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Official Report of Debates (Hansard)

M-14

Standing Committee on the Legislative Assembly

Connecting People to Home and Community Care Act, 2020

1st Session
42nd Parliament

Wednesday 17 June 2020

Chair: Kaleed Rasheed
Clerk: Valerie Quioc Lim

Journal des débats (Hansard)

M-14

Comité permanent de l'Assemblée législative

Loi de 2020 pour connecter la population aux services de soins à domicile et en milieu communautaire

1re session
42e législature

Mercredi 17 juin 2020

Président : Kaleed Rasheed
Greffière : Valerie Quioc Lim

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Wednesday 17 June 2020

Mercredi 17 juin 2020

The committee met at 0900 in room 151 and by video conference.

CONNECTING PEOPLE TO HOME AND COMMUNITY CARE ACT, 2020

LOI DE 2020 POUR CONNECTER LA POPULATION AUX SERVICES DE SOINS À DOMICILE ET EN MILIEU COMMUNAUTAIRE

Consideration of the following bill:

Bill 175, An Act to amend and repeal various Acts respecting home care and community services / Projet de loi 175, Loi modifiant et abrogeant diverses lois en ce qui concerne les services de soins à domicile et en milieu communautaire.

The Chair (Mr. Kaleed Rasheed): Good morning, everyone. I will call this meeting to order. We are meeting to conduct public hearings on Bill 175, An Act to amend and repeal various Acts respecting home care and community services. Today's proceedings will be available on the Legislative Assembly's website and television channel.

We have the following members in the room: MPP John Fraser, MPP Robin Martin, MPP Jim McDonell. The following members are participating remotely: MPP Sam Oosterhoff, MPP Teresa Armstrong—she's joining us via phone—Madame Gélinas and MPP Joel Harden.

Interjection.

The Chair (Mr. Kaleed Rasheed): MPP Logan Kanapathi, can you please confirm the city and the province you're joining from?

Mr. Logan Kanapathi: Yes, good morning. I'm joining from the city of Markham, Ontario. Thank you, Chair.

The Chair (Mr. Kaleed Rasheed): Thank you.

Interjection.

The Chair (Mr. Kaleed Rasheed): MPP Christina Mitas, if you can please confirm the city and the province you are joining from.

Miss Christina Maria Mitas: Hi, I'm joining from Toronto, Ontario.

The Chair (Mr. Kaleed Rasheed): Thank you very much.

MPP Donna Skelly, are you on as well, too? MPP Donna Skelly, your mike is open. I just wanted to confirm if—

Interjection.

The Chair (Mr. Kaleed Rasheed): Okay, we'll come back later then. Okay, thank you.

We are also joined by staff from legislative research, Hansard, interpretation, and broadcast and recording.

To make sure that everyone can understand what is going on, it is important that all participants speak slowly and clearly. Please wait until I recognize you before starting to speak. Since it could take a little time for your audio and video to come up after I recognize you, please take a brief pause before beginning.

As always, all comments by members and witnesses should go through the Chair.

Are there any questions before we begin?

CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION

ONTARIO FEDERATION OF INDIGENOUS FRIENDSHIP CENTRES

ONTARIO HEALTH COALITION, GUELPH WELLINGTON CHAPTER

The Chair (Mr. Kaleed Rasheed): Seeing none, I will now call on Canadian Mental Health Association, Ontario Division. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin. Thank you.

Ms. Camille Quenneville: Good morning, Mr. Chairman and members of the committee. My name is Camille Quenneville. I'm the CEO of the Canadian Mental Health Association, Ontario Division. I want to thank all of you for this opportunity to present our perspective on Bill 175, Connecting People to Home and Community Care Act, 2020.

I also want to just take a moment and acknowledge that these are unprecedented times, and I want to thank all members of the committee and the staff in the Legislative Assembly for making this happen today in these extraordinary circumstances. We're very grateful, as an organization, to have this opportunity.

Our comments will focus predominantly on schedule 1 of this bill, which is focused on updates to the Connecting Care Act, 2019.

Founded in 1952, CMHA Ontario and our 28 local branches are part of the community-based mental health and addiction sector, which serves approximately 500,000 Ontarians annually. CMHA Ontario actively contributes

to health systems development by recommending policy options to improve the lives of all Ontarians. Through leadership, collaboration and the continual pursuit of excellence in community-based mental health and addiction services, CMHA works to achieve the vision of a society that embraces and invests in the mental health of all people. This perspective informs our comments and recommendations on Bill 175.

Community-based mental health is defined as care provided outside of the hospital setting. It includes services and supports provided across the continuum of care, including health promotion, illness prevention, treatment and recovery. It includes not only treatment and crisis response, but also outreach, case management and related services such as housing and employment supports and court diversion programs. Community-based mental health and substance use care identifies the importance of communities in supporting recovery. This philosophy is supported by the fact that individuals receiving care generally prefer to do so within their community, and that for most individuals, formal mental health services are just one piece of the treatment puzzle.

Community-based mental health and addiction agencies such as CMHA are integral components to ending hallway medicine and relieving the pressure on hospital emergency departments and in-patient care, as well as the criminal justice and social service systems. The CMHA branches across Ontario offer holistic approaches to care, where clients receive appropriate clinical services, as well as supports in areas such as housing and employment, to address the social determinants of health.

