-care beds, 139 housing units, and you have some assisted living.

Mr. Akos Hoffer: Correct.

M^me^ France Gélinas: Is your assisted living being financed by CCAC or by the LHINs?

Mr. Akos Hoffer: It's by the LHINs.

M^me^ France Gélinas: It's by the LHINs. So my question to you is that some presenters have talked to us about why is it that the community care access centre continues to fund agencies when the LHINs are already set up to do that kind of thing? Because you know as well as I do that community care access centres will fund services to provide assisted living, and we have the LHINs that fund services to provide assisted living. Why do we need two bureaucracies to do the same thing? Do you have a comment on that?

Mr. Akos Hoffer: Well, in terms of assisted living services, there's a contract that's signed with us to deliver that. The advantage, from my perspective, in having a Perley Rideau or a Bruyère provide this kind of care is that it sets the stage for a warm transition, so you get to know, potentially, your future residents and then carry on that relationship over time. That has been tremendous. It's our own staff that we deploy to provide care in the apartments and in the surrounding community.

The same way, we've put a proposal in to the LHIN to establish a primary care clinic on our campus with the South-East Ottawa Community Health Centre. It's a similar concept. It's getting to know the consumers of health care better.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes the time. We very much appreciate not only your coming, but your willingness to sit down on such short notice to give us your presentation.

Mr. Akos Hoffer: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): That recess we just took a few minutes ago, we are really going to take it now.

The committee recessed from 1359 to 1412.

UNITED WAY/CENTRAIDE OTTAWA

The Chair (Mr. Ernie Hardeman): We thank you very much for being here. We'll just give our committee a moment to find their chairs again.

We have Michael Allen here, president and chief executive officer of the United Way/Centraide Ottawa. Thank you very much for being here this afternoon and taking the time to come out and talk to us. You'll have 15

minutes in which to make your presentation. You can use any or all of that time for the presentation. If there's any time left over, we'll have some questions from the committee.

With that, your 15 minutes starts right now.

Mr. Michael Allen: Thank you very much, Chair, and I apologize; we had timed our travel to get here just in time, and of course, I should have realized that you were running early. Normally when I come out this way, I have three teenage—some of them are more than teenagers, and we always make our beeline for the hockey rinks. We allow enough time to change. Anyways, I didn't factor that in. But thank you very much for the opportunity to appear before you and to speak a little bit about the United Way of Ottawa and its relationship with our Champlain Local Health Integration Network. I hope it contributes positively to the review that all of you are undertaking. Thank you for visiting our region.

Let me offer a bit of a context for our presentation today. Most of you, I hope, would be aware of the United Way movement across our nation. The United Way of Ottawa is no different in that over the last number of years we have undergone quite a profound transformation in terms of our work. I won't bore you with all of its details, but I will speak to some of the characteristics of that transformation; they'll be familiar to you. They were born out of a sense that the work that we were doing in terms of fundraising and investment was not sustainable in and of itself, that we had to begin to focus on priorities that we felt were the most important and where we could have an opportunity to make an impact and a contribution. As well, we recognized that the work that we undertook, in terms of our desire to effect community change, could not be done alone. We had to reconcile that, in order for us to be successful in terms of the ambitions that we had, we had to work with others.

In that regard, I'll speak to some specific examples of how we found in the LHIN a very willing and helpful partner. Again, it won't be a surprise to you that while we identified the goals where we felt we could have an opportunity, unlike many issues in our communities, we found that the lines between health and community services and human services were blurring. So we found ourselves intersecting, in many areas, between the work of the local health integration network, the provincial government and the work that we do in terms of the community sector. I want to bring to your attention at least two of those examples, and I believe they speak to the kind of characteristics that the LHINs were designed to address. The first is flexibility and nimbleness to local community dynamics; the second is the ability to calibrate, within a region, the community capabilities and the institutional capacities that exist and the ability of this arm of the provincial government to be sensitive and calibrate accordingly.

The first example that I want to offer to you is one that I know at least one of your committee members will be intimately familiar with. We've worked with him throughout the years on it. It's a project that we refer to as Project STEP—support, treatment, education and prevention—and it speaks to the issue that we were faced with in our community about local youth drug addictions. Today, in Ottawa, 57 secondary schools across all four school boards and a number of non-mainstream academic settings for teen mothers, street youth and aboriginal youth have access to school-based substance abuse counselling and supports. Left unchecked, you'll all know that youth addictions can have devastating consequences for everyone: crime, underemployment or unemployment, hospital care, homelessness. To intervene requires crossing government jurisdictions, sectors, professional boundaries and resource requirements. We found, as I mentioned earlier, a very willing partner with the local health integration network, but that partnership did not end with just ourselves and the LHIN. It included the private sector organizations like the Ottawa Senators Foundation; it included the city of Ottawa, through its public health authorities; and it includes all four school boards. All of us are equal funding partners for this work that now covers 57 secondary schools across our region. The result is that as of today, we have two facilities that deliver residential drug treatment, but probably more importantly and upstream, we have this service in the schools.

We can report some results to you as a result of this work. Three out of every four students were able to reduce or stop using one or more drugs in less than one school year, as our stats indicate over 2013—and a significant decrease in use, or abstinence. Students who were experiencing moderate to severe difficulty upon entering school showed notable improvements in health and well-being. Some 6,200 students in our school systems participate in prevention education sessions, and 1,600 of these were connected with counselling. Probably most significantly—and certainly a metric that we are disciplined about measuring, and I suspect that organizations like the LHIN will be equally committed to that—is that 92% of the students who were admitted to the counselling programs stayed in school and finished their school year. As I say, the local health integration network, together with business, together with school boards, committed to this work, and the flexibility and nimbleness that our LHIN demonstrated made them a very active and important partner for us.

The other example I want to leave with you is the role that I believe, at least, through the lens that I have, that our LHIN supported is its ability to calibrate. One of the dynamics I know that is alive and a debate that's alive, which I don't fully appreciate—only you folks will fully appreciate it—is the requirement for both the community sector and the health care institutions like hospitals to play. The LHIN, we believe, is capable, particularly on a local basis, of calibrating that accordingly. An example of that for us has been in our area of aging in place for seniors—the ability to keep seniors, with dignity, with supports, in their homes and not in institutions, where it's unnecessary. There are a number of examples that we can

speak to. The one that I will speak to is, again, a dialogue that we have had with the LHIN around Rural Ottawa South Support Services. This covers a number of more rural parts of our community—Manotick, Greely, Osgoode and Rideau—and again, it was an opportunity for us to work with the LHIN where we complemented our respective services and funding support.

