Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

SP-26

Standing Committee on Social Policy

Convenient Care at Home Act, 2023

1st Session
43rd Parliament

Wednesday 15 November 2023

Chair: Brian Riddell
Clerk: Lesley Flores

Journal des débats (Hansard)

SP-26

Comité permanent de la politique sociale

Loi de 2023 sur la prestation commode de soins à domicile

1re session
43e législature

Mercredi 15 novembre 2023

Président : Brian Riddell
Greffière : Lesley Flores

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House Publications and Language Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400
Published by the Legislative Assembly of Ontario

Service linguistique et des publications parlementaires
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400
Publié par l'Assemblée législative de l'Ontario

ISSN 1710-9477

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Wednesday 15 November 2023

Mercredi 15 novembre 2023

The committee met at 0904 in committee room 2.

CONVENIENT CARE AT HOME ACT, 2023

LOI DE 2023 SUR LA PRESTATION COMMODE DE SOINS À DOMICILE

Consideration of the following bill:

Bill 135, An Act to amend the Connecting Care Act, 2019 with respect to home and community care services and health governance and to make related amendments to other Acts / Projet de loi 135, Loi modifiant la Loi de 2019 pour des soins interconnectés en ce qui concerne les services de soins à domicile et en milieu communautaire et la gouvernance de la santé et apportant des modifications connexes à d'autres lois.

The Chair (Mr. Brian Riddell): Good morning, everyone. The Standing Committee on Social Policy will now come to order. We are here to resume public hearings on Bill 135, An Act to amend the Connecting Care Act, 2019 with respect to home and community care services and health governance and to make related amendments to other acts.

As a reminder, the deadline for written submissions is tonight, Wednesday, November 15, 2023, at 7:00 p.m. Eastern Standard Time. Legislative research has been requested to provide committee members with a summary of oral presentations and written submissions as soon as possible following the written submission deadline. The deadline for filling amendments to the bill is 5 p.m. Eastern Standard Time on Thursday, November 16, 2023.

The Clerk of the Committee has distributed today's documents with you via SharePoint. Witnesses have been scheduled in groups of three for each one-hour time slot. Each presenter will have seven minutes for their presentation. Following all three presentations, there will be 39 minutes of questioning for all three witnesses, divided into two rounds of seven and a half minutes for government members, two rounds of seven and a half minutes for official opposition members, and two rounds of four and a half minutes for independent members.

To ensure that everyone who speaks is heard and understood, it's important that all participants speak slowly and clearly. Please wait until I recognize you before starting to speak.

For virtual people on Zoom: After I have recognized you, there might be a brief delay before your audio and video is ready. Please take a brief pause before you begin speaking. In order to ensure optimum sound quality, virtual participants are encouraged to use headphones or microphones if possible.

As always, all comments should go through the Chair. Are there any questions before we begin?

NIAGARA HEALTH COALITION

BAYSHORE HEALTHCARE

ONTARIO DISABILITY COALITION

The Chair (Mr. Brian Riddell): I will now call on the next group of presenters to please come forward. Niagara Health Coalition will be in person, Bayshore HealthCare is virtual, and Ontario Disability Coalition is virtual.

As a reminder, each of you will have seven minutes for your presentations, followed by questions from the committee members. I will provide reminders of time remaining during the presentations and questions.

Please state your name for Hansard, and then you may begin.

Ms. Suzanne Hotte: My name is Suzanne Hotte, and I'm with the Niagara Health Coalition. Just to let everyone know, I am hearing impaired, so if you're asking me questions, please make sure that you speak loudly, which I think most of you are really able to do. Thank you.

The Chair (Mr. Brian Riddell): To help her out—if you could speak closer to the mikes, because this room is terrible for sound.

When you're ready.

Ms. Suzanne Hotte: Thank you very much for the opportunity to speak with you this morning. My name is Sue Hotte, and I'm the chair of the Niagara Health Coalition. We have a membership of about 3,000 people in Niagara. The primary mandate of our non-partisan group is to protect and improve our public health care system in Niagara and Ontario. We work to ensure that our health care services, including home care, are provided based on population needs, under the principles of the Canada Health Act. We are determined to protect our public health system from threats of underfunding, cuts and privatization.

We reviewed Bill 135 with the lens of how it will help those who need home care and their caregivers. How will it help Helen living in stage 4 Lou Gehrig's disease? Her mobility is limited to head movements and one foot which

can be raised slightly. She is bedridden and needs 24-hour care. She gets about two hours of care a day, and her caregiver has respite weekly, for four hours. That gives him a chance to do the shopping. Despite his calls for help, he is usually on duty 24/7.

And what about Jim who lives in rural Jordan? He is still recuperating from a serious ankle surgery and fighting a festering leg wound. When he came home from the hospital, he needed wound care, and it wasn't available. There was no suitable transportation to get him to clinic. He had to lay in the back of an SUV in order to be driven to Beamsville to the wound clinic. He only received wound care at home the second time he came back from the hospital.

What about the 70 residents in Black Creek retirement community who need a range of care services and are having difficulty getting them?

These examples reflect what Ontarians seeking care are facing because of past government action and inaction. The care that's provided is reflecting the working conditions of the provider. We know there are staffing shortages. There are missed or late appointments. Patients aren't receiving the care they need. The strict timelines for appointments are totally inadequate. That increases the stress levels of everyone. And MPP offices, including yours, are inundated with calls for help.

How did we get there? Well, in the late 1990s, the Mike Harris government dramatically reduced hospital funding, forcing the off-loading of patients to home care. Caps were put on how many hours patients could get. Grants were cut off for non-profit home care organizations like the Red Cross, and they brought in competitive bidding. For-profit companies, for the most part, underbid the non-profits, and then, to realize their profit margins, salaries were reduced, travel time was not counted in working days, benefits were slashed, and mileage stipends were reduced or not paid at all. This resulted in many nurses, personal support workers and health professionals leaving. That was the beginning of the serious staffing problem that we have today with home care.

0910

The Liberals did bring in some changes. They brought in the LHINs, basic employment standards, increased funding. So that stabilized it a bit.

Now we have Bill 135, the Convenient Care at Home Act—an interesting title. Where does this bill fit in? Will it help resolve home care issues, or will it result in worsening conditions? The devil is in the details, and given the lack of details in the act, one can assume that this bill will not improve home care. The primary aim is to increase the privatization of home care, and it's not surprising, because it has been the aim of the Ford government to privatize as much of Ontario's health care system as possible. The present government is looking at privatizing the coordination of home care, something which is currently under public administration in Ontario, presently by the LHIN. Home and Community Care Support Services will now be responsible for the coordination. They will basically contract out care coordination to service providers who, for the most part, are for-profit corporations providing the care, and who by virtue of their makeup, are driven to make a profit. How will this profit motive interfere with the objective assessment of the interests of patients? How will it play out as they look for more revenue streams, basically forcing desperate caregivers and patients to pay for additional services and charges which in the past were paid for by our public health system? The act has made it open season on profiteering from the public purse.

Bill 135 will not improve the quality of home care.

Ontarians deeply value equal access to public health care regardless of income level for all.

Once again, the government has presented the bare bones of an act. Regulations are to be added at a later time. These add-ons will not be discussed in the Legislature because the cabinet, behind closed doors, without a public hearing process, will make the final decision. There is no democratic accountability and transparency. The public, who fund and use the services, have been silenced. Dramatic changes to home care delivery are being done by stealth.

What recourse do the patients have if there are problems in accessing the care or in the delivery of care? There is no complaint process in the act that the patient and caregiver can use to address their concerns.

Restructuring will divert the attention of the ministry responsible for home care, which is at the same time dealing with a serious crisis in home care. The implementation of huge changes in the structure of the coordination of home care will not be smooth sailing.

The Chair (Mr. Brian Riddell): Thirty seconds left.

Ms. Suzanne Hotte: Okay.

The costs involved with the restructuring have not been discussed. Will the ministry provide funds for the coordination providers to cover their set-up administrative costs, like offices etc.? Given that funding for health care presently does not reflect the inflation rate, how much money will there be for the actual delivery of home care services?

After reviewing Bill 135, the Niagara Health Coalition has concluded that it will not resolve the home care crisis we are presently facing; in fact, the opposite will occur.

The Chair (Mr. Brian Riddell): Thank you, madam.

We will now go virtual with Bayshore HealthCare.

Ms. Janet Daglish: I am Janet Daglish, national director, government relations, at Bayshore HealthCare. Bayshore is a Canadian-owned organization and the country's leading home and community health care provider for over 55 years. We aim to enhance the quality of life, well-being, dignity and independence of Canadians of all ages. We deliver HCCSS-funded, government-funded home care services through all 14 HCCSS regions. At Bayshore, we invest in innovative care models and digital health solutions that lead to great patient, family and provider experiences. We have made significant investments in our digital ecosystem that has high impact on patient outcomes, including remote patient monitoring, access to scheduled care team communication and family update reports on a 24/7 basis.

We partnered with over 20 hospitals in building innovative transitional care programs that have high impact on patient flow, ED diversion and improved system and patient outcomes.

Our CareChart@home program partnered with 74 cancer treatment centres across the province, which has diverted over 80% of oncology patients from avoidable ED visits, helping them to remain safely at home.

As we understand, the proposed future structure in Bill 135 would have home care funding flowing to OHTs or HSPs, who can assess the amount of services approved for delivery and then also decide to deliver the home care services directly themselves or contract those services to a provider.

We propose that the dual function of assessing and approving the quantity of services and also delivering those same services creates an inherent conflict of interest. To avoid this conflict, we propose more bundled funding models through contracted relationships with providers, who hold accountability and transparency in the health system for outcomes. These bundled models—hospital/home programs—have already been proven to be effective. We need to spread and scale these bundled models.

Not all home care providers can be designated as HSPs, creating an unlevel field between organizations based upon tax status, rather than what needs to be the focus, which is the quality of care and achievement of proven health outcomes. This is unfair to most of the providers who have been delivering home care for the past number of decades in this province.

Access to home care must remain the top priority for the health system. Ontarians want access to home care, and they want more. There is an opportunity to further improve the home care experience for patients, with faster access. We must remove the piecemeal approach to allocating fragments of home care service in a way that prevents providers from providing all of the services needed to develop the care plan that reflects the patient's needs. There are wait-lists of patients awaiting services, resulting in people stuck in hospitals, blocking beds. Transforming home care through more flexible service models and faster access needs to be a critical focus for this legislation.

I would like to share a patient story. I can tell this story, as I was the daughter of a frail elderly person with dementia. My mom was declining, and we could not care for her alone. We reached out to HCCSS for her to access home care. It took one and a half years, with five care coordinator assessments every three months conducted by five different care coordinators, who each told us that we had to provide 24/7 care for my mother. We were also told that they couldn't provide any home care services, nor any respite care. We were devastated. In the end, my mom passed in a long-term-care home from COVID. This was not the vision of how we wanted her final days to play out. In my perfect vision, our family doctor would have sat down with my mom and our family and we would have talked about her care needs; the physician would have prescribed home care based upon her needs; then, we would receive a call that week to arrange for care to start; we would get regular updates, working with the provider team of nurses, PSWs, therapists and pharmacists to monitor my mom's goal, which was to enjoy her last years at home.

0920

Our recommendations are that Bill 135 and regulations should reflect:

—adding a transformative step where we create fast access to home care;

—a strong link between primary care and home care, so that health care professionals have a direct link to escalate and address patient care issues as they arise;

—prescribing physicians to support access to ODB, to avoid the hurdles of care coordination waiting for ODB health card approval;

—home care providers need to be referenced equitably based upon quality of services delivered, not based upon tax status. The conflict of interest in having a gatekeeping function—

The Chair (Mr. Brian Riddell): You have one minute remaining.

Ms. Janet Daglish: Thank you—that assesses the amount of care and also delivering that care. The evolving role of care coordination is a valuable service when there is high complexity of care needs, including non-home-care services such as housing, food, access to mental health and addictions support. Let's save that role for only the most challenging cases.

Thank you for the work in developing Bill 135 as it relates to the modernization of home care. We believe that additional considerations will help to build a stronger home care system, recognize care as an essential service, and drive positive health outcomes for Ontarians and their families.

The Chair (Mr. Brian Riddell): Thank you.

We will now go to the Ontario Disability Coalition.

Ms. Sherry Caldwell: My name is Sherry Caldwell. I'm the cofounder of the Ontario Disability Coalition and caregiver to my 18-year-old daughter, Ashley, who happens to have medical, intellectual and physical disabilities. Alongside me is Nicole Payette-Kyryluk, an advocate and dedicated mother to Alexa, a medically fragile, complex-special-needs child who is also palliative.

Today, we represent the voices of countless families in Ontario grappling with the challenges of supporting loved ones with disabilities. Our goal is to illuminate the urgent need for systemic changes in our home and community care systems.

Our health care system, particularly home and community care, is in a state of crisis. Legislative changes, including Bill 124, Bill 60 and this proposed Bill 135, have unintentionally strained our already fragmented system. These changes have led to a significant exodus of skilled staff seeking better opportunities elsewhere, leaving a gaping hole in the care available to our most vulnerable populations. The COVID pandemic further exacerbated these issues, revealing and amplifying the weaknesses in our care infrastructure. Families are left navigating a complex system that is not only difficult to understand but

that often fails to provide the necessary supports for those with complex medical needs.

Moreover, there is a disturbing trend of inadequate representation in the decision-making process. Many caregivers, often the most knowledgeable about the needs of their loved ones, are excluded due to language barriers, lack of resources, or simply not being invited to tables, such as the one we're sitting at right now, where important decisions are made. This exclusion results in policies that do not fully address the nuanced needs of individuals with disabilities and their families, and it can lead to life-and-death consequences for Ontarians.

The present system has no mechanism to ensure accountability from home care providers, which results in erosion and depletion of home care services.

With the introduction of Ontario Health, families are reporting that they are being allocated less hours than before, which results in less supports. Our coalition has heard from caregivers that they're being denied services despite having children with medically complex needs such as ongoing seizures, G-tube feeds, and physical disabilities. These families would have previously qualified for services, but now they're being told that they do not qualify.

Across Ontario, families are struggling with similar challenges. There are children who have lost months of schooling due to unavailable necessary nursing care. Parents are being forced to step into roles that they are neither trained for nor prepared for. Families usually have to give up jobs and careers and other family responsibilities. Families are clearly struggling. The emotional, physical and financial toll on these families is immense and goes unnoticed.

Ms. Nicole Payette-Kyryluk: My daughter Alexa was born with an extremely rare neurodegenerative disorder called intermediate Salla disease. It's a cross between ALS and MS. It's devastating. She's on a ventilator. She has seizures, and she requires suctioning, GJ-tube feedings and 24/7 ICU-level nursing care in the home. She also has unresponsive episodes that require resuscitations. Often, I'm in a situation where we don't have a nurse present and I'm having to do the care myself.

Alexa is medically fragile. She has intellectual, physical and developmental disabilities. She is also non-verbal.

Despite her clear and critical needs, the process of securing and coordinating the necessary care is fraught with obstacles. Funding comes from various sources, each with its own set of bureaucratic challenges, leaving families like my own in a perpetual state of uncertainty and financial strain, which leads to caregiver burnout and mental health issues.

I'm going to show you a copy of Alexa's care map; I don't know if you guys can see it. We're going to provide a copy later with the submissions. Basically, Alexa has over a hundred different care coordination teams that we have to deal with, so we're basically coordinating care with over a hundred providers, including five nursing agencies, five sources of funding, in addition to medical teams, school teams, hospitals, therapy, medical vendors, and multiple pharmacies—and that's just to name a few. The administrative burden is exacerbated when having to coordinate with multiple ministries. Alexa's home and community care coordinator has been critical over the last 10 years to facilitate and provide essential supports for children with complex needs.

With Bill 135, there's no plan on how to address the coordination of the palliative and complex special-needs population, and that's really scary for me. I don't want to lose my coordinator.

Unfortunately, as a result of not having the necessary home care supports, families of medically fragile children are having to resort to institutionalization of their children. This cannot become the norm and should only be provided as a last resort.

We're proposing solutions in a call to action. To address these issues, we propose several key solutions—first, the creation of a lifetime caregiver income benefit that would be providing financial support to families who have to make the significant sacrifices to care for their loved ones. This benefit would acknowledge and value the essential role that caregivers play in our society.

Secondly, we advocate for there to be a streamlined approach to funding and care coordination. Families like mine and countless others should not have to navigate a complex maze of different funding sources and administrative hurdles. A unified system with a single point of contact for coordinating care would significantly ease the burden on families.

We also call for greater involvement of caregivers and individuals with disabilities in the policy-making process.

The Chair (Mr. Brian Riddell): You have 45 seconds remaining.

Ms. Nicole Payette-Kyryluk: Their first-hand experiences are invaluable in shaping policies that are truly responsive to their needs.

Lastly, we urge for an immediate reassessment of the impacts of recent legislative changes on our home and community care system. Policies should be evaluated and revised in light of real-world consequences they have on families and individuals with disabilities.

In conclusion, the time for change is now. We must act swiftly and decisively to rebuild a system that genuinely supports, respects and empowers individuals with disabilities and their caregivers. We ask you to join in this crucial endeavour for the well-being of our families and the future of our community.

The Chair (Mr. Brian Riddell): We will now start our two rounds of questioning, with the government for seven and a half minutes, followed by the opposition for seven and a half minutes, followed by the independent member for four and a half minutes.

The government now has the floor. I recognize MPP Pierre.

Ms. Natalie Pierre: Thank you to all of this morning's presenters.

My question is for the Niagara Health Coalition. Thank you for your remarks.

I want to start by saying that there is nothing in this legislation that changes the role of non-profit and for-profit providers in home and community care. I heard you talk about the aim of this legislation—looking to privatize health care. I just wanted to let you know that there's absolutely nothing in this legislation that will change that. Ontario Health atHome will be a crown agency just like Home and Community Care Support Services.

I also want to talk to you a little bit about some of the public capital funding that has been streamlined to Niagara; specifically, around the construction of the new South Niagara Hospital capital project. This was a project that received stage 1 approval in 2014 and construction approval in 2017. The new South Niagara Hospital is a construction of a new hospital in Niagara Falls that will replace existing sites in Port Colborne, Fort Erie and downtown Niagara Falls that have reached the end of their life. The Welland hospital will remain open. The new hospital is planned to have 469 beds, which is 156 more beds than the combined total number of beds at Port Colborne, Fort Erie and Niagara Falls—so an increase in the number of publicly funded hospital beds available. The new South Niagara Hospital will be a full acute-care hospital with 24/7 emergency services, diagnostic, therapeutic, surgical services, and medical, surgical, intensive care units; ambulatory services; centres of excellence specializing in stroke, complex care, geriatric and seniors' wellness and aging. The contract for the construction was executed in February 2023, with EllisDon Infrastructure Healthcare. The construction started with the groundbreaking held just this last summer. It looks like the hospital will take about five years to build, with an opening date scheduled for 2028.

0930

To date, the province has paid $87.1 million towards this project. So, obviously, the government is supporting Niagara Health and awarding a contract to design, build, finance and maintain this new South Niagara Hospital project valued at $3.6 billion. The new hospital will add more hospital beds, which we talked about, and bring together acute-care services, improve access to high-quality health care.

Can you see how this multi-billion dollar investment in public health care could be a benefit for your community?

Ms. Suzanne Hotte: Definitely, it is a benefit to have the new hospital. The Niagara Falls hospital is at its end of life, so we're certainly looking forward to the new hospital.

There's also a new hospital being built in Grimsby, the West Lincoln hospital, and that's greatly appreciated, and there's an increase in the beds.

Back in 1990, Niagara had a little over 2,100 hospital beds. By the time 2000 came around—1999, 2000—there was a dramatic decrease. In about 2003, we were looking at 684 beds, and that includes West Lincoln. So we are now easing our way up to having better access to hospital beds. I think we're at 1,064 for the Niagara Health System, and West Lincoln has about 60, although it's in the process of construction—so there's give or take.

The fact that we are getting more beds is greatly appreciated because, obviously, for our growing population, we don't have enough beds. The population growth in Niagara in tremendous. For example, Thorold South was in the top 10 fastest-growing communities in Canada. Its population went up about 20%—it's still growing—and the same with Fort Erie and the whole area. There are lots of people moving in. Primary care is a huge problem. There are about 70,000 people who haven't got access to a doctor. So, definitely, we welcome the new hospital and having more beds.

But we also need to have funding for home care, because our population is getting very old. For example, Niagara-on-the-Lake is at 25% over 65; Port Colborne is at 27%. We have many communities in our area that are getting older and need appropriate home care.

We are very thankful for all the work that's being done and finally getting some hospitals and the much-needed beds. We appreciate that.

Ms. Natalie Pierre: Thank you. I just wanted to let you know that our government has invested $1 billion in home care over three years.

What are some of the ways that you feel improved integration of home care with local health care partners and Ontario health teams could help benefit patients and patient care?

Ms. Suzanne Hotte: One of the big problems in accessing care is how many people are actually working in home care. Depending on the provider, we're—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Suzanne Hotte: Okay.

Depending on the provider, the working conditions can be very different in terms of salaries, in terms of whether or not they're getting paid for their travel time, what the benefits are like. So it's very difficult for them to have staffing. Oftentimes, what happens, for example, for a PSW—I know some who have quit, and they're actually working somewhere else. There's less stress. It's predetermined what their salary is.

Care conditions are based on the working conditions that people have. So there really needs to be more thought in terms of: How are you recruiting people? What are the employment standards for that particular group?

For example, my friend Helen, who has Lou Gehrig's disease, lives in North Bay, on Trout Lake. There is no bus transportation there—

The Chair (Mr. Brian Riddell): I'm sorry, madam; I'm going to have to cut you off there.

We'll now turn to the opposition for seven and a half minutes. I recognize MPP Gélinas.

M^me^ France Gélinas: My first question will be for the representatives of Bayshore.

Bayshore has the biggest contract for home care in my community. They serve most of the communities in Nickel Belt.

Last week, a mom came to my office, and she has a very disabled child who is now in school and needs G-tube feeding. Bayshore gets an hour and a half once a day to

come to the school, set up the G-tube feeding and make sure he's fed. The contract is for an hour and a half. The nurse actually comes for about 15 minutes, sets up the G-tube feeding, then takes off because she has other patients she has to go to. If the G-tube feeding machine starts to beep or whatever, the mom is called, and she has to leave work and come and handle the G-tube feeding.

How many hour-and-a-half appointments that Bayshore gets paid for are actually delivered in 15 minutes? Do you keep track of those?

Ms. Janet Daglish: Thank you for your question.

I can't speak to any specific patient care needs, but what I can speak to is that it is our goal, particularly when a child is in a school setting, to work collaboratively with the school administration as well as the parents to set up a care plan where we can best set up and meet those needs of that individual patient, who is the child in this case. It does require working flexibly to be able to meet the most needs of the community and the patients within a geographic area.

It's important in home care to have the plan A, plan B, working with all of our stakeholders, which must include the family. The family is core to being able to deliver the continuity of that care, and it's critically important that we work with the family where we need—

M^me^ France Gélinas: I agree with you.

You did work with the family, and the family said, "You have to stay there. I cannot leave work every second day because the pump is beeping." The response from Bayshore was that they're not able to honour this contract anymore, and you refused to serve this patient. Presently, the family has to, through the care coordinator, try to find somebody else.

0940

A second case that came to me last week is a man who has severe wounds that need to have dressings changed twice a day. The dressing changes are scheduled for 8 o'clock in the morning and 4 o'clock in the afternoon. Bayshore has the contract. Bayshore does not show up at 8 o'clock. He phones at 9; nobody picks up. He phones at 10; nobody picks up. He phones at 11; nobody picks up. At 2 o'clock, Bayshore calls back and says, "We have somebody who will be there at 3." He says, "Well, don't bother, because my 4 o'clock appointment is there." Bayshore still gets paid for that appointment because he did not accept the care.

How many appointments that are not being delivered when they were supposed to are Bayshore being paid for but not delivering the care?

Ms. Janet Daglish: With all due respect, that's not the way the system works.

M^me^ France Gélinas: That's the way it works. I could give you many, many other examples.

Do you keep track of how many times you get paid for an appointment that you don't provide the care?

Ms. Janet Daglish: For clarity, we do not get paid for any care that we do not deliver.

M^me^ France Gélinas: You do if the patient cancelled the care.

Ms. Janet Daglish: No, I'm sorry.

M^me^ France Gélinas: I will advise you to have a look at your contract, because I can guarantee you that in the contract that you've signed with all 14—what was the CCACs became the LHINs became Home and Community Care Support Services. If you are ready to provide the care and it's the patient who cancels, you still get paid.

How well is Bayshore doing with recruitment and retention of staff? Do you keep track of staff turnover?

Ms. Janet Daglish: Keeping a strong and engaged workforce is one of our priorities. We know that having supported employees who are health care professionals, who are PSWs, who are therapists, who are pharmacists—it's critically important that they feel that they're supported. They work as a team.

You're really helping to focus on one of the key points that we raise here, and that is, we need to move towards more integrated teams. Right now, the home care system is based upon the referral of piecemeal, service-based care.

I would love to be able to help Nicole's family by being able to say, "Here's one team"—and we organize all of the services wrapped around. That would be brilliant. I would love to be able to offer that.

M^me^ France Gélinas: I would agree with you.

You've also asked that there should be more bundled care funding. You do have bundled care funding in the CCACs, LHINs, home and community care that I represent. The bundled funding is for post-discharge of hip and knee replacements. Post-discharge of hip and knee replacements, you're supposed to send a nurse to change the bandages, you're supposed to send a physiotherapist to do the rehab, and you get paid a bundle to send all of this. You had a physiotherapist on staff who has not provided the follow-up care for teaching people how to do stairs—

The Chair (Mr. Brian Riddell): One minute remaining.

M^me^ France Gélinas: —how to walk on an even floor, and all of this. Yet you still get the full amount of bundled funding for that care.

In how many other LHINs of the 14 LHINs do you get paid for bundled care where you don't provide the full spectrum that you get paid for?

Ms. Janet Daglish: For clarity, we do not get any funding for bundled care through HCCSS anywhere in this province. I have to be very clear. We do not get funded for bundled funding through HCCSS.

Where we have been able to build these innovative models are when we partner directly with the hospital. The hospital is able to identify which patients, who either are ALC-bed patients or they're at risk of becoming an ALC, and these bundled models help us to work more directly with the hospital care team. We plan the discharge and we put the care plan—

The Chair (Mr. Brian Riddell): Your time is up. Thank you very much.

I will now go to the independent member for four and a half minutes. I recognize MPP Brady.

Ms. Bobbi Ann Brady: Building on what my colleague was saying about billing for cancelled or missed

appointments, I too have heard from PSWs and I've heard from clients in my riding, and they tell me that clients will often get a phone call in the morning and they're being told that their PSW cannot make the appointment that day—and are they willing to cancel? It seems like coercion to me. You have an elderly person on the phone and they're saying, "I'm not cancelling." "Well, we can't come. So do you agree to cancel?" And if they agree to cancel, then the agency gets paid. That's wrong, and we've got to stop that.

I saw some head-nodding while I was saying that, so perhaps the two folks nodding their heads, could you chime in on that?

Ms. Nicole Payette-Kyryluk: With most of our agencies, we have cancellation fees. If they're not given enough notice with the cancellation, we are charged for at least four hours, whether they provide care or not. So, yes, it happens with the nursing. And a lot of times, we're not given a lot of notice when nurses are calling in. There's a lot of miscommunication that we're finding, so we're left with, often—in my case, last week I was left with no nursing for 14 hours. It's really tough. You've got to drop everything, and you become the nurse for the shift, when nurses can only work 12 hours legally. But then the parent is working 14 hours with a critically ill child. There are a lot of issues with that.

Sherry, did you want to add something?

Ms. Sherry Caldwell: Even with a planned vacation, they don't have enough staff in the system to find replacements, even with weeks or months of notice. There just isn't the skeletal staff to meet the needs of the community.

Ms. Bobbi Ann Brady: I sat through yesterday and, of course, this morning's public hearings, and I hear how terrible the current system is. We have the government that has now ushered in Bill 135, in an attempt to make the system better. Yet we are continually hearing that Bill 135 could actually make things worse.