Community mental health and addiction agencies are an essential component of the community-based care that must be considered in every health policy decision, and Bill 175, in the creation of Ontario health teams, allows our CMHAs to embed this type of thinking into new plans for local health care. That's because many CMHA services are offered in partnership with other service providers and with multiple government ministries. So it didn't come as a surprise to anyone in our organization when we learned that our branch partners were key in Ontario health teams as they were formed across the province.

A key focus of CMHA's work within Ontario health teams is to address the needs of Ontarians living with substance use and addictions conditions, offering harm-reduction programs, rapid access to addiction medicine, withdrawal management, and other treatment services and supports. One significant challenge that CMHAs are facing is the geographic boundaries of the Ontario health teams. CMHAs are regional service providers, and as such, each branch is being asked to be part of multiple Ontario health teams. Being part of multiple OHTs may have the unintended consequence of dividing the existing integrated care delivery in each branch region. In spite of this boundary issue, we remain pleased that OHTs are placing a significant focus on mental health and addiction care locally.

Layered on top of the local service delivery piece is the Mental Health and Addictions Centre of Excellence within Ontario Health, another development we're happy to support. As recommended by the Select Committee on Mental Health and Addictions a decade ago, Ontarians deserve provincial leadership and a system-wide approach to receiving connected, accountable and high-quality mental health and addiction care. The proposed aims of the centre meet those needs well.

CMHAs recommend that the upcoming investments for the centre focus on establishing core mental health and addiction services, a comprehensive data and performance measurement strategy for the sector and quality improvement supports, especially for community-based agencies. The immediate objective of the centre should focus on establishing a core set of province-wide mental health and addiction services that provide seamless programs and support across the lifespan, from children and youth to adults and seniors. All Ontarians should have the same access to the same programs and quality of care, regardless of where they live in the province.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Camille Quenneville: Another focus should be placed on increasing harm reduction, substance use and addictions treatment programs for Ontarians. Core services will ensure consistent treatment delivery across Ontario, reduce hospital emergency department visits, help individuals navigate the health care system, and lead to better health outcomes. The centre of excellence should prioritize building data infrastructure in our community sector. Many agencies lack capacity as well as financial and technical resources for collection. Without valid, comparable, consistent data, we cannot adequately measure performance, and without robust performance measurement indicators, we cannot fully understand gaps in performance or how to improve quality of care.

These metrics are important for provincial accountability. Local data is instrumental for knowing how we're performing within a region, but without robust provincial data, we cannot know how we're performing as a province-wide system. Quality improvement initiatives cannot succeed without this necessary data infrastructure, and we need investments for that.

Mr. Chair, this concludes my remarks to the standing committee. Thank you for this opportunity, and I look forward to the questions.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentation this morning.

I will now call on the Ontario Federation of Indigenous Friendship Centres. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin. Thank you.

Ms. Jennifer Dockstader: Good morning. My name is Jennifer Dockstader. I'm the vice-president of the Ontario Federation of Indigenous Friendship Centres.

I'd like to start by acknowledging that while this meeting is taking place virtually, we are on the treaty territory of the Mississaugas of the Credit First Nation, as well as the ancestral and traditional lands of the Anishinaabe, Haudenosaunee and Huron-Wendat nations.

0910

I'd like to thank the Standing Committee on the Legislative Assembly for inviting the OFIFC to speak on Bill 175. Today, I will be providing an overview of the implications of Bill 175 on urban Indigenous home and community care as delivered by the OFIFC.

Ontario is home to the largest population of Indigenous people in Canada, with 374,395 Indigenous people living in the province. According to the 2016 Canadian census, approximately 85.5% of Indigenous people in Ontario live off-reserve and 57% of the total Indigenous population in Ontario lives in towns or cities with a friendship centre.

The friendship centres are dynamic, culturally based community hubs where Indigenous people living in urban and rural areas can access culturally based programs and services every day. They exist as an expression of the urban Indigenous people's self-determination and their responsibilities to one another as communities based on reciprocity. We represent the most significant off-reserve Indigenous service infrastructure in Ontario and are dedicated to achieving greater participation for all urban Indigenous people in all facets of society, inclusive of First Nations, status/non-status, Métis, Inuit and all other people who identify as Indigenous.

We have 20 years of experience delivering culturally based home and community care programs to the urban Indigenous population through our Life Long Care Program. This program has 48 Life Long Care workers across 26 sites all across the province providing program supports, including congregate dining, home maintenance, caregiver supports, adult day services, medical transportation, friendly visiting, security checks and Indigenous cultural supports. Because of our services, the elderly, frail, physically disabled, those living with cognitive impairments or chronically ill are able to participate in the social aspects of the local community, living independently for longer periods of time and enjoying an improved quality of life. The Life Long Care workers have earned the trust of the clients and the community and are able to help them manage their health and introduce health promotion activities and concepts.

Life Long Care also works collaboratively with local organizations to address service gaps. Relationship building and cultural awareness with mainstream agencies is an ongoing provincial and local priority of the Life Long Care Program.

With the introduction of this bill, we're well into the Ontario health transformation with staged transitions of home care and community services into Ontario Health, Ontario health teams and the local health integration networks. It is imperative that the legislation and regulations maintain at the forefront the intention to improve the health outcomes and front-line experiences of the urban Indigenous population.

We submitted a document that outlines our full position on the bill and its proposed regulations. Today, we will be focusing on three areas: the recognition of urban Indigenous communities and organizations, health equity and partnership.

We are concerned with the direction of Ontario's relationship with Indigenous people, as expressed through communication about Bill 175. Specifically, the Ministry of Health references maintaining the government-to-government relationships with Indigenous communities in the delivery of home and community care services. The government-to-government approach does not recognize the overwhelming majority of Ontario Indigenous people who live in urban communities and are served by urban Indigenous organizations like us, providing culturally based and community care services.