1420

For the LHIN, they began to engage in the support through organizations around the transportation network, to make sure that seniors, for example, could get to their hospital appointments.

Where the United Way stepped in with funding—because of that—was around social recreation: keeping seniors active and healthy. Again, a nice opportunity to engage and complement and calibrate the relationship between the institutional supports and community supports within the community where different funders could play different roles. For us, these things have been tremendous characteristics that the LHINs have brought to our work. They have provided a great place for us to have a conversation about what role the community sector can play, what role another funder can play, together with what role a government entity can play.

The final area that I'll speak to—and this is not so much a local dimension but nevertheless something that we have found tremendously helpful from our local LHIN—is, generally speaking, the drive that we see within all levels of government, the provincial government being no different, and one that we have embraced for the community sector, and that is accountability and measuring results, measuring impact. The LHIN, I believe, has continued to embrace that within the institutional setting, with hospitals, but that is beginning—and, I believe, out of necessity and absolutely an appropriate thing—in the community sector as well. Work that we have been able to do together around services like 211 and our local work around the Ottawa Neighbourhood Study have been examples of that.

We will be submitting a written submission to your committee; we'll outline that a little bit more, but we continue to commend the provincial government and the LHIN to encourage that discipline, that accountability, that transparency of the voluntary sector. That's a great help, and frankly, we believe it's an important thing for the community sector to be able to step up to.

Thank you, Chair.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We just have a touch over five minutes. We start this time with the official opposition. Ms. Elliott.

Mrs. Christine Elliott: Thank you very much for your presentation today and for the great work that you're doing in your community. I'd particularly like to congratulate you on the success of the STEP program. It sounds like it has been really doing great work with young people.

I'm wondering, because one of the presenters earlier today said that there's an opportunity for the LHINs to get together to share best practices: Have you been able to speak to other LHINs about the success of your program? Are any of the other LHINs sort of following the lead that you've taken in this respect?

Mr. Michael Allen: I'm not sure I'm capable of answering the latter part of your question, Ms. Elliott, but I can say that we've been very flattered to have folks from the LHIN and from the provincial government, and frankly other organizations nationally, which have recognized with awards the work of Project STEP. Without being boastful about it, we are very proud of the results that we have received.

I suspect you'll be familiar with the term "collective impact," which describes a collective impact model for our community, where organizations and funders get together to agree on objectives, to agree on measurements, to agree on strategies to complement towards a specific goal. I'm not sure about the LHINs themselves, but certainly we have received generous attention from the provincial government, the Ministry of Health in particular, about this model and the struggles of perhaps replicating it. I know it exists there, but certainly we're aware that there's an appetite to see that kind of activity.

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

M^me^ France Gélinas: I don't know if you'll be able to answer, but I'll ask you anyway. The same with me: I want to congratulate you for the great work that you have done.

Some of the presenters earlier on talked about some of the historical disparities, as in the money that is flowing to the Champlain LHIN, given the population, the complexity and the type of tertiary services you have, versus, let's say, Toronto Central. Historically, there are some significant differences between the amount of money that comes to Champlain versus the other LHIN. How would you suggest that we address some of those historical disparities now that we have this regionalization?

Mr. Michael Allen: You're right, Madame Gélinas: I don't think I can address that, although I'm going to make a note of it. But I guess I would address it slightly differently, and that is that one of the benefits of a local entity with that macro perspective is being able to bring a sensitivity to the capacities within each community, because they are distinct. We sense it even here. Between Ottawa and this part of our region, there are tremendous disparities. We sense it within the community sector, and I understand now that you're saying you sense it within the province as a whole.

One of the benefits of what the LHIN has brought to us is an understanding, a respect, a sensitivity to capitalize on those distinctions and build and, in turn, share with organizations like ours, frankly, the responsibility that we have for our entire region. So I think that's a helpful way to begin to address some of those disparities.

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

Mr. John Fraser: Thank you very much, Michael, and thank you very much for mentioning Project STEP. I think it's something in Ottawa we're all very proud of

and it has been very successful. We've managed to, I think, replicate it in some sense around suicide prevention—start with something and have it grow, and it is growing.

The question I want to ask you is more about the social determinants of health, because I know that that's something that is of key importance to your organization. Dr. Keon mentioned it this morning. What do you see, going forward, for the LHINs with organizations such as yours?

Mr. Michael Allen: Well, John, first of all, I know this is not the forum for it, but I will just tip my hat to the support that you offered for Project STEP. I think it's indicative of the kind of thing that MPPs do in their ridings, and your previous role in an MPP's office was very helpful.

I think it speaks, John, to the kind of intersections that we see. It used to be that the United Way would be fairly rigorous about our sense of, "We're involved in the community sector, not the health sector." Those lines are blurring now significantly. Our work in mental health, as you point out, our work with addictions, our work with seniors' supports—those things all intersect in terms of the care of our neighbours, of the people who live in our communities. The more that an organization like our provincial government, whether it's through LHINs or through any other structure, can be sensitive to and work with the capacities that are within the community sector—I think, as a going-forward proposition, that's what we're facing. We would look forward to ongoing dialogue with organizations that adds capacity to communities.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes your time. We very much appreciate you taking that time to come and talk to us.

Mr. Michael Allen: Thank you, Mr. Chair. My pleasure.

EASTERN ONTARIO REGIONAL LABORATORY ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next presentation is Eastern Ontario Regional Laboratory Association: Craig Ivany, chief executive officer, and Bernard Leduc, chair of the board.

Good afternoon, gentlemen. Thank you very much for taking the time to come and talk to us today. As with previous delegations, you will have 15 minutes to make your presentation. You can use any or all of that for the presentation. If there's any time left over, we'll have some questions and comments from our committee. With that, the next 15 minutes are yours.

Dr. Bernard Leduc: Thank you very much, Mr. Chair. Thanks, and good afternoon. My name is Bernard Leduc, and I'm here as chair of the board of directors of the Eastern Ontario Regional Laboratory Association, EORLA for short. I'm here today with Craig Ivany, EORLA's CEO, to present our recommendations regarding the Local Health System Integration Act.

EORLA is the largest voluntary integrated medical laboratory in Ontario. As such, it's one example—probably the most important one—of integration of health services in Champlain since the introduction of the Local Health System Integration Act that saw the creation of the LHINs. We will be presenting on the history behind the creation of EORLA and what role the LHIN actually played as a catalyst that saw 16 hospitals come together to create this integrated medical laboratory service.