I agree—I've seen it—that family is left out of the decision-making process time and time again but then end up doing the majority of the care for their loved one.

Do you think there is an opportunity to put families in the driver's seat here by providing funding directly to families to access help the way they feel fit?

Ms. Nicole Payette-Kyryluk: Right now, I have funding from the Ministry of Health and the Ministry of Children, Community and Social Services. The issue is that it's so fragmented. There are school hours, home hours, private funding. I have try to tell each agency—four agencies—how to pay the bills. The administrative burden is insane. I would like to see one big pot of money for Alexa. It's all taxpayers' money in the end. So you would have one coordinator, one administrator who can do the scheduling and everything else, and then you would have one bookkeeper who holds the funding accountable—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Nicole Payette-Kyryluk: At the end of the day, it's taxpayers' money. We want to make sure that everything balances so that families don't have to do the accounting piece. That's what I would like to see. That would be my dream—and then it's direct-funded so that families can hire who they need with the right skill set.

Ms. Bobbi Ann Brady: Do you believe that would be a good idea too, Suzanne?

Ms. Suzanne Hotte: Sorry?

Ms. Bobbi Ann Brady: To put families in the driver's seat by funnelling more money directly to those who are providing the care for their loved ones at home?

Ms. Suzanne Hotte: I think that would be a really good idea because it would solve some of the problems that they have. They're trying to access care. They're calling everywhere that they can to be able to get care. If you have a system where it's not responsive, there's no one who's coming, they're waiting and waiting, the aggravation of what they have to go through—ideally, we should have a system where the care coordination—if they're coming from the hospital, this is what they need to have. Everything is in place, and you can move forward on that, and you have the staffing that's available. But the family has to be part of it. Oftentimes, the discussion is just with the patient, we'll say, at the hospital. They're really stressed out, so they may not be thinking it through. Whereas with a caregiver, the family can say, "Hey, wait, let's back up a bit. This is what we need to"—

The Chair (Mr. Brian Riddell): Thank you for your answer.

We'll now move to round two, with the government for seven and a half minutes. I recognize MPP Wai.

0950

Mrs. Daisy Wai: This question is directed to the Ontario Disability Coalition. Thank you very much for coming.

Actually, I'd like to say thank you to all the presenters for coming in and sharing your ideas and plans with us.

I would like to address especially that the Ontario government is building on the work that has already been done, for ODC. It's to better connect the people to home and community through Your Health: A Plan for Connected and Convenient Care by moving forward with the transition of home care to Ontario Health Teams.

We did listen carefully and work closely with service provider organizations. With these changes, we improve the way people connect to home care services and break down long-standing barriers. This is why we are doing this bill and improving on what we all want to get better.

I'd like to hear if you can share how the government and the Ontario Health Teams can ensure that access to services is equitable across the province while ensuring the health care system is flexible enough to respond to local needs. This question is directed to ODC.

Ms. Nicole Payette-Kyryluk: Do you want to start, Sherry?

Ms. Sherry Caldwell: Yes.

Thank you, Daisy, for that question.

I think it's really important to know that our children and people with disabilities have very different needs, and a standardized approach is not going to help many, many

families, especially those families with the most complex of needs.

My daughter has a care coordinator with home and community care, and she's a valued member of our team. She's the one person we can call if our service providers—my daughter has had nursing and PSW care since birth. If they're calling to say they don't have someone to show up that day and they're calling again the next day and the next day, I can call them and actually say to the care provider, "Thank you for calling. I'm going to let my case manager know." When you say that to someone at an agency, it actually matters to them. They take note when you say you're going to engage. It's one level of accountability. So we're worried—these ministry-funded roles have to be there. They're valuable, and they're needed.

Mrs. Daisy Wai: Thank you very much for sharing. We will listen to that, and we will make sure that we keep on top of that for you, as well.

The Chair (Mr. Brian Riddell): I recognize MPP Hogarth.

Ms. Christine Hogarth: I want to thank everybody for being here.

This conversation is emotional for many of us—home care. I went through something—and we learn sometimes when we're tossed into it that we're not prepared. It's something we all have to figure out—how do we help out our loved ones quickly? It's not something we expect. My sister and I had to learn very quickly, on the fly, how to look after our mother. So I'm sorry if I get emotional or maybe even a little angry at the system, because we need to do better. We need to do better for our seniors, for our loved ones.

We have to make sure that we have a model that works for everyone, no matter where you live in the province. We have a large province and geographical regions. Even in the city of Toronto, where it's complicated to get from Etobicoke to downtown Toronto to Scarborough, it's not that convenient and it's not that easy, even if you take transit. Sometimes transit is faster, obviously, than driving. But it's a very complex system.

When we look at this legislation, we're trying to make things better. We have to continue to make things better and move forward.

I appreciate hearing your stories. We all have stories about people showing up or not showing up.

I can comment on when people don't show up and get paid. That does actually happen—unless somebody is looking at it and lets people know that someone didn't show up. So we're diligent in taking notes when people did show up to work or when they didn't, because if we didn't take notes—my colleagues are correct—they did get paid for that time of service.

There also was a disconnect between how much time these caregivers need to stay. It was an hour—well, if the person they're serving doesn't know it's an hour or they aren't watching the clock, or maybe they have ailments that don't allow them to notice the time, 20 minutes go by and they leave. So we have to make sure that we have proper care. We're looking after those who are in need, and making sure those caregivers are there, not—I could tell you a story about somebody who was at my mother's condo and took selfies the whole time on her balcony and did not feed her until the end.

Anyway, there are a lot of stories we can all share.

In the thought process of making things better for our seniors, our elders, those who have disabilities, I'd like to ask you all the same question, because you all have some different experiences. Based on your experiences, how can home care service providers and the Ontario health teams be supported to work together to make a difference?

We'll start with Suzanne, and then we'll go around.

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Suzanne Hotte: For them to be well coordinated, the left hand has to know what the right hand is doing to begin with and what the situation is with regard to the care needs of that particular person. And then make sure they have the personnel necessary, that everything is in place that they can get there, that the time allocation—and you talked about how much time will they need to actually do the care. That all has to be put into play, and having a really good discussion with the families so that it works well. There are always hiccups, but you can get rid of a lot of hiccups and frustration if you can say, "Hey, we have the team. We're ready to go"—and you're on time as much as possible. That's a big one.

Ms. Christine Hogarth: Thanks for that—when you said "on time," and a team is important.

How about Bayshore? Do you have anything to add?

The Chair (Mr. Brian Riddell): The time is up.

We'll now go to the official opposition for seven and a half minutes. I recognize MPP Gates.

Mr. Wayne Gates: I'm going to pick up on what the Conservatives said to the Niagara Health Coalition. They talked about the new hospital in Niagara.

I want to be clear: The new hospital was brought forth in 2014, under a planning grant that was under the Liberal government. And from that time—because the community came together; we fought to get that hospital—it took 10 years. No hospital in the province of Ontario should take 10 years before the shovels get in the ground. That's the one thing.

The second thing about that comment that was made by the Conservatives—what they didn't mention is, to get a new hospital in Niagara Falls, we closed Niagara-on-the-Lake Hospital. We closed the Fort Erie hospital and turned it into an urgent care centre. We closed Port Colborne and turned it into an urgent care centre. We closed two St. Catharines hospitals to do that one hospital in Niagara. And then when they say about $3.6 billion—I think it is over $4 billion now.

So when you talk about health care and the reason why we don't have the number of beds we had in 2014—substantially less beds—it's because they closed all the hospitals, and then, the hospitals that were left, including Niagara Falls, had some of their mental health taken out and put into St. Catharines, and they also took maternity. This is one that I really don't understand, because if any-

body is listening over there instead of talking, they would understand that Niagara Falls is the honeymoon capital of the world. So people come to Niagara Falls make babies, and we can't even deliver them because they took the delivery out of Niagara Falls during this restructuring.

So to talk about that hospital, you have to take a look at exactly what happened in Niagara. And we're still going through the cuts in Niagara, quite frankly, under this government, and they have cut over the last—well, since they have been in—five years.

So maybe you can update—and do it quickly, because I have to get to Bayshore, too, because they've got some issues. Can you tell us what's going on with the Fort Erie hospital? Here we are, 10 years later. What's going on in Fort Erie? You mentioned that it's growing by leaps and bounds in population and senior population. Maybe just touch base on that for a minute. That would be great.

1000

Ms. Suzanne Hotte: That's right. The Fort Erie hospital had 24/7 urgent care, which was very, very important, when you consider that almost half of the population don't have a primary care doctor. What happened, without any notification—two days' notice—is, the Niagara Health System reduced the hours from a full 24/7 to that it is operating from 10 o'clock in the morning until 8 o'clock at night. So it really reduced access to care. They did the same thing in Port Colborne, at that urgent care. So here you have a community where people go to the hospital—lots of seniors, as I mentioned—and where are they going to go? They can't go to the Welland hospital because the emergent care has reduced times. They'd have to go to Niagara Falls. Well, there's no public transit and no taxis operating at night. So how do they get there? And if they call the number that Niagara Health has posted, well, then, somebody is going to come and get them, hopefully; how in the heck are they going to get back? Plus, this is in a snowbelt. Last winter, everything was closed. Nobody could get in. They couldn't get out of Fort Erie.

So how in the heck do you access the care? This is one way: Keep the services open. Keep them all open 24/7—including the emergency, the two urgent care. They need to be kept open, period.

Mr. Wayne Gates: I appreciate that response.

A couple of other things that were discussed here is that the Conservatives—I'm not sure which member said it. They're investing a billion dollars in home care. Well, what they're not saying is that out of that billion dollars, 30% goes to a for-profit company like Bayshore right off the hop. Wouldn't it make sense to take that billion dollars and put it straight into home care for our seniors?

And to Bayshore, who said that seniors are bed-blockers: They're not bed-blockers in our hospitals. I want to be clear about that. That was also said.

I want to ask a question to Bayshore.

You're making a lot of money on the backs of our seniors and those who need home care. There's no doubt about that. Your CEOs are doing extremely well.

I'd like to know why Bayshore pays their workers approximately $7 an hour less than in any other province when home care is run for not-for-profit. My issue is that if we want to fix home care—like we do for my colleague's mom—why are we still running for-profit instead of not-for-profit and not putting every single dollar that this government has into home care, in not-for-profit? No company should make money on the backs of our seniors and people who are sick, including those with disabilities. Wouldn't it be nice if you had more money to take care of your sons and your daughters, those with disabilities? Maybe Bayshore can answer why you're paying your workers an average of $7 less than they do in other provinces.

Mr. Stuart Cottrelle: We pay our workers as much or more than every other service provider. So if you have an issue with respect to other provinces, which is reasonable, that has to do with respect to what other provinces are allowing—and $7 higher in other provinces is more than it actually is.

The 30% profit is a total fallacy; it is absolutely incorrect. As an organization, we make about 1% of revenue to the bottom line. What do we do with that money? We have consistently reinvested it.

And how much do I make as the CEO? I make less than 20% of the amount that the CEO of Ontario Health makes.

So we consistently invest back in our employees, and, sir, it shows up with respect to what our employees have to say about our organization.

I'm not trying to say we walk on water; I'm trying to say we consistently reinvest, and those fallacies that are consistently passed though about private companies, that you keep trying to support in the House, are incorrect.

Mr. Wayne Gates: Well, I know what's correct is that if you take every single dollar and put it in for not-for-profit, the care is better.

I'll give you an example. I don't know if you have long-term care as well with Bayshore, but in long-term care—

The Chair (Mr. Brian Riddell): One minute remaining.

Mr. Wayne Gates: I appreciate that.

In long-term care, we know that we had 6,000 of our moms, our dads, our aunts, our uncles, our grandfathers die during COVID, and 78% of all the deaths were in for-profit. Do you know why? Because it wasn't about care; it was about profit. It's not about those with disabilities who need a PSW at a time—it has never been about that.

And I have no idea what you make, but I would think you make more than the PSW who's providing that front-line care every single day in those homes.

So I disagree with you.

I believe that France and my colleague from the Liberals—there are appointments that are being cancelled. There are appointments that are being charged. There are appointments where you're not paying for that PSW to drive to the appointment, and you're telling them they have X number of minutes to do X number during the shift. All those things are happening, but they wouldn't happen in a not-for-profit, and that's my issue.

I'm sorry, Bayshore—you're here today, supporting the bill. We might not be supporting the bill.

I'll tell you what I do support. I support making sure that we're taking care of the kids who have disabilities. I want to make sure that our seniors are being taken care of.

I don't think money should go to corporations and CEOs before they go to taking care of our seniors, our moms and dads, our grandparents.

Thank you for coming. I appreciate it.

The Chair (Mr. Brian Riddell): We'll now turn to the independent member for four and a half minutes. I recognize MPP Brady.

Ms. Bobbi Ann Brady: I'd just like to politely correct the record. I am not a Liberal. I am an independent.

Mr. Wayne Gates: I apologize.

Ms. Bobbi Ann Brady: That's okay.

I'd like to thank you all for taking time out of your busy lives to come before us and share your personal and your professional knowledge and views.

I'd also like to thank my colleague across the way for her very honest remarks.

I sit as an independent, but I am a fiscal conservative, and I often believe that money doesn't always fix all of our problems.

I think most of us can agree that the current system is heavy with bureaucrats, and it's very hard to navigate. The way I see it is, a tree can't stand strong if its roots or its base is unhealthy.

I'm going to ask all of you, would you agree that overhauling the current system would be superior to ushering in Bill 135, if the province would invest in stabilizing the home care workforce?

Ms. Sherry Caldwell: We've been calling for wage parity for home care nurses, PSWs—especially the nurses—since the beginning of the pandemic. Home care nurses are leaving because of higher-paid jobs in every other sector of health care, and it's falling on caregivers to a severe point.

If a caregiver cannot go to work—young families are facing a cost-of-living crisis, and families, we know, are turning to the government and saying that they can't care for their children. This is happening to young families at SickKids.

We've seen the government investing in organizations, in the last budget, like Sunbeam—

Ms. Nicole Payette-Kyryluk: Faith Haven.

Ms. Sherry Caldwell: Faith Haven. This is shameful.

The government needs to invest in families. We want to raise our children at home. But you can't expect a family to pay through-the-roof rents, high grocery costs, and stay at home and raise a child and have—the idea of having nurses come or PSWs come, potentially someone can work somewhat and try to survive. Mothers cannot survive today.

Ms. Bobbi Ann Brady: Suzanne, do you have anything to add to that?

Ms. Suzanne Hotte: Definitely, the workforce has to be stabilized. The working conditions have to be improved. They need to be paid well for the work that they're doing. That's the end of the story. You need to pay people for the work that they're doing. It is important work, and oftentimes the workers in that field are not treated very well. They need to have good wages. They need to have a good stipend, in terms of their mileage. That's what needs to be done. If you can stabilize it, then you're going to have more people, and you're not going to have missed appointments, and you're going to have the health professionals, you're going to have the nurses.

Ms. Bobbi Ann Brady: As legislators, as you know, we don't always have the answers, nor should we. I'm a big believer in consultation ahead of time.

I'm just wondering if any of your organizations were consulted prior to Bill 135 being introduced.

Bayshore?

Ms. Janet Daglish: No.

We do want to just reinforce that we, too, want to make sure that we are able to pay all of our staff for the work. They are all passionate and care about making a difference in the lives of patients, and we want to be able to flow more money to the front line. We already pay above average right across the province, but we need to reflect the different labour markets in the province. We need to be able to recognize the skills and the exceptional knowledge and expertise of many of our nurses—

The Chair (Mr. Brian Riddell): Thank you for your comments. Your time is up.

I'd like to thank everybody today for their participation. If you would like to submit any written materials to the committee in addition to your presentation today, the deadline for written submissions is tonight, Wednesday, November 15, 2023, at 7 p.m.

The committee will now stand adjourned until 1 p.m. this afternoon, when we will resume public hearings on Bill 135.

The committee recessed from 1011 to 1302.

The Chair (Mr. Brian Riddell): Good afternoon, everyone. The Standing Committee on Social Policy will now come to order. We are here to resume public hearings on Bill 135, An Act to amend the Connecting Care Act, 2019 with respect to home and community care services and health governance and to make related amendments to other Acts.

As a reminder, the deadline for written submissions is tonight, Wednesday, November 15, 2023, at 7 p.m. Eastern Standard Time. Legislative research has been requested to provide committee members with a summary of oral presentations and written submissions as soon as possible following the written submission deadline.

The deadline for filing amendments to the bill is 5 p.m. Eastern Standard Time on Thursday, November 16, 2023. The Clerk of the Committee has distributed today's meeting documents with you virtually via SharePoint.

Witnesses have been scheduled into groups of three for each one-hour time slot. Each presenter will have seven minutes for their presentation. Following all three presentations, there will be 39 minutes of questioning for all three witnesses, divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members,

and two rounds of four and a half minutes for the independent member.

To ensure that everyone who speaks is heard and understood, it's important that all participants speak slowly and clearly. Please wait until I recognize you before speaking. For virtual participants on Zoom, after I have recognized you, there may be a brief delay before your audio and video is ready. Please take a brief pause before you begin speaking. In order to ensure optimum sound quality, virtual participants are encouraged to use headphones or microphones if possible.

As always, all comments should go through the Chair. Are there any questions before we begin? I look at Wayne Gates over there, who's not saying anything today.

Mr. Wayne Gates: What's that?

M^me^ France Gélinas: No, he's good.

The Chair (Mr. Brian Riddell): I'm just being funny.

WERPN
ONTARIO COMMUNITY SUPPORT ASSOCIATION
MR. JAMIE CHURCH

The Chair (Mr. Brian Riddell): I will now call on the next group of presenters to please come forward: WeRPN. Just a reminder, you will have seven minutes for your presentation, followed by questions from the committee members. I will provide reminders of the time remaining during the presentations and questions.

You may begin when you're ready. When you speak, please say your name first for the record.

Ms. Dianne Martin: Thank you for inviting me to join you today. I appreciate the opportunity to address the standing committee regarding Bill 135, the Convenient Care at Home Act. My name is Dianne Martin, and I am the CEO of WeRPN, the professional voice of Ontario's registered practical nurses, or RPNs.

RPNs are the second-largest group of regulated health professionals in our health care system. With over 61,000 RPNs across Ontario and approximately 7,000 of those RPNs working in home and community care, this legislation will have a significant impact on our members.

Home and community care has long needed appropriate attention. Home is where many clients prefer to receive care, and home care is very cost-effective. This bill represents a unique opportunity to address some of the important challenges facing nurses in the home and community care sector.

Right now in Ontario, nurses are struggling. Their workload and work processes, which were severely impacted during the pandemic, have not recovered. They have spent three years on the front lines of a global pandemic that most of the world has moved on from, and yet they cannot.

In addition, there remain many instances where the wages of RPNs have not kept pace with inflation. At the same time, we have seen PSWs get well-deserved wage increases, but those increases have resulted in wage compression for RPNs. This has been a key driver of dissatisfaction among RPNs. Wage compression happens when there are differences in pay that ignore education, experience, skill level, accountabilities or seniority. Today, we have situations where PSWs earn wages very close to some RPNs despite the differences in those areas. This leaves many nurses I speak with facing a terrible decision: Do they stay in the job they love that doesn't provide opportunities to provide appropriate care or pay enough for them to make a good life for their families, or do they give up their dream job? Unfortunately, many are choosing to leave, which could have disastrous impacts on our health system.

A recent survey we conducted showed that nearly seven in 10 Ontario RPNs are actively considering leaving the profession. Wages and workload are the key factors cited. In the home and community care sector, this is exacerbated by a lack of recognition of the true time and resources that nurses commit to their jobs. Many RPNs are not compensated for the time spent travelling from one client to another, and some aren't even reimbursed for their gas. Can it be any surprise that home care is one of the hardest sectors to recruit nurses to? In a province as vast as Ontario, where recruiting more nurses is critical for clients who rely on them, making sure they are fairly compensated for their time and expenses must be addressed. Let's use the powers being granted to the government in this legislation to mandate that for everyone providing home care services.

When it comes to workload, the reality of a day at work for far too many RPNs is choosing what care to provide based on the limited time and resources available rather than providing all the care that is necessary. I regularly hear from members about the moral distress this causes. Nurses are educated to provide the best care possible, and when they are forced to decide between what is best and what is feasible because of lack of resources, it takes a toll.

For nurses who work in home care, it is often the case that they are assigned and paid by visit, not by the time it takes for the level of care that visit requires. This means they are forced by the system to get in and out as quickly as possible, often leaving clients with unsolved issues because it's the only way to make all of the visits that are assigned to them that day. This leaves clients and nurses experiencing a great deal of distress. Let's use this legislation as an opportunity to change that by ensuring there are enough nurses in the system to provide every client with the level of care and the amount of time they deserve, and recognize the needs of nurses by not asking them to work outside the geographical area where they already live and work.

This legislation also speaks about the new standards for home and community care. For nurses, the creation of any new standards they have to meet must coincide with the provision of educational opportunities for nurses to be prepared to meet them. Supporting continuing education and consulting RPNs on standards to ensure that they account for the lived experience of home care nurses is critical in the modernization of our home care sector.

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Further, this legislation provides an opportunity to reduce overreliance on nursing agencies. The use of nursing agencies creates a two-tiered system of compensation for nurses that exacerbates staffing shortages by encouraging nurses to leave their permanent jobs, and because nursing agencies charge significantly more than the cost of a staff nurse on an hourly basis, budgets are being used up without enhancing the quality of care.

The creation of Ontario Health atHome is an opportunity to address the many fundamental challenges facing the RPNs—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Dianne Martin: Thank you—who deliver home care services and the issues faced by their clients as a result. Let's use this legislation to ensure nurses are fairly compensated for their time and expenses. Let's use this legislation to ensure nurses have the time and resources to provide the care they are educated to do. Let's use this legislation to reduce the use of nursing agencies that are taking money from the system without improving care. Let's use this legislation to make being a nurse in home and community care a career that people aspire to. Finally, let's use this legislation to ensure that home is the best place to receive care as a client. I hope you will not let this opportunity pass.

The Chair (Mr. Brian Riddell): Thank you.

We will now move on to the Ontario Community Support Association, which will be virtual. You may start when you're ready.

Ms. Deborah Simon: I want to thank you for the opportunity to appear before this committee and share the perspective of the not-for-profit home and community care support sector on Bill 135, the Convenient Care at Home Act.

The Chair (Mr. Brian Riddell): I'm sorry to interrupt you, but we need you to state your name for the record.

Ms. Deborah Simon: Oh, very sorry. My name is Deborah Simon. I'm the CEO of the Ontario Community Support Association. I'm joined by my colleague Patrick Boily, the director of policy.

We see this legislation has promise, but we also want to share what we feel is needed beyond these legislative changes to ensure that we have the right people to deliver care that is needed to keep people living well at home and in their community.

Your ridings are home to many of the organizations that provide these valuable services to seniors and people with disabilities—services such as in-home nursing, personal support, Meals on Wheels, Alzheimer's day programs, transportation to medical appointments or assisted living services. Many of these services such as friendly visiting and Meals on Wheels rely on volunteers, who donate three million hours of service across the province every year.

And 85% of seniors who receive home and community care services say the services have helped them stay at home.

Our association supports the government's goal of creating a seamless transition between hospitals and home care across the entire health system. We recognize the potential that the Ontario health teams have in creating an integrated health care system by strengthening collaboration between service providers, across the sector.

We see this legislation primarily as the legal reorganization that lays the groundwork for further system transformation and improvements down the road. There is a need to leverage this health system transformation to wraparound care based on population needs. This means ensuring community support services, primary care and home care all work together. Integrating primary care, community support services and home care fosters a person-centric model that prioritizes continuity and personal care. Clients benefit from a more cohesive and coordinated health care experience and with smoother transitions between different levels of care. This not only enhances client satisfaction but also contributes to better health outcomes by ensuring that individuals receive the right care at the right time in the most appropriate setting. Such a system facilitates a holistic approach to health care ensuring that various components of care, including community support services, primary care and home care, interact seamlessly and collaborate. This collaboration enables a comprehensive understanding of an individual's health profile, fostering preventive measures and early intervention.

That said, we can only achieve this type of health system if we have the appropriate health human resources in place across the sector to deliver this care—and I heard very clearly my colleague Dianne speak to this just prior.

Personal support workers and the home care system provide the bulk of the care to provide care for over a million Ontarians every year. However, even with the recent PSW wage increases, PSWs in home and community care earn approximately 21% less on average than PSWs in hospitals and 17% less than PSWs in long-term care. Retroactive salary increases awarded after Bill 124 was struck down will mean that this gap will widen again, reversing the progress made to reduce the gap between sectors over the last few years. This profound wage gap means our members are constantly facing significant recruitment and retention challenges amidst a rising demand for services. Vacancy of key front-line positions remain around 20%, and the annual turnover for staff is still around 25%.

Recently published research demonstrated that wage parity would retain one in five personal support workers who would be left in the sector. Retaining these PSWs would create over 23 million additional hours of care for vulnerable Ontarians. Shifting care from institutions to community settings could result in a return on investment of 26% in saved health care expenditures.

The government needs to implement a health human resource strategy urgently to attract and retain PSWs, nurses and other health care providers in the home and community care sector. This strategy must include a plan to close the compensation gap for front-line workers

between the home and community care sector and institutionalized care such as hospitals and long-term care.

We acknowledge that the transition to Ontario Health atHome will likely bring forward some improvements, such as standardization of contracts and reporting templates to reduce administrative burden on home care providers. However, we also see this transition would initially require additional efforts and costs on the part of service providers to align and comply with these new structures.

Embedding care coordination under the direction of OHTs as proposed by this legislation creates an opportunity to break silos across sectors. However, the nature of the contracting relationship between OHTs and Ontario Health atHome risks creating a very narrow role for the care coordinator. It could limit their responsibilities to only deliver home care services.

In conclusion, this legislation takes a step in creating a framework that will allow for standardization of contracts in some reporting processes in the home care sector. OCSA sees it as an enabling framework to proceed with some real changes that are needed in the sector which must include—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Deborah Simon: Thank you—a strong focus on prevention and health promotion, prioritizing wage parity across the sectors and building capacity in the home and community sector to meet our community's growing need for services.

The Chair (Mr. Brian Riddell): Thank you.

We will now call on Ability Members Group. Please state your name and your position for the record.

Mr. Jamie Church: I'm Jamie Church, CEO of Ability Members Group. Thank you very much, Chair, for inviting me today. I acknowledge the Vice-Chair, MPP Gélinas; thank you very much. Committee members, thank you for the opportunity to talk to you today.

I'm here to talk to you about Bill 135, which is, in our opinion, a transformational bill that will take pressure off our health care system.

I represent Canada's largest network of home medical equipment providers in Canada—88 locations in the province of Ontario—but I'm not coming as a result of representing this organization. I have over 22 years of experience in community health care, working alongside pharmacy, specialty pharmacy, medical device and RFP response.

I've seen the transformation of home care over the last 22 years from the OACCAC, where we went from 44 CCACs, which were locally responsive and community focused, to 14 LHINs. The integration of those LHINs—I listened over 22 years; I provided minimal feedback in terms of the transformation of those.

I see the opportunity with Ontario Health and Ontario Health atHome, as I mentioned earlier, being significantly transformative and having a significant impact on the patient.

In February of this year, there was an RFP that was released with Ontario Health, and the focus was on negative pressure wound therapy, infusion, medical supplies and equipment. The RFP related to that particular sector being more about transactional.

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I believe, with the solution to integrate the providers in that sector that I've just mentioned and bringing them forward with the nursing agencies to be able to have connected and convenient care—which is a representation of the government's focus at this moment—and focus on connecting the patient within the community, could have a profound impact.

I believe right now, when devices are, if you will, prescribed from the discharge planner—I see this almost every day—there is a disconnect in terms of the product or the device that should be administered in the patient's home. This, actually, is done blind, if you will. The discharge planner does not see the environment that patient or client is moving into, nor does the PSW or the therapist or nurse who is walking into the environment with the device that has been dropped off.