As Ontario moves forward with legislated policy change, we need to be included in the community care system across all levels of government, and that means that we're actively including the urban Indigenous community and people and service providers in all strategies, initiatives and mechanisms that impact Indigenous health in Ontario. The failure to do so would mean not only driving up inefficiencies and costly end goals, it would also misalign with ethical responsibilities to Indigenous people living in Ontario.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Jennifer Dockstader: We recommend that Ontario broaden its direction to build relationships with all Indigenous partners, programs and policies and that we be included in the home and community care modernization with urban Indigenous people.

We like the language of the preamble of The People's Health Care Act used in Bill 175 that states, "The people of Ontario and their government ... recognize the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities."

There is also no provision on health equity to improve access to care, quality of care or health outcomes.

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Jennifer Dockstader: An internal survey of the Life Long Care Program found that the urban Indigenous people and friendship centres lacked quality cultural competency and partnership engagement, that it's inconsistent in its service delivery and extensive wait-lists, and that there were impediments to accessing home and community care.

There isn't much time left, but we are asking that we be included at all levels of discussion. We believe that that will raise the efficiency of what is being produced in this field, and we look forward to being included. Thank you.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentation this morning.

I will now call on the Ontario Health Coalition, Guelph Wellington chapter. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Magee McGuire: Good morning. My name is Magee McGuire. While I chair the local chapter of the Ontario Health Coalition, I am also an RN of 37 years, working in very many venues, including critical care and community care. I also have taken on a leadership role in the community and coordinate many grassroots communities. I receive a lot of information and disseminate it through a market boost.

I say good morning to my fellow presenters and members of Ontario Parliament. COVID-19 compounded what I already knew: the sad testimonial to many dysfunctional long-term-care homes, where some residents already experience neglect, abuse and rationing of essential personal care, whose families watched them die alone and prompted me to speak today.

Listening to Premier Ford, I was convinced that his need to rush through a compassionate, client-centred bill came from the heart; however, I am shocked because many of the solutions already enshrined in laws that actually helped to put the patient or resident at the centre of care have been removed in Bill 175.

For example, the bill of rights and the power of the minister to enforce is gone. A complaints process which could interface with the office of the Ombudsman is missing. There needs to be a set of performance indicators for every provider that could alert the government to establish a needed oversight, not just define it. There is a need for a wait-list, not a refusal of service. Any new legislation must include standards of care, giving reasonable hours of care to each patient, as recommended by the Registered Nurses' Association of Ontario, the best-practice leader in the world—and nutritious food without rationing.

To achieve excellence, knowledgeable information improves outcomes. Collaboration is what pools knowledge and brings people into the flow.

Now, I'm going to digress for a minute to use an example from the insurance industry. For the fiscally prudent MPP, there is an article, "Lessons for Ontario," on the international platform Comparing Health Systems. Some suggestions were about what to improve and some were guides to show us how to maintain important elements.

0920

For medically necessary services, it states that inequity in access occurs for publicly and privately insured patients. Private insurance does increase health care cost by providing higher payment to existing private hospitals and physicians, not including administrative cost, and it does not reduce wait times for publicly insured patients, which it professed to do. When pharmacare is enabled, the good news is it will allow employers to off-load insurance costs and stream that money into industrial competitiveness.

I'd like to apply that to long-term-care homes. Most are privately owned. We are not building capacity, but the population needs are growing. Wait lines stand at around 4,000, and in this paper it seems like nobody wants to know about this.

So how do we keep people content to stay home? This article would suggest a better use of e-communication to unify that group. I suggest a refocus of home care to first develop a measurement model and collect information via e-consultation across Ontario. An example is already in place for hospital wait-times in the Champlain LHIN. It would allow patients to follow their care plan and connect patients with similar needs.

For example, falls hospitalize seniors in staggering numbers. A whole e-program to strengthen seniors could be in place during the wait, before they break.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Magee McGuire: Education in nutrition and occupational support can be given. Mood disorders and psychological disorders have shown in Britain to be effectively administrated in this way.

Regulations have a place but should not be the sole consideration in an unpredictable health care setting. Our elders paid for this system and they have experienced authoritarian attitudes of health insurance companies in the 1950s, copay in the 1960s and the Canada Health Act in 1984, chaired by Conservative Madame Bégin. Their stories are being repeated here today. I see nothing to be proud of. I see no evidence that the principles of the Canada Health Act, endorsed by the Romanow commission of 2003, have been written into this legislation.

Do not throw the baby out with the bathwater. Bill 175 is the same old, and worse. Please take this back to the table. It's not good enough.

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Magee McGuire: Thank you very much.

The Chair (Mr. Kaleed Rasheed): Thank you so much for your presentation this morning.

Interjection.

The Chair (Mr. Kaleed Rasheed): Sorry, MPP Fraser, do you—

Mr. John Fraser: Sorry, I was asking about the rotation.

The Chair (Mr. Kaleed Rasheed): Oh, okay. You're number two.

Mr. John Fraser: Perfect.

The Chair (Mr. Kaleed Rasheed): Thank you.

MPP Donna Skelly, can you please confirm the city and the province you are calling from?

Interjection.

The Chair (Mr. Kaleed Rasheed): She's gone? Okay, awesome.

Perfect, we are now going to start the question session. The first round will go to the opposition side. It's MPP Teresa Armstrong. Please go ahead.