Although long in its gestation, EORLA is still young in its history as a functioning entity, only coming together as of April 1, 2012. I can state that the support of the LHIN has been an important key factor to our success. Thank you for allowing us to do the presentation.

Craig, I'll pass it to you now.

1430

Mr. Craig Ivany: Thank you, Bernard. Good afternoon, and thank you for the opportunity to address your committee.

The Eastern Ontario Regional Laboratory Association—we call it EORLA—is a member-based, incorporated, not-for-profit organization delivering high-quality, cost-effective and safe medical lab services. EORLA membership comprises the 16 acute care hospitals within the Champlain LHIN. On April 1, 2012, the 16 member hospitals turned over the operations of their medical laboratories to EORLA, and at that point, EORLA became the largest voluntary integrated laboratory in Ontario,

While April 1 was the first date of operation, the concept of laboratories working together in eastern Ontario dates back to the mid-1990s. The partnership between the Ottawa Valley Hospital laboratories and the Queensway Carleton Hospital lab was one of the first collaborations of its kind in Ontario.

The eastern Ontario laboratory coordination program, the precursor to EORLA, was based on the concept of labs working together for mutual benefit. In 2000, the laboratory branch of the Ministry of Health and Long-Term Care mandated all Ontario laboratories to participate in group strategic exercises and prepare regional plans for the delivery of lab services. The first business case for EORLA was prepared at that time. The Eastern Ontario Regional Laboratory Association was registered as a not-for-profit organization in 2003 and consisted of 16 member hospitals. This was one of the first major initiatives to implement a coordinated, regional business model for hospital labs in Ontario.

During the period from 1998 to 2006, hospitals experienced a 45% increase in the number of lab procedures, requiring an annual increase in costs of 6%. At that time, it was projected that without some form of intervention, the region's hospitals would be faced with the challenge of unmanageable laboratory costs.

Simultaneously, EORLA established a successful partnership agreement with Gamma-Dynacare Medical Labs for the provision of expert resources, purchasing

agreements and management services. In 2005, the EORLA board retained Gamma-Dynacare's services to prepare an updated business case. The ministry followed up with a third party review of the 2005 business case and the infrastructure required for the delivery of quality patient services. QSB Consulting conducted the review and released a report confirming the value of the integrated laboratory model.

Concurrently, Ontario introduced the Local Health System Integration Act, which created the local health integration networks. The inaugural Champlain LHIN CEO, Dr. Robert Cushman, engaged the LHIN in furthering the EORLA concept.

During the period from 2006 to 2008, development focused on the many elements of creating a sustainable organization and determining the optimal models for all aspects of the business, including governance, leadership, medical and scientific, human resources, quality assurance, administration and financial. Cost-containment initiatives commenced through the regional standardization of test platforms and supply contracts. At this time, the LHIN emerged to play a key role as funding agent, change agent, integration champion and mediator to support the building of an acceptable model for all members.

The concept of regional lab service delivery has been gaining global acceptance over the last decade. Drivers for integration include health system happenstance and laboratory medicine industry factors. The typical pressures of the health system include financial sustainability, access, quality improvement and demographic changes.

The global trends in lab medicine further accentuate the need to consider alternative business models. These elements include technology development and complexity, aging workforce, point-of-care testing, the explosion of genomics, the promise of personalized medicine and the need for substantive information management to bring all elements together.

The reality beginning to emerge is that without substantive ongoing investments by individual hospitals, laboratory services will quickly lack capability to respond to the changing demands of the health system. Therefore, the foresight of the leaders in eastern Ontario to investigate regionalized laboratories in the mid-1990s has been subsequently validated by the evolution that is presently occurring in lab medicine.

During the period from 2009 to 2010, EORLA continued to move through the work of structuring its model. One of the key challenges during this period was project fatigue and the emergence of turf protection, causing the target date for implementation of April 1, 2009, to be pushed to April 1, 2010, and beyond.

At this point, financial commitments were made in support of the integration by both the Ministry of Health and the Champlain LHIN. The ministry provided $2.7 million, and the LHIN provided $1.86 million in funding to EORLA between 2009-10 and 2013-14 to cover the transitional and one-time cost of integration.

Supported by this financial commitment, key leadership from the LHIN and hospitals facilitated the future of EORLA. The EORLA board of directors was renewed with hospital CEOs appointed as board members and the ultimate decision was made to proceed with the EORLA model on April 1, 2012.

It was clear that a change in the current methodology behind lab operations was essential for survival, and that full implementation of the EORLA model would ensure sustainable, high-quality, cost-effective and responsive laboratory services in the future. A series of legal agreements defining the transition and ongoing operation model were executed by all EORLA member organizations in early 2012. The LHIN also played an instrumental role through the inclusion of performance obligations within the hospital service accountability agreements for the acute care hospitals to commit and participate in EORLA. This was an important means to encourage the move forward as an integration of lab services. The HSAA condition remains in place to encourage continued commitment by the member organizations.

On April 1, 2012, some 850 lab technologists and technicians in 19 sites across the Champlain LHIN were reassigned to their new employer and the laboratory operations commenced under EORLA's banner. EORLA has continued to progress as an organization with a number of key achievements:

EORLA board of directors has moved through a period of renewal culminating in the appointment of three community-based members.

EORLA lab quality has been maintained through the transition and stabilization periods and work has now begun on revising and enhancing the quality metrics.

EORLA has successfully standardized lab testing platforms across the network, specifically in haematology and biochemistry.

EORLA will have transferred 75 medical and scientific staff from five hospitals by March 2014.

EORLA has exceeded the business case savings objectives and has also maintained a zero per cent increase in lab costs to members for 2012-13 and fiscal 2013-14. Budget projections for 2014-15 hold a zero per cent growth for lab costs to members.

EORLA has successfully completed consolidation and improvements in processes that have delivered improved costs, quality and timeliness of its services to its members.

EORLA's structure and critical mass enable the organization to become more innovative and effective in the delivery of high-quality lab medicine to its members.

EORLA is currently pursuing implementation of cutting edge technologies such as:

—full lab automation, mass spectrometry and next-generation polymerase chain reaction testing for MRSA—methicillin-resistant staphylococcus aureus—in microbiology;

—looking at PCR testing for the flu virus in virology;

—the development of molecular oncology diagnostics in anatomic pathology; and

—regional automated slide imaging in haematology.