To lead on this point, in its current format, the way the RFPs are rolled out, a delivery driver will drop off a patient lift—I've talked to individuals and clients and caregivers and nurses about this. A patient lift will be dropped off. Over two weeks, it will be kept with a sling on the floor, not utilized at all because the PSW, the nurse, the therapist or the caregiver or patient do not know how to utilize that device. That device could cause serious harm for that patient—using that anecdotally, it has happened, and I've talked to ministry staff, frankly, about their experience within the current environment. I wanted to share this with you.

The home medical providers are the foundation on which the program will be successful. Our impact would support all community health care staff, caregivers and patients. For context, hundreds of vendors provide life-sustaining devices and solutions in Ontario. Every client is unique and every script is unique. When we launch the RFPs, we're launching—particularly on infusion therapy—with the fact that there is a shortage of infusion nurses in the marketplace in the province of Ontario.

There is also a shortage of NSWOCs, nurses specialized in wound, ostomy and continence. They are not part of the continuum of care in the community at this point. Those nurses provide specialized care, collaborating with providers to deliver the best care for the patient.

Utilization of these devices, with appropriate home assessment, training and product recommendations, would maintain patient safety, support the caregiver and alleviate pressure on hospital discharge planners and health care professionals who care for patients, with measured time to provide the appropriate recommendation and set up the product and training of all stakeholders.

The current situation does not provide the time, training or home assessment to discharge planners, health care staff, caregivers and patients. The focus of this time that I

have with you is to highlight the impact that current RFPs can have with your transformative proposed changes.

If the recommendations are that health care providers and home care equipment providers are connected in some way, formalizing the connection with the nurses, occupational therapists and physiotherapists who provide assessment and treatment, we can develop a remarkable system to care for the patient at home.

I strongly agree with all the presenters today and yesterday who focused on home care. It brings value to the patient. The patient and the caregiver want to stay at home longer. It's a cost-effective process. It's a cost-effective program. It cares for the patient, but done in the right way, in terms of connecting the patient to all stakeholders to ensure that the patient is at the centre of this, to reduce hospital readmissions and maintain the patient.

The Chair (Mr. Brian Riddell): One minute remaining.

Mr. Jamie Church: Thank you.

In its current structure, as I mentioned, the delivery of HCCSS RFPs is limiting to patient, family, caregivers, as I mentioned, discharge planners and nursing care. Limits are placed on selecting the safest products for patients to be discharged home safely with the equipment.

Historically, as I mentioned, the system was regional in scope, with 42 CCACs, down to 14.

If there was an approach to coordinate more localized care with nursing agencies as well as the providers, you could have a responsive and more intimate approach to ensuring that the patient is cared for time after time.

The Chair (Mr. Brian Riddell): Thank you.

We will now start round one, with the official opposition having seven and a half minutes. I recognize MPP Gélinas.

M^me^ France Gélinas: I would like to start with Ms. Martin. You made it clear as to what is needed for our home care system to be able to meet the needs of the people who require care. You had five points, and I'd like to take them one at a time.

Fairly compensated—could you give us an idea as to how much RPNs make if they work in home care versus in other areas?

Ms. Dianne Martin: Unlike acute care, which has more balanced wages, it can really vary in home care. We have members who tell us that they make as low as $22 an hour. Others work for other types of agencies where they're making a bit more than that, even close to $30 an hour, but still remarkably low for the service that they provide—by the way, what would work out to as a yearly wage into that amount. But because it's assigned by visit, not hours, the number of hours in a day they spend to see the 14 to 18 patients that, many times, they are required to see can reach well into the evening, especially if they encounter something unexpected at one of those visits.

M^me^ France Gélinas: Would you say that most of the RPNs working in home care do not get paid in between clients?

Ms. Dianne Martin: Our understanding is that they don't—it is by the visit. I spent time one day with a home care nurse from rural Ontario, and the drive between visits was quite extensive; the day that we were going was particularly bad weather-wise. So, yes, it can really be a long day, with the compensation not reflecting the length of the day.

M^me^ France Gélinas: Would you know what percentage of home care agencies have started to use nursing agencies to fill RPN positions? Is it common? Is it just one-offs once in a while?

Ms. Dianne Martin: I don't know the answer to that question. I know that it exists in home care. I don't have any way of finding out a solid percentage.

Most nurses I speak to on a daily basis, regardless of their sector, are working with agency nurses.

M^me^ France Gélinas: So an agency nurse would be doing the same work they do for the same home care providers?

Ms. Dianne Martin: Yes.

M^me^ France Gélinas: And that's in most of the areas? Do you have members throughout the province?

Ms. Dianne Martin: The whole province.

M^me^ France Gélinas: Thank you.

I'd like to ask the Ontario Community Support Association—I fully understand how important the work that you do is to keeping people at home. Meals on Wheels—if you don't eat, you cannot stay at home. If nobody comes and helps you shovel your driveway, you cannot stay at home. So you do very important work.

When was the last time your members had a base budget increase?

Ms. Deborah Simon: Well, we're anticipating one this year—hopefully, we'll see the money through. We're still waiting for funding letters to come through this year.

Overall, I'd say that over the last decade our base increases have not kept up with the rate of increase in terms of the cost of living. So most of our members are lagging way behind in terms of the ability to keep the infrastructure going in their organizations and operations, and what is hardest hit is salary.

M^me^ France Gélinas: What would be reasonable compensation for people who work within your sector? What is it right now, and what could it look like in order for your members to be able to recruit and retain a stable workforce to do the important work that you do in keeping people safe at home?

Ms. Deborah Simon: Patrick, do you want to speak to that?

Mr. Patrick Boily: Sure. What we're really looking for, and I think what would be fair and adequate is wage parity across the different sectors. One of the biggest barriers to recruitment and retention within our sector is very much the wage gap. PSWs who earn between $20 to $24 an hour in our sector can earn an extra $5 an hour in long-term care and an extra $7 an hour in hospitals, so it's very hard. On the nursing side, the gap is even higher; it's a gap of up to $10. As we've mentioned, with the Bill 124 arbitration awards, that gap is just going to get larger, with increases of up to 11% for the hospital workforce.

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M^me^ France Gélinas: It will be really hard to recruit and retain a stable workforce, absolutely.

You also talk about building capacity—does that mean your members doing more, or do you see agencies starting to provide community support services?

Ms. Deborah Simon: What we would like is for our members—our not-for-profit members who have been solid members of these communities in providing service for decades—to be increasing in their capacity across the province in all the communities. Certainly, the question you asked previously around the base increases is incredibly important to them. They have always had a great need for more support in terms of infrastructure.

Now we are moving into an Ontario health team. That integration is going to depend on a really strong operation, including things like technology and other supports that will need to be in place. So capacity-building in the not-for-profit sector and across the home and community care sector is going to be incredibly important for the success of teams going forward.

M^me^ France Gélinas: Do you see anything in the bill that says we will have wage parity across sectors? Do you see anything in the bill that says you will receive money to connect to technology and increase your capacity? Or are you just hopeful?

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Deborah Simon: Well, unfortunately, this is enabling legislation, so the meat of the legislation will probably fall on the regulation and policy. We hope to be fully engaged in this going forward, because this is a system that really will require a very knowledgeable—very long-standing providers to be able to help move it forward as we go through. So, not in the current structure of the legislation do we see that right now.

M^me^ France Gélinas: Were you consulted for this, before this bill came out?

Ms. Deborah Simon: We've had many ways of connecting with government on it. We've certainly submitted on every opportunity our views on what needs to be done as they move forward, and hope to continue, particularly as you raise the issue of what unintended consequences on consultation, as we see—

The Chair (Mr. Brian Riddell): Thank you for your presentation.

We will now go to the independent member for four minutes and 30 seconds. I recognize MPP Shamji.

Mr. Adil Shamji: My first question is for Ms. Simon from the Ontario Community Support Association.

As we know, under this legislation, the 14 local health integration networks get amalgamated into a single institution. I was just wondering if you could share your reflections on the impact that may have, for better or worse, for the delivery of home and community care in northern and rural areas.

Ms. Deborah Simon: Well, you may know that our sector has undergone numerous changes in terms of structures; we've gone from CCACs to LHINs to HCCSS with Ontario Health. So this has been a sector that has seen a lot of structural changes.

Structural changes don't result in improvement to client care or patient care. Often, they are very laborious, and they actually take up the oxygen for providers who are really focused on trying to deliver care to very vulnerable individuals. The structural changes anticipated—I'm not seeing all of the improvements on the client and patient side, and we are very keen to see that this will result in improvement for people in Ontario.

Mr. Adil Shamji: On the subject of this bill primarily being on structural change: I wonder if, Ms. Martin, I could ask you, with the preoccupation with structural change, is there anything in this bill, at all, that addresses any of the human resource challenges that are handicapping our home and community care sector?

Ms. Dianne Martin: There certainly isn't anything that gives any level of detail on how those issues will be resolved. We're really appreciative that there is a bill that will give us a chance to hopefully fix home care, but the details of how all of that's going to happen are missing, in my opinion, throughout the bill. That's why it's so important to us to be able to address those issues, so that we might get appropriate—how it will be done in the regulations.

Mr. Adil Shamji: For all of our witnesses: One of the things that this bill proposes to do is to increase the amount of integration, to centralize things into a single institution. Yet I note that when you compare the services that the LHINs provided versus the proposed service that this institution will provide, they don't overlap perfectly. For example, this new organization will not provide regional discharge planning. It does not have a provision in place for what happens if there isn't a service provider in a particular area. So how do we fix that in the interest of promoting integration, recognizing that there are a number of gaps in this bill?

Ms. Dianne Martin: I'll take a stab at that. I think one of the things we have to do is make sure that we know who is going into a home before a person is gone from the hospital.

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Dianne Martin: We have some problems with people arriving home, needing care pretty much immediately, only to find out that they will have to wait two or three days until there's someone available, leaving a gap in care that could put them right back in hospital. I think that's just common sense. And I think, absolutely, we need to have processes in place that allow for nurses who encounter something unexpected in someone's home, like mismanaged pain or something, to stay until that patient has become stable rather than transfer to hospital.

Mr. Jamie Church: Certainly, you can increase the number of providers in a geographic region to have responsive and more intimate care to the patient, versus the smaller number of providers both on the equipment as well as the nursing care agencies—it's much smaller and harder to get to from a geographical area to reach out to those patients when they're being discharged. I do believe that

if you have an increased number of providers in a certain region, you can provide that specific care.

The Chair (Mr. Brian Riddell): Thank you very much.

We'll now go to the government side. I recognize MPP Martin.

Mrs. Robin Martin: Thank you to all of our witnesses here today. It was very interesting to hear some of your comments.

I want to start with the Ontario Community Support Association. I was listening carefully to what was presented, and I understand that you're positive about the home care legislation and recognize the potential of our Ontario health team transformation to strengthen co-operation between health care providers and ensure that community supports, primary care and home care foster a person-centred model of care—I think that was your wording—allowing smoother transitions, better care and a more holistic approach.

I just want to ask you if you had any further comments about why you think this team-based approach is going to enhance home and community care services, because certainly this is the direction that the government wants to go in to make sure all parts of our system are working together.

Ms. Deborah Simon: Thank you for that question.

I think that what will be really critical, going forward, as part of the modernization approach will be to look at our front line and look at our health human resources, which is why as part of my presentation I did talk about the need for an overall HHR strategy.

The pandemic has been particularly hard on our sector. Because of compensation, because of the nature of going into people's homes in the community, we have had a great turnover in staff. And the only way we're going to be able to attract staff back to our sector is through looking at the broader needs of the staff, compensation being a very large component of that. I think that while we're looking forward to all of the other integration opportunities, we can't deliver on this without having a really strong workforce.

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Mrs. Robin Martin: Thank you very much for the response.

You may know that our government has announced that we're working on a health human resource strategy for the long term, which I think is a first in Ontario health care. It's very important, obviously, at this time when we have an aging demographic, increased demands on our health care system, and a lot of new immigration and international students and other things putting pressure on our health care system. So we certainly have to plan for the future, and health human resources are critical. That is a big part of what we're working on.

You also mentioned that you thought embedding home care in Ontario health teams was an opportunity to break silos, and I wondered if you could elaborate a little on what you meant by that.

Ms. Deborah Simon: [*inaudible*] goes across and touches all parts of the health care system. So from the perspective of people who are coming home post-surgery, those who are awaiting or are in their aging years and want to have care at home, we cross all of those sectors. You can't have a healthy health care system without a really strong and robust home and community care system to hold that up. It actually has been described as the third leg of a health care system—-without strong home and community care, the whole system falls down.

So integration of those services across the spectrum of health care is going to be incredibly important, and service navigation, not only just in home and community care but across the entire system, is going to be critical because it is a complex health care system. We won't change that, but we do need to have a strong ability to navigate people to where they need to go, when they need to go there.

Mrs. Robin Martin: I guess that's why I believe it was the other Mrs. Martin in the room, the one who is here to give evidence, offered that home care has long needed attention—I guess home and community care, one could say, have long needed attention. I understand Mrs. Martin, the witness, looks forward to this bill because home care is getting some attention with this bill, and I think that is the focus of our government.

Let me ask a quick question to Mr. Church, who brings a different perspective today. I was just wondering if you could share with us, based on your experience—and you described a little bit of that—how Ontario health team partners could work with medical equipment groups to advance high-quality, equitable services in home care?

Mr. Jamie Church: MPP Martin, I'll mention this in terms of my experience. Seeing as right now the current structure really is a delivery driver dropping off equipment and leaving it at the front door, in some cases, this poses challenges both to the caregiver as well as the health care professional. In some cases, they will have to assemble the device and place the device in the patient's home safely, which often provides risk if the device is not correct. The solution, frankly, is connecting the home medical equipment providers with the nursing agency.

I touched on, in terms having more localized care—we went from 44 CCACs to that 14. We do have an opportunity in the bill—that mentioned that there is an expansion of Ontario Health atHome. This is a positive bill that can have a profound impact, but we need to be connected. There was an instance, when the RFP was released in February or March—there was an indication that one provider was going to service the north. It's impossible, based on the geography. It's not fair to patients, it's not fair to caregivers and, moreover, it's not fair to the nurses and health care professionals who are in the community.

With more connected care, working with all stakeholders, whether it's through technology, whether it's within a connection to the long-term cares in that region or the hospital particularly, you can demonstrate, frankly, real connected care to the province.

Ontario Health has a virtual care model right now as well as remote care monitoring programs. It's being rolled out with Toronto Grace hospital. I talked to the CEO of

Toronto Grace hospital—there are over 30,000 patients that that remote care monitoring services used.

The Chair (Mr. Brian Riddell): One minute remaining.

Mr. Jamie Church: So that service alone can be a conduit to ensure that the patient is safe at home once it's installed, and ensure that the actual right product is delivered so it takes the burden off the caregiver, the nurse, as an example, as well as the provider delivering the appropriate equipment—as well as reducing waste. I mentioned the example of a lift and a sling being dropped off at a patient's home and not being used for two weeks. That's waste in our system. How can we efficiently prescribe the right device, noting that every client is different, every prescription is different and every device and its utilization can be used in its best-performing method to keep the patient away from the hospital and keep them at home longer?

I'm optimistic with this. It's encouraging. I'm positive about this. Collaboration will be key across all jurisdictions and all agencies. It's not happening right now, and it never happened in the time that I've been involved, for 22 years, in this process.

The Chair (Mr. Brian Riddell): We will now go to round two for the official opposition, seven and a half minutes. I recognize MPP Gates.

Mr. Wayne Gates: Thanks to the presenters.

I will ask Dianne from WeRPN, how much consultation did you have over this bill?

Ms. Dianne Martin: We submitted recommendations—we were asked to submit, and we have submitted that, and we will be giving that to the committee to see as well.

Mr. Wayne Gates: How many times did you get a chance to sit down with the minister during the consultation process?

Ms. Dianne Martin: I have not yet had an opportunity to meet the Minister of Health.

Mr. Wayne Gates: And how many members do you have?

Ms. Dianne Martin: We have 17,000 members.

Mr. Wayne Gates: So you have 17,000 members in this sector who would—

Ms. Dianne Martin: Oh, sorry—who work in home care. In Ontario, practical nurses—there are 7,000 who work in the home care sector.

Mr. Wayne Gates: Would you think it would be fair and reasonable that the minister would have taken a look at your membership, the incredible work that you do every day in home care, to maybe sit down with your organization and say, "We're looking to do a bill. We want it to be the best bill possible"—which would be a myth. But would you not think that would have been a good idea to do that? Because I always hear this. They've got this Working for Workers bill. I don't know if you've ever heard of it. I think it's Working for Workers 14 or 15—I don't know what number they're at now. But you would think if that was accurate, they would have sat down and said, "How do we improve this? How do we make sure this is going to take care of loved ones at home and make sure they're staying at home?" You're telling me that never happened? The minister never once said, "Let's meet with your organization"? Is that fair?

Ms. Dianne Martin: I would love to have a meeting with the Minister of Health, but I have not yet had that opportunity.

Mr. Wayne Gates: The government never says this, but I'm going to ask you this question, and I'll see if you answer it the way I think you would—but obviously answer it the way you like: What, in your opinion, is the primary cause of the recruitment and the retention crisis or the staffing shortages in our health care system today in the province of Ontario, including for home care?

Ms. Dianne Martin: We survey our members every year and ask that very question. The answer, ever since the beginning of the pandemic and since the beginning of Bill 124, has been wages and workload, and that stays the same every year. We also are noting a much easier time recruiting into acute care than home care and long-term care, so we know that those issues are much greater in long-term care and in home care.

Mr. Wayne Gates: You also mentioned Bill 124. You and the other presenters may or may not know that the NDP has been against Bill 124 since the day it came in.

Are your members happy that they're having their wages attacked under Bill 124, or do they say, "No, it's not an issue for us"? What do you think of Bill 124?

Let me just finish one other part: When they talk about investing in health care, there is nothing more important to do than investing in the workers and our nurses.

So give me an idea of where your members are at—maybe your members like Bill 124.

Ms. Dianne Martin: I think Bill 124 is the single most hurtful thing that has happened to nurses. I've been a nurse for 44 years, and I think during those 44 years it's the single most hurtful thing that has happened both to the sensibilities of nurses, their self-worth, their love of the profession, but also in terms of the broader health care that we are tasked to provide—much, much harder to provide when nurses move on to other professions.

Mr. Wayne Gates: This is one that I've raised and my colleagues have raised—I don't usually get it raised from the government very often, although we do try to help them out on what we think would be helpful. I think my job, as official opposition, is to give them ideas that might help the health care sector. What effect do you believe that for-profit nursing agencies have had on your membership—the agency nurses who are coming into different workplaces, whether that's in retirement homes, long-term care or home care. I know the bill is on home care, but I think agency nurses are causing a real problem right across our province of Ontario.

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Ms. Dianne Martin: First of all, I want to be clear that I don't hold it against any nurse who says, "I need to take more control over my work life," in a world where they have no control over their workload and other pressing—how many people show up for work and those sorts of

things, how many weekends they are asked to work. It has been a very difficult thing.

My daughter is a nurse. She works alongside agency nurses who she says are very good. And she's very good. She works in critical care. The fact that they're making so much more than her on a shift—of course, that is a very, very difficult thing for her to do. To stay permanently employed in the hospital where she's employed is a decision that she has made, but she understands those who haven't made that decision.

Mr. Wayne Gates: I want to stay on agency nursing, because I think it's causing a crisis not only in home care, but long-term care as well.

I didn't realize your daughter is a nurse. Make sure you say thank you for what she does every day.

Ms. Dianne Martin: I will.

Mr. Wayne Gates: Do you think it's not only fair, but is it good for the workplace—because you're going to work to take care of patients. That's what you do. I don't call them "clients"—I'm sorry, I don't like the word; I don't want to use the word. Certainly, you're going to work to take care of your patients, and you do it very, very well. Do you think it's fair that two people working side by side—one is making sometimes two and three times more per hour. Having said that, if I'm the nurse who's making $30 and the other one is making $90, I'm thinking to myself, why would I stay in a public system where I'm getting paid $30, when I can do the exact same work and pick my shifts—I might not even have to work weekends—and make $90 an hour?

Do you think that Bill 124 and the agency nurses are causing nurses to leave the public system—which I think is going to have even a bigger crisis on our home care and our long-term care and our retirement homes and our hospitals. What do you think of that? Maybe I'm wrong on that. That's why I thought I'd ask an expert.

Ms. Dianne Martin: I think that it is incredibly unfair. I think the nurses are doing it for reasons that have to do with the pressures they're under.

I also want to point out, in sectors like long-term care, the agency nurses who arrive don't know the clients. Clients don't wear identification because this is their home. The risks to residents when the nurses don't know them well is a very—that's really risky business.

In terms of all sectors, like home care, I think it is demoralizing to nurses to know that they are not all recognized the same, paid the same, through no fault of their own.

The Chair (Mr. Brian Riddell): We'll now go to the independent members for four and a half minutes. I recognize MPP Brady.

Ms. Bobbi Ann Brady: I apologize; I came in late. Some of you may have addressed this and I missed it. I've just come from a meeting with the nurse practitioners. We hear a lot about not enough hands on deck. We're having a hard time getting enough people to go out into the community to perform home care. And yet, I just met with nurse practitioners who tell me they can't find a job in the community. I met with one of my own constituents who works in Guelph because there isn't a funding model available in Haldimand–Norfolk where she can secure a job.

I understand that the way it works now, anyone in home care is followed by a physician who has their own roster of patients within their family practice, and then they are also responsible for those in home care. So the access—if that doctor needs to be accessed due to a question that someone has in home care from being in a patient's home, that disconnect is sometimes hours long and they don't get an answer.

Do you feel that there is a possibility that we could be putting nurse practitioners on the travelling system, where they go and they deal with home care, kind of looking over what PSWs are doing—eliminating the physician aspect by putting the nurse practitioners in that role instead?

Ms. Dianne Martin: I'm going to defer that question to RNAO, who's speaking in the next hour, or to Deborah Simon.

Ms. Deborah Simon: I think the description that you had of the role of the nurse practitioner is not exactly the role that nurse practitioners would play in home and community care.

I just want to be clear that you know that there are NPs who are functioning in home and community care in many roles. Is there more need? Probably. And in areas where there are clients who need primary care and they're not able to access any, there's a role for NPs there, for sure—exactly where across the province and how many, I'm not clear. But absolutely, nurse practitioners could play a huge role in home and community care.

The Chair (Mr. Brian Riddell): I recognize MPP Shamji.

Mr. Adil Shamji: In the twilight of our questions here, I just wanted to give everyone an opportunity—are there any amendments that you would like to see in this legislation? I'm seeing a no from Jamie. Ms. Martin? No. Ms. Simon?

Ms. Deborah Simon: I would like to say that one of the challenges with the current legislation—again, as I mentioned earlier, it's enabling legislation. So the meat of what the change will be in terms of this act is yet to be seen because it needs to be pulled out in regulation and policy. I think it's going to be absolutely critical for government to engage with organizations like ourselves and WeRPN and others that are delivering and providing care in the community, so that unintended consequences of policy decisions and regulations don't occur as a result of not having good feedback from these organizations.

The Chair (Mr. Brian Riddell): We will now go to the government for seven and a half minutes. I recognize MPP Barnes.

Ms. Patrice Barnes: My question is for Jamie.

You have been in the industry for 22 years, and you've talked about—there was a larger group, we condensed it into 14, and now we're condensing it again into one unit, with the idea of the integration being way more at a localized level, way more responsive and effective. In looking at that system, that being the direction of govern-

ment, what would be some of the things you'd highlight that probably would need to be in this bill to make that a successful integration?

Mr. Jamie Church: I truly believe that, first off, the challenge is limiting the number of providers. I'll give you an example. Years ago, there were, let's say, 15 to 20 infusion providers in the province of Ontario; now they're limited to five—impossible to service the province. There's an opportunity, frankly, as I mentioned earlier, to increase the number of providers in a region, including nursing agencies.

We talked about the health human resource challenges. If you had a larger number of providers in a particular region that are actually servicing the region in particular and managing hospital discharges much faster, it would reduce, frankly, the challenges of nurses or occupational therapists and physiotherapists moving from one region to another to service that patient, travelling large distances. Rather than one, if you had three to four to five providers in, let's say, the Niagara region servicing that area, you could prevent hospital readmissions because of the response time as well as the commitment to care that could occur. You could manage it, if it's a cost system. We understand what the costs are in home care right now, in terms of the RFPs that we've been doing for the last 22 years. So if we understand the RFPs in terms of what our cost of servicing is, you use that as your model, and your providers then can indicate, "Yes, I want to serve that entire region," and you could increase the number of providers.

When we had the CCACs, let's just say, in the Niagara region, we had smaller locations servicing smaller areas and we were able to get to the patient much faster, with a hospital indicating that this patient is being discharged faster. You're able to keep the patient in their home—rather than going into long-term care or going back into hospital.

1400

I think you understand what costing is, but the limitation is with, if you will, the red tape that was introduced post-CCACs. It eliminated the number of providers that could service the province. That, I think, is being removed—the red tape that exists. If that red tape is removed, you may see an increase in providers, whether it's nursing agencies that believe in home care and be able to attract new staff—more importantly, the infusion providers, the home medical equipment providers, would be able to respond much faster, as I mentioned earlier, in that particular community.

So reducing red tape, understanding what your cost systems are, ability to invite more providers to service that particular region—would be one answer to solving the crises and challenges in home care.

We all agree in this room that home care is an important part of our health care system. I think this bill shines a significant, important light on it. It's promising and encouraging, frankly, that we are making this change happen. So I want to thank the committee as well as the government—to be able to open up for conversations. For 22 years, I was in this, seeing both in pharmacy as well as home care, and there was no significant consultation to make change happen. No one was listening in those periods of time post-CCACs.

I also look at providers, more importantly. We made a major change in recognizing this impact that community pharmacy, during the pandemic and post-pandemic in terms of minor ailments—and the role that community pharmacy can play in taking pressure off the system. Home medical equipment providers can play the same role. We're at that, if you will, inflection point that can have a significant impact on patient care. Pharmacies proved it—whether it's the rollout of vaccines, as well as minor ailments. Twenty years ago, pharmacy didn't want to do meds checks, didn't want to do flu shots—and see where the change was, frankly, in terms of how they had an impact on patient care. It's happening today. That pressure is being taken away from emergency rooms as well as family physicians. The pharmacists are playing a significant role in community health care. Providers and nursing agencies can do that as well, given localized and more focused attention to that particular community.

Ms. Patrice Barnes: We've had so many conversations, and we've heard so much about care at home, care in the community, access of care, especially when we're talking about having localized pieces and teams that service areas. That will create more equity across systems, because when you're talking about our different communities, whether or not they're marginalized, whether they're racialized, whether or not they are communities in poverty, with localized teams, you can actually respond to care as it stands.

I want to thank you for that.

My other question goes to Ms. Simon in regard to—OCSA has been a key contributor to our round tables with the Minister of Health in regard to feedback around home care modernization. I just wanted to tap into some of those conversations that you've had at the main table in regard to how we can get to that point of integration where we put patients at the very centre of care and how we can best service them with this new model of care. We're talking about a centralized system that moves all the staff—

The Chair (Mr. Brian Riddell): One minute.

Ms. Patrice Barnes: Sorry—that we have right now and moving—talking of all the staff we have now that will move over to the system.

What would be some of the things that you'd like to flag as we migrate to this new—to flag?

Ms. Deborah Simon: It's a great question.

I think the real challenge ahead of us, specifically for government, is trying to find what will be the right balance between provincial direction and local flexibility. The whole intention of the legislation is to be able to enable Ontario health teams to be able to provide integrated services to people in their communities. We are now, with this legislation, looking at an Ontario Health atHome that should be more back office in supporting the OHTs.

I think what we'll see going forward, because we've been through so many changes in home and community

care, is that there will be a tension between provincial direction and local flexibility. I think that's going to be for all of us to be able to solve as we move forward, to make sure that we are providing the right amount and care services for everyone, regardless of what community they are, and particularly those for which health inequities are really a challenge for—

The Chair (Mr. Brian Riddell): Thank you for your comments.

I'd like to thank everyone for their comments today. If you would like to submit any written materials to the committee in addition to your presentations today, the deadline for written submissions is tonight, Wednesday, November 15, 2023, at 7 p.m.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

SE HEALTH

ONTARIO HEALTH COALITION

The Chair (Mr. Brian Riddell): I would now like to call the next group of presenters to please come forward: Registered Nurses' Association of Ontario, SE Health, and Ontario Health Coalition. I'd like to welcome everyone.