Ms. Teresa J. Armstrong: Good morning, everyone, and thank you to the presenters for being here this morning. I first wanted to ask the Canadian Mental Health Association, Ontario if you were consulted on Bill 175.

Ms. Camille Quenneville: Thank you for the question. Forgive me, I'm going back—I don't think there was a formal consultation, if I recall correctly; I think there were conversations at that time. But I would say, no, there wasn't a formal consultation.

Ms. Teresa J. Armstrong: Going forward, are you confident that you will be contacted and be able to have a formal consultation? You went at length describing the centre of excellence and the importance of it. Do you think that that should be something that you should have access to: government representatives to have a formal discussion and basically illustrate the importance of the information you're referring to?

Ms. Camille Quenneville: That's a really terrific question. I can tell you that we're not generally very shy in sharing our opinion with government. We've had the good fortune of having the opportunity on several occasions to raise our viewpoint about what the centre should focus on. We've done that face to face with Minister Elliott, and I know from her time 10 years ago on the select committee—I understood where she envisioned the system from that time. I happened to work in child and youth mental health at that time, and I was an active part of the select committee process 10 years ago.

With that in mind, we did speak to the minister, I would say, on more than one occasion. We've subsequently been very close to the individuals who have been, on an interim basis, managing the centre of excellence, and we have also shared with them our desire to see rigorous data collection and a renewed focus on the infrastructure needed to do so, on quality improvement and performance measures. I outlined in my brief the importance of that to ensure that the system is always delivering the highest-quality care possible. I can tell you that my colleagues have actually asked for this. This would not be something that's imposed on them. They fundamentally believe this is a core component of who they are, in wanting to deliver the very best care.

And then last but certainly not least is ensuring that there is a consistent set of core services across the province in terms of what is being delivered in every community, so that whether you are in Windsor or Belleville, if you are presenting with a certain mental health or addiction issue, you can expect, and in fact demand, the same level of care across the province.

Ms. Teresa J. Armstrong: The core services that you're referring to: Are they anywhere in the bill? Is there a reference in Bill 175 to ensure that there's a core basket of standard services for people? Have you seen that or read that anywhere in the bill?

Ms. Camille Quenneville: No, I have not. Again, in our conversations—to your point, I will tell you—with the minister and others with the centre, obviously not on public record, but certainly very thoughtful conversations that we've been having back and forth, we have pressed for those three priorities. We haven't had any, I would use the words "pushback" or "lack of agreement" that those are really going to be very key to improving the overall infrastructure of the system, which I think we can all agree has for far too long been underfunded and not kept up with the broader health sector.

Ms. Teresa J. Armstrong: Thank you very much.

My next question is to Jennifer Dockstader, the VP of the Ontario Federation of Indigenous Friendship Centres. Ms. Dockstader, were you consulted, was the Ontario Federation of Indigenous Friendship Centres consulted on Bill 175?

Ms. Jennifer Dockstader: No, and we were actually a little bit disappointed, given that we have such a long history of providing home and community care. But we believe that there's still time to rectify that. Come and talk to us. We believe that meeting the needs of the urban Indigenous community is critically important—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Jennifer Dockstader: —given the health disparities that exist for Indigenous people.

Ms. Teresa J. Armstrong: So do you feel confident that—I mean, you like the preamble; they are mentioning having Indigenous services and respecting that. But do you feel confident that the process that they are going to engage in will actually meet the standards of their preamble or be true to what their preamble states?

Ms. Jennifer Dockstader: Well, again, as I've stated before, part of the issue is the nation-to-nation relationships. It leaves out the urban Indigenous community, and again, it's the urban Indigenous service providers, of which we are the largest provider of services for the urban Indigenous community. So it can't just be nation to nation; it also has to be inclusive of the OFIFC. It only makes sense, for efficiency's sake.

Ms. Teresa J. Armstrong: The fact that you weren't consulted prior to, and now they're rushing it through and we are in the midst of a pandemic—are you confident that they will reach out to you and get you to have a consultation basis and hear your concerns?

Ms. Jennifer Dockstader: I certainly hope so.

Ms. Teresa J. Armstrong: Okay. How much time do I have, Chair?

The Chair (Mr. Kaleed Rasheed): About 40 seconds.

Ms. Teresa J. Armstrong: To the Ontario Health Coalition, Guelph Wellington, I just want to say thank you to registered nurse Magee McGuire for her seven years of experience. If you want to add anything in the last few moments we have, please feel free to add anything that you didn't get in your presentation.

0930

Ms. Magee McGuire: I have been a nurse for over 37 years and I have seen a lot. In my mind, what prompted this Bill 175 to be rushed through was the need for priorities like long-term care and fundamental issues of home care, which are core to running—

The Chair (Mr. Kaleed Rasheed): Thank you very much, and apologies to cut you off.

Now, we are going to move to the independent member. MPP Fraser, please go ahead.

Mr. John Fraser: Great. Did you want to finish up, Ms. McGuire? Is there anything else you wanted to say?

Ms. Magee McGuire: I did not address—sorry—

Mr. John Fraser: Maybe we'll come back in the next round.

Ms. Magee McGuire: I'm sorry. Carry on.

Mr. John Fraser: Not to worry; it's okay. You probably weren't expecting that. I just wanted to make sure you had the opportunity.

Thank you to all the presenters for being here today. I very much appreciate your efforts, your presentations and all the work that you're doing inside your communities.