EORLA represents a unique approach to health system integration. It represents the best principles of collaboration and has moved from concept to operation by the collective will of the hospital leaders within the Champlain LHIN, the support of the Champlain LHIN and the support of the Ministry of Health. The model embraces the values of the Ministry of Health by delivering patient-focused, results-driven, integrated and sustainable laboratory services to its members today and into the future.

We'll close with the two recommendations that we would present for consideration.

Recommendation 1: EORLA supports regional planning and recommends the continuance of the Local Health System Integration Act. Health system integration, done well, can lead to improvements in care delivery and sustainability while respecting the unique offerings of individual elements of the system. The presence of an integrative agent, such as the LHIN, neutral to the various agencies, provides the right environment to move new initiatives forward.

Recommendation 2: EORLA recommends that the LHIN continue to be a key funding source to seed planning and integration initiatives. The LHIN has a capability to seed the full system delivery needs within the local region and can facilitate priority integration opportunities through targeted funding.

Thank you very much. Merci beaucoup.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have just over four minutes left, so we'll start with the New Democratic Party for a minute and a quarter.

M^me^ France Gélinas: Use them wisely? Thank you so much. Just a very quick question: You really feel that after all the work that you had put, it was because the LHINs were there to give the last push to get you through the finish line?

Dr. Bernard Leduc: I think it was instrumental in terms of getting the focus and getting the ball rolling. There had been discussions for many years. Change in leadership at the board level also made the movement important. But again, putting it in the accountability agreement of the hospitals to participate and see EORLA come to fruition I think was a key component.

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M^me^ France Gélinas: Do you ever see you going into community labs?

Dr. Bernard Leduc: It's something we're doing a strategic plan on right now, and thinking about.

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

Ms. Helena Jaczek: How do you explain the fact that you did have, between 1998 and 2006, a 45% increase in the number of lab procedures? Were there duplications occurring between facilities?

Dr. Bernard Leduc: There was growth, just expansion from some of the services happening in that particular time, but also lab medicine. Medicine relies more and more on laboratories, so one of the key components where, actually, we haven't seen the benefit of the regionally integrated model is looking at utilization and using that expertise, not just in one hospital but across the sector.

Ms. Helena Jaczek: So have you centralized in one lab? Have you taken the labs out of the 16 hospitals and had one centralized lab, so that you can share equipment? Why is this so good?

Dr. Bernard Leduc: There is a centralization of one big lab, but each bigger hospital—the 16 hospitals do have their labs. We're in a period of consolidation right now and looking at what would be the best practices in terms of consolidating, but what you get is a normalization of the standards and the quality across all 16 hospitals at the board.

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

Mrs. Christine Elliott: Your second recommendation talks about the LHIN needing to continue to be a key funding source. Some of the presenters have indicated that they have a few problems with the way the funding is operating, and have expressed a wish that funding could maybe be retained and saved for further projects down the line. Do you have any experience with that, or any comments you'd like to make on how that might be improved, perhaps?

Dr. Bernard Leduc: Funding is for the fiscal year. That's the rules that the LHINs are operating in right now. I'm sure that, if there are some efficiencies in the system, retaining them for the benefit of the whole system would be something that we would consider positively.

Mrs. Christine Elliott: Thank you.

Dr. Bernard Leduc: Craig? Any—

Mr. Craig Ivany: Absolutely.

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

Mr. Craig Ivany: Thank you. Merci beaucoup.

CANADIAN RED CROSS

The Chair (Mr. Ernie Hardeman): We have the Canadian Red Cross. Colette Lavictoire? Thank you very much for joining us this afternoon and presenting some points to help us in our deliberations in the review of the LHINs. As with the previous delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for the presentation. If there's any time left, we'll have some questions from our committee. With that, the next 15 minutes are yours.

Ms. Colette Lavictoire: Thank you. First of all, I'm here to represent Lori Holloway, our national director of health. Just so you know, I'm taking her place today.

My name is Colette Lavictoire. I'm with the Canadian Red Cross at the Cornwall branch, and I am the manager of community support services. Thank you very much for the invitation. It is greatly appreciated by the Canadian Red Cross.

I do not have a PowerPoint presentation, but I did give out the presentation that I will be going through in the next few minutes. If anyone has any questions in French, I am definitely able to answer your questions, just to let you know.

About the Canadian Red Cross: Our mission at the Canadian Red Cross is to improve the lives of vulnerable people by mobilizing the power of humanity in Canada and around the world. The vision of the Canadian Red Cross is as the leading humanitarian organization through which people voluntarily demonstrate their caring for others in need.

The Canadian Red Cross Society is part of the largest humanitarian network in the world, the International Red Cross and Red Crescent Movement. This network includes the International Committee of the Red Cross, which we refer to as the ICRC, the International Federation of Red Cross and Red Crescent Societies, and 187 national Red Cross and Red Crescent Societies dedicated to improving the situation of the most vulnerable throughout the world. Throughout the world and here in Canada, the Red Cross is known for its leadership role, mostly in disaster management and both emergency and community-based health care.

Our commitment to community-based health care in Ontario: The Canadian Red Cross has recognized the necessary and critical leadership role it must play in improving the health and well-being of Ontarians. Whether it's ensuring a meal is delivered to an isolated senior, access to transportation is available to attend medical appointments, personal care is provided to a physically disabled adult, or a senior is cared for in their home, the Canadian Red Cross has been working on a daily basis to address health and psychosocial needs in our communities.

The commitment of the Canadian Red Cross to community health care is clearly articulated in our strategic plan: People will have improved health status through community-based actions by enabling the elderly, the ill or injured to live more safely and independently.

As we build on this foundation toward a vision and strategy that will take us to 2020, we recognize and will embrace new models of health and wellness programming that will address, in a holistic and resilience-based approach, the needs of Canada's most vulnerable individuals. With the solid foundation of our home care and community support programs, we will continue to work collaboratively with government and community partners to build local and community resilience to vulnerability through client-centred, integrated and cost-effective community-based health care.

There is a growing recognition of the role that home and community support services can play and will play in the health and wellness of Canadians. The transition of health care to the home and community is a wise one being undertaken by the government of Ontario as part of Ontario's Action Plan for Health Care. In fact, we believe that the community sector can be utilized to an even greater extent to ensure greater access to quality health care in the home and the community; more integrated and seamless access to a full basket of services that not only keep people aging within their own homes but also allow focus on the social determinants of health, such as social interaction, which ultimately improves health, wellness and quality of life; and more cost-effective solutions to manage low-acuity patient needs while decreasing the strain on long-term care and hospitals and ensuring adequate resources for high-acuity and complex patient needs.