As a reminder, each of you will have seven minutes for your presentations, followed by questions from the committee members. I will provide reminders of the time remaining during the presentations and questions. Most importantly, please state your name and then you may begin.

Registered Nurses' Association of Ontario, you can start when you're ready.

Dr. Doris Grinspun: I am Dr. Doris Grinspun, CEO of the Registered Nurses' Association of Ontario. RNAO represents 51,650 registered nurses, nurse practitioners and nursing students across the province. Let me highlight that this is a voluntary membership, so the power is in the numbers. I am joined by Christina Pullano, RNAO's senior policy analyst. We thank the standing committee for the opportunity to appear before you regarding Bill 135.

RNAO's vision is for a health system that is accessible, person-centred, equitable, integrated, publicly funded and not-for-profit delivered. RNAO measures all legislative proposals, including Bill 135, against this vision—this is the vision that an ongoingly growing number of members are asking. We have always welcomed and supported the notion of deeply integrated and publicly accountable health teams. As partners with Ontario's health teams, or OHTs as we call them, through RNAO's Best Practice Guidelines Program, we are witnessing excellent, innovative care models.

RNAO, however, cannot conclusively endorse or oppose Bill 135, as it does not provide, in our view, full transparency regarding our government's plans for Ontario's health system. Given that Bill 135 is transitional legislation, we are deeply concerned that the government has yet to fully define or communicate publicly the end state of the health system. What we have been told by the health minister is that Ontario expects to designate OHTs by this time next year, but core characteristics of these OHTs—funding, governance, plans for public accountability and more—have yet to be at least publicly communicated. Maybe the government knows; we don't.

That said, there are some general elements of Bill 135 that we do support. We welcome the dissolution of LHINs and their successors, HCCSS, and we have been on record for I don't know how many years about that. Further, we welcome the proposed assignment of care coordinators for client-provided organizations and other front-line health settings—and again, we have been for years on that, provided that the employment status and labour rights of nurses are fully protected. We believe that home care organizations are best positioned to coordinate the care required by their clients, as long as there is accountability for quality care expenditures. We also believe that deeper integration of health sectors makes way for innovative care and funding models and will provide better care for clients and better outcomes for the province.

In contrast, RNAO is deeply troubled that the bill does not address major challenges within Ontario's home and community care sector: inadequate access; outdated funding models; and a deep shortage of health human resources, in particular nurses. More than 15,000 Ontarians are on the wait-list for home care services, and over 150,000 Ontario residents privately fund millions of hours of home care—of course, not everybody can do that, right? That's where the hiccup is.

1410

The unmet need for home care services affects the entire health system, with 540 hospital beds being occupied by people waiting for home care supports. The evidence shows that thousands of long-term-care residents could have remained at home with the proper home care supports. That's where people want to be—at home.

Changing demographics also point to the urgent need to enhance and expand home and community care, with a 22% increase in Ontario seniors aged 65 and older projected by 2027-28. Health human resources are desperately needed to satisfy current and future demand for home care, yet Ontario is in the midst of a full-blown nursing crisis. Our province is 25,000 RNs short compared to the rest of Canada on a per capita basis. RN vacancies have skyrocketed over the course of the pandemic, with around 10,000 RN vacancies in the last quarter of 2022.

The home and community care sector is particularly vulnerable to staff turnover, largely because staff are subject to unstable employment conditions and much lower wages and benefits than in other health sectors. Another significant constraint is the sector's outdated funding model, which pays service providers for visits—much like doctors, I must say, or at least some doctors—not for client outcomes. This provides little opportunity for persons in their care—and few incentives to focus on quality improvements. The more visits, the more money.

The Chair (Mr. Brian Riddell): One minute remaining.

Dr. Doris Grinspun: Bill 135, as presented, does little to address these fundamental issues in home care.

The point is that we must, today, ensure that the balance of this bill hangs until our government officials define and publicly share the end state of their desired transformation of Ontario's health system. The funding formula, governance and public accountability measures of OHTs are critical to the success of health system transformation and optimized health outcomes for Ontarians.

We seek an accessible, person-centred, equitable and integrated health system. It should be publicly funded and not-for-profit delivered. There should be no user fees for home care, at least for an expanded basket of services, making it accessible to all based on their care needs, not the size of their wallets. If we don't do that, we will continue to trip the health system and people will end up in hospitals again and again and again.

The Chair (Mr. Brian Riddell): Thank you for your comments.

We will now switch over to SE Health for seven minutes. You can begin when you're ready.

Ms. Madonna Gallo: Thank you so much for having us. I am Madonna Gallo, the vice-president of strategy at SE Health. With me is Kim Utley, our clinical director of health care solutions.

SE Health is a national not-for-profit social enterprise that has been supporting people to live and age at home for 115 years this year. We take pride in our team of 8,000 nurses, personal support workers and therapists who work collaboratively to deliver care to over 25,000 patients and families every single day.

Today, I'm here to express our belief that Bill 135 presents a promising foundation for the improvement of our health care system. I have worked in this sector for over 20 years and would like to acknowledge both the complexity of the file and the importance of getting it right. We appreciate the ongoing effort and commitments by this government and our colleagues at both the Ministry of Health and Home and Community Care Support Services to invest in and modernize our sector. However, we also see room to further enhance this legislation and, in turn, home care services for Ontarians.

We have three key recommendations for the bill's improvement. First and foremost, we encourage greater clarity around the ultimate objectives of the bill. While the bill contains many elements, its preamble and legislative debate have yet to clearly define the desired outcomes for home care, particularly as it relates to the patient experience, as well as that of front-line care providers across the sector.

Our second recommendation is to more clearly establish the roles and responsibilities of Ontario Health, the Ministry of Health, the new shared services agency and home care service provider organizations. The current model lacks clarity in how each entity would operate under the new system, and a clearer delineation of roles would facilitate a smoother transition.

Finally, as a home care provider, we welcome the opportunity to participate meaningfully in the transformation. SE Health has been a leader in developing and scaling integrated funding and bundled models of care with hospital and community partners since 2015. Today we have 40 such programs in the field across the province. Under home care modernization, we encourage Ontario health teams to work with their local partners to continue to adopt and scale these models so that more Ontarians can benefit.

To shed light on the remarkable work being done through one well-known and loved program, Southlake@home, I'll hand it over now to my colleague Kim Utley, who is a proud registered nurse.

Ms. Kim Utley: I'm very proud. My name is Kim Utley. I'm clinical director for health care solutions at SE Health. SE Health has a long-standing commitment to patient care and well-being, and we are absolutely dedicated to delivering patient-centred, innovative care models. In collaboration with Southlake Regional Health Centre, we've been running one of those innovative models since March 2019.

Given the challenges facing the health care system, from the impact of COVID-19 to the increase in alternate-level-of-care, or ALC, rates, SE Health and Southlake co-designed an integrated solution to address these issues and more. We refer to this as the Southlake@home bundled model of care program.

Southlake@home is a 16-week transitional integrated bundled care model. It offers a direct path home for patients who have finished their acute-care treatment in hospital but have complex medical and social needs that require some post-acute-care planning. This program involves an interdisciplinary team of community-based staff working closely with local community and support staff and services, with primary care and with acute care to create a plan of care that is tailored specifically to that patient's and family's needs. This ensures a smooth and coordinated transition from hospital to home and then the community support services and support after discharge from our program

This care model matches services to each patient's unique needs. Upon discharge from hospital, patients are supported by an interdisciplinary care team comprised of caregivers as well as the care providers. The program offers continuous wraparound support, a 24/7 helpline for additional patient/family support, a shared care plan, and the integration of technology for communication and self-care.

This bundled model empowers the care providers to allocate resources based on the changing needs of the patient and families. It optimizes scope of practice and provides the necessary care in a very flexible, patient-centred manner. This approach shares the risks and benefits between Southlake and home care providers, while enhancing patient access and caregiver resiliency.

The results of this program have actually been quite impressive. The average ALC length of stay at Southlake has been reduced from approximately 14.2 days to 10 days. Over the past four years, this has resulted in roughly $21.5 million in cost savings.

Patient readmission rates are also very closely monitored, and 28% of our discharge patients actually experi-

enced a reduced risk of future ED visits and hospital readmissions compared to non-enrolled patients.

This program has achieved a 94% satisfaction rating among patients and families, along with a reduction in caregiver burnout reported by more than half of the patients and caregivers.

To maintain these positive outcomes, it's essential that we have the funding structure—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Kim Utley: —that allows for flexibility in the care model and in the utilization of health care resources across the systems. These innovative care models have definitely demonstrated their value and should be explored and scaled throughout the province. We hope that, as previously stated by the minister, the government will support and expand such models of care across the province.

I'll turn it back to Madonna.

1420

Ms. Madonna Gallo: Thank you, Kim.

Given the time, I will just say that we look forward to being part of the discussion and answering any questions that you may have. Thank you.

The Chair (Mr. Brian Riddell): We'll go to the Ontario Health Coalition, which is virtual. You may begin. You have seven minutes.

Ms. Natalie Mehra: Thank you very much for allowing me this opportunity to present. I did try to get on the Zoom last night, and it wouldn't connect, so I appreciate being able to slot in today with someone who has cancelled.

My name is Natalie Mehra. I'm the executive director of the Ontario Health Coalition. We represent more than 750,000 Ontarians in a network of more than 50 local chapters and more than 500 member organizations. We have been working on home care for at least 30, 35 years in Ontario. And to understand this legislation, we think it's important to understand the history, because, in some ways, this legislation takes us back about 30 years.

Pre-1994, when the then NDP government made the first big step towards modernizing home care, the main complaint that we got from our members in the seniors organizations and people with disabilities and people receiving home care was that home care was ad hoc. It was, at that time, mostly not-for-profit; for example, in 1995, 82% of home nursing services were non-profit. It was ad hoc, provided by municipalities or non-profits. It wasn't organized. There was no clear regional governance. There was no clear entitlement to home care. People really wanted a coordinated, integrated system, to be able to age at home for as long as possible.

From the 1980s on, the hospitals were downsized, and a big off-load of hospital patients happened in the late 1990s. Under the Harris government, hospital patients were off-loaded in the thousands to home care, and home care was restructured again, but this time, to create a system of competitive bidding, to invite the for-profits to bid against the long-standing not-for-profit providers, and ultimately, they took over the majority of the so-called home care market.

In 1999, service caps were instated on home care. The government got rid of all elected local governance of home care, and the elected boards and memberships were wiped out. And then the Liberals froze that when they came into power in 2003—froze that system in place, essentially, with some slight improvements. They brought in basic employment standards for home care workers. They brought in the minimum wage for PSWs. They removed the caps entirely for people waiting for long-term care and increased the caps otherwise. But basically, the system was frozen in place.

Since the Ford government has gotten in, there have been two major pieces of health care legislation that have moved us towards devolving and privatizing more of home care. And this bill, Bill 135—although, as people say, it isn't clear in some ways, it does clearly do a couple of things.

But just pre this bill, this is where we stand now: 62% of home care funding, according to the latest special audit by the Auditor General, now goes to the for-profits, so the majority of "market share" is held by the for-profits. The reported billing rates in that audit were $58.20 to $76.60 per hour for nurses—that's the billing rates of the for-profit companies. The nurses themselves, of course, were only paid, at that time, around $30 per hour; for PSWs, the billing rates, similarly, were double or more than double what actual PSWs were paid—a huge amount of lost money in the system that is going to profit. By that audit, there were 260 contracts with 160 home care companies in Ontario. And in a 2013 review, which is the latest review that I know of, there were 14,000 contracted rates over 94 different service categories.

And yet, with all of that, the big complaint that clients have in home care is that they may be eligible to get home care but the care never shows up at their door. The nurses don't show up, the PSWs don't show up because of the profound staffing crisis and because of the—

The Chair (Mr. Brian Riddell): I'm going to ask you to pause here for a second. The bells are ringing. There's a vote—

Interjections.

The Chair (Mr. Brian Riddell): The committee will recess until after the vote.

The committee recessed from 1426 to 1442.

The Chair (Mr. Brian Riddell): We'll now resume where we left off. You have two minutes and 20 seconds left. Please continue.

Ms. Natalie Mehra: Thank you. As I was saying, as of the last review of the system, we had 260 contracts with 160 home care companies, 14,000 contracted rates over 94 different service categories. And yet, with all of that, the chief problem is that people don't get the home care that they're even assessed as being eligible to get; it just doesn't arrive at their home.

While it is unclear—some of the things—this act clearly does do two major things. It eliminates—and all of these changes, from the beginning, from the initial plans in the

1990s to set up an integrated home and community care system that would be public, all of the changes after that have really been guided disproportionately by the interests of the provider companies, against the interests, in many cases, of the clients in home care.

This act does two things: It eliminates the LHINs and the regional public governance of home care, finally, completely, and the whole system of governance and oversight. It centralizes some of that to a new body that would be a subsidiary of Ontario Health called Ontario Health atHome.

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Natalie Mehra: Thank you.

There are no public governance provisions for that—no public board meetings, no public reporting, no ability for communities to have input there. And then it devolves and privatizes roles that were formerly held by the LHINs, by the regional governance bodies, that were public, including, vitally, care coordination. So at this point, under this new legislation, care coordination would be handed over to the provider companies, service providers and Ontario health teams, which are loose amalgamations of provider companies—again, the majority of which are now for-profit—to provide themselves. This is the fox guarding the henhouse. Because we have a majority of for-profit providers, care coordination then being controlled by the same companies that are selling home care services directly to clients for payment out of pocket that are more expensive than publicly funded home care is a serious problem. It's an impossible-to-overcome conflict of interest and—

The Chair (Mr. Brian Riddell): Thank you for your presentation.

We will now go to round one, starting with the independent members for four and a half minutes. I recognize MPP Brady.

Ms. Bobbi Ann Brady: My first question goes to Dr. Grinspun. The previous presenters told me to ask you this question. I just met with nurse practitioners this afternoon, and from what I understand, they're being underutilized in our health care and our home care system. I spoke to one who lives in my riding of Haldimand–Norfolk—she actually lives in Elora five days a week so that she can work in Guelph. She can't find employment as a nurse practitioner in the area that she lives in. I think that they may be a missing piece to this puzzle—including RNs as well. I'm just wondering if you might be able to comment on whether or not you feel they're being underutilized as well.

Dr. Doris Grinspun: Yes, I do. Not only that, I believe that Ontario, even though it's better than other jurisdictions in Canada—we shouldn't measure up to other jurisdictions in Canada. On this one element, perhaps the only one, we need to measure to the US—the US has probably 10,000 more NPs than Ontario, and Ontario is better than other jurisdictions. So, yes, we need to increase the utilization of nurse practitioners not only in home care—absolutely in home care—also in primary care.

As you know, we have over 10 proposals with Minister Jones. Yesterday, we got good news that decisions have been made, but they need to be announced, because we have, as you know, a tremendous shortage of access to primary care, and these proposals—these NPs with NP-led clinics—are ready to go the day after the announcement comes, and it will become a huge, huge solution for the system.

So, yes, NPs need to be much, much more utilized; they are in other countries, and we are lagging behind, even though we are better than the rest of Canada, but that doesn't satisfy the RNAO.

Ms. Bobbi Ann Brady: Could you describe for me what role they would largely fill in the community?

Dr. Doris Grinspun: Yes. Let me talk about two things—by the way, we do represent RNs and NPs, just to make sure that you understand, but we also understand the role of RPNs, our colleagues who presented before.

Both NPs, us, their function is now expanded—because we are missing mental health forms expansion for them, form 1 and others, and RNs, with RN prescribing, which—kudos—finally was announced, so that's good. In home care, specifically, they could prevent a lot of complications. For example, they could free up physicians for coming to see patients—because their RNs are there anyway. The colleagues who work in home care are there anyway. So everything from assessment, diagnosis, treatment and then prescribing medications—and if you think about the pandemic, and we did speak hugely during the pandemic about that, home care was awfully underutilized. Terrible, terrible—there are countries where primary care and home care led the show and with much, much better outcomes—

The Chair (Mr. Brian Riddell): One minute remaining.

Dr. Doris Grinspun: Home care was almost decimated during the pandemic. That's partially why we have the shortage, quite frankly, in home care—because nurses left the sector, NPs and RNs and RPNs.

Ms. Bobbi Ann Brady: And one other question, if we can sneak it in, to Madonna: You said Bill 135 provides a good foundation to address the complex issues in home care. Can you identify which parts of Bill 135 are good ideas?

Ms. Madonna Gallo: Well, we support the general direction of winding down Home and Community Care Support Services and moving towards more integrated models within Ontario health teams. I think this is a very exciting development for all of us in the province—trying to bring providers together. Having separate structures and agencies that are just focused on one particular aspect of the system does not necessarily drive that integrated thinking that is required. So that would be one example of something that we support as a very—

The Chair (Mr. Brian Riddell): Thank you for your comments.

We'll now go to the government for seven and a half minutes. I recognize MPP Martin.

1450

Mrs. Robin Martin: I want to thank all the witnesses today for coming and giving us your input on this bill. It's a fairly short and simple bill. It's not very complicated, but it is enabling certain improvements, I think, in our system, and that's what we're going for here.

I was very excited to hear from Kim about Southlake@home. Our former Minister of Health, Minister Elliott, was very impressed with that model. I wonder if you could go over for us a little bit how that works and how that is actually improving home care for patients.

Ms. Kim Utley: This patient population is a complex patient, typically an older adult, and we know that this level of patient requires quite a bit of care coordination. There's a direct correlation between complexity and the amount of care coordination that's required.

This model identifies a primary nurse who is assigned to each individual patient. This primary nurse, in addition to providing that direct patient care and being that single point of contact for the family and services, also provides the assumption of the care coordination activities. This individual is in the home, patient-facing, really understanding what the gaps are in the patient service needs, so is able to very quickly and nimbly put that in place in a just-in-time, relevant way.

Mrs. Robin Martin: It's an interesting model, and I heard from the minister about how it was working. It seems to be a way to smooth the transitions and make sure that people are getting the care they need.

We had SickKids in here, I think, yesterday, and they were talking about the specialized care required for some of their patients who were discharged, some of whom have very medically complex conditions. There are often family caregivers who are providing some of that care for them with some help, hopefully, from other providers. I just wondered if you could see this model applying in that kind of a context as well. They were emphasizing the specialization of the particular needs, and I just thought I would put that to you while you're here.

Ms. Kim Utley: Yes, we've actually had conversations with several of our larger children's hospitals about how this type of a program could be scaled or modified to meet that patient population. We are doing some really innovative work with CHEO right now—not necessarily this model, but it takes into consideration your specialized education or care provision that's required.

Right now, a lot of pediatric care is very—the education is very patient-focused, and we don't necessarily have the ability in our current funding structure to work from a pool of people who are educated to care for a pool of children. It's more one-to-one, and if that particular individual is not available, that particular child does not receive care.

What we need to do, if we do create this type of a model, is have, again, that dedicated team approach to a small population.

Mrs. Robin Martin: With this new model, does the whole movement toward integrated care, Ontario health teams—is that what opens up the possibility of creating these kinds of integrated relationships to better provide care to some of these patients, especially the ones with the most complex needs?

Ms. Kim Utley: Yes. The impact that this has on the patient experience, having an integrated care model—people are talking to each other, the patient is not repeating their story 50 times, and it also significantly reduces the duplication of services and assessments that happen in our current environment.

Mrs. Robin Martin: In this case, it's the hospital, because it's Southlake, and the home care providers working as a team with the nurses and doctors, I guess, in the—whoever is providing care to the patient.

Ms. Kim Utley: Yes, and community support services, primary care, yes.

Mrs. Robin Martin: To make sure you're meeting those needs, whatever those needs are identified as?

Ms. Kim Utley: Correct.

Mrs. Robin Martin: We had a home medical equipment representative in just a minute ago—and maybe also those kinds of needs, you would have to work with.

Ms. Kim Utley: Correct.

Ms. Madonna Gallo: Just to highlight another component that I think really is different with these models and sets it up for integration—is the integrated funding model, or bundled care approach. Typically, in home care we see more of a fee-for-service, transactional, task-based model where the nurse, for instance, is there to do one particular thing and is not able to deviate from the plan. Within this Southlake@home approach, we get an envelope of funding, so there still is some control around the spend and the level of need, but then, there's a lot more flexibility for the front-line team to work with the patient and family to determine how best to use those resources to meet their needs.

If things change along the way, then again, there can be some flexibility. If the nurse shows up, thinking that maybe she's going to do one thing or help the patient with one thing, but it has been a bad night and something else comes up, then they're able to address the most important case.

Mrs. Robin Martin: So they can use their clinical judgment—

Ms. Madonna Gallo: That's right.

Mrs. Robin Martin: CEO Doris Grinspun from RNAO, thank you for coming and for giving us your input as well. I know you wanted to comment on this. So why don't you start with that?

Dr. Doris Grinspun: I want to comment on this, but also on all the places you mentioned, because all the places you mentioned—whether it's Ron, Alex Munter, or all of them that you mentioned are part of the Best Practice Spotlight Organizations program of RNAO. Not only that, Southlake@home is part of the BPSO OHT—so it's one of the OHTs that we actually work with them on evidence, sustainability and on staff engagement.

The Chair (Mr. Brian Riddell): One minute.

Dr. Doris Grinspun: I will give you another example that you may or may not know is a person who was unhoused. That will be very interesting for everybody.

Within this program of Southlake@home, working with RNAO, we succeeded actually to find the social services that this individual needed. It was something remarkable—because nothing of that had happened before they entered into the Southlake@home, plus the BPSO OHT model.

Mrs. Robin Martin: That is good news. I'm delighted to hear that.

I went to St. Mike's urban health initiative. They also got a homeless man, who had been homeless for many, many years and who also struggled with alcoholism, off the streets and housed.

So we can make a difference, but sometimes, for some of these people, you have to have very specific things available to support them when they need them. That's, I think, what this model leads to.

I'm very happy to hear that the best-practice guidelines are being used by some of the OHTs. I'm sure they'll all adopt those at some point, because it's a way to propagate, I think, the best kind of care and to take advantage of the expertise that those best practice guidelines offer.

The Chair (Mr. Brian Riddell): Thank you.

We will now go to the official opposition for seven and a half minutes. I recognize MPP Gélinas.

M^me^ France Gélinas: Thank you to all of you for presenting.

I will start with RNAO. You were there in the late 1990s, when Mike Harris was going to make the home care system better, faster and cheaper by competitive bidding. Do you figure the bringing in of the for-profits into home care helped our system deliver better care or no?

Dr. Doris Grinspun: Let me make a very distinct difference between Premier Harris and what's happening now—we did not support the competitive bidding because it basically led to disruptive care. OHT is a different situation. I think that we need to understand the differences.

Also, I do want to make a difference of good publicly funded, bad publicly funded or publicly delivered; the opposite, also—and I'm going to talk about Bayshore. They promote sending out care.

I think that to provide solutions, we need to be very careful that we absolutely have the governance, that we have the clear funding formulas, that we have public accountability, and that we provide accountability for the dollars spent and given by government to the outcomes that are delivered, and that we stick to those outcomes tremendously. Because if we were to say all of the for-profits—like Bayshore, which is very different than a group of many investors and etc.—I think that you will stay without home care services.

So I think we need to understand what is going on and create the criteria and the sticklers to deliver the outcomes that people need. We do not believe that the fee-for-service that home care is doing—and we work, actually, with several home care agencies on this—that their delivering depending on how many visits my colleague gets, versus "Here's the money. You decide which patients here need that care. You provide the care coordination," so no one else is actually telling you how many visits and then you will say, "Well, we couldn't."

1500

And also link to primary care, friends; it needs to be linked back to primary care. That's a piece that we are also asking for—that the system be anchored in primary care so that you end up utilizing less hospitals, quite frankly, and if possible, less nursing homes too, because people want to live at home.

M^me^ France Gélinas: We agree. Ninety-five per cent of elderly people want to stay in their home. They don't want to go into a long-term-care home. No offence to SE Health. You provide a really, really good long-term-care home; you're the exception to the rule.

I'd like to ask the Ontario Health Coalition—you made a very good review as to what happened in our home care system, always with the goal of integrating our home and community care system, which I would say was not a success. The people coming to you saying that care is not showing up—they come to me every single day. There's not a day at our office that we don't start the day listening to the answering machine—we still have answering machines—and there will be people complaining because the home care worker did not come. And it goes on and on.

Do you see anything in this bill that will improve care, that will improve access to care, that will improve the rights of patients to have home care? Do you see anything in that bill that will address the core problems of our home care system?

Ms. Natalie Mehra: No. The bottom line is, this bill is for the providers—and you can hear that from the providers—but it does not answer any of the long-standing problems in home care; for example, the fact that 50% or so of the funded hourly rate that is given to the companies to provide care does not actually make it to the front lines of care; it does not go to the nurses and PSWs. That's as per the Auditor General's report. As long as we continue to have hundreds of contracts with hundreds of agencies and so on, and most of those are for-profit, that markup is going out of the system to profit.

The second problem is, from the beginning, what patients and clients wanted was clear eligibility for home care, so that you couldn't be denied, so that you wouldn't be discharged from hospital to no home care, which happens all the time now—and accountability, so that that system actually provides care. In this bill, they're handing the care coordination over to the same companies that are charging double the rate that they pay the workers to provide home care from the government funding. They're also charging patients directly for home care higher costs per hour than they're funded at the public home care rate.

When the person who decides what level of home you get, what your care plan is and so on, answers to that for-profit company, they're in a direct conflict of interest all the time.

I think we all agree that the best practice is that care coordinators be directly integrated with care provision, but that requires a public, not-for-profit home care system. It cannot be done in a for-profit system, where the majority

is held by the for-profits, because their interest is actually in charging that higher rate for private care, not in maximizing public care. It's a conflict of interest.

The only thing, really, that this bill does is eradicate all public governance and hand over to the OHTs and the service providers the function of care provision. And there's no governance. There are no public boards, there are no public meetings, there's no access to minutes. Patients have no way to complain about their care. There's no public accountability for it. It doesn't improve any of those things that have been the longest-standing problems in home care at all. I appreciate—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Natalie Mehra: —that the provider companies want it, but it is not actually what patients have been calling for for now 30 years.

M^me^ France Gélinas: So what you're saying is that the care coordinator could be part of Ontario health teams—the Ontario health team is made up of extended care for long-term care and made up of Bayshore for home care, so Bayshore has their own care coordinator who says, "Yes, if you're easy to serve, we'll give you a lot of home care. If you're a difficult patient, if you're a faraway patient, then we will decide that you don't qualify for home care." That's what you're afraid of?

Ms. Natalie Mehra: That, and that they have an interest in selling, at a higher rate, home care provision to those same patients. They're providing both publicly funded and private home care to the same patients, so it's a conflict of interest. How could they then run the care coordination? And who does that care coordinator answer to? They're supposed to be employees of Ontario Health atHome, and then—

The Chair (Mr. Brian Riddell): Thank you for your comment.

We'll now go for round two, with the independent member. I recognize MPP Brady.

Ms. Bobbi Ann Brady: I have a quick question for each of our presenters this afternoon.

I'll start with you, Natalie. Should Bill 135 be scrapped, or could it move forward with specific amendments, and what would they be?

Ms. Natalie Mehra: It needs to be scrapped. They need to go back, because it's the last piece of the Connecting People to Home and Community Care Act—so it's the final piece of that. As Doris Grinspun said quite eloquently, the end goal of the health system isn't there at all, nor is any kind of public accountability, public governance, democracy, ability for patients to appeal, ability for patients to have any say over their health care, any responsiveness to communities. It's all gone. What they've done is a step by step by step devolution and further privatization of the system.

What Ontario needs is a fully integrated—we all agree on that—public, non-profit home care system, which could absolutely be built. And the kinds of things that people are talking about here, that we all support—moving away from the fee for service, which was created in order for market competition, because you had to turn nursing care into an hour visit, then a half hour visit etc., for the companies to bid against each other and get volumes of service and so on. Get rid of that. Have bundled care. Half of the care is not for post-surgical patients, post-acute patients. Half of the care is for people, right now, who are trying to live at home and age at home with disabilities and as they're aging, and that care is profoundly different than the post-acute care. The system needs to be set up to provide for those two very different types of patient groups.