My first question is for Ms. Quenneville—Camille—who I have known for a long time. Thank you very much for being here. I want to get some context here because COVID-19 has put a lot of pressure on mental health and mental health agencies across Ontario. Could you take

about a minute or so to say the challenges that you have, that you had—the ones you would be able to resolve and maybe the challenges that are ahead of you right now?

Ms. Camille Quenneville: Thank you for the opportunity. I think you're quite right, there has even been a fair bit of media coverage about this, frankly, some generated by us, because we did some public opinion polling on this. We were deeply concerned that, in addition to anxiety and depression, as a result of the long periods of self-isolation, that in fact people were self-medicating through substance use. We have really understood that alcohol use has increased dramatically. Very unfortunately, the rate of overdose deaths has also spiked considerably over the last several months, one could argue directly related to the supply chain, which has changed through COVID-19. So there are some very, very significant societal issues that, frankly, won't go away overnight, even when we start to go back to our regular routines. I'm very, very concerned on the substance abuse side.

We're currently undertaking a very in-depth study on the issue of loneliness, in particular, which, if you can imagine, we actually started before the pandemic. We are looking at an international review of the latest research on loneliness and the impact of that on your mental health, which is obviously very apropos right now.

Our ability to serve people—I'm exceptionally proud of my colleagues in my branches, who maintained 94% of service delivery throughout the pandemic. We provided PPE to them so they could do so. We also were happy to support them in any way we could, helping them move to virtual platforms, where that was necessary for them to continue to see clients.

I can assure you that our BounceBack program, which is part of the province's Mindability structured psychotherapy program, has had a significant increase, despite the fact that most referrals for that generally come through primary care, and that has not been an option for most people throughout the pandemic. So clearly people are recognizing that they are struggling and reaching out, and we're doing our level best to make that as easy as we can for them.

It's extremely concerning. We have research that shows that the fourth wave of this, if you will, is mental health, and it is the last wave, and we have seen that. Although my colleagues in this sector and I have had many conversations about that, we don't feel there's a wave coming. We feel we're in a wave right now and that people are absolutely struggling right now. Keep in mind that many people will not go back to resume the life that they know. They've lost their job. They are economically disenfranchised etc. So we have a long way to go here.

Mr. John Fraser: Thank you for the work that you're doing. It's a bit overwhelming, I know, having talked to different people in the field and colleagues in Ottawa. One of the concerns I have about us going forward with this bill right now is that we're actually in the middle of a pandemic, where we have agencies and organizations—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. John Fraser: —that are having really serious challenges just coping with what's going on right now. I'm just concerned that this is something that requires some deliberation and thought. There are things that are being removed from legislation and put into regulation that really should be something we're debating here. It's a big concern.

I'm going to lead up to the next round of questions with this statement, and then I won't ask a question. I'll just go forward, Chair.

As Ms. Dockstader very aptly and correctly indicated, the preamble in the bill is important. It's a signal of intent, but it essentially has no effect in law, right? It's kind of, "Here are the nice things we're going to say about what we want to do," and inside the bill is actually the stuff that we intend to do—

The Chair (Mr. Kaleed Rasheed): One minute.

Mr. John Fraser: —that we, basically—I won't say we engrave it in granite, but we make it pretty solid. That's what I want to talk about in my next round of questions: How do we make this permanent and solid and not easily changeable? I'll leave it at that.

The Chair (Mr. Kaleed Rasheed): We are now going to move to the government side, I believe to MPP Martin. Please go ahead.

Mrs. Robin Martin: Thank you all for your presentations. I listened carefully to what you had to say and I want to thank you for bringing your perspectives here today.

My understanding is that the Ontario Federation of Indigenous Friendship Centres did participate in a briefing by the ministry on home and community care modernization, and obviously we are still looking forward to having input from all of you on the regulations going forward. They've passed the 60-day public comment period, but we're still seeking more input, and we had posted the summary of regulations when we tabled the bill on February 14. We look forward to engaging further on that. That, frankly, is where the substance is, because this is an enabling piece of legislation. The substance of the details will all be in the regulations, and we certainly do want to hear from you on that.

My question is going to be for Ms. Quenneville of the CMHA. I noted that you talked about the importance of data for provincial accountability. I think we all agree on that. I know Steve Lurie, who is in my riding at the CMHA local there, is a big data fanatic and overwhelms me every time I meet him with all the data on mental health. You mentioned that your branch partners—I think you're one of the community organizations that is longest-standing and most ever-present around the province—are working with the Ontario health teams, and how this kind of legislation will help ensure that community mental health is integrated with health care, which is one of our big objectives.

Ms. Camille Quenneville: Thank you for the question. I have two comments before I get into the meat of that. The first is that, yes, Steve Lurie is a walking encyclopedia, has been with our organization for 40-plus years and is really quite a treasure. And you're right: The

Canadian Mental Health Association is in fact Canada's oldest nationwide health charity, at 101 this year, so we have what I would say is a very proud history across Canada.

To answer your question: My colleagues across the province have engaged very directly in Ontario health teams. As you know, many that are proceeding have identified mental health and addictions as their priority. That is, I would argue, in no small measure through the advocacy of my colleagues, who really want to improve mental health and allow for addiction support for citizens in their community, and a recognition by those health providers of the importance of that to the overall health of their community, as well. That has been a very positive thing, I would say, to have a spotlight in those areas of the province where it is prioritized.

Where it isn't prioritized, I would say that my colleagues continue to work very well with their sector partners. As I said in response to a different question, we're not shy and we do try to appropriately insert ourselves into tables where it makes sense and to press for more and better support for our clients and their care.