Our budget recommendations: Keeping people living independently in the community and out of hospital is a more cost-effective means of health delivery than institutionalized care. Investing in home and community care frees up hospital beds and unclogs emergency waiting rooms while also decreasing long-term-care placements and long-stay hospitalizations, all at a lower cost to the health care system.

We applaud the government for past investments in the sector but have several recommendations for more targeted investments in the coming year.

Our first recommendation: Recruiting and retaining workers is made difficult by the disparity in compensation and working conditions between the community health sector and the institutional health sector. We must ensure, to meet current and future demand for home and community support services, that there is sufficient funding flexibility afforded to sector agencies to attract and retain qualified personal support workers. We recommend a commitment that would allow for immediate wage increases for home care and community support service personal support workers, which are greatly needed to stabilize the workforce.

Our second recommendation: Even with designated increases for the community sector in the last two Ontario budgets, home and community care agencies are still behind on maintaining the necessary infrastructure, as budgets have been frozen for several years and funding increases have been targeted to increasing service volumes only. Zero-based budgeting is destabilizing the sector. We will be unable to keep up with the demands of more service at home if this is not addressed.

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Acknowledging and addressing this reality is a key determinant in ensuring the effective delivery of quality results that the government and public rightly seek. We recommend that, moving forward, infrastructure costs and cost of living be recognized as a true cost of operations of community support services.

Our third recommendation: Ontario and Canada are experiencing more natural disasters and emergencies, yet we lack the proper protocols in place to ensure the most vulnerable people can be supported during an emergency. The Canadian Red Cross is part of an innovative program in the Sault Ste. Marie area called the vulnerable persons registry that has won international awards for its innovation. So we recommend that the Ontario government invest in an expansion of the vulnerable persons registry, which, through a community-based, volunteer-driven

model, could provide daily supports for independent living, plus act as an incredible resource in times of emergencies to ensure that first responders find and support the most vulnerable people in our communities first.

Thank you again for the opportunity to provide input into the Ontario pre-budget consultations.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. It does sit somewhat together with what we're doing here, but it's not the pre-budget consultations.

Ms. Colette Lavictoire: Okay.

The Chair (Mr. Ernie Hardeman): But we do appreciate it. We have six minutes, two per party, and I think we start with the government side. Mr. Fraser?

Mr. John Fraser: Thank you very much for your presentation. I'd like to go back just to your last point, where you were talking about the vulnerable persons registry. Could you just give us a description of how that is held together and how that came to be?

Ms. Colette Lavictoire: Yes. I don't have all the details, but there was definitely a need in that particular geographic area to address the frequency—as you know, there were a lot of natural disasters and emergencies. This is how, I think, the community and the providers in that particular area figured that this would be a very good program. Certainly, I can find out more details about it, but this was a way to address those issues in that area.

Mr. John Fraser: So that was something that was built out, and the Canadian Red Cross was part of that community coalition that did that?

Ms. Colette Lavictoire: Yes, exactly, and working very closely with the LHIN in that area, and other community partners.

Mr. John Fraser: Okay. So it was an initiative very similar to a lot of initiatives that we've heard about over the course of the hearings.

Ms. Colette Lavictoire: That's correct.

Mr. John Fraser: Thank you very much.

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

Mrs. Christine Elliott: Thank you very much for your presentation. I'm wondering if you could tell us a little bit more about the interaction that the Canadian Red Cross has with the local LHIN, and the projects that you're working on.

Ms. Colette Lavictoire: Yes, definitely. If I use the Cornwall branch, for example, we currently have a very good partnership with the Champlain LHIN. We do provide several services in this area, such as supportive housing, assisted living for high-risk seniors, transportation, attendant care and also aging at home. Actually, our interaction with the LHIN—we have a very positive working relationship with our Champlain LHIN. At any time when it had been identified that there was a need to expand certain services, all the information was shared with the LHIN, actually working in consultation with them. They've been very supportive, when we have identified that there was a need of a certain client in the community, to expand certain services.

Actually, the most recent program was the assisted living for high-risk seniors, which again was to decrease the number of ER visits and address the ALC. So, actually, this has been a very great program for our seniors.

Mrs. Christine Elliott: Terrific. Thank you.

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

M^me^ France Gélinas: Through the work that you do, do you also have contracts with the community care access centre?

Ms. Colette Lavictoire: We work in partnership with the community care access centre. Actually, the community care access centre will make referrals to the various programs that we have that are directly funded by the Champlain LHIN. For example, attendant care: If the community access centre does identify a need to refer a client that would need assistance with their personal care activities of daily living, in a lot of cases, they are the referral source. For our assisted living for high-risk seniors program, the CCAC is the main referral source. They maintain the wait-list and, because we're funded right now for 60 units in our area, the CCAC will refer the clients if we have a discharge and have some space within the program.

M^me^ France Gélinas: Do you have any home care PSW services?

Ms. Colette Lavictoire: All our personal support workers are working directly for the Canadian Red Cross, but they have their personal support workers. So, actually, it would be the equivalent of some of the personal support programs that exist through the CCAC, but we are servicing the clients as part of our community support services. It's not meeting sometimes the mandate of the CCAC, so they will make the referral for our programs.

M^me^ France Gélinas: Do most of your programs have a cost to the clients who use them?

Ms. Colette Lavictoire: There's no cost to the client except for the transportation program. There is a cost to provide the transportation, because this is volunteer-based, so we have a group of volunteer drivers taking clients to their out-of-town medical appointments, but sometimes if someone cannot maybe afford the full amount, we get some type of subsidy. In our case, it's with our United Way funding to assist these clients who need to get to their medical appointments and, unfortunately, sometimes cannot afford to pay the full price.

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

Ms. Colette Lavictoire: Thank you.

ROYAL OTTAWA HEALTH CARE GROUP

The Chair (Mr. Ernie Hardeman): Our next presenter is the Royal Ottawa Health Care Group. Nicole Loreto is here to present—the vice-president of the group. Welcome, and thank you very much for taking time to come and talk to us this afternoon. As with other presenters, you will have 15 minutes to make your

presentation. You can use any or all of that time for your presentation. If there's any time left, we'll have questions from our committee. With that, the next 15 minutes are yours.