Ms. Bobbi Ann Brady: Just going back—you said it can be done; we can have a coordinated system that is streamlined. Who do you think would be best to spearhead such an initiative?

Ms. Natalie Mehra: All of that expertise exists in the system already, so as you were to create a new, public, non-profit system, the existing expertise would be taken up into that new system—just as the plan to create, say, a multi-service agency that was public and not-for-profit, that would integrate home and community care. And if you could integrate primary care—we don't really have a primary care system, but if you could integrate primary care with that as well, that would work best for patients and could absolutely be done. All of that exists currently in our system. It's about reforming those structures and then making that system responsive to communities and to patients—or clients, as they call them.

Ms. Bobbi Ann Brady: Madonna, maybe you guys could comment on whether or not we should move forward or scrap—and if we should move forward, what are the amendments?

Ms. Madonna Gallo: I would suggest that it could absolutely move forward with some amendments. As I outlined in the opening remarks, I think a couple of those things could look like—number one, greater clarity up front around the future end state, particularly as it relates to the patient experience.

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Madonna Gallo: I do think there's lots of discussion happening around that in the health system, and so potentially some of those guiding principles could be incorporated into the intro.

The second piece really is around greater clarity around the roles and responsibilities of the various players. Whenever the system is in flux, I think there are some complications, and clarity is important so everybody understands the role—but also understanding, as we move to build new systems and new ways of working together, that we need to be open to new approaches.

Ms. Bobbi Ann Brady: And to Doris, quickly: Scrap it or amend?

Dr. Doris Grinspun: I would say that the government needs to disclose the end game here, the end state of the system, and once that is done, we need to have clarity on funding formula, governance and public accountability at the government level. OHTs then will have clarity on what they're supposed to deliver as a whole, and organizations need to move to relational care with better wages and

better benefits. Some are doing that and they will not have a shortage of nurses.

1510

The Chair (Mr. Brian Riddell): We'll now move to the government for seven and a half minutes. I recognize MPP Jordan.

Mr. John Jordan: My questions I'll direct to SE Health.

The whole Ontario Health structure is about better coordination and better communication among our service providers. I did have the opportunity to work with an Ontario health team, and we had a broad scope of organizations, physicians, our hospitals, our primary care providers, our mental health agencies, the Alzheimer Society, and home and community care. That really brought together some partners. So I'm very optimistic about the potential for Ontario health teams. Within that structure, we have Ontario Health atHome, with very large responsibility for home and community care. I appreciate that because home and community care has been one of the big challenges for all of us.

To my question: What is your experience to date with Ontario health teams and working with Ontario health teams, and how can home care service providers and Ontario health teams be supported to work together and continue this evolution, if you will, of Ontario Health?

Ms. Madonna Gallo: I can start and then pass it over to Kim.

We at SE Health are a proud member of 28 Ontario health teams across the province and so we have, I would say, diverse experiences engaging with teams. They're all, like our communities, a bit different, and I think, truly, the strength of the model is representing the different partners, the different providers and strengths within communities. I'm from a small, rural community up in cottage country, so the types of concerns to us locally would be different—some shared, but some different as well—from Ontario health teams in other areas of the province.

I'll pass it over to Kim to comment on her experience with OHTs.

Ms. Kim Utley: I think there is a broad shift to a state where partnerships are desirable. I think, more and more, we're seeing that.

As far as working together, I think we need a seat at the table. We need an opportunity to be a partner and to be able to provide our home care expertise from a patient perspective, working in partnership with our other organizations. I'd say, number one, we need some integrated technology solutions, for sure, for communicating not just to each other but also with primary care and the patient.

The Chair (Mr. Brian Riddell): I recognize MPP Quinn.

Mr. Nolan Quinn: As I'm sure some in the room are aware, I did work for Saint Elizabeth Health Care, in the human resources department, 20 years ago. It seems like a lifetime ago. We did do a tour of downtown Toronto—all the HR departments in the PSW realm. Then I just did one a couple of months ago in the Cornwall area. As much as there were many similarities between downtown Toronto and Cornwall, the biggest difference I noticed was the travel time, ultimately. It's a bit more challenging in the rural areas.

The question is for Saint Elizabeth. How will Ontarians benefit from home care being better integrated with other parts of the health system?

Ms. Madonna Gallo: Well, where do we start? I would say that number one is, we know, and it has been recognized already, that Ontarians, and older adults in particular, overwhelmingly want to live and age at home. It's the centre of their life. So we spend a lot of time at SE Health thinking about how to bring health to their lives. That's a very different starting point than thinking about a structure or a chart of the health system, where so many of the providers work within buildings and teams that are more on the health system turf and territory.

I think as we really move toward patient-centred care, move to more integrated care, the opportunity, as Kim said, to work together, clinician to clinician, to share information, to communicate, to align all of the services appropriately and to surround a person's needs, that includes health and medical services, but it also includes home and community services and other types of supports that may be available through people's cultural or faith community, for example. That's the type of wraparound support that programs like Southlake@home really are able to stitch together for the benefit of patients and families, and that's why we would like to see those integrated models expand under OHTs and under this new Ontario Health atHome system.

Mr. Nolan Quinn: Kim, I don't know if you want to expand—the 14.2 days to 10 days, $21.5 million of savings. That's impressive.

Ms. Kim Utley: Yes. I have more. Definitely, the integrated care models allow us to truly provide value-based care. It allows us to live under an evaluation—the quintuple aim principle—and really look at moving forward cost savings and provider experience. Our retention data, just with our transition staff or these integrated care model staff, is so much better than our broader organization as a whole.

Actually being able to collect data and measure patient outcomes, even at a granular level to measure the impact of very targeted care interventions, is new information that we have access to. This is going to very quickly expand the level of care that we're able to provide this patient population. Doing all of this under the umbrella of improving equity and access to care is fundamental to these programs, for sure.

Mr. Nolan Quinn: Is it possible to expand on the retention, being that I'm a human resource person, knowing that we're having struggles with health human resources?

Ms. Kim Utley: Yes. You're moving away from a fee for service. All of a sudden, there's a guaranteed salary. This is a luxury that community health staff didn't previously have access to—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Kim Utley: —so that alone is significant. But there's also a strong desire to work in a team and as part of an integrated care team, especially for our PSW staff.

The number one reason they stay working in these programs is because they feel like part of the care team. We've seen significant improvements in our provider experience surveys as well as our staff engagement surveys with these program staff.

The Chair (Mr. Brian Riddell): There are 30 seconds left. MPP Martin.

Mrs. Robin Martin: Thank you very much for that comment. Retention is always the poor brother of the recruitment and training, and the retention doesn't seem to get as much attention, so I'm pleased that you mentioned that. One of the things that we've talked about is how important it is, I think especially in home care, to make the people providing home care part of the broader team; they haven't been, up to this point. So thank you for sharing. That was a very good insight, I think, of something we need to evolve.

The Chair (Mr. Brian Riddell): I'd like to thank everyone today—

Interjections.

The Chair (Mr. Brian Riddell): Oh. Very, very apologetic.

Interjection.

The Chair (Mr. Brian Riddell): It's all for you. All right. I apologize. You have your seven minutes.

Mr. Wayne Gates: You get seven and a half minutes of me. I'm sorry, but the Chair doesn't like that—but anyway, it will be.

I'm going to start with Natalie and Doris. Natalie first, and then Doris, you can answer the same questions except the first one.

Natalie, you were very clear that your organization has 750,000 members with 57—or whatever the number was. How often or how many times were you consulted on this bill? Who talked to you about the bill? Did you meet with the minister or—

Ms. Natalie Mehra: No, we were not consulted on this bill.

Mr. Wayne Gates: You weren't consulted. My colleagues over there—I'm always trying to help; I think you can appreciate that. It's one of the things I try to do, as the opposition.

She mentioned retention, and I've been talking for almost a day and a half now on—I feel I have a solution for retention, so I'm going to say it, and you can answer whether you agree or disagree with me. Why don't we get rid of Bill 124? Repeal Bill 124, stop fighting our nurses and health care workers in the courts, and take that money and invest it in our nurses and set a cap in their wages at 1% total benefit, which would mean including benefits, and stop attacking their collective agreements.

I've got a couple of more for you, and then you can answer and then she can answer. I'll give them all at once so you can do them all at once.

So that would be, I think, one way that we could fix the retention problem very quickly, quite frankly.

Again, we're using agency nurses. I know in an emergency situation, we may have to use agency nurses, but the reality is that they're being used now so much that—it's really terrible that the agency nurses and those corporations are making millions of dollars in profit on it, are getting paid between $150 and $300 per hour for each nurse or health care worker. It's absolutely ridiculous. I'm trying to help the government to say, "Get rid of the overuse of agency nurses."

1520

The other one that I think me and you really agree on is that if you want to fix home care, take the privatization out of home care. Instead of putting all that profit into some corporation or CEO, you could actually put it right back into not-for-profit home care, like this company we're talking to today, and that, I think, would fix it.

Maybe you can give me an idea to let me know—maybe I'm wrong on these types of issues that I don't see in this bill. Do you agree or disagree with some of those solutions that I'm trying to give to the Conservative government?

Ms. Natalie Mehra: Definitely, we agree that Bill 124 should be revoked, and free and collective bargaining should be allowed to resume permanently without the court challenge etc. We agree that the use of agency nurses should end because it has been really catastrophic for the health system. And we agree totally with taking privatization out. I think those are part of it.

I think, critically, for home care, people have to have a clear entitlement to receive care. Shifting all kinds of care out of hospitals to people's homes is okay, but if you're going to do that, then people have to not be moved out from under the umbrella of the Canada Health Act. They need a positive entitlement to receive care.

I'm thinking of Helen Hamilton in Welland, down in your area, who just wrote in to us about her husband who was discharged from the Welland hospital after 35 days to no home care at all at home. She has become a full-time caregiver. He's got 11 medications. He just had a post-surgical infection. He has diabetes and all kinds of complex care conditions. She cannot cope doing that at home. They're elderly, and she has to provide all that care at home with no help at all. That's not acceptable. I'm thinking about, so what does this legislation do to stop that? Nothing. There is nothing there at all.

I'm thinking about another woman, Marilyn, who just sent in to me two days ago—her husband was discharged home. His home care—they couldn't get wound care at home, so they sent in an untrained RPN. He got an infection. His toes went necrotic. Ultimately, he ended up in London Health Sciences. His leg was amputated from the knee down. He lost his other leg also as a result of infection—discharged home again to no home care at home.

The situation for clients and patients is critical, and these are not answered by this legislation. There needs to be the patient's rights in the legislation—it needs to be in the law. The government has to be accountable for providing the home care that people need. That's the cornerstone of a public health care system, and it's just not there. This is all about the provider companies and not about the clients.

Mr. Wayne Gates: I appreciate that.

Doris, I'll let you answer the question. I just want to say one other thing, because it was raised over here—about amendments. I can tell you that in every committee I've sat on for the last five years I think they've been in power, the NDP puts in amendments that try to help the bill, make it better and make it work for Ontarians. They've voted against every single one of our amendments. That's the problem with what goes on sometimes in these committees.

Doris: Bill 124; agency nurses; the cap to your members, which I think is causing a lot of problems; and then the privatization, particularly around agency nurses who are making two and three times what your members are making, doing the same job—I don't know how they even do it, quite frankly.

Dr. Doris Grinspun: As it relates to this bill, I will talk, because that's where we are focused.

The nursing crisis is the first thing that needs to be fixed. Two ways related to this bill and home care in particular—one is wages and benefits, and we have been on record on harmonizing—

The Chair (Mr. Brian Riddell): One minute remaining.

Dr. Doris Grinspun: —within each category, for RPNs, for RNs and for NPs across all sectors. That will fix that problem. Relational care is the other, versus suite for services in home care. Care coordinators—actually, we have been on record—must be devolved from where they were in the LHINs, because they were not effective, quite frankly. They limited the type of care—"She got more care than what she needed," maybe, or at least was told to get more; "I got less," etc. The care coordinators need to be in primary care—we have been on record—and in home care. That's where they need to be—and at the OHT level, to help system navigation.

The colleague was asking me about NPs before. Put NPs in OHTs as health system navigators, and not only will you catch health care issues, medical issues; you will also catch social issues etc.

NPs in OHTs will transform the system too, but RNs, RPNs, PSWs within each category—the same across all sectors. Why is it that one in ICU gets more? It's not just about the agency nurses; it's nurses, period—

The Chair (Mr. Brian Riddell): Thank you for your comments. That concludes our questions for today.

I'd like to thank everyone for their comments. If you would like to submit any written materials to the committee in addition to your presentations today, the deadline for written submissions is on Wednesday, November 15, 2023, at 7 p.m.

HOME CARE ONTARIO
HAMILTON HEALTH COALITION
MS. HELEN LEE

The Chair (Mr. Brian Riddell): I would now like to call on the next group of presenters—they're all virtual: Home Care Ontario, Hamilton Health Coalition, and Helen Lee.

Welcome. As a reminder, each of you will have seven minutes for your presentation, followed by questions from the committee members. I will provide reminders of time remaining during the presentation and questions. Please state your name for the Hansard, and then you may begin.

We'll begin with Home Care Ontario.

Ms. Sue VanderBent: My name is Sue VanderBent. I'm CEO of Home Care Ontario.

Good afternoon, MPP Riddell. Thank you for inviting me. It was a pleasure to meet you last week at the pre-budget hearings in Cambridge. And thank you to all the committee members.

Home Care Ontario is the voice of home care in this province. Our members are the hearts and hands of home care. They provide more than 100,000 hours of care to Ontarians every single day. It's my pleasure to be here today to provide you with our feedback regarding Bill 135, as it's pivotal to the future of the provincial home care system.

To begin, I want to highlight that the Minister of Health, the Honourable Sylvia Jones, has been a strong advocate for home care, and we are very grateful for her support and encouragement.

Indeed, improving access to home care is one of the key elements of your government's Your Health plan and is an objective that Home Care Ontario strongly supports. We support this aim because it's critically necessary, given the pressures that are about to be felt by our home care system. In the next five years, Ontario's seniors' population is set to increase by 15%. That population increase will cost billions, if we assume the health care system has the capacity to provide additional care, but right now, we know it doesn't. Ontario's health system is already struggling to meet today's demands. Stories of lengthy waitlists, filled hospital beds and closed emergency rooms are far too common. While reforms are under way to create capacity across the system, one thing is very clear: Ontario needs more home care now to meet the demands, and it needs to ramp up to meet the next five years' expectations. That is why Bill 135 is so important. This legislation will be fundamental to creating a structure that will allow Ontario's home care system to interact with Ontario health teams effectively and efficiently once they actually come online.

There are over 100 approved organizations delivering home care in the province today, and these organizations cannot be expected to contract with close to 60 OHTs that are being created. Such a situation would be highly inefficient and will quickly become unwieldy. In fact, today's system is already too complex. Authorized home care providers in Ontario, such as my members, currently manage hundreds of contracts across the 14 Home and Community Care Support Services, or HCCSS. While these 14 organizations have played a critical role in our health care system, they each have varied and irregular processes and reporting requirements. This creates a complex and often unnecessarily burdensome structure for

organizations that work across HCCS boundaries, one that drives up administrative costs and slows down the delivery. The streamlined system being introduced through Bill 135 will help to address this issue. The introduction of a single standardized province-wide contracting process and administration will provide three main outcomes: system inefficiencies will be reduced; improved accountability and coordination amongst home care providers; and providers will be able deliver care more quickly, efficiently and effectively, allowing providers to better focus on outcomes and patient care. Together, these three outcomes will lead to the delivery of more home care and better home care for Ontarians.

1530

We support Bill 135. However, from our perspective, the bill still could be improved, and we are proposing an amendment we believe is necessary, and we respectfully urge you to address it at committee. Specifically, we recommend that you affirm the ministry's position that home care remain a contracted service.

Ontario's home care system is a critical part of its health care system. The vast majority of home care is delivered through contracts with health or care organizations, either through fee-for-service models, similar to the way much of primary care is delivered, or through bundled models of care. The government has repeatedly stated its intentions on home care—to continue to be primarily a contracted service, and that no direct funding relationship is envisioned between home care providers and Ontario Health. However, neither the Connecting Care Act, 2019, nor the amendments proposed in Bill 135 will give any direction on this important point. This creates challenges on the ground as organizations, such as OHTs, attempt to interpret in varying and conflicting ways what it is the government actually wants them to do. More importantly, this ambiguity and uncertainty is having an impact on our health human resources. Change can be very worrying and concerning for staff, and front-line home care workers are worried about what the future might entail for them. Much of this fear can be calmed if the government's intention to maintain the current contracted delivery model will be helpful to our staff.

In our submission, which I will send to you, you will see specific language that we recommend be added to the bill to clarify this situation.

Once again, MPP Riddell, I want to thank you very much for having me here today, and I appreciate your attention.

The Chair (Mr. Brian Riddell): We will now go to the next one, which is Hamilton Health Coalition. You can begin.

Ms. Janina Lebon: I'm Janina Lebon, speaking on behalf of the Hamilton Health Coalition. Thank you for this opportunity to speak to Bill 135, the home care legislation, which will create Ontario Health atHome, which then becomes a subsidiary to Ontario Health. So we will have two huge departments running health—and, ironically, if you look at Alberta, they have just dismantled theirs. The LHINs as we know them will disappear, and the details on the future structure is limited. I'm hoping the regulations will explain it.

The role of Ontario Health atHome is to subcontract home and community care to provider agencies, and I have some specific concerns on behalf of us, not exactly to do with the legislation. In the past, there were public meetings. We were allowed to attend those meetings, we had notice of meetings, minutes were posted, documents and plans were available. Currently, it does not seem to be available, and doing this in secret leads some of us to wonder about what's really happening.

The minister's role is quite interesting in that he or she will make a lot of decisions. They will decide on a board of directors—six to be appointed by the minister, three to be appointed on the recommendation of the agency. That is nine people. Who will decide what's their criteria for selection? And will the determining factor be making donations to a political party? The composition of these people—will it represent experts in the medical field, professionals in the medical field, doctors, nurses? Will it include labour? Will it include management? Or will there be strictly a business approach to it? Will the board and the agencies represent the Canada Health Act in its principles to maintain public health delivery?

Those of us who are aging want to stay at home, and that's where home care comes in. It is very important for us. Comments about funding concern me, because should the federal government decide that we will be having funding available for home care, a national home care policy, only the minister can approve that. There is no autonomy apparent in these agencies. The same, by the way, goes with fundraising—everything has to be approved by the minister.

There is concern about lack of liability—totally ignored. So how do we look at people and ensure that they do things the right way?

The Ontario health teams are of concern, because they can be formed with any entity—it doesn't suggest that hospitals are part of that. Again, there is fear that we will see for-profit, such as the real estate investment teams, involved. The bigger concern is, if it's American-owned, then we have difficulties with the free trade agreements.

My last issue is that of privacy and medical confidentiality. The minister is going to get access to personal information of the service recipients—the clients or the patients. How is the minister to receive that information? How many hands will it fall through? Who else will have access—we know that the organization at the bottom will, but to give it to the minister, how will that be done? By staff? By designation? And how will that information on health be kept confidential?

The other issue is, where will this information be stored? We have heard, especially recently in southwestern Ontario, of cyber attacks on hospitals. We need guarantees that that information will not be shared.

And lastly, on that: The patient is supposed to give informed consent, but what if the patient does not? Does that mean they're denied service? And will Bill 135 supersede the privacy legislation? I expect that there has

been consultation with those responsible for the privacy act. The other issue is, there is currently a court case where informed consent of patients to be moved out of long-term-care homes is being challenged.

So, all in all, there are different concerns. As I have said, home care is the alternate for those of us who do not want to end up in a long-term-care home; we want to stay and age at home. So I—

The Chair (Mr. Brian Riddell): One minute reminding.

Ms. Janina Lebon: Thank you for the opportunity. That's my presentation.

The Chair (Mr. Brian Riddell): We'll now go to Helen Lee.

Ms. Helen Lee: My name is Helen Lee. Thank you for the opportunity to share my experience and my comments on Bill 135. Janina, you made some very good technical points on that.

I'm a seniors' advocate, and I'm active in the community supporting family councils in long-term care, and I do a lot of community work. But today, I am here as a caregiver. I work in human resources professionally, labour relations, change management, and I did a lot of restructuring in the Ontario public service for over 33 years, serving all three political parties.

I retired to spend time with my grandmother Foon Hay Lum as she entered long-term care. She lived independently, on her own, in her own home until the age of 107. We had almost four years together before her long-term-care home had a terrible outbreak in wave one, and 31% of the residents died—31% within just weeks; 43% if you factor in excess deaths. All levels of government were caught unprepared. My grandmother died alone at the age of 111 in a facility that had only 20% staff and little PPE. The family was totally separated. She died alone.

1540

The pandemic revealed that Ontario had the highest number of COVID deaths in long-term care and also the highest percentage of for-profit homes—more than 5,000 COVID deaths in long-term care, not counting excess deaths. Yet the long-term-care operators were shielded from liability, and no licences were revoked or penalties or fines, and many were issued new 30-year licences. The pandemic clearly showed that ownership matters, as the private, for-profit homes had higher mortality rates; 80% of the homes that were investigated by the military were for-profit.

Fast-forward to March 2023: My dad is 93 years old and he is the sole caregiver to my mother, who has Alzheimer's. She's in her seventh year of diagnosis. He's sick and he's hospitalized. We're told that he has late-stage bile duct cancer. Well, I can have a close look now at what's happening in hospitals: staff shortages; burnout; staff are trying their best; doctors are rotating around every two weeks. I advocate for my dad. I stay with him at the hospital. I watch him like a hawk to make sure that he doesn't have a fall, because his falls are bad. I work on his mobility, work with the team, and everybody is delighted because he got better and he was able to go home—because they had written him off.

Home care: My dad is palliative, and now we get to see how home care works in Ontario. We don't get much home care, just 40 minutes a day; 16 hours of respite a month. On top of that, I look after my mother, who has Alzheimer's, 24/7. It took two months to transition, but we have a good routine now, and the staff continuity is great. And I want to say that the provision of equipment was very quick and effective.

Home care is the worst-impacted sector of health care, has the worst staffing crisis, and they are paid the lowest. Wage parity is absolutely necessary.

I will say, Bill 135 does nothing to improve home care. It does nothing to improve access to care, define quality of care, standard of care, patient rights or client protection. It is not family- or client-focused. There is no complaint escalation process; nothing to stabilize the workforce; no whistle-blower protection for public safety. There's no reference to diversity. Key aspects of governance and structures are moved out to regulations. I had 30 years in the OPS. Regulations? Seriously. It is easy to amend. Transparency and public accountability are missing. This bill will further destabilize the already-fragile workforce.

Home and community care has been restructured and renamed so many times and uses so many alphabets, we don't even know—CCAC, whatever.

Seven HCCSS-area offices left funds on the table last year—possibly due to workforce capacity issues to deliver, I would suggest. Shortage of workers may have caused the area office to not meet the demand for home care. I can't imagine there wasn't a need for that service in that area. Families who needed service paid out of pocket or supplemented with family members who were either competent or not.

The root causes—workforce stability; sufficient funds for home care; improved working conditions.

Take the unsafe stuff out. Take the out-of-pocket expenses out. Do not contract out health care coordination services. It cannot have the same entity—access-approved delivered services is inherently a conflict of interest, particularly if companies are private, for-profit.

What concerns me is, less transparency, more complex and convoluted—I get the impression that it's going to be top-heavy; bureaucratic; more political appointments. Government money is going into the purses of private, for-profit health care. Naturally, any transition is going to have some confusion, regardless of how you communicate or organize. It's going to be less agile and responsive to the client, so the clients are going to complain. They're not going to know where to complain, and neither will the people working in that system. All the while, while seniors suffer, caregivers will be burnt out. Caregivers are your final line of defence.

I say governance, accountability, transparency, standards and measures are all critical factors to delivery of care, and health care excellence and home care excellence. When we're talking about quality home care, patients, caregivers and workers should be front and centre. I see

nothing of this in Bill 135. You talk about outcomes and patient care, yes, but do I see any of that in the act? No, I don't. Perhaps you can point me to it.

Move services back to non-profit, invest in them, ease the staffing, designate and fund non-profit home care worker co-ops—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Helen Lee: —allow families to also direct their support services; paid family caregiver option; introduce a patient advocacy function; PACE works; community housing; naturally occurring retirement homes. That would be great.

My dad is palliative, and he worries that my mother in late-stage Alzheimer's—what's going to happen to her when he's gone? He tries to still care for her. I worry about the road that my dad and I are on. Will my dad get timely support or will he be left in anguish and pain in the last days and hours? I've heard so much about that.

My grandmother, at age 111, did not have a dignified death. It was horrible.

I believe Bill 135 should be withdrawn. It does not represent the interests of aging seniors or caregivers, and home care is way too precious, and it affects lives.

Please remember our family. Thank you.

The Chair (Mr. Brian Riddell): Thank you. We will now go to round one, with the government for seven and a half minutes. I recognize MPP Martin.

Mrs. Robin Martin: Thank you to the witnesses for coming today and giving us your testimony, your evidence here today. We appreciate all of you coming.

I want to start by asking a quick question of Helen. Helen, you're with the Ontario Health Coalition; is that right?

Ms. Helen Lee: Yes. I'm the chair of the Halton Health Coalition. But I'm here as a caregiver.

Mrs. Robin Martin: But the Ontario Health Coalition is the same one—we just heard from Natalie Mehra. That's the same group? But you're here as a caregiver—

Ms. Helen Lee: No. I applied as an individual caregiver.

Mrs. Robin Martin: Okay. I'm just asking if that's the same group.

Ms. Helen Lee: No, it's not the same group. It's a different region.

Mrs. Robin Martin: But it's part of the Ontario Health Coalition?

Ms. Helen Lee: Yes.

Mrs. Robin Martin: Okay. Thank you.

Ms. Helen Lee: But I applied as a caregiver, and my testimony is a caregiver—

Mrs. Robin Martin: I got that. Thank you very much.

Ms. Helen Lee: —experience of long-term care—

Mrs. Robin Martin: Thank you very much. I heard that.

I also was a caregiver to both of my parents. It's certainly a lot of pressure when we're in that situation, but it's really important, I think, to make sure that we give back to our parents, who took such good care of us. I think that's very important.

Janina, you're with the Hamilton Health Coalition. Is that a member of the Ontario Health Coalition as well?

Ms. Janina Lebon: We are part of the Ontario Health Coalition, but I am also part of a number of other groups, one of which is—

Mrs. Robin Martin: Thank you very much. I was just asking about that.

You mentioned privacy rules. There's nothing here that's changing privacy rules.

You also said, "If a patient does not give consent, are they going to be denied service?" I don't know what you're referring to when you said that, but I can assure you that we don't provide services to people who refuse service. That's their choice. They have to be able to consent to service or have their power of attorney for personal care consent; otherwise, we would be forcing health care on people who don't want it. That isn't how it's done. I'm sure you know that.

And then thank you to—

Ms. Janina Lebon: I would disagree with you—

Mrs. Robin Martin: I didn't ask you a question; I'm sorry.

I want to go to Sue VanderBent of Home Care Ontario. Sue, thank you for coming today and for giving us your input on this.

You emphasized the importance of this legislation. I know we've been taking several steps, in this case, to move away from the LHINs, the local health integration networks, partly because we felt that the local health integration networks were basically bureaucracies; they weren't health care providers who were being asked about how to work together to deliver care. The new model is for Ontario health teams, which are health care providers, to work together to deliver care. That's one of the innovations here.

I remember you were at the connecting care to home and community act, or something—I believe, in that act, we eliminated service maximums on home care. Obviously, we need to have more staff so we can deliver more home care, and that is certainly our objective.

1550

You were talking about how important this piece of legislation is to get us to the stage where we can realize home care in our Ontario health teams, as an active player. Sue, could you share with us how you see that happening?

Ms. Sue VanderBent: Thank you very much for the question.

Obviously, we want to expand home care—if I could just take a quick second to tell the committee that the extent of the publicly funded home care system now should be doubled. At this point in time, we deliver care to 730,000 people a year. We provide more than 59 million hours of care a year. We employ more than 60,000 staff. We do more than any other part of the health care system, and we also have multiple types of care staff. We have nursing care, home supports care, personal care, physiotherapy, OT, social work, dietetics, speech-language ther-

apy, respiratory therapy, infusion, pharmacy and medical equipment and supplies.