0940

I could go on, but if you want to pose a different question or—

Mrs. Robin Martin: Thank you, Ms. Quenneville.

Ms. Camille Quenneville: I'll take your guidance.

Mrs. Robin Martin: Thank you. I'm going to pass to my colleague Ms. Mitas.

The Chair (Mr. Kaleed Rasheed): MPP Mitas, please go ahead.

Miss Christina Maria Mitas: Hi, everyone. Thank you. And Camille, my question is also for you. Thank you to all of the speakers as well. I will first say that we've had, I believe, 41 individual speakers and organizations present to our committee, which I think is an unprecedented number. So there's a lot of interest here, and it's really great to hear from so many people.

My question is, you also mentioned improving performance metrics in regard to local data collection, which I think is so very important. I was wondering if you could tell us how Bill 175 will assist you with this data collection and what that will mean for the community?

Ms. Camille Quenneville: Well, let me just explain what we're talking about in terms of the particulars of that. We currently work with our partners at Ontario Health and our sector partner, Addictions and Mental Health Ontario, in a program called Excellence through Quality Improvement or E-QIP for short. What we have essentially done through this relationship is, we have provided both quality improvement in data coaching on site in all community-based organizations across Ontario to help put them at the starting line of building the metrics that will help to allow us to look at data and understand what's happening in real time in terms of how we're serving clients.

All of the things that we take for granted in the physical health world, we're trying to get there, and we believe that only through more rigorous data collection and better performance metrics and better quality improvement processes can we go to government and say, "Here's what's happening across the system. Here's what we understand to be the case today. Here's how we believe we can improve it, and here's how we think that can happen." There's nothing dissuading us from that bill. The centre of excellence, we believe, should host that and work with us in a continual way to make sure that that happens.

Miss Christina Maria Mitas: Great. Thank you very much, and I'll pass it on to MPP Kanapathi.

The Chair (Mr. Kaleed Rasheed): Thank you very much.

MPP Kanapathi, you have just over 30 seconds.

Mr. Logan Kanapathi: Okay. In 30 seconds I can't make any comment. Thank you, everyone, for your presentation and comments.

I ask Camille—I know you're passionate about mental health. My wife and I spoke about—she's a family medical doctor dealing with a diverse community and diverse patients in Markham and in York region. You mentioned about geographical challenges you have when you're dealing with mental health. Could you elaborate on that, please?

The Chair (Mr. Kaleed Rasheed): Sorry. My sincere apologies to cut you off. The toughest part of this job is to cut people off.

Next round we will start with the independent member. MPP Fraser, please go ahead.

Mr. John Fraser: Thank you very much, Chair, and I'll go back to my last statement with regard to the importance of having some things in the force of law in legislation and not in regulation, which is easily changeable and not debatable. Consultation is incredibly important—no question about that. The ability of the people who represent the people of Ontario to debate these things is critical.

What's happening inside this legislation right now is that a number of things are actually being taken out of the legislation and put into regulation with a posting of potential and some broad descriptions of what they want to do inside that regulation. That's all well and good in its intent. The reality is that can change any time after that legislation has been passed, any time they decide to change that, that another government decides to change that, remove something, take something in, take it right out, eliminate the regulation. One of the critical things is a consumer or a patient bill of rights which is now being taken out of the legislation and put into regulation.

I guess the questions I have for the presenters—and we'll start with Ms. Dockstader, then Ms. McGuire and then Ms. Quenneville in that order. Do you believe that the patient bill of rights or consumer bill of rights is a critical thing in this legislation? Do you think there are any things that we should be adding to that? If you could tell me those things, that would be great.

Ms. Jennifer Dockstader: I'm glad that you raised that. Unless you specifically mention issues of health equity and the specific inclusion of the urban Indigenous people, and you actually require that Ontario health teams build meaningful relationships with the urban Indigenous

community and organizations, it's not going to happen. We've got a long history of, "If it's not included, then nobody's going to do it." So my short answer is that those are the three things that are critically important: inclusion, relationship-building and actually putting it into the legislation.

Mr. John Fraser: Thank you. Ms. McGuire?

Ms. Magee McGuire: Well, when legislation is enacted, the intent is always altruistic, but frequently, it's not realistic, unless as the Canadian Mental Health Association representative—I've forgotten her name. As she explained her process for approaching the government with her data collection—I do not believe that this is going to happen when there's regulation and I do not believe that there will be good public consultation. So I am worried about all of this legislation being deleted from previous acts and being put into regulation, where it comes from the cabinet, not from the people.

I believe that democracy includes the people and all the different platforms, like the two that were represented here today—the two other ones. I mean, there are so many. I've been watching this over the three days and I observe how mammoth this responsibility is, and I admire anybody for tackling it. But we must centre on what is in common with all of us to give direction, to save money, to be firm in our approaches.

There is a lack of trust. I hear it all the time because that's my position, to listen. How are you going to gain trust when you remove people from being heard? I am very, very concerned about this regulation business.

And transparency. I have been trying to follow the money in this province—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Magee McGuire: —and I can't find the way to do it. Nobody knows anything. I even went to the federal government because they've passed money to the province, and you, as a province, have not written the letter you promised to write every year to show where that money went. It was supposed to go to mental health, we're sure, and to long-term care, we're sure. I have no idea if it ever got there. I do know a number of administrations that received money and transfers because it was in the news, and they gave themselves raises, but they still weren't able to perform the work. The CCACs got absorbed. The government finally got the message.