Ms. Nicole Loreto: Perfect. Great. Thank you very much. Bonjour, tout le monde. I just brought a presentation in English, but I'm willing to answer any questions in French—M^{me} Gélinas, en particulier. I totally didn't get a chance to bring one.

I'm here on behalf of my boss, George Weber, who was unable to attend. We thought this was a good opportunity to give our perspective from the Royal. As you see in the presentation, we're one of the 24 academic health science centres of Ontario, and one out of two that specialize in mental health. There's ourselves and CAMH in Toronto.

I thought I'd spend a couple of minutes just giving a really quick overview because we operate an Ottawa campus and a Brockville campus, and we have a range of programs. In Ottawa, the main service is with the Ottawa mental health centre. This is where we have 190 beds. Specifically, of 96 that are attached to the mental health centre, we have 32 recovery beds—and I can get into that if people have questions, because that's something seen more as a step-down program as people leave from an in-patient unit back to the community—and then 64 long-term-care beds, and that's something that we're involved in.

In Brockville, the services are specifically in terms of those that we offer for the not-criminally-responsible. We run a large unit there, which is 161 beds. We have 100 beds which is the STU, which is another ministry, not the Ministry of Health but the Ministry of Community Safety and Correctional Services. Also, we oversee 183 beds of special homes out in the community, where residents who have been an in-patient have now moved into the community.

The next two pages are basically who we serve. We're a tertiary care centre, obviously for people living with serious and persistent mental illness. The list is quite detailed there.

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We also serve primary care physicians through a service that we have called consultative services, and shared care, just because with mental health, you have the primary health care centres. The hospitals have their emergencies where they get serviced, and then if there's persistent need, let's say beyond the two weeks, then they would come to the Royal for specialized care. In terms of our role as an academic health science centre, we also provide all the training for the future psychiatrists, psychologists, social workers, nurses and recreational therapists for eastern Ontario. As part of the Royal, too, on one of the slides you'll see that we also have the Institute of Mental Health Research. That's part of our mandate in terms of looking at specialized research in mental health. We're quite excited because obviously there are some new developments, and we want to actually work towards finding better solutions to help people with mental illness.

On one side you have the list of all our programs, everything from anxiety disorders to youth programs. We also run a women's mental health centre, a sleep disorders clinic and, in particular, the Ottawa Operational Stress Injury Clinic. We got funding from Veterans Affairs to run a specialized clinic for post-traumatic stress disorder for the military. One of the key programs that is known, I think, in the province is the geriatric; it's one of those models where we provide intense care, but we actually have a rotating team that goes to all the long-term-care facilities to assess the needs of people in residential care.

Obviously, I know my time is going quickly, so the next two pages are the list of people we serve. It goes over 26,000 from admissions, in-patient to outpatient, and students. We also have the number of staff listed on those two pages.

We wanted to take this opportunity to cover a couple of points. The Royal, as a member of the OHA, believes in the principles of a high-performing health centre, the nine principles that they've outlined. We're going to comment today in particular on one, which is the interconnectedness of services.

We have just a couple of points to make in terms of the LHIN. For us, the Champlain LHIN has been very supportive of our work and understanding the needs of the region. This has evolved over time, I think in the last couple of years in particular. We've had to undergo significant restructuring with the 1997 directive. That was important particularly in Ottawa and in Brockville. There was a lot of support there and a genuine willingness, I think, from the CEO to the staff, in terms of understanding our business because we offer so many programs right across the region, everything from geriatrics to youth. Even our youth program is something that we share; we work with CHEO specifically to make sure to minimize any of the gaps in service delivery for youth. That's something that's quite complex, and there has been a genuine willingness to understand our operations to the point where even the CEO has attended our board retreats with our board of trustees, and also a member of their staff when we do our strategic planning. We think it's important, especially when we look at the continuum of care.

One of the points I wanted to highlight, as an example of the relationship, is our new Regional Opioid Intervention Service. This is something that we're particularly proud of and is also something that we aspire to in the future in terms of a model. We had two physicians actually develop the idea of having an opioid intervention service for those 30 years old and under, so to try to do some early intervention. That's been quite successful; we've now celebrated just over a year. Why the LHIN has been particularly supportive of that is, we've kind of presented a hub-and-spoke model where a lot of the intense services and assessments are delivered at the Royal but in partnership with all the community partners

because relapse is such a critical issue for people, and we wanted to make sure we had that type of model. They've been very, very supportive, and it now has actually become a main program. We have to say that we were actually honoured to also win—our two physicians won the innovation award from the ministry earlier on, at the end of November. That was one example and we think it's a good model for the future.

In terms of other points, we believe that the Champlain LHIN should have a broader mandate, or at least a mechanism to influence and coordinate the funding. When you're running a mental health centre and you have funding from different parts within one provincial government, it's very difficult. Children and youth is on one hand, then the Ministry of Health and Long-Term Care, and then within the Ministry of Health and Long-Term Care there's a forensic component if they're not criminally responsible, and then there's also the whole correctional services and community safety.

In terms of the coordination for funding, especially because often you'll see some of the members of the public in some of those programs—not all—we think that there might be some benefit in having the LHIN have greater influence and some kind of mechanism for that, particularly when you look from prevention to intervention at all the levels.

For us, it has to be one system trying to follow the patient, also depending on where they are. We see that often in children and youth, where they might be in the system, they might have come from CHEO, they're in the Royal, and then after that the adult system happens. There are gaps in there, and there's also trying to coordinate the services so that you can actually support the clients throughout, because mental illness is a chronic disease and we need to structure it that way.

Another two points: We think the Champlain LHIN—and other LHINs, obviously—should have oversight on public health, primary care and ambulance services. Public health—because I think you've heard other speakers talk about social determinants of health—again, it's a patchy system. You have some services overseen by the city, in terms of housing. We have clients with special needs, not only dual diagnoses, but also developmental needs and mental illness in the community, and then trying to have those types of services. Then we also do all kinds of psychiatric; we have a psychiatric outpatient team that actually does assessments for those currently not in the mental health system. They're actually in the shelters or on the streets, so it's trying to look at those services.

In primary care, one of the reasons why we've had to change part of our system is because right now the waitlists are very high, and sometimes it's trying to see if it's more for providing consultative services to physicians who want to maintain and try to help some clients, or if they require specialized care. So that still has to be figured out.

I think we're evolving quite nicely in terms of the system and the feedback we're getting from primary care, but there has to be better connection. I think, from that perspective, the LHIN can certainly help from a capacity-building side.