As well, people think that we only serve people in their older years. Actually, 15% of home care users right now are children—children born with birth issues, who need long-time supports. Some 20% are adults with diseases such as COPD, CHS or diabetes; 60% are seniors who have illnesses of old age; and 5% are palliative—and these patient populations need to grow to match the demographics that we are seeing. In the polling that we have done, 96% of our patients and people are saying their plan is to stay at home, to live at home, to receive care at home, and to end their days at home. The home care system is really a jewel in the crown of the whole health care system, but it's too poorly funded. Even though we know that the government is trying to invest more, the reality is, the demographics mean that we have to double and triple in the next 10 years to meet the growing needs of patients. We only have to look to other countries like Denmark, Britain and Sweden, where this is in fact happening. They are not building expensive long-term-care beds; they are keeping people at home.

This is the kind of thing that we believe: If we take this kind of system change and have our Ontario health teams, who are very knowledgeable about what is needed in their particular areas, focusing on working with our home care providers, we can generate tremendous supports for people—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Sue VanderBent: —and we can demonstrate more and more people who are staying at home, who are receiving care at home and who are ending their days at home, which is a huge goal—a stretch goal, I suppose you could say—in terms of health system modernization. If you look at other, very developed systems, people do end their days at home, with great home care support from all of the types of skilled professionals that I've told you about.

Last thing: One in nine people, according to CIHI, could have stayed at home if they had had better home care supports. I bet you if we were doing that research right now, that number would be doubled or tripled.

Mrs. Robin Martin: I think we all agree that we want to invest more in home and community care. We want to have more care in the home and community. Of course, we need to build long-term care as well; otherwise we can't move people from hospitals so that we have the hospital space to treat people in hospitals. That's part of the system and the integration of all the parts of the system. There are many places to make investments. But I think everybody is agreed—

The Chair (Mr. Brian Riddell): Thank you for your comments.

We'll now move on to the official opposition. I recognize MPP Gélinas.

M^me^ France Gélinas: My first question would be for Mrs. Lee.

You shared a pretty sad turn of events about what happened to your 111-year-old grandmother—I've never met anybody who lived to be 111 years old—and the way she died alone, and then your work as a caregiver to your mother with Alzheimer's, and to your dad.

What would you like the home care system to look like? Let's start there.

Ms. Helen Lee: Well, I think it has to be integrated, in the sense that you have to work with your family doctor. I know we have primary care issues as well, but it all has to be integrated—primary care with home care and community care, and with the hospitals. I am all for integration, but it can't have lots of structures and structures and boards of directors and boards of directors. That's not going to work. It has to be simplified and flattened.

There are naturally occurring retirement communities—and PACE would be good for home, to introduce that. There's community housing, and PACE would work there too.

People have to also have power to direct the care—right now, you're just waiting, and you're so vulnerable. If you could direct some of that care, that would be good.

Home care co-op workers—I think that's a really innovative new idea. As an HR person, I'm very interested in learning more about that. That would alleviate some of those staffing issues.

So those are some of the ideas.

M^me^ France Gélinas: That's good.

Ms. Helen Lee: It can't be bureaucratic. It can't be just like this is an operational thing. You're talking about people's lives.

M^me^ France Gélinas: Do you see anything in the bill that brings us closer to that vision?

Ms. Helen Lee: No. I don't see anything in the bill that does that. That's why I am here—to tell you that, as a caregiver, I'm very concerned about that.

M^me^ France Gélinas: So that's why you suggest that we just withdraw it and focus on what is important to patients, what is important to families, what is important to family caregivers, and that's not to have—

Ms. Helen Lee: Yes, and workers.

M^me^ France Gélinas: And workers—

Ms. Helen Lee: And workers. I look at the bill, and it says here, under "Ontario health team"—"7. Any other prescribed health care service or non-health service that supports the provision of health care services." I have no idea what you're talking about there, but that concerns me.

M^me^ France Gélinas: It concerns all of us.

I will ask the Hamilton Health Coalition a similar question.

When you did your presentation, you made it clear that the system we had before had its problems, but at least local people could be involved, local people could be informed. There was a local board of directors. We knew who those people were. There were minutes of meetings; you could attend. None of that will be available once we go through the ministry to Ontario Health to Ontario Health atHome to God knows what.

Why is it important for the community to be involved in decision-making when it comes to home care?

Ms. Janina Lebon: The community and the families know what is needed. They can look at the structures, they

can look at the organizations, and they can contact them and share. It's a very difficult process. I did have a mother in long-term care. I was fortunate. She had a wonderful place and no problems. They contacted me, kept me informed. There's got to be direct communication.

In addition, we need more staff.

I have a person here in Hamilton who needed help, never got it, complained—we need a system where, if we complain, we get results and we get solutions.

The community has first-hand knowledge of what's available, who to go to and where to go.

M^me^ France Gélinas: Do you see any of this in the bill right now?

Ms. Janina Lebon: No. I see the bill going into what I had said, the for-profits, because there the goal is money and it is not the care of the patient.

To refer back to what Helen said, the SSAO—Seniors for Social Action Ontario—did a freedom-of-information, and over $77 million got turned back. Why? Was it because there was no staff, or because people didn't care? It boggles my mind. The bill, as I see it, does not have solutions. It's going to create more problems.

I'll make a prediction: If you think the greenbelt was a scandal—health care is next.

1600

M^me^ France Gélinas: Probably.

My next question would be for Home Care Ontario. Sue, you said that you will be sending us written direction to make sure that home care remains a contracted service. With the integration that we see in the Ontario health teams, what harm would there be for a community health centre to have home care staff providing care? It would not be through a contracted service; it would be part of the primary health care team—to have home care workers as part of it. Why are you opposed to that?

Ms. Sue VanderBent: Well, authorized home care providers in Ontario, which are my members, MPP Gélinas, currently manage hundreds of contracts right now across the 14 Home and Community Care Support Services, or HCCSS. That is a central place where people go through to access the home care system. The OHTs—and I hope I'm answering your question—are closer and on the ground in terms of their own particular region's issues and would have, I think, a clearer idea of what kind of issues need to be addressed in particular areas of the province—

The Chair (Mr. Brian Riddell): Thank you for your comments.

We'll now move on to the independent member. I recognize MPP Shamji.

Mr. Adil Shamji: I have no questions.

The Chair (Mr. Brian Riddell): Okay. We'll move on to round two. The government has seven and a half minutes, starting now. I recognize MPP Martin.

Mrs. Robin Martin: I'm just looking around to see if my colleagues had a question; I don't want to take all the time.

Sue VanderBent of Home Care Ontario, thank you again for your comments. I was trying to follow what you were saying in response to MPP Gélinas. I think you said you would have a proposal for an amendment, and I guess we'd like to see what you're bringing forward. Can you tell us a little bit about what that amendment will achieve?

Ms. Sue VanderBent: Yes. The amendment at this point is to ensure that there is ability to contract the services so that we maintain the incredible amount of knowledge—the deep knowledge and practice wisdom—of the current providers that work across the province. Ultimately, that is a huge issue that we need to address.

I would say that the introduction of a single, standardized, province-wide contracting process and administration would support three main outcomes: System inefficiencies will be reduced; there will be improved accountability and coordination among home care providers; and providers could be able to deliver care more quickly and efficiently, and it will allow those providers to better focus on patients and outcomes.

We need to get more home care into the home. We need to spend less money on bureaucracy. We need to support patients, like Janina, who have had family members who have gone without. The sooner we can get more and better home care into people's homes to help them stay at home and live at home and receive care and end their days at home, the better. So our amendment is necessary because we want to maintain the ability and the agility of the sector to answer patient need.

Mrs. Robin Martin: Can you share with us what changes some of your members, the service provider organizations, are making to improve care delivery in home care?

Ms. Sue VanderBent: I was talking to you earlier about the fact that we are connecting more with primary care. In fact, the Ontario Medical Association and Ontario Hospital Association have been very, very supportive of the home care system growing and having a greater reach and more financial ability to care for more patients.

We want to connect our staff—all of those amazing nurses, home support, OT/PT, social work, dietetics, respiratory therapy, inclusion therapy—all of these amazing services that right now are limited in a significant way because of the cost of the bureaucracy. So we have to maintain an ability to have front-line providers who are delivering care to 730,000 people a year to do even more care.

We also need to talk to you about the need for digital investment. This has not been spoken about very often, but in fact, your home care provider does not have interoperability with hospitals, with long-term care, with primary care, with other parts of the system, and it is really incredibly important that your home care nurses—or any of our staff members or personal support; again, all of our therapy—know what is the patient's problem. What do we need to do for them, right here, right now, when I'm standing? I've driven to your home, I'm standing on the doorstep, and I need to know what dosage you need for this IV that I'm setting up. It's as clear as that.

I've actually had family doctors call me and say, "Sue, why am I having to go out and set up this IV?" We in home care, unfortunately, do not have an interoperable digital

health system. And right now, we're working very strongly with OH and with the Ontario Medical Association to get a better digital health interoperable system moving for our home care system, to support our patients.

Mrs. Robin Martin: Well, thank you for mentioning that, Sue. That, I agree with you, is a really important priority. We were talking earlier with SE Health about how important that is to be able to make even our home care providers feel like they're part of a team and have access to the information they need to do their jobs well. That certainly is something, as you said, that Ontario Health is working on. We have the digital strategy.

I think you also know that part of the reason for making this transformation to Ontario health teams, Ontario Health and Ontario Health atHome is to get rid of the bureaucracy that was there with the LHINs, to take the money from the people managing the care and put it back into front-line health care, to make sure we can use those resources to have more health care providers, more access to health care for our patients. I think you know that's where we're intending to go with this, and that's certainly something that we're focused on. Do you feel this legislation is going to help us get there?

Ms. Sue VanderBent: Yes, I do. I think for a long time, we have needed to be more granular in looking at the needs of Ontarians across the system, in local areas. The Ontario health teams are local. They understand how their system works, and they understand what the needs of patients in their particular area are.

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Sue VanderBent: Therefore, we can titrate the care to meet those specific needs much better.

Mrs. Robin Martin: I think that's what we're all striving for.

My mother, as well, received home care when she was suffering from cancer, and I was trying to do the kind of thing that Helen has been doing with her family—and I guess Janina also mentioned she had some experience with that.

What we really want to do is improve our home care system so that those services can be there for people who can stay at home and be well enough at home to be cared for with the assistance of people at home. That's why we took the service maximums off—to make sure that the home care delivered could be adequate. So we're working with you and others to try to make sure we staff up and have the people to deliver that care in the most specific and targeted manner to people to meet their needs.

1610

The Chair (Mr. Brian Riddell): We will now move on to the official opposition for seven and a half minutes. I recognize MPP Gates.

Mr. Wayne Gates: Thanks for your presentations.

I'm going to start with the Hamilton Health Coalition. The Conservatives made a comment about the coalition and—you guys run independent.

I want to say that I know Rolf very, very well from his days as being president of the Steelworkers. I don't know how he's doing. I haven't seen him for a few years. So if you get the opportunity, please say hi to him for me.

You made a comment about the bill—and you think that the next big scandal is going to be health care. I just want to say that I agree with you. There's billions and billions and billions of dollars in health care, and I think that may be the next one—outside Ontario Place, which I also think is going to really hit this government very, very hard. There's so much money in health care for private—

The Chair (Mr. Brian Riddell): I'm just going to remind the committee that we're considering Bill 135.

Mr. Wayne Gates: She mentioned it in her comments.

The Chair (Mr. Brian Riddell): I'm just making that comment.

Mr. Wayne Gates: I appreciate that.

Helen, is there anything else you would like to tell us? I know you didn't finish, when you did your presentation—I think we were all moved by your comment, only because I think we've all faced it. I think some of the Conservatives have said today that they've had family members who have gone through caregivers at home—it has happened with my family and I'm sure other families who are here. Is there anything else you'd like to say? I know you were cut off when you did your seven-minute presentation.

Ms. Helen Lee: I think the patient advocacy function is really important, and I think system navigation is very important when you introduce superstructures upon superstructures.

I must be sleep-deprived, because I hear words like "granular," "closer to service" and things like that, and then I read the bill and I don't see any of that there. I'm not sure if we're looking at the same thing or you're looking at a vision, but you're reading words that don't say what's in the vision. Put it in the bill. Put it in the act—seriously, with all due respect.

Mr. Wayne Gates: I think they're fair comments. We see that a lot in a lot of bills—where they don't put it right in the bill and they leave it up to regulation.

Helen, I think I recognize you from before; I'm not sure—maybe not on this issue.

The reason you say "put it in the bill" is because it's a lot stronger than it is in regulations. I agree with you; they should be putting it in the bill.

Helen and Janina, you both said that we should get the private operators out of home care. Maybe each of you could expand on why you think private is really hurting home care.

Ms. Janina Lebon: Having private, for-profit means, let's say, 30 cents on the dollar does not go into health care; it goes into profits. That is more money that could be put into health care and used there. It's very difficult to understand why we want to assist profit-making. Their interest is their shareholders; it is not the patient. It's the patient who should count.

Mr. Wayne Gates: Helen, do you have any comment on that?

Ms. Helen Lee: I think it's very obvious. It didn't work in long-term care, it's not going to work in hospitals, and it's not going to work in home care.

Mr. Wayne Gates: You're right. I've been having that discussion since COVID started—particularly in long-term care. We had problems in long-term care before COVID—but it was really showed off on the private side of it, where I think it's around 80% of everybody who died in long-term care died for profit.

I'm going to ask the Hamilton Health Coalition again—you said 30 cents of every dollar goes into profits.

Ms. Janina Lebon: Approximately. The figure varies—it depends on if it's long-term care, if it's home care or whatever. The whole intention—I'm thinking of the hospital envelopes—there is one that goes that if it's not spent, it's returned to the profit-sharing company. So that has to be looked at in greater detail. But every penny that's spent not on health care is a loss.

Mr. Wayne Gates: I don't know if you've watched today—I know it's riveting, so probably a lot of people are watching this at home. So you agree with myself—because I have said, a few times today, around that figure. The government is saying that they're spending a billion dollars into home care, so what you're saying, out of that billion dollars, if 30 cents of every dollar goes—that's $300 million that would be going into a number of corporations, not necessarily just one corporation. And you feel, like I feel—wouldn't it make a lot more sense to take that $300 million and put it back into home care? I don't want to put words in your mouth. I'll let you answer that.

Ms. Janina Lebon: You don't have to put words in my mouth, because I agree—if we have a billion dollars for home care, it should all go into home care.

Mr. Wayne Gates: Helen, have you got any comments on that?

Ms. Helen Lee: I agree with what Janina said.

Also, working conditions really impact the quality of care.

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Helen Lee: There are no shortcuts. So you have to have good working conditions for the staff. It's a system. If they're happy at work, there's going to be continuity of care.

Mr. Wayne Gates: I appreciate that.

In fairness, because Home Care Ontario is a private company, do you agree with that—that every dollar should go back into home care and not-for-profits?

Ms. Helen Lee: Yes.

Mr. Wayne Gates: I'm asking Sue.

Ms. Sue VanderBent: Home Care Ontario is an association of provider members. I represent the broad spectrum of home care providers in Ontario, regardless of tax status.

Mr. Wayne Gates: I appreciate that non-answer—but I do appreciate the answer; that's for sure.

Janina, can you please tell Rolf that I always think of him and tell him I say hi—

The Chair (Mr. Brian Riddell): Thank you.

We'll now go to the independent member. I recognize MPP Shamji.

Mr. Adil Shamji: I would like to start by thanking all the witnesses for your testimony today. I'm sorry that I missed your earlier remarks, but I was debating something in the House. Your perspectives are deeply appreciated, and I will be reviewing that afterwards. If I ask a question that has been covered in your remarks, I do apologize in advance.

Sue, I was wondering if you could share, from your experience and your perspective, what you believe are the top two or three things you think are necessary to reform our home care system in Ontario and whether you think these are present in the bill before us.

Ms. Sue VanderBent: We have to increase the funding, absolutely. The funding is obviously the root cause of so much inability of our sector right now to be able to address all the issues that we have to deal with.

Home care is a very complicated service. It is not a situation where we are providing care in a vetted environment. All home care providers, regardless of their tax status, have to have staff. They have to have transportation. They provide the cost of transportation in cities, and they have to drive. We have labour and occupational health and safety issues. As I said before, we have cyber security issues, because all systems are going highly technical. We have to have technology to support the vast labyrinth of patients and of staff who are out on the road—to 730,000 people a year. It's a logistical amazement to me that we are able to look after so many people in Ontario who need home care in their homes, and also in places that they call homes. Retirement homes are also part of that. If somebody lives in a retirement home and they pay rent to that place—that is also their home.

Home care is a very expensive part of the system, in terms of all of the services that it has to offer, and so it is time to grow it in order to stabilize people to live at home, and we have to not just increase it by little dribs and drabs—this has to be significant funding now.

1620

We're very, very grateful to Minister Jones and the Conservative government for the billion dollars. It went right back into patient care, and that is critical to tell you, because we have to get our home care system built up to prepare for the coming demographic bulge. I can't stress this urgency enough. We don't have time to wait. We need to produce three times the kind of care functions that we do today in these coming years.

Mr. Adil Shamji: You referred to a billion dollars that has been committed to home care and that it has been going straight into patient care, which is amazing. How much of that have your partners seen so far?

The Acting Chair (Mr. John Jordan): One minute left.

Ms. Sue VanderBent: Well, at this point, we're still negotiating. We are certainly getting increases. There's a process for getting funding out to the sector. We're continuing to work with the government on that. But it's promised funding. Promised funding is absolutely import-

ant to have, for us, in order to be able to continue functioning—and looking after 730,000 people a year and delivering more than 59 million hours of care a year. I think we have to employ twice as many staff in the coming five years.

Mr. Adil Shamji: So I understand a billion dollars was committed a year and a half ago, and you're still negotiating for that money.

Thank you very much. I have no further questions.

The Acting Chair (Mr. John Jordan): That concludes our time for this round.

Interjection.

The Chair (Mr. Brian Riddell): I'd like to thank everyone for their comments today. If you would like to submit any written materials to the committee in addition to your presentations today, the deadline for written submissions is Wednesday, November 15, 2023, at 7 p.m.

THUNDER BAY AND DISTRICT INJURED WORKERS SUPPORT GROUP

MS. SUSAN WATSON

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr. Brian Riddell): I will now call forward the next group of presenters. Please come forward, Thunder Bay and District Injured Workers Support Group, which will be virtual; Susan Watson, which will be virtual; Ontario Medical Association, which is in person.

I welcome each of you. As a reminder, each of you will have seven minutes for your presentation, followed by questions from the committee members. I will provide reminders of the time remaining during the presentations. Please state your name for Hansard and then you may begin.

We'll start with Thunder Bay and District Injured Workers Support Group. You may begin when you wish.

Mr. Jules Tupker: My name is Jules Tupker. I'm a board member with the Thunder Bay and District Injured Workers Support Group. We provide support and information to injured workers and their families.

I am also a social justice advocate and a retired union rep who has served CUPE's rep here in Thunder Bay. I'm also involved with Poverty Free Thunder Bay and the Thunder Bay Community Elder Abuse Prevention Committee, and I'll be referencing some of the work that I have done with them over the years.

You might ask why Thunder Bay injured workers are joining this presentation. There are over 1,000 injured workers who are not receiving proper compensation through the WSIB. There are over 300,000 claims for injured workers that are made every year in Ontario; of those, about 10,000 to 20,000 of those claims are for long-term injuries or illnesses. So we have a lot of members who are injured workers accessing home care. We are very concerned about the changes that are being proposed in this legislation, which we feel will diminish the value of home care. We're very concerned about that, so that is why we're making our presentation.

I was going to go through a bit of history, but I don't think I'm going to do that. Certainly, I was watching, and Natalie Mehra went through a number of the issues, as far as history goes. Although I do want to point out that the Harris government, in the 1995-96 period, did privatize—opened the door to competitive bidding on home care. They were able to do that—home care, private corporations—were able to undercut and lowball the existing not-for-profit organizations that were providing home care services by reducing wages, reducing benefits, reducing abilities of workers to earn a living. Of course, we know that 70% to 80% of a cost to a home care organization is wages. So if they cut the wages, these private corporations were able to lowball and make low bids, thereby replacing the not-for-profit organizations that were paying a fair wage, and they ended up with the for-profit corporations taking over home care, which has basically—and we know now—destroyed the home care process because of the situation that I'll be talking about in a few minutes. Coincidentally, the Harris government did lowball it and opened the door to privatization. Of course, former Premier of Ontario Michael Harris and his wife opened up their own home care service, by the way, called Nurse Next Door; it's quite the coincidence, I might add.

Also, I'd like to point out that the Ford government now has allowed these for-profit corporations to control the coordination of their own for-profit care providers. This new legislation we see as allowing the provider of the corporations to provide their own care providers, and we feel that that is going to limit the ability of the general public and anybody else to have any input into how home care is being provided. We find that Bill 135 is not going to do anything to improve home care, and that is a real concern that we have.

I just want to give you a little bit of history for a minute. As a servicing rep with CUPE back in the mid-1990s, we heard about, in Fort Frances—I was servicing in Fort Frances, and there was a move afoot to create a comprehensive health organization, which is a part of the integrated health process that the government was looking at in the late 1980s and early 1990s. When I investigated the comprehensive health organization that was to be implemented in Fort Frances, we investigated it and we found out that the whole idea of integrated health services sounded like a great idea and seemed to make sense; we thought it was very interesting. The continuum of care is very important, and we knew there were problems with the severed services that were being provided by doctors then going to hospitals and long-term care and things like that. We dug into it a little bit more and found out that the comprehensive health organization was looking at "rostering." Basically, rostering is when a patient is registered with a family practice, family physician or a team—once you are registered with this organization, then you have to stick with the services that are provided by that organization; if you want services outside, if you have to go to a special service provider, then you have to leave that organization, and once you leave, you are no longer allowed to be a part of that health organization.

I don't know if you understand, but the Ontario health teams sounds very familiar to what the comprehensive health organization was. And I'm very concerned that what's going to happen with Ontario health teams is that they are going to be able to force people to register with them. Right now, I don't hear anything about having to pay, but we see Bill 135 as being taken over by private corporations—the health care being taken over by private corporations—and then deciding, "We need to make some more money"—

The Chair (Mr. Brian Riddell): You have one minute remaining, sir.

Mr. Jules Tupker: —"so if you want to be a member of this Ontario health team here in our community, you're going to have to start paying." We have a real concern about that.

I have a number of stories, as a former CUPE rep—I have talked to a number of people who are working in health care, now in home care. I have some stories, and I will try to relay those further on. I also have been in touch with people who have given me stories about the problems that they've had in home care, and I would like to talk about those also. I will wait, maybe, until somebody asks me those questions and I can relate some of the stories that I've heard from people who are providing home care to their family members. In fact, I got a call this morning from a woman in tears who had to tell—home care was basically not showing up for their care.

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I will end it at that and say that we are very concerned with Bill 135, and we recommend that Bill 135 be withdrawn and—

The Chair (Mr. Brian Riddell): Thank you for your presentation.

We will move to Susan Watson. You may start when you wish.

Ms. Susan Watson: Chair Riddell and members of the Standing Committee on Social Policy, my name is Susan Watson. I was a primary caregiver during the six-year Alzheimer's journey of my late father, Dr. Alan Watson. He had a 43-year career as a physician serving Ontarians. Two of our years of experience with home care were spent interacting extensively with the system—first, with caregivers in my parents' home over a one-year period, and then with publicly paid home care delivery when my father was a resident in a memory unit at a retirement home.

Although my father was showing early signs of cognitive decline in 2016, it was a serious head injury sustained on a tennis court that catapulted my dad and my family into the home care system. My dad was misdiagnosed at the hospital and not sent for the rehabilitation which he needed, so he landed at home after one week in hospital, needing 24-hour supervision as an extreme fall risk.

I actually moved in with my parents for five or six weeks, and my mother and I would nurse my dad for 16 hours during the day, and then hire privately paid overnight care so we could both sleep in preparation for the next day. We hired the same agency, Bayshore, that was providing the completely inadequate two hours of publicly paid home care that we had been allocated. But as a result, I had a front-row seat to the comings and goings of a revolving door of personal support workers who came to care for my father, both overnight and during the day. Even for me as a client, paying hundreds of dollars for private care in addition to the publicly paid care we received, Bayshore was unable to provide any consistency of care. The constant churn of different faces was profoundly draining for my mother, as she had to orient someone new every evening.

As someone who has lived with health care workers all my life, I have to say that I was taken aback by the involvement of for-profit corporations in my dad's home care. It wasn't what I had expected, and I guess I hadn't understood that there had been a transition from the non-profit public service agencies like the Victorian Order of Nurses and the Red Cross, to for-profit corporations that are bidding on home care contracts. It quickly became apparent to me that the for-profit structure of home care was incapable of delivering the consistent, adequate care that was needed.

PSWs who came through our door were overwhelmingly immigrant women who were precariously employed. I learned from many late-night conversations that these women often worked for two or three different agencies in order to simply pay the bills. None of the agencies wanted to hire them full-time because they didn't want to have to pay benefits. And because everyone was part-time with several different agencies, no one agency could deliver consistency of care. These women were also booked to work at the last minute and cancelled at the last minute, usually without remuneration, and it's my understanding that there is little or no compensation for travel time between clients.

If I booked a PSW through the agency my family was paying $35 an hour, I learned the worker was receiving $14 and change at that time. I know the publicly paid PSWs were making a few more dollars per hour, but I have no idea what the agencies are paid by the government.

So it's no wonder that there is a staffing crisis in this sector. Who would want to do this kind of work, in these kinds of conditions, for this kind of pay? As a result, millions of home care dollars have gone unspent by the Conservative government in the midst of a home care crisis. What does it look like on the front lines when staff are overworked and overstretched? I can give examples in the question period, if you are interested in knowing.

I don't see anything in this new legislation that is going to improve the quality of home care, provide better access to care, articulate the rights of Ontarians to care, address the staffing crisis, or deliver transparency, democratic control and accountability. It looks to me, and clearly to others, like this government is completing the privatization of this aspect of health care by privatizing health care coordination, which, until now, has been publicly delivered.

It is astounding to me that, as far as I understand, the client or patient bill of rights is being cut from this legislation. The current lack of oversight and accountabil-

ity for the care of some of our most vulnerable citizens is already unacceptable without weakening it further. Frankly, I resent that my tax dollars and those of other Ontarians are being siphoned off to line the pockets of the shareholders of these private home care corporations. This directly impacts the working conditions of the PSWs who are delivering the care, and the conditions of work are the conditions of care. Every health care dollar needs to go to providing care for Ontario citizens, not to private profits.

I find the name of the bill, the Convenient Care at Home Act, frankly, Orwellian. I think drawing a parallel to what happened with the greenbelt and overrides of local official plans is relevant. Those changes and carve-outs were not about delivering housing to Ontarians; they were about richly rewarding the corporate cronies of the Ford government. Likewise, the series of changes to home care culminating in this bill are not about providing better home care to the "little guy"; they are about enriching friends of this government who are gorging themselves on our health care dollars.

Anyone who is planning to be old, sick or vulnerable—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Susan Watson: —in this day and age in Ontario should be frightened. They should be very afraid.

As elected MPPs, you need to think about what you owe your elderly constituents—the ones who actually show up and vote for you. Is your loyalty to the needs of these constituents or to the private interests of donors with deep pockets who donate to your party coffers? It really is a fundamental question of democracy.

In my view, the corporate vultures need to be evicted from home care and Ontario needs to return to the full investment of health care dollars in publicly funded and publicly delivered long-term care and home care services.

The Chair (Mr. Brian Riddell): We will now move on to the Ontario Medical Association. Please state your name for the record.

Dr. Andrew Park: My name is Dr. Andrew Park. I'm the president of the Ontario Medical Association. Thank you for having me here today on behalf of Ontario's 43,000 physicians.