This has to stop, this nonsense. We've got to go back to the better parts of our models. And the front-line workers, like the nurses, the orderlies, the ambulance drivers—

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Magee McGuire: —they know where the efficiencies are. They're the smart people.

Mr. John Fraser: Thank you very much, Ms. McGuire. I'm going to give Ms. Quenneville an opportunity to answer the question as well. Thank you.

Ms. Camille Quenneville: Thank you very much for this opportunity. I think a patient bill of rights is inherently an accountability. We've talked a lot about the accountability we would like to build into the mental health and addiction sector. As a public statement, I think it's valuable for people to know what they can expect, and frankly, core service delivery is part of that.

I want to express my agreement with my colleague Ms. Dockstader around health equity. This is an area that we have tremendous concern about as it relates to the mental health of Ontarians. Frankly, a very present-day example: I'm really delighted to see a move towards collecting data and outcomes in testing around those COVID-19—

The Chair (Mr. Kaleed Rasheed): Thank you very much, and again, apologies to cut you off.

0950

We are now going to move to the government side, I believe to MPP Oosterhoff. Please go ahead.

Mr. Sam Oosterhoff: Thank you to all the presenters today. It's nice to see you all, and I really appreciate all the work that you do in your respective sectors and bringing your perspectives here before the committee. It's important that we hear from many voices across the province.

My question today is for Ms. Dockstader. It's very nice to see you. Thank you so much for coming before the committee. My question is around the fact that the preamble to the Connecting Care Act recognizes the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities.

I have a twofold question. My first question is that if this legislation passes, it's going to be bringing home and community care under the purview of the Connecting Care Act. Do you feel that Indigenous clients could benefit from having home care better integrated with other aspects of the health system and from having a role in the planning, design, delivery and evaluation of those services? And then I'm just wondering if you could speak to the importance of that in the Ontario health teams model.

Ms. Jennifer Dockstader: It's complex, what you're asking. Thank you for the question. I do think that there are great possibilities for improvement, but it has to be specifically stated to include urban Indigenous organizations. The province's stance to nation-to-nation relationships isn't really dealing with the reality on the ground for the urban Indigenous community. Again, that's where the service provision is happening within our urban Indigenous organizations.

When you leave us out of actually being a part of the process and consulting at the local level to solve local issues for the urban Indigenous community, you miss a real opportunity to really get to that health equity piece that we're talking about and to really change the health outcomes for the urban Indigenous population. Urban Indigenous people face terrible outcomes due to a bunch of systemic issues, and it's important to start to recognize this. This is an opportunity to change where we've been in the past and move forward in a better way.

Mr. Sam Oosterhoff: Okay. Thank you. I'd love to follow up and chat with you about the OHTs, perhaps offline, and how that process has gone, but I know some of my other colleagues—I believe MPP Kanapathi had a comment.

The Chair (Mr. Kaleed Rasheed): MPP Jim McDonell.

Mr. Jim McDonell: Thank you, Chair, and I want to thank everybody for coming through for the discussions, not only today but over the last three days, as we've seen probably the most delegations I've seen on any of the committees I've been on over the years.

Just to the comments before about us rushing through this legislation: This legislation was worked on last year, since we've become government. Long-term care has been a priority of ours. Really, I look back to my 2011 election, and it was a priority for our party then, where we committed to 60,000 long-term-care beds, because we knew there was an issue. We sat here 10 years later, and there was still no action, so we definitely knew that it was time to do something. We put this together before this pandemic started, and it's time we make some changes. To think that we'll wait another two years—because that's about the time people are talking about to get through this pandemic—to do anything, I think, would just be irresponsible.

The regulations have been up, and I hear talk about where the bill of rights is. We've seen it in the legislation for years with no results. I don't think anybody's happy with the current situation—at least, that's not what I've heard over the last three days. Certainly in my office at home, I have a steady stream of people coming in, not happy with the situation, so action has to be taken. This pandemic just shows us how much work is needed.

And mental health is a huge issue. We're seeing a spike in overdoses over the last few months right across this country, from Vancouver to Ottawa to Toronto. Maybe I could ask Canadian mental health, Ms. Quenneville: We've targeted a lot more money, we've doubled the money—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Jim McDonell: —that the government has been putting into mental health over the next 10 years. Have you seen some of the light at the end of the tunnel on where we're going with this?

Ms. Camille Quenneville: Well, I will tell you that it's a bit too soon to tell. I think that we are really wanting to focus where some of the future investments are going to go. You're right: This government has committed to $3.8 billion over 10 years, and we are very interested in wanting to partner in prioritizing those investments.

Thank you for your comment around concern about increasing overdose deaths. We share that concern. We are very conscious of the fact that they continue to rise and there is no solution that is—

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Camille Quenneville: —immediately presenting itself to that.

I'm happy to have a more fulsome conversation with you about needed investments. I think the initial investment around Mindability or the structured psychotherapy program is great for the mild-to-moderate population. I think we could talk about what happens to those who are more seriously ill.

Mr. Jim McDonell: I think my colleague is—

The Chair (Mr. Kaleed Rasheed): MPP Kanapathi.

Mr. Logan Kanapathi: Thank you, everyone, for your presentations and comments. I will ask the first question to Camille. I'll start with your last comments. Thank you for your great work that you do. You guys are doing a lot of great work during these challenging times aiding vulnerable and marginalized sectors in the province.