Ambulance services, as well—we've highlighted it there just because it's the feeder system, because they're the first ones that actually have to deal with some of the patients. Right now, sometimes if they don't get to hospital they might be elsewhere, and we have to find a way to make sure that all the services are coordinated. For us, that is pretty key.

Now, obviously the big question is in terms of reviewing the role, and there have been all kinds of suggestions. We find that there are lots of changes currently in the mental health system, but also just in the health care sector, and we fundamentally believe that, instead of trying to change something, we need to build on what we have, because I think there's a lot of opportunity for the future in terms of making sure that we provide one system of care. From our perspective, we believe in trying to enhance what we currently have as the way to go.

I've gone really quickly, but I'd love the opportunity to answer any questions.

The Chair (Mr. Ernie Hardeman): Thank you very much, and we do have some time for questioning, but only one caucus, so we'll start with the government caucus. Ms. Jaczek?

Ms. Helena Jaczek: Thank you very much. Thank you for coming. Can you describe for us exactly how you do currently interact with the LHIN? What sort of committees? How does it work between the Royal Ottawa and the LHIN now?

Ms. Nicole Loreto: Currently, I think, with the LHIN there are all kinds of different committees on needs. There's obviously the mental health and addictions committee. We're involved at specific levels, also the ALCs between all the hospitals. We try as much as possible to work within the hospital sector, so anything that's required from the LHIN—I think even one current project that we're going to start is to look at some of the capacity needs in the system.

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Ms. Helena Jaczek: And you weren't sort of interacting with the acute care sector so much before? Can you say the LHIN has really made a substantial difference? Do you see progress?

Ms. Nicole Loreto: I think we're seeing progress in the sense that now there's a greater perspective in terms of the regional needs, and I think that has been an evolution. We interact with the acute sector on a daily basis almost, just because often the patients, if they're not able to stabilize in the hospital, will be referred to the Royal. Right now, the only way you come into the Royal is either through one of the hospitals or referral through physicians specifically. There's only one program, which is our concurrent Meadow Creek, where we do detox—that's the only self-referral where someone can actually come and ask for service. The rest is really through the current hospital system.

Ms. Helena Jaczek: But your current patients, presumably, come from much more than just the Champlain LHIN, being one of two in the province, pretty much, academic health science centres—

Ms. Nicole Loreto: Most of our patients are from the region, and we have a breakdown we can actually circulate. We've done an assessment in terms of looking at where we service and what the actual rates are to be able to project for the future to understand that better. But it's mostly residents; the only one where we'll get people from outside the region is because of our detox centre. We have a level 4, and we'll accept people, let's say, with a certain level of addiction who would not be accepted elsewhere, in particular Toronto. They actually come to the Royal. The OSI is for the military. We service all of eastern Ontario and the western part of Quebec and Nunavut. We do some consultation services up north, but generally the population is in the region.

Ms. Helena Jaczek: Do I have more time?

The Chair (Mr. Ernie Hardeman): Yes, for a very quick one.

Ms. Helena Jaczek: And what current contact do you have with the public health units?

Ms. Nicole Loreto: Again, a lot of individual physicians, just because of some of the work that they're doing in the shelters, so there's a lot of existing coordination. We're also trying to bring in some new tools, common tools, in terms of assessing needs and requirements in terms of where we could best serve the patients. But that would be generally—it's our physicians on a day-to-day basis, depending on the client. Particularly our community ACT teams, because they're out in the community, will interface a lot with public health.

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

Ms. Nicole Loreto: Thank you very much.

CHAMPLAIN MATERNAL NEWBORN REGIONAL PROGRAM

The Chair (Mr. Ernie Hardeman): Our next presenter is Marie-Josée Trépanier from the Champlain Maternal Newborn Regional Program. Thank you very much for coming in. As you're getting set up, we'll set the ground rules for your presentation. 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 over, we'll have questions from the committee. Your time won't start until you put the first picture on the screen.

Ms. Marie-Josée Trépanier: Okay.

The Chair (Mr. Ernie Hardeman): I usually say, "It starts now," but I didn't want to do that. That's not fair.

Ms. Marie-Josée Trépanier: I don't mind starting.

The Chair (Mr. Ernie Hardeman): Okay, very good. The next 15 minutes are yours to use any way you see fit. The clock is starting to tick.

Ms. Marie-Josée Trépanier: Okay. Bonjour. Merci de m'accueillir. Mon nom est Marie-Josée Trépanier. I'm from the Champlain Maternal Newborn Regional Program, going from mental health to care of moms and babies in our region. I'm pleased to be here to just give you an overview of our program and what we're up to and what we've been achieving over the past few years.

Our program has actually been in existence as a regional maternal newborn integrated program since the early 1980s by a visionary called Patricia Niday, who thought about and knew about the vision of having the planning for moms and babies at the regional level. Since the creation of the LHINs, we became more official under the Champlain LHIN.

You have my presentation. Hopefully, the writing is large enough.

Historically, since the early 1980s, we've actually worked very closely with the South East as well, so that's why we're including the South East and the Champlain. Although our name is Champlain Maternal Newborn Regional Program, we do work very closely with the South East.

Our name changed over the years. In 2010, we became the Champlain Maternal Newborn Regional Program when it became incorporated within the Champlain LHIN officially, with the integration decision.

Who we work with is the tertiary care hospitals in Ottawa—CHEO and TOH—as well as Kingston General Hospital; the large community hospitals; the eight small community hospitals in both Champlain and South East; the six regional public health units; the 11 midwifery practices; the 12 primary care community health centres; the two universities; and various other community agencies that have anything to do with the care of mothers and babies during pregnancy, during birth, and after, in the postpartum.

Interjection.

Ms. Marie-Josée Trépanier: Oh, is it there? Sorry, I'm just going to take a second here.

The goal of our program is, obviously, to improve maternal newborn care through the integration of patient-focused planning at the regional level. This is to improve the health of moms and babies. This is the start of life; this is the start of health. We truly believe in the importance of setting the stage for newborns, through the health of their mother and their family.

We want to improve appropriate, timely access to standardized and high-quality care and promote more effective, efficient management and coordination of services. This is done through everyone working together.

Did you find it?

Interjection.

Ms. Marie-Josée Trépanier: Sorry for the interruption.

We also work very closely with the universities. We want to establish a strong academic health program to be a major resource for education, learning and research, and work closely with the heads of the departments of obstetrics and gynecology and of pediatrics.