The OMA appreciates the government's desire to improve home and community-based care. Bill 135 has the capacity to make meaningful change. It is critical that action be taken to address the need for expanded and integrated home and community-based care. In the aftermath of the COVID-19 pandemic, it has become abundantly clear that we cannot wait to address the long-standing issues in Ontario's health care system. The time to act is now.

Before I go any further, I would like to take a moment to recognize the tremendous work done by home and community care providers, who work to maintain and elevate patient dignity at the core of their work and provide the best care possible given system constraints.

In the lead-up to this bill, the OMA has had the opportunity to work closely with government, and we appreciate the collaborative spirit we have seen from elected officials in this room. On October 16, we hosted our highly successful Queen's Park day, which was attended by over 100 physicians joining meetings with over 70 ministers and MPPs of all political parties. This event was representative of the shared interest between doctors and elected officials to improve Ontario's health care, and I'm confident that we will build on the work we have done so far.

The OMA has released pragmatic solutions to address the top three issues facing the health care system, following extensive consultations with physicians, stakeholders and the public. One of our three key priorities is the need to increase community capacity and tackle hospital overcrowding. Far too many Ontarians are languishing in hospital beds when they could be discharged and better cared for elsewhere. One significant cause of hospital overcrowding is a lack of access to home care, long-term care and palliative care. This bottleneck of patients, referred to as alternate level of care, or ALC, has existed in Ontario for many years, with its root causes remaining unresolved. In the meantime, extended hospitalization comes with risk of adverse outcomes, such as accelerated functional decline, infections, delirium and falls. We can and must do better for these patients.

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First, we must focus on funding home care and home care providers. When physicians refer patients to home care, the case is often accepted immediately, but there may be a delay between acceptance and provision of care that can span weeks if not months. There are simply not enough professionals, nurses and support workers to provide this necessary care, and as a result, our patients must rely on informal caregivers such as partners, family and friends to provide the support.

One of the root causes behind home care staff shortages is a significant differential between home care and other sectors. The Ontario government must accelerate its efforts to recruit and retain home care staff, which means paying them a wage that makes it abundantly clear how vital they are.

Another key solution is embedding care coordinators and home care professionals in primary care teams. Physicians could work with dedicated care coordinators to better advocate for their patients at the time of need as opposed to the time of failure. Anecdotally, the top complaint from physicians regarding care coordination is a lack of effective and efficient communication. Team-based care presents an opportunity to streamline communication and eliminate barriers between health care professionals.

Lastly, we can use hospital-at-home programs, which provide therapies, tests and monitoring typically provided in hospitals for patients who are sick enough to require acute care but stable enough to receive that care at home. These programs require flexible home visits, remote monitoring and 24/7 access to health care professionals. In Canada, British Columbia and Alberta have formally implemented programs for this.

These are just a few of the solutions outlined in the OMA's Prescription for Ontario: Doctors' Solutions for

Immediate Action, which I have here, and there are copies available. I encourage you to read it in full. We want to work in tandem with the government to build a better and more reliable home care system.

With respect to Bill 135, I do have a few specific comments.

Regarding centralization of LHINs, the goal of centralization should be that Ontario Health atHome sets standards for home care, ensuring that it is of high quality, provided at appropriate and equitable levels, with availability that is commensurate with need, regardless of where patients live. The balance, however, is that Ontario Health atHome must avoid a one-size-fits-all approach, prioritizing autonomy for OHTs and health care professionals. Centralization does not mean rigidity—because if implemented poorly, there is a risk of creating a centralized entity incapable of addressing the different socioeconomic and demographic needs across the province, such as the situation currently seen in northern and rural Ontario.

With respect to forms, in consultation on home care, the physicians have voiced the need for a single standardized referral form for home and community services, which should ideally be uploaded through the physician's EMR or e-referral platforms.

Around responsiveness, Ontario Health atHome should help facilitate OHTs to be able to accept referrals as well as provide home care 24 hours a day, seven days a week to reduce avoidable emergency department admission.

Around OHT readiness, the new centralized home care structure must account for the different levels of OHT readiness across the province, especially considering northern and rural Ontario, where these teams may be less developed. There should be a process in place to assess OHT readiness in advance of the transfer of responsibility for care.

Lastly, care coordinators: As noted in our solutions report—

The Chair (Mr. Brian Riddell): You have one minute remaining.

Dr. Andrew Park: Thank you, sir.

As noted in our solutions report, home care coordinators must be embedded within primary care, acute care and OHTs to support better collaboration between care coordinators and physicians.

These are just a few points of feedback for the committee on Bill 135, but I invite you to read our written submission to learn more about the OMA's position on this bill.

Once again, I want to thank you for your attention, and I look forward to discussing the subject further in the Q&A.

The Chair (Mr. Brian Riddell): We will now go to round one. The official opposition has seven minutes and 30 seconds. I recognize MPP Gélinas.

M^me^ France Gélinas: I would like to start with you, Dr. Park. You made it clear that care coordination should go in primary care, acute care.

What would you think if the care coordinator is embedded within, let's say, Bayshore—so Bayshore has the contract in your area to provide home care, and the care coordinator gets to decide who gets what and then provide that care, versus in primary care, where the people know the patients.

Dr. Andrew Park: Thank you for the question.

I think it is really important to recognize that physicians have comprehensive and longitudinal relationships with their patients and understand what their patients' needs are because of their communication with family, caregivers, as well as the patients themselves, and that's so critical. In order to build a patient-centred system, it's really about listening to what the patient needs are and driving care towards providing that.

It's important to set the standards for what it means to be patient-centric in the system and how we go about that. Patients' physicians and their care teams are best equipped to provide that wraparound care for the patient, and that does include care coordination around home care.

M^me^ France Gélinas: Right now, most of our home care is delivered by private, for-profit companies that bid on contracts. Would you see value in having integrated primary health care teams also having home care workers as part of the team—so not only would there be a social worker, a nutritionist or a nurse; there would be a PSW assigned to the patient roster for that integrated primary health care team?

Dr. Andrew Park: I think it's really about ac cess and capacity. The issue is that with care coordinators available with primary care teams, they're able to then determine which services are required, when and where, and be flexible to the needs of the communities, particularly in the north and rural communities, where those needs are disproportionate and there's an equitable lens to be applied to how we provide care for patients in the north—and in a lot of cases, that does not happen. I think it's really important to ensure that, as part of a team, we have what the needs of the patient are considered—and in this case, care coordinators would help do that within the primary care lens.

M^me^ France Gélinas: So, really, your message is that we stay away from one-size-fits-all and focus on Ontario Health atHome? They set the standard, they set the levels and then let the local people who know the patients decide how this is going to best be offered?

Dr. Andrew Park: Yes, I think that those communities across Ontario—what works for Windsor does not work for Sudbury per se or Marathon or other outlying communities, certainly in the north. Again, I want to reiterate that there needs to be an equity lens applied to this, and that does require a degree of flexibility. You're right; as I said, it can't be a one-size-fits-all.

M^me^ France Gélinas: I will go to the Thunder Bay workers support group and Jules Tupker.

You want this bill to be withdrawn. You want to make sure that care is available based on your members' needs, not on what the private corporation is willing to give.

You were also worried about the Ontario health teams and how this could end up being a barrier rather than moving us forward. What are your worries?

Mr. Jules Tupker: I'm concerned. As I said, when we had the comprehensive health organization in Fort Frances and we addressed the rostering issue, we said they would have to qualify to become a member of the comprehensive health organization, which is very similar—it's exactly the same as the Ontario health teams that they're talking about, because they're talking about the Fort Frances clinic, the hospital and the long-term-care home being that health organization. In other words, that would be the health team, and then people would have to be rostered—and if you had complex health issues, this health organization could deny you admittance into that team, so all of a sudden, you wouldn't have any health care.

In a town like Fort Frances, there is only one clinic—two doctors belong to it—and one hospital and one long-term-care home. So if you weren't accepted into that team, where were you going to go for health care? I see that happening.

This bill and this government are leading to more and more privatization. I can see, with the way the system is set up now—what I read from this system is that it's all going to be run by private corporations. I can see them changing the whole rule and then saying, "We can't make enough money. These organizations can't make enough money. So we're going to start charging people to be a member of this health team." That's a concern. I think that's going to wipe out—and especially my members. A lot of them are living in poverty because they're not getting compensation. They're living in poverty, and they won't be able to afford anything else outside of what's being provided in that health team. It's a very serious concern that our members have.

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M^me^ France Gélinas: To Ms. Watson: Looking back in my community, it was VON who provided home care. They had nurses with 35 years of experience. They were good at home care. Then the competitive bidding process came, VON went bankrupt, and Bayshore got the contract etc., and it has been downhill ever since.

You talked about your personal experience. I can tell you that not a day goes by in my office that we don't start the morning listening to the messages on the answering machine, and they're all about people whose home care worker did not show up and then they ran into problems.

Do you see anything in this bill that will help with the health human resources crisis in home care?

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Susan Watson: I don't see that it can be solved with a privately delivered model, because they're grinding down the costs, the salaries, in order to maximize profits. Like I said, who wants to work in that system? Everyone is working part-time for three different agencies.

The lack of accountability already is scary. I had a PSW walk out of the house while my dad was in the middle of using a bed urinal and was not done, because she was going on to her next appointment and said, "Sorry, I can't stick around." Then, when he was in long-term care, there were workers coming in who didn't work for the care home, and nobody would chart. I was on their tail just to do basic charting so that I would know that a dad with Alzheimer's was getting a bath—which I found out he wasn't. No one was providing that accountability, even through a chart. So—

The Chair (Mr. Brian Riddell): Thank you for your comments.

We'll now move on to the independent member for four and a half minutes. I recognize MPP Shamji.

Mr. Adil Shamji: I just want to begin by thanking all of the witnesses for being here, giving us your time, taking a moment to review the legislation, and for sharing your valuable perspectives.

Also, just in the interest of transparency, I should mention that I am a member of the Ontario Medical Association, although I don't foresee that as being a problem here.

I want to direct my first question to Dr. Park. We have heard from many witnesses, today and yesterday, a concern that there are a lot of details that are left out of this legislation. A very reasonable counter-argument to that has been that this legislation is intended to be enabling legislation and that the details will follow afterwards. The reason I'm asking you this question is, the last time that I remember enabling legislation that had a material impact on our health care system was in the development and implementation of Ontario health teams. In the wake of that, it strikes me as though we have a patchwork implementation of OHTs—some are very good; some are struggling. There is a lack of consistency in terms of quality. I know that the OMA was very involved in the rollout and development of OHTs. I was wondering what lessons there are from that to ensure that, when the details get filled in, if this legislation is passed, we actually ensure quality, consistency, equity and fairness across the health care system?

Dr. Andrew Park: It's a great question.

It's really important to take what learnings we had in that experience and bring them forward here. Perhaps some of the biggest challenges that I've seen with the OHTs in particular are knowledge translation consistency and scale and spread. I think those are the key lessons that—going forward with implementation of a program like this, it's paramount to ensure that whatever lessons we've had in that regard are translated for it here so that we don't start three steps behind.

Standards are obviously very important. When you talk about where the legislation is now, we want to be part of that co-design, ensuring that those standards are there, that there is a lens around equity, particularly in how care is delivered across the province.

I think that the OHT issue is a concern for us, as I mentioned in my opening statement—that the state of readiness impacts whether or not they will be able to deliver the care from a home care standpoint. That is of concern, and I think that's something we're going to have

to see thought through in terms of how we actually deliver the care. If they're obviously not equipped or ready, that's something that we need to focus on.

Mr. Adil Shamji: I appreciate you making that comment, because that is something I'm very worried about, and I've made this point before with other witnesses. When you look at the previous functions of the local health integration networks and the proposed function of Ontario Health atHome, those functions do not overlap. Historically the LHINs, for example, if there was not a service provider in a particular area, would step in and could help to facilitate that. In the absence of that function, without that function being delegated and without it being in the realm of Ontario Health atHome, and with the fact that there are many OHTs that are not ready to assume that function, do you think that it may be premature to be introducing this legislation?

The Chair (Mr. Brian Riddell): One minute remaining.

Dr. Andrew Park: I think, certainly, that when we look at where the OHTs are in their implementation and development—I think that's something that's going to require contingency on how we deliver that care. And if they're not ready or they're not equipped, then there would certainly need to be a recognition of that and then an implementation of a contingency around how we go about delivering care to those areas.

Mr. Adil Shamji: One of the other comments—sorry; there are a lot of questions on OHTs, because I think they'll play an important role in this. One of the points that you made was that under a single institution, Ontario Health atHome—it is one, but it needs to be nimble. How do you think that we can facilitate that kind of flexibility and nimbleness in a—

The Chair (Mr. Brian Riddell): We'll now move on to the government.

Mr. Adil Shamji: We'll come back.

The Chair (Mr. Brian Riddell): I recognize MPP Wai.

Mrs. Daisy Wai: I also want to say thank you to all the presenters for sharing your thoughts. It is important for us to gather the information you have for us.

I would like to ask a question to the OMA.

I thank you for letting us know that you're representing 40,000 of the physicians, and you have extensive guidance to the physicians as well, which is why I think it is so important for us to get more information from you.

I assume you know that the Ontario government has already proposed a lot of changes, especially finding ways to improve how people connect to home care services, and we are doing a lot to break down the long-standing barriers between home care and the parts of the health care system.

I thank you for your analysis just now. I'm sure you have valuable information for us.

I have two questions that I would like to ask, if you don't mind sharing your thoughts with us. How can the government support improved integration of home care and primary care, especially through the Ontario health care teams? And the second question that I have for you is, can you provide us some advice that OMA can offer to enable people to get the right care at the right time in the right place?

Dr. Andrew Park: Thank you for those questions. Around the first one, around how we can ensure integration—that's a definition of a system, is integrated parts working in a coordinated fashion. In parts of our health care, we struggle with that. That's blatantly—

The Chair (Mr. Brian Riddell): Excuse me; I'm being asked if you could move just a little bit back from your mike.

Dr. Andrew Park: Yes. Sorry.

The Chair (Mr. Brian Riddell): No, it's fine.

Dr. Andrew Park: Thanks. I appreciate that.

I think what we really need to look at when we're implementing new programs is, are they parallel programs? How well do they integrate with the needs of our community now? And how well can providers and patients navigate those systems in a way that's coordinated and connected? Home care, in particular, has a massive role to play in this.

Again, as an emergency physician, I see the impacts of home care—or the lack of home care, at times—to be part of my daily work experience. It's gut-wrenching to see patients in a hospital who don't need to be in a hospital, because we know the impacts, as I mentioned in my opening comments, around delirium and falls. Hospitals are not fail-proof places of existence, and so when we see those impacts on our elderly for things that they didn't need to be in the hospital for, that is both detrimental to their health—as well as the impact it has on the overall system.

So ensuring that integration through transitions of care, whether it's from primary care to avoid hospitalization, or from the acute-care experience, to be discharged from hospital and not waiting—again, it seems like we're waiting sometimes for failure to happen, as opposed to saying, "How do we support the patient when they need it, at the point they need it?"; as opposed to waiting for them to fail to then decide that that's when we need to implement services for the patient.

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So those are my comments around primary care.

Your second question around advice—is being at the table with you. Certainly, we see the unintended consequence of criteria around health care. When we have patients who, as I said, don't need to be in a hospital but end up in hospital, we want to be part of the solutions for how we go about implementing and designing team-based care for our patients and our communities. So, certainly, we're at the table, and we want to continue to be there.

The Chair (Mr. Brian Riddell): I recognize MPP Barnes.

Ms. Patrice Barnes: Thank you for your feedback.

We talked about that integrated level of care. Right now, the government has moved somewhat to the nurse practitioner clinics, where you have that integrated level of care. I wanted to get your feedback on that model that is emerging now that—we talk about looking at the system and doing things that make things better. So that's one of

the entities that have come online. In regard to how you see that integration spreading out across the province, including from a doctor's point of view—what you think that would look like if you had that magic wand-type thing in regard to making an integrated home care so it can serve at a local level.

Dr. Andrew Park: I appreciate the question.

For care to be effective and efficient, it needs to be coordinated. Multiple individuals working collaboratively at scope, together, to provide care is really critical for that care to be effectively placed for patients and patient-centred. Not every patient has the same needs, so recognizing those parameters around each individual patient is critical, because we can't paint groups with a brush and say, "We've provided all the care that person needs because we have implemented one pocket or one node of care." It's really important that we are flexible, that we are integrated, that we do understand individual communities as well as individuals and their family needs in order to—

The Chair (Mr. Brian Riddell): One minute remaining.

Dr. Andrew Park: —thank you—provide holistic care. That's why this has been such a big stress of ours around integration and coordination. Right now, there are just too many silos in health care, and that does need to change.

Ms. Patrice Barnes: You also talked about the standardized referral form for doctors to—out into the system. What would be some of the integral pieces that you'd think would need to be on that?

Dr. Andrew Park: I think that's something that's important to think about in terms of what is common across the different regions. Right now, I can tell you, it's paper—there are different requests for different areas that you need to write in. It's not standardized. It's faxed off somewhere. You oftentimes don't know when you're going to get an answer, when the care is going to be initiated. That's why it's really important to have point A to point B around standardized referrals and to ensure that that pathway is set so we know that once that communication is delivered, with the options for flexibility for patient care, that it's received and we—

The Chair (Mr. Brian Riddell): Thank you for your comments.

We'll move on to round two, with the official opposition having seven and a half minutes. I recognize MPP Gates.

Mr. Wayne Gates: I'm going to ask Andrew a question.

Why I'm so concerned when it comes to private home care or privately delivered health care—I'm a firm believer in publicly delivered, publicly funded, period. No surprise there—we've talked before. Today, it came out, from Canada Healthwatch—"Ontario government paying for-profit clinic up to 3.2 times more than hospitals for OHIP-covered surgeries." Are you aware of that?

Dr. Andrew Park: I was aware of the article in the CBC the other day, yes.

Mr. Wayne Gates: Do you think that's a good reason why we shouldn't support for-profit, when you're charging that kind of extra—I don't even know how to explain how you can say that to anybody, that you're paying two and a half times.

I know probably the easiest way to do it—although they were exempt going back, was Shouldice. Shouldice is really very similar to why I started saying I don't want anything to do with a private company because—I can give you an example, and then I'll turn it over to my colleague.

When I got my hernia operation—this is going back a few years ago. I had a choice—I could have went to Shouldice. At Shouldice, you have to be fit, like me, and they'll take you; if you're overweight, you've got to lose your weight. So I said to my doctor, "I want to get operated on in Niagara Falls by a doctor who's covered by publicly funded, publicly delivered—not a private company." They're still covered by your OHIP card—but the difference at that time was that it cost $1,200 to get my hernia operation in Niagara Falls; it would have cost $11,000 at Shouldice.

When you hear that comment, "Well, you're still paying with your card"—you're sucking all those dollars away from the public system. The more you do that, the less it's going to have for our public system—it will, at some point in time, collapse, whether it's home care, whether it's our hospital system.

Anyway, I'm glad you're aware of that.

Hopefully, at some point in time, we can have a longer discussion.

I'll turn it over to my colleague France.

The Chair (Mr. Brian Riddell): I recognize MPP Gélinas.

M^me^ France Gélinas: I would like to go back to you, Ms. Watson. You made the comment that you would have liked the bill to have a right to care. What did you mean by that?

Ms. Susan Watson: If I'm not mistaken [*inaudible*] or a client bill of rights. My concern is that that is being removed in Bill 135. Am I correct on that? I think it needs to be stated in the legislation, because in these situations where someone just walked out the door mid-care for my dad or that I can't get charting done, where is it—this bill needs to protect the interests of Ontarians and their right to care, not protect the interests of the for-profit corporations. So I want to see that in the legislation.

M^me^ France Gélinas: You're absolutely right; there is no bill of rights for home care or community care patients or clients in that bill. You would feel better if it was in—

Ms. Susan Watson: Absolutely.

M^me^ France Gélinas: You also talked about the staffing crisis, and you made the link between you having to pay 35 bucks an hour and the PSW getting $14.50 an hour. Do you link the two together—that the staffing crisis is linked to the wages, similar to what Dr. Park said?

Ms. Susan Watson: Yes, absolutely. People are getting hired at a moment's notice, cancelled at a moment's notice. I think they get little or nothing for travelling

between clients. Then some of them are making minimum wage or a couple of dollars above that, and then they're working for several different agencies. Because they're working for different agencies just to make ends meet, then no one agency can deliver the consistency of care that you need. What if it was publicly delivered and somebody had a full-time job, and then they could be a consistent caregiver to the various individuals?

I really feel like profit does not belong in our health care system in any area, full stop.

M^me^ France Gélinas: I fully agree with you. It brings in conflict of interest.

I can assure you that a patient bill of rights is not in the bill, that minimum staffing ratios and making PSW jobs good jobs—that kind of stuff is not in the bill. We're talking about ministry to Ontario Health to Ontario Health atHome to Ontario health teams and a whole bunch of other service providers that—we still don't know who they will be, but my guess is that it will be a bunch of for-profit corporations that would get those contracts.

Coming back to you, Dr. Park: You made an interesting comment by saying, as an emergency room physician, that you see the failures of the home care system, as in some of the patients that you see are in the emergency room because home care was not there for them. Is this what you meant?

1710

Dr. Andrew Park: Sorry; what I meant by that was that when we get patients who could be at home but were unable to implement home care fast enough, so they have to come into hospital. They don't have an option in those instances. So it's not those patients necessarily—and sometimes it is. I wasn't painting a picture about those who already had home care in place—I was saying that those who have the unavailability in that particular instance to have it implemented in time before a discharge from an emergency department.

M^me^ France Gélinas: Do you figure that happens solely in the emergency department where you work, or does it happen pretty much everywhere in Ontario where the home care system is not able to meet the needs of the patients that you or your colleagues see, so they need to be admitted?

Dr. Andrew Park: What I would say is that, like I said earlier around a system being a system, I think there are failure parts in different parts of the system, home care being one of them, where that happens. And I think those are the areas, but particularly around home care—and we've highlighted primary care, again, in our solutions. We've talked about the implications of what that means on an acute-care system—and there are patients that could have gone home, did not need to be in hospitals. We talk about our ALC population being 10% to 20% of hospital occupied beds. That has a huge implication for those patients who are going in for—

The Chair (Mr. Brian Riddell): There's 30 seconds left.

Dr. Andrew Park: —standardized acute care, and that impacts their care, so, yes.

M^me^ France Gélinas: So making our home care system more robust is kind of a pillar of making sure that the other parts of our system can work good?

Dr. Andrew Park: Nothing works in isolation, so, absolutely.

The Chair (Mr. Brian Riddell): We'll now go to the independent member for four minutes and 30 seconds.

Mr. Adil Shamji: Back to you, Dr. Park: When we were last exchanging remarks, I was asking you about the comment you made in your testimony in regard to the need for Ontario Health atHome to maintain its ability to be responsive and to be nimble, and I wondered if you could elaborate a little bit on how we can ensure that.

Dr. Andrew Park: I think it's important to have a standard set around quality and have those benchmarks be measurable and be accountable to those benchmarks, but then ensure that the areas that home care is deployed have the flexibility to provide care that is patient-centric, to the needs of those patients.

Again, I think about the unique needs of patients in—I even think about my own family being an immigrant family, and their care needs are very unique from the family—I was just in Dryden, and those communities are going to be very different.

You can't set a standard that is so rigid that you can't accomplish your objectives in delivering care. We've seen that as physicians, and I think it's important that the organizations have the flexibility to determine what needs are required and be able to deliver on them. As I said, it can't be a one-size-fits-all.

Mr. Adil Shamji: I wonder if we can go back to Jules, if you don't mind. In your comments about accessing home care in Thunder Bay, some of your remarks resonated with some of the concerns that have run through my head—specifically, around the fact that the farther it seems we get away from major urban centres such as Toronto, such as Ottawa, oftentimes the more difficult it becomes to access care. That's, broadly, care across the health care system, but certainly that's true of home care as well.

From your read of the legislation, what do you expect to be Bill 135's impact on home care delivery specifically in rural or—I recognize, of course, that Thunder Bay is not rural—in northern areas, father away from major urban centres?

Mr. Jules Tupker: Especially in northern Ontario, we have many communities that are three, four hours away from Thunder Bay. The people who require home care services—they're not there, or they're very limited, so it becomes a real problem.

I don't see anything in this bill that expands home care. This bill is—all I see is that it encourages private home care services to continue and expand at the expense of people who require the home care. We have injured workers across northwestern Ontario, across the province, who require home care and who are not able to afford to pay for home care, and they will not be able to get those services. It is a scary situation. As Ms. Watson said, there are no rights that the clients have in accepting that service. It's a scary situation for anybody who requires home care.

I don't see this bill doing anything to improve that. For private corporations, their modus operandi is to make money.

The Chair (Mr. Brian Riddell): One minute remaining.

Mr. Jules Tupker: They're for-profit corporations. Their first modus operandi is to make money; their second is to take care of patients and their clients. The first thing they're going to worry about is making money. It's a scary situation.

Mr. Adil Shamji: So let's imagine that we're able to insert into the legislation that any home care providers will operate in a not-for-profit manner. What is your sense about eliminating 14 LHINs and bringing them into one agency? Do you think that a single agency would make it easier or better to access care in the north?

Mr. Jules Tupker: Well, that's hard to say; I'm not an expert on that. Before we had the LHINs, before we had the CCACs, we had the Ministry of Health that took care of it. There was one organization; now we have about five or six. As France Gélinas pointed out, there are about five steps in that whole process. That seemed to work well before when the Ministry of Health looked after it. They allotted the money to the organizations, and there was only one administration to take money out of the process. Now we have five levels of administration. There's not enough money to do that—

The Chair (Mr. Brian Riddell): Thank you for your comments.

We'll now move to the government for seven minutes and 30 seconds, starting with MPP Jordan.

Mr. John Jordan: Thank you, Dr. Park, for coming today. I did attend your Queen's Park day, and I appreciated your comments around interdisciplinary care. I think it's very important.

When I look at Ontario health teams, I look at that almost as an extension of interdisciplinary care, where we're bringing all the health service providers together—our mental health agencies, our primary care physicians, the Alzheimer Society. In the Ontario team that I was involved in, there were all kinds of different partners coming together to address—almost like a situation table, if you will, to work together.

This Ontario health team, now that we've incorporated Home Care Ontario, if the bill passes—is to bring home care into that group and better coordinate and communicate the issues and problems and the solutions that can come together.

It's very difficult to engage physicians sometimes; you're very busy people. I'm wondering how you feel physicians can best be engaged into that process.

Dr. Andrew Park: That's a great question. I thought you were saying we had a personality defect.

Laughter.

Dr. Andrew Park: Yes, right.

Physicians want to be involved in the process. Part of the reason we want to be involved is because the system isn't allowing us to practise the way we practise, the way that patients need us to be there for them. We're seeing engagement across this province in ways that we haven't seen before in part because of the frustration and the burnout that our members feel about doing this job.

When I think about home care in particular—the number of forms, the inability to have that communication that really tells us that our patients are being cared for, those after-hours phone calls to ensure that we're following up on those things can be really frustrating in terms of actually getting the care to the right places at the right time. So we want to be part of the solution. Our membership is telling us that loud and clear. As an association, we want to be part of that. So I don't think you will find a shortage of willing volunteers to say we're absolutely happy to help co-create what it is from a patient lens, and a delivery of care that we see our patients and our members want.

Mr. John Jordan: I'll just expand on that a bit. The collaborative council—we did have some physicians who were able to sit on that, some champions within our community, and therefore go out and communicate with other practitioners in the Ontario health team. Is that something you think would work, or is it more on a service level—developing a system that you can successfully get to the services that you were just describing?

Dr. Andrew Park: Frankly, if I may, I'd say both. I think certainly at the co-creation table for those OHTs where we look at how do we better integrate services across our region—absolutely. But then individual physicians and care coordinators working together to provide the care for their patients is absolutely critical because they know their patients better. Certainly, when I am working in a system that's more seamless, I can get care for patients a lot faster and more efficiently. And that's what we're proposing—to say that if you have care coordinators that are integrated with primary care who know their patients very quickly, it's a quick text; it's not search through a file folder or some Internet thing and then look for a form and print it off; or it's different from the other form and you get the wrong form, and it's a postal code lottery. That's not what we're trying to create here. I think it's both that creates more seamless and efficient care.