You spoke about Bill 175 allowing a reimagining of how CMHA can work with partners to deliver—

The Chair (Mr. Kaleed Rasheed): I'm so sorry, MPP Kanapathi. I have to cut you off.

We are now going to move to the opposition side. Madame Gélinas, please go ahead.

M^me^ France Gélinas: Thank you. I'd like to make a brief comment that I'm happy to see that members of the Conservative Party are happy to see that holding consultations with deputants is worthwhile. They keep saying that this is the most they've ever seen. It's because we've allocated 19 hours for that bill. Bill 74 had 300 people who wanted to speak, but they only allocated five and a half hours, so very few people could take part. I hope we all learn that there is value in getting people on the record. We learn a lot and a better law will come out of this.

My question to you is, would you like to see in the bill a provision that says that funding and delivery of home and community care services should go to a not-for-profit agency? I'll start in the order that you presented. Camille, if you want to go first.

Ms. Camille Quenneville: Generally speaking, given that we are a not-for-profit provider, we take great value in not-for-profit service delivery. I think that if there was a desire to move outside of that, we would absolutely demand very strict regulation around how those services are provided. Our preference, obviously, is the not-for-profit sector.

M^me^ France Gélinas: Thank you. Jennifer?

Ms. Jennifer Dockstader: Absolutely. We've got a 50-year history of providing services to our communities through the friendship centres. We provide efficiencies all the time, and the standards that we're held to are greater because we're not-for-profits. I think it makes better sense to put it in the not-for-profit sector.

M^me^ France Gélinas: Thank you. Ms. McGuire?

Ms. Magee McGuire: I totally agree with Camille and Jennifer. Accountability is one of the factors that government always fail in the health care sector—not all the time, but when they have been approached through NPs, they don't feel heard. Everyone has a different perspective and a different understanding, and I believe that education and understanding better is where the solution is.

But I definitely do not appreciate that my boards are filled with big business. Even though they may be so very much smarter, they are talking about the majority of people and making plans for a majority of people who are not in their positions. They have no idea how we live or how we think or how we feel.

I believe, like you say, that it's better to stay in the not-for-profit sector—if the government has to contract out, not-for-profit. In history, it's shown that it operates fairly smoothly and is sensitive to the principles of the Canada Health Act, and I am very, very keen on the Canada Health Act.

1000

M^me^ France Gélinas: Thank you so much. So are we. We will try to put it in the bill that funding for home and community care be restricted to not-for-profit, as well as the delivery. Now, Joel Harden, please.

The Chair (Mr. Kaleed Rasheed): MPP Harden.

Mr. Joel Harden: Following what my colleague just mentioned—thank you very much for your presentation—section 23.1 of this bill is permissive in that it says that if in regulation it is specified that home care organizations and community care organizations are allowed to charge copayments and charge for the services of home care and community care, it is appropriate. I'm wondering what you all think about that and if you have any advice for the government as they develop regulation to make sure that copayments and a private model of accessing home care and community care—is that something that you support or not? I'd start with Ms. Dockstader.

Ms. Jennifer Dockstader: That is a good question. I don't think that that actually works as well as people like to make it seem. Only certain people have access at that point. I think that the differences between the not-for-profit sector and the for-profit sector are wildly different.

The Chair (Mr. Kaleed Rasheed): Two minutes

Ms. Jennifer Dockstader: One is to actually raise revenue; the not-for-profit sector is actually to make a difference in people's lives. I think that you see that across the board. So I don't think that's a good idea.

Mr. Joel Harden: Ms. Quenneville?

Ms. Camille Quenneville: Frankly, the issues of health equity are broad and include financial ability as well. I think, quite truthfully, that's not a model I'm familiar with, as you described; I don't think any of us necessarily are. My preference, as stated earlier, would be that we focus on not-for-profit delivery and that we work in tandem with government to ensure that we provide the very best high-quality care.

Mr. Joel Harden: Ms. McGuire, before I hand it to you, I want to thank you for your 37 years of service. But over to you.

Ms. Magee McGuire: You're welcome.

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Magee McGuire: I believe that copayments scare people away, but if they really need health care, they'll pay for them. They feel that they have no choice. But different organizations and different businesses have different models, different mindsets and different philosophies. Copayments might be for one thing, but there is evidence that copayments have been charged throughout the process, so there are many copayments, and that is what raises the costs.

It's particularly evident in the eye clinics. The research was done through the University of Toronto. The cost was anywhere from nothing—there are a few non-copays for eye clinics—and it went up to $3,000 at a boutique. So that's for somebody who can afford it. You have to be really careful with what kind of copayments you allow, because some—

The Chair (Mr. Kaleed Rasheed): Thank you very much, and sincere apologies to cut you off. Thank you to all the presenters this morning. That concludes our business today.

As a reminder, the deadline to send in a written submission will be 6 p.m. on June 17. That is today.

The deadline for filing amendments to the bill with the Clerk of the Committee is 6 p.m. on Friday, June 19, 2020. This is a hard deadline. Please coordinate with the Clerk when filing your amendments. Also just a note over here that if you are submitting, you can only submit via one method, whether it's online by email or a hard copy; it's not both methods. So please pick one method of delivery, whether email or a hard copy to the Clerk's office.

The committee is now adjourned until 10 a.m. on Monday, June 22, 2020, when we will meet to commence clause-by-clause consideration of Bill 175.

Does anybody have any questions? Members, any questions? Awesome. I truly appreciate all your support and coordination during these three days of consultation. I appreciate it. Have a wonderful day. Thank you.

The committee adjourned at 1006.

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