Interjection.

Ms. Marie-Josée Trépanier: Is it possible that it's not advancing yet? Okay, it's stuck here. Well, we can keep going with this.

We want to become a program of excellence to compete in the global market, to address an anticipated shortage of trained professionals, and we want to have exceptional people who can be recruited and retained within our program of excellence. We're actually quite unique in the province of Ontario as an integrated regional program, and we're often cited as an exemplar program in a community of practice networks.

I'm just going to go ahead here. Over the years, when we became CMNRP, there was a large group, hundreds of professionals, who got together over many, many months to create A Blueprint for Healthy Mothers, Healthy Babies, Healthy Future, and became the CMNRP that we know now. That was published in November 2009. A copy of that would be on the Champlain LHIN's website as well as our website.

In September 2010, the Champlain LHIN announced the appointment of our program's leadership team, with myself as regional director. I'm replacing someone who was in that role previously. Our medical lead for obstetrics and gynecology is currently Dr. Mark Walker, and the medical lead for newborn care is Dr. Thierry Lacaze. They're from the Ottawa Hospital as well as CHEO.

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Our program hosts a secretariat, and it's managed administratively within CHEO's infrastructure with, other than myself, five perinatal nursing consultants, both in Kingston and in Ottawa. We also now have neonatal nurse practitioners who provide services in the level 2 and level 3 neonatal units in our region, one project manager who is working on a capital project at the moment, and administrative assistants.

The next slide is going to be very busy, so I apologize. I'd be happy to forward you the full version. I meant to bring copies of that.

Just to see how we work very closely with the LHIN, you can see here in the middle that the leadership team works under the network, which works as a council, which is right under the Champlain LHIN. Some of the maternal newborn health service providers are funders, and the maternal newborn partners are all the health care professionals who provide services to mothers and newborns in the region. We have the program staff. We have developed quite a strong, solid structure of committees that ensures full participation of health care providers across our region, working on the various projects that we have going. We have a steering committee, but I'll come back to that. We have joint capital planning, which is looking at planning of infrastructure for care of mothers and newborns in our region. We have quality and performance management, which looks at data, monitoring that so we can improve care and services; interprofessional education and research; and a family advisory committee that provides advice on all the planning that goes on. The chairs of those committees make up a steering committee that reports back to the network. And we have various subcommittees: breastfeeding, research, joint orientation, education strategies etc. As you can see, there are a lot of committees and subcommittees, but it's all about working together with interprofessional groups.

I'll just go through many of the ongoing activities of our program, from conferences to workshops, courses at the university and Algonquin, and skills days.

We have telehealth sessions across the province, and those are through OTN.

We do annual visits to our partner hospitals. Just so you understand, we, as a leadership team, visit every hospital in our region to talk to them about how they're doing, their data, their key performance indicators, and provide advice and training as required. We do this every year. We provide consultation, design policies, procedures and guidelines, and we publish a newsletter, as well as communicate to keep all of our partners in line with what we're doing.

These are our three neonatal nurse practitioners providing care to very sick and unstable newborns in our level 2 and level 3 neonatal units.

Just a very quick overview of our main accomplishments: This year we have created our very first regional report, which is unique, again, to our region of Champlain and the southeast, around key performance indicators for our partners, and we share that with them so they can see how they measure up against similar hospitals in the province.

We have undertaken a very specific initiative around Caesarean section rates and have achieved a reduction. We're one of the only regions in the province where we've seen a significant reduction in Caesarean section rates in a particular population.

We're looking at tracking and monitoring a newborn-bed availability tool to help us have babies born at the right place at the right time and moved between units so that we're ensuring effectiveness—benchmarking as well, and some other guidelines that we've been working on.

We've also been working on research from a regional perspective. Breastfeeding is going to be very high on the ministry's radar, coming up. There are some big initiatives coming down from the provincial level that we are very much in line with.

The family advisory committee is very active in looking at everything else we're doing at the regional level and giving us their input. That's a large committee of about 20, and half of those are actually family advisers and looking at our initiatives.

The joint capital planning committee has been active since the blueprint was published a few years ago in looking at amalgamating some of our hospital maternal newborn care from five sites currently in Ottawa into three. You can imagine the significance of working together, those five organizations, and planning together to ensure that a new maternal newborn centre is built

down the road in a few years, but making sure that all the master plans occur at the same time or are lined up so that we can maximize the effectiveness of maternal newborn services in our region.

We've worked together for a few years now. What we want to do is build a state-of-the-art tertiary care centre that integrates obstetrical and neonatal programs. Right now, they're divided up between three sites in Ottawa. We believe that bringing them all together will enhance the effectiveness of the care and the planning.

The last little bit I'll tell you about: The most recent announcement in Ottawa is the building of a stand-alone midwifery-led birth centre. CMNRP was involved in the application process as well as the development, working closely with our midwifery groups. We were successful in being designated as one of the two pilot sites in Ontario. We're pleased that it actually opened last week, and the first baby was born on the weekend. We're excited about this project and the fact that CMNRP was able to work closely with our partners to make it a successful initiative.

Is there time for questions?

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

Mrs. Christine Elliott: Thank you very much for your presentation. My question just relates to the role that the LHINs have played in the development of your program, since you have been around since the 1980s. Can you tell us what the difference has been since the LHINs were implemented several years ago?

Ms. Marie-Josée Trépanier: Since the LHIN—the program didn't have that structure at the regional level, although it was kind of an understanding that we would all work together. But now it's much more formal, and we do have LHIN representation at the network level as well as some of our committees. At the quality performance committee, we have a LHIN representative, as well as at joint capital planning.

The Champlain LHIN CEO works very closely with the other CEOs, especially around the capital planning, and was instrumental in recruiting our medical leads. They're providing funding for the medical leads as well as for the new neonatal nurse practitioners that we have on board now. So their support has been instrumental.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That does conclude the time. We thank you very much for coming out and making the presentation.

Ms. Marie-Josée Trépanier: You're welcome.

The Chair (Mr. Ernie Hardeman): With that, I believe that concludes all the delegations that came today. We thank, first of all, all the presenters, and we thank the committee for your indulgence. We hope that with your visit during the lunch hour to other attractions in the village, you didn't have to suffer much this afternoon to get through the meeting.

With that, the committee stands adjourned, to meet again tomorrow morning at 9 o'clock in the city of Kingston. We stand adjourned.

The committee adjourned at 1529.

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