1720

I think it's important that when we're considering a bill like this, we also consider the infrastructure that's required to ensure that the ability to have that communication and that seamless transition of care is available or supported.

The Chair (Mr. Brian Riddell): I recognize MPP Martin.

Mrs. Robin Martin: Thank you to all the witnesses.

I also went to the OMA's event. It was very nice, thank you. I also appreciated your speech and appreciate the fact that you said in your submissions that the OMA has been working collaboratively with the government on these steps to try to integrate care. We've now got to this place, Bill 135, and it is the next step in embedding home care, which I think you said is a critical and foundational part of the system—and it should be, I think you said, working with primary care, acute care and the Ontario health teams.

There was a comment made by another witness, I think, about rostering patients. I know that patients get rostered

with family health teams and family health organizations, but I didn't realize they got rostered with Ontario health teams. I thought the Ontario health teams were to cover an area. Is that correct?

Dr. Andrew Park: Not that I'm aware of. They are rostered with their family health organizations.

Mrs. Robin Martin: With family health teams?

Dr. Andrew Park: Yes.

Mrs. Robin Martin: And those are funded by the government, and I guess the limit on rostering is how many patients the doctor in the team can manage for that.

Dr. Andrew Park: Yes.

Mrs. Robin Martin: You made a couple of suggestions of things that you would like to see with respect to Bill 135. You talked about, importantly, I think, the balance between centralization and also flexibility of the Ontario health teams to meet the local needs. You talked about the form, which my colleague raised, and you talked about accounting for differences in OHT readiness.

My understanding is that some of the OHTs are further along than others, partly because they started sooner. So my understanding is that part of the development will be working with the ones that are more ready at first to see what they can do, and then maybe learning from those experiences. Do you think that's a plausible way to proceed with the Ontario health teams as we go forward? And can we learn from what we experience with those?

The Chair (Mr. Brian Riddell): One minute remaining.

Dr. Andrew Park: Yes, I certainly think it's reasonable to see where you have driven the most success and then drill down to see what the learnings are from that process.

You're absolutely right; OHTs are at different phases of development and growth, and certainly there is a pandemic in there to kind of—

Mrs. Robin Martin: For an extra challenge.

Dr. Andrew Park: To add an extra challenge, absolutely. So I think that it's very reasonable to say where we have the most success and—again, what is our north star, what is our driving feature around quality and patient-centredness? And then learn from there how you deliver it.

I will also say that, again, in this one-size-fits-all, what works for one OHT—and this is why we have this regionalized care—may not work for another OHT, and we have to be flexible even in those learnings for how we translate knowledge.

Mrs. Robin Martin: There's certainly a lot of potential. For example, when one community has a lot of people who have sickle cell, to have an expertise there shared with others who have the same issue—maybe other OHTs. But it won't be an issue everywhere in the province.

The Chair (Mr. Brian Riddell): Thank you very much for your comments.

If anyone would like to submit any written materials to the committee in addition to your presentations today, the deadline for written submissions is Wednesday, November 15, 2023, at 7 p.m.

OTTAWA RAGING GRANNIES
VISTA CENTRE BRAIN INJURY SERVICES

The Chair (Mr. Brian Riddell): I will now call the next group of presenters to come forward: Ben Guest, who I think is a no-show, and—this name I love—the Ottawa Raging Grannies, and Vista Centre Brain Injury Services.

Welcome. As a reminder, each of you will have seven minutes for your presentation, followed by questions from the committee members. I will provide reminders of the time remaining during the presentations and questions.

Please state your full name for the Hansard, and then you may begin.

We'll start with Ottawa Raging Grannies.

Ms. Jo Wood: My name is Jo Wood, and I am here to represent the Ottawa Raging Grannies. We're in opposition to Bill 135. The Raging Grannies are committed to making a better world for our grandchildren, but in this case, we also speak out about the continuing privatization threat to our own cohort. We are now at an age when home care becomes vital to keeping ourselves, our friends and our partners at home rather than sending them to long-term care. We struggle to get by with the small amount of home care help that we receive, and we are very worried about even more cuts to services.

Bill 135 will reduce patient protection by turning public nurse supervision over to the private sector. History tells us that privatization reduces services and leads to poor outcomes. The Ottawa Raging Grannies have long protested against reduced public service in all parts of our health care system. We have watched one restructuring after another in our many years. These restructurings—three in home care—cost a lot of money and do not help with fundamental problems of understaffing, too-low pay and decent access to care.

The rest of our presentation, I hope, will be a video by the Raging Grannies, who often present our messages in song. We've been having some technical difficulties, so I'll see if they can play it. That's it for me.

1730

The Chair (Mr. Brian Riddell): We're just loading it up right now.

Audio-visual presentation.

The Chair (Mr. Brian Riddell): We'll now move on to Vista Centre Brain Injury Services. You have seven minutes, sir.

Mr. Denis Boileau: My name is Denis Boileau. I am the executive director of Vista Centre Brain Injury Services.

I just want to say that that's a hard act to follow. Unfortunately, I do not dance, but I can tell you an awful lot of good jokes.

Anyway, thank you to the committee for actually inviting me to talk a little bit about Bill 135.

I will simply start by giving you a little bit of background. Vista Centre Brain Injury Services have been in existence for 45 years-plus. We are a service provider, and we provide services to anyone in our region—the Champlain region—who has an acquired brain injury. Just

to give you a little bit of background, in my area of Champlain, there are about 6,500 cases yearly of people with an acquired brain injury. Some of the services we provide are a day program, the residential program, of which we have two, and the independent living skills. Just to give you a little bit of insight, we do have two residences. Unfortunately, I will share with the rest of you that if you require that particular service, our wait-list or wait time is about 15 to 20 years, which is about average throughout the province of Ontario.

Let me move on now to Bill 135. Within this bill, we do see that OHTs and HSPs, which is health service providers—and I do apologize if sometimes we get into these acronyms; in health care, we have an awful lot of acronyms. So OHTs and HSPs are a better transition and reflection of local needs—I do not argue with that; I thoroughly believe that is the case, but I will argue with the fact that the care coordinator is employed by one organization but the direction comes from another organization, which seems contradictory but also baffling for perhaps the worker. My suggestion would be that the HSP give direction and employ, I'm going to say, the care coordinator, so that this reflects better the needs of the clients, as well as the services provided.

In Bill 135, we need clearly, better-defined accountabilities, clarity of roles—and I mean by that the Ministry of Health, Ontario Health East and OHTs. I would also add that client needs should be the primary subject of this bill, and the whole care planning of how this is being done to ensure the quality and the flexibility of care to clients. I will use the words "client" and "patient" throughout my presentation because, to me, they're both the same.

My question to the rest of you is, how will the care coordination occur across 58 OHTs? Just in my area, there are six OHTs, so I'm curious how we will ensure that care coordination. I would suggest to you that if we're talking about care coordination, well, maybe care coordination should be part of what the HSP does, or the service provider.

I would also add that, in this bill, I do not see any complaint procedures—neither a role for the caregiver. I would suggest that, again, when it is affiliated with an HSP, we do have a complaint procedure and we do have a role for the caregivers.

Within all of this, our health care system is very complex and we do need navigators to direct people—even within the health care system, but also people who are not within the health care system—where to go, what to do etc.

I see that the goal of Bill 135 is really to improve access to care. I would hope that when we're talking about access to care it really does mean that the access to care is in the home, because we all know that if you are giving care in the person's home it is certainly a saving of dollars. You do not want them in the emergency room or in the hospital.

The second goal, I think, of Bill 135 should be to ensure accountability of services but also the accountability of the organization in how they deliver the services.

I will say that the last suggestion that I have for the goal of Bill 135 is an integration of services and that all of this integration should be client-focused.

I will touch upon another point. I'm sure that you've heard about this today and from other speakers, but I'm going to talk about funding, which I do not see anything about in Bill 135 or anything subsequent to that. I would just like to share with the rest of the committee that, in terms of base funding, in the home health care sector we are lacking funds.

I can share with you that, for example, in my agency, base funding has not occurred yearly and we are really behind the ball, whereby our wait-lists get longer. As I mentioned, for example, in a residential setting the wait-list is for 15 to 20 years.

Also in regard to funding, I think if there is an increase in funding it sends a message from the government about the recognition of the sector, which is very important. We have a primary role to play because we see about 80% of the clients or the patients while the hospital only sees about 20%.

The Chair (Mr. Brian Riddell): One minute remaining.

Mr. Denis Boileau: The last point in regard to funding is salary and workloads. We need both increases in salary and a decrease, probably, in workload in order to be able to retain our workers, because as we are seeing there is some burnout, and the projection is that 30% of burnout will occur in the next few years.

That is my presentation. Thank you for listening to me. Hopefully, I can answer some of your questions.

I would like to thank this committee for doing the work that they are doing. The work that you are doing is very important.

I will end with simply one word—"integration" is the fashion to go.

Thank you very much for your time.

The Chair (Mr. Brian Riddell): We will now go to round one. We'll start with the independent member, for four minutes and 30 seconds.

Mr. Adil Shamji: My first question is for the Ottawa Raging Grannies. How long did it take to make that amazing video?

Ms. Jo Wood: Well, actually, not so long because we have a really wonderful videographer who helped us do it. We did it in a couple of hours.

Mr. Adil Shamji: Great.

I really appreciate all of you for taking the time to read through the legislation and to join us to share your perspective.

Jo, in that video, some of the members referenced their current home care experience. Could you elaborate on what it feels like right now and the change that you would like to see instead of Bill 135?

Ms. Jo Wood: Well, I think there are a lot of problems with just getting the home care people need and finding out even how to go about it at times.

We have one of our members right now whose husband has Parkinson's and so on, and she's starting to get some help, which is really useful. It's gotten so she can't help him get out of bed anymore when he's so stiff in the morning, and get dressed and so on, and I think there is someone coming in for that now. But other than that, because he has

to be monitored quite closely—well, she's not in the video because she couldn't leave him. She's hoping that she's on the list to get him into a day program once a week, which would give her a chance to get out and so on.

1740

My own personal experience—it was a little while ago now. We were three friends sharing a house—one person got Lewy body, and the other two of us were doing all we could to take care of her. When we tried to access services, they saw that the two of us were quite healthy, so all we got was one bath and hair washing a week. Other than that, she needed very constant care; at least there were two of us to do it. I think they assessed us as being healthy enough to do it, and I guess we were, but it sort of puts your own life on total hold for a while.

We're seeing that with friends all over the place. Some are ending up in long-term care, when, with a little more care, that wouldn't have been necessary. You always see that it's tearing apart the person who's doing the caretaking, because they don't want to send them to long-term care, but they start thinking they're going to go before their spouse does.

So I would say those are the kind of things that we struggle with, and we don't see a restructuring, especially one that seems to let—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Jo Wood: Yes—something that lets every little unit kind of do its own thing. As I read it, I'm afraid there will even be distribution differences by how rich a neighbourhood is. I don't know if that's true.

The Chair (Mr. Brian Riddell): We will now go to the government for seven and a half minutes. I recognize MPP Martin.

Mrs. Robin Martin: Thank you to the witnesses for sharing your time and theatrical abilities with us. I can't say that I appreciated the video at all, because I do think that this is a very serious subject. I know you're trying to make a joke, Jo, but it is a very serious subject.

We're trying to improve home care because we realize how important home care is. My understanding is, over the last term of the last government, the 15 years under the former Liberal government, home care got virtually no attention whatsoever and nothing was done to improve the services, which I fear is why we're in the situation we are now.

As a 60-year-old woman myself, I've lost both my parents, but I had some experiences with home care for them.

None of us think that the current status quo is good. That's why we're trying to fix it.

You certainly have a lot, Jo, of concern about turning over to the private sector and cuts to services, which—we've increased health care spending by $16 billion under this government. That is, on average, a 6% increase per year in health care spending, which is pretty much unheralded, and unheard of before this day. We've been increasing at an exponential rate because we know the needs are so great, partly because of our aging demographic and partly because we've got so many new immigrants, which is a decision made by the federal government, but it is the Ontario government that has to provide health care services to all those people.

You're concerned about turning things over to the private sector, Jo. What I wanted to ask you was if there was something in the legislation that you could point me to that is turning things over to the private sector—because that certainly is not what the government's intention is. The government is trying to fix home care services.

Ms. Jo Wood: Well, I understand that the supervision that is now under the public health nurses is going to be given to the individual units instead. Have I got that wrong?

Mrs. Robin Martin: Sorry; what's under public health nurses now?

Ms. Jo Wood: That they do the coordination and oversight of different—

Mrs. Robin Martin: Currently, services are provided through the HCCSS—Home and Community Care Support Services—which is the body that took over from the CCAC. After this bill is passed—if it is passed—then it will be done by a body called Ontario Health atHome, which will be a crown agency—a subsidiary of Ontario Health, which is a crown agency. So there's no private part to that.

What we're trying to do is make sure that the home care services that you are provided with will be seamlessly integrated with your primary care, your acute care and other care that you might need in your community—long-term care etc. You did mention long-term care, and you said nobody wants to go there and everybody wants to stay at home, and that's certainly our view. We want to keep people healthy and at home as long as possible, but we also recognize that if we do not have long-term-care spaces available, then no one can leave the hospital. Often, they need that level of support, and that's why we're also investing heavily in building long-term care.

What concerns me about your video and the messages of anti-privatization that are commonly brought forward by the NDP here—the opposition—and others, and a lot of Ontario Health Coalition witnesses that we talked to today, is that these words are weaponized. Dr. Jane Philpott said in an interview on TVO's The Agenda that people weaponize these words rather than focusing on how to fix our health care system.

So what this government is trying to do is focus on how to fix our health care system. And I worry—and I wonder if you worry—that we're not scaring people who may be older, who may be in need of home care and who may be vulnerable, by suggesting that there's some nefarious intent and that their home care is going to be taken away.

I actually had a phone call from a woman I have known for years who said, "You're not going to close down home care, are you—your government?" And I said, "Does that make any sense to you? It's cheaper for the government to keep people at home."

Do you know, Jo, that we had a piece of home care legislation before this one? And one of the things we did in that home care legislation was take off the maximum number of hours. It used to be you could only get four

hours of home care a day, no more, and we took that off because we believe that people should get the home care they need and be able to stay at home, and it's still a better deal for the government if we do that.

I don't know if you want to say anything in response.

I worry that we're fearmongering and trying to scare people—vulnerable people who shouldn't be scared.

Ms. Jo Wood: Yes, well, I don't think our intention is to scare people, but our intention—we do find that, as things become more private, it is hurting our public system a lot. Things like—

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Jo Wood: —making private clinics on the weekend for hip replacements and things like this.

Why not just better fund the public system to—

Mrs. Robin Martin: Right, well, can I tell you why not, Jo?

Ms. Jo Wood: Yes.

Mrs. Robin Martin: Because, since we put in those four new clinics, 14,000 more cataract operations happened this year—since January. That's 14,000 more people like you who can read to their grandchildren and do things to get on with their lives.

What we want to do is make sure that people have more access to care, so that's what we're working on.

Ms. Jo Wood: I understand that, but at what cost?

Mrs. Robin Martin: Are we done?

The Chair (Mr. Brian Riddell): There are 12 seconds remaining.

Mrs. Robin Martin: Four? I can live without—

The Chair (Mr. Brian Riddell): Eight seconds.

1750

Mrs. Robin Martin: Thank you very much for your time. I don't have enough time to ask another question, but maybe next round.

The Chair (Mr. Brian Riddell): We'll go to the official opposition now for seven and a half minutes. I recognize MPP Gates.

Mr. Wayne Gates: First of all, I want to apologize to the Raging Grannies because, obviously, the Conservatives don't understand your organization—that a lot of the things that you do are through song, quite frankly. You wear your red hats. I can tell you, I've enjoyed the Raging Grannies, which you're probably aware of. Even though you're from Ottawa, every year, they come to the Prince of Wales at the Fort Erie Race Track, and I know some others from other communities come down. It's a wonderful day. They do some songs. That's how you get a message out. I understand they might not like the song, but that's what you guys do. That's who the Raging Grannies are. So I just want to say that I enjoyed the video a lot more than the Conservatives did, but that's fair. If you get a chance, send it to my office. I'll make sure I get it up on social media for you.

Ms. Jo Wood: Thank you.

Mr. Wayne Gates: The second thing is, you're actually on the money when it comes to privatization. Seniors should be scared, and I'll tell you why: because in long-term care, we saw 6,000 of our moms, our dads, our aunts, our uncles, our grandparents, our brothers and sisters die from COVID. We know that it was around 80%—I might be out by one percentage point—of those people died in long-term-care homes that were run by private corporations. Some of the worst offenders, quite frankly, have gotten long-term agreements from this government to continue, even though the municipalities are saying, "No, we don't want this. It was awful"—even when the military was called in. So some of the reasons that you may be scared, or some seniors may be scared, I think is fair; I think it's balanced when you read the headlines that people continue to die in these facilities.

I know today—I don't have the exact number, but I know we're going through the same thing now in long-term-care facilities, where we're having more outbreaks. We have more COVID in long-term-care facilities. I don't have the exact number, but I know we have them. So that's all being done secretly. They certainly didn't tell the critic that they were doing it. You have to wear masks now in long-term-care facilities—they didn't put that out in the newspaper or anything, but they told them to do it.

So your concerns, I think, are valid. Quite frankly, I have concerns. I've had family members end up in long-term care and didn't have great results as well, like a lot of other people.

I want to say to the Raging Grannies, thank you for being here today. Thanks for your presentation.

Also, to the brain injury group: You touched on some things that are really, really important. Not really a question, but I think it's sort of a question you can ask—and you guys can chip in anytime you want. You talked about funding for brain injury. I know that, as an organization, even in my area—maybe you can tell us the last time that you got core funding to not only make sure that you keep your very talented staff, but also be able to invest in that.

And then you said something else—I'll let you answer that one, but you said something else: that 6,500 people have brain injuries every year. That's a lot. Maybe you could say how they're happening, and maybe we could look into how we stop it.

Anyway, I'll let you answer those two questions.

Mr. Denis Boileau: The first question, in regard to funding—I will certainly share with you that this year, we received a 2% increase in our base funding. But I would also share with you that if I go back 10, 15 years or whatever, we did not get any increase in base funding, or very little. And if I were to keep on this, 3% is the inflation rate, and if we haven't received in 10 years any base funding, well, we're behind by 30%. So that's very hard for service organizations—such as myself, which is small. Without any increase in funding, I cannot give, for example, increases to my workers. The 2% that I received this year was really specific to, again, program delivery, and not for salaries.

In regard to your second question, the 6,500 cases—that is directly a number from the Champlain LHIN, when they were in existence, and it is just in my area, just in the Champlain area.

Again, an acquired brain injury can occur to anyone, at anytime. It doesn't matter what your economic level may be—but I will simply say that it comes from all over. Certainly, one of the main causes are motor vehicle collisions, but they do come from all over—workplace, it could be from mental health and addictions. It spans the whole gamut of things. And when your brain does not function very well—imagine trying to cope with our health care system the way it is right now—it is very difficult to manoeuvre or navigate the system.

Mr. Wayne Gates: I appreciate that, yes—a lot of falls on work sites, a lot of head injuries, particularly in the construction trades. Some of the safety measures that we should be looking at—they're falling off the roofs and stuff like that on some of these builds. So I'm aware of those.

You talked about the 2%. They said, "Here's 2%, but you can't use it for wages." But one of the ways to keep your staff, quite frankly, is to pay them properly—or you may need it for extra health and safety training.

I'll ask this question of both of you; I don't want the Raging Grannies to think I forgot about them. Do either one of you know that the inflation rate was between 6.5% and 7.5% over the course of the last year? Maybe you could answer that.

Ms. Jo Wood: Yes.

Mr. Denis Boileau: Yes, I'm quite aware of that.

Again, I will specify that, in terms of the base funding this year, we got 2%. I am also part of the Ontario Community Support Association, and we've been told that we will get another 1%. But we are still waiting for that funding. Hopefully that 1%, if we do get the 1%, is not tied and we can actually use that to at least—

The Chair (Mr. Brian Riddell): One minute left.

Mr. Denis Boileau: —give a small amount of increase to the salaries of our workers.

Mr. Wayne Gates: It would be a very small increase if you only get 1%. The reality is that the core funding should have kept up with inflation over the last 10 years.

You're not the only organization that's really hurting with that. I know there's Pathstone in my area—although they got a 5% increase this year, they had gone years without an increase.

The core funding is important, particularly to pay your staff.

I just want to say quickly, on the funding, the reason why you're concerned about the privatization, I would think, is that 30% of the billion dollars that they're investing in home care will go to private—not necessarily one company, but overall to a private. Maybe you guys could agree or disagree or disagree with me that it would be a lot better to take that $1 billion and put it right into home care. I think that would make a lot of sense.

Thank you very much for your time.

And the Raging Grannies, I'm very serious, if you get me that video—Wayne Gates, MPP for Niagara Falls—I'll make sure I put it up on social media for you. It was very good. Thanks.

The Chair (Mr. Brian Riddell): We'll go for round two, to the independent member. I recognize MPP Shamji.

Mr. Adil Shamji: Jo, I just want to begin by apologizing for the condescending manner in which you were spoken to by the government members. If you have a fear, you're entirely valid to have that fear—especially if there's a concern about potentially nefarious purposes. We have the Premier, who faces an RCMP criminal investigation right now. Three of his ministers have resigned in shame. And we just learned yesterday that some of the private for-profit surgeries are getting compensated at three to four times the rate of public. So I actually think that you do have a valid concern there, and we certainly shouldn't be dismissive of that.

I'd like to turn to Denis. I wonder if you could elaborate on what you think we need to improve on within our current system of home care in Ontario.

Mr. Denis Boileau: The keyword that I would probably leave you with is "integration." If you talk to any of the service providers, we certainly are willing to talk to one another to start to integrate, because I think what we realize is that the client is at the centre of all of our care. We do share some clients with other agencies, but if we had, I'm going to say, a core team to ensure that that whole integration happens, that would be great.

I will give you a practical example: Where I am, if you have a brain injury, you will go to the hospital, then you go to the rehab centre, then you come to community organizations such as where we are. One of the things that we started four years ago is a transition program whereby we have a worker from my agency—which is a community health agency—and a worker from the hospital. They are both working together to ensure the care and coordination so that the patient, and the client, actually moves through the system more rapidly—so a saving of dollars in terms of hospital care—and moves through the system into the community and to provide services to the community. But it's that integration between service providers, between a hospital setting as well as the community health sector setting.

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Mr. Adil Shamji: That's perfect. Thank you very much.

I have no further questions, Chair.

The Chair (Mr. Brian Riddell): We'll now go to the government for seven minutes and 30 seconds. I recognize MPP Martin.

Mrs. Robin Martin: I'm sorry my friend opposite thought I was being condescending to you, Ms. Wood. I was not being condescending to you; I was just trying to explain the government's intentions, and also to express my legitimate concern, which I grounded in an example of an older person in my riding calling me, concerned that she was going to lose her home care because of rumours. That was what I was trying to talk about, so I apologize if you took it the way my friend opposite took it, but I certainly did not intend it that way.

Ms. Jo Wood: I was not particularly upset. I was upset by you saying we were doing a joke, because no, we don't

consider our singing to be a joke. We take it very seriously and try to use it to make a point, and—

Mrs. Robin Martin: I understand that. I understand the value of humour. That part wasn't lost on me, and I know that Monsieur Boileau was very entertained by it. I could see he was having a good chuckle.

Ms. Jo Wood: Well, people like it or don't like it, depending on our message. That's how it goes, and that's fair.

Mrs. Robin Martin: Well, that's true. And it's the message, really, that I was trying to discuss with you. That's why I asked you if there was something in the bill that you thought was leading to privatization when I was talking to you.

Let me just go over to Monsieur Boileau before we lose our time.

Monsieur Boileau, I appreciate you coming and giving us your testimony as well today and bringing your perspective on this.

I wanted to mention that in our last budget, 2023, we increased acquired brain injury funding 10%. Unfortunately, our opposition members voted against that and didn't support us. But that resulted in a lot of base funding increases for brain injury associations—I guess not for you specifically; yours was a 2% increase, you said, as a member of the Ontario Community Support Association? Is that how that came through?

Mr. Denis Boileau: No. Our funding comes directly from Ontario Health East, and the funding that we received as base funding was 2%. I know that the Ontario Community Support Association is working on behalf of all the community health sector to actually get another 1%, if that is a possibility, and we hope that that is a possibility.

We would look forward to any increase that we will receive. It will be greatly appreciated, because we can directly put it into services or for the retention of our employees through their salaries.

Mrs. Robin Martin: Well, we certainly appreciate all our home care workers. We know how important they are. We're working on trying to improve ways to recruit, train and retain those home care workers and other health care workers across the system, at a time when we do have some demographic challenges, on top of post-COVID, I think, exhaustion from a lot of health care workers—because that also challenged our system.

The other thing you mentioned, Monsieur Boileau, was having a care coordinator employed by one group but directed by another. I think you're referring to the fact that Ontario Health atHome would be the technical employer, but they would be working embedded within Ontario health teams—but not all of them, because some of them would be also with acute-care hospitals and stuff like that.

I just want to clarify that Ontario Health atHome, when they do have Ontario health teams, having the care coordinator embedded there, will be providing the back-office function, effectively—the contractual work and stuff like that, which we don't really need to spend money on replicating 58 times across the province.

Our objective, really, is to take the money out of the administration of health care and put the money into more home care workers and retaining more home care workers and other health care providers.

This whole transition—and this is what this Bill 135 was leading to—was a transition to get us to get rid of the superstructure or bureaucracy of the LHINs and make the Ontario health teams basically coalitions of local providers who will provide care. So we get rid of people who are just there to administer—and have more health care providers is the idea.

Anyway, I appreciate the work that you do.

I know that you mentioned two important points: that patients are the centre of care—I think everybody agrees with that; this whole innovation is about trying to put patients at the centre of care—and accountability of services and organizations. I wondered if you could elaborate on that latter point. What did you intend by saying this is important—the accountability of services and organizations?

Mr. Denis Boileau: Again, being a service provider and reporting to Ontario Health East, it is part of our agreement—or, if you wish, our contract—that we do have some accountability in there. The accountability is certainly from year to year in terms of service levels etc. I would not want this bill to lose sight of that accountability. It should be built in that that accountability is still there. Whether we report to the OHT or whether we report to Ontario Health, that accountability, for me, is very important in terms of service levels and the proper services given to the client or the patient that we see. That was my point in regard to accountability.

Mrs. Robin Martin: Okay, I understand now.

I agree with you; that's incredibly important. We're always trying to measure outcomes. We always say if we can't measure the outcomes—

The Chair (Mr. Brian Riddell): One minute remaining.

Mrs. Robin Martin: —then it's very hard for us to know what happened and whether we should invest more into that or change things.

Jo, I want to go back to you. I wondered if you wanted to share any improvements you're seeing for home care services in your community.

I think you mentioned you had a friend who has someone coming in now.

Ms. Jo Wood: Yes.

Mrs. Robin Martin: Has that worked well for her?

Are there suggestions you would make about on-the-ground care and how we can improve that?

Ms. Jo Wood: I think it's beginning to happen; it has just taken a while. I don't exactly know the history of it, but I know we were all concerned about her health—trying to manage him when things were moving quite slowly.

I guess just that availability and not being in waiting lines for things like having somebody help you get your husband out of bed in the morning is very important—

The Chair (Mr. Brian Riddell): I'm going to cut you off there—

Ms. Jo Wood: That's okay.

The Chair (Mr. Brian Riddell): —and we're going to go to the opposition. I recognize MPP Gates.

Mr. Wayne Gates: I think this is our last segment of the day, isn't it?

The Chair (Mr. Brian Riddell): That's correct, sir.

Mr. Wayne Gates: Jeez, it went so quick.

The Chair (Mr. Brian Riddell): You get the final word—but then I really do.

Mr. Wayne Gates: It's always good to do that.

Some stakeholders have told us that there is significant concern with the centralized decision-making structure of the new organization that will be created by this bill.

Could you discuss the concerns you may have with the bill that could strip accountability for many of these for-profit service providers with tight central control? Do you have anything on either of those points?

Mr. Denis Boileau: My understanding about all of this is that, again, there is a transition that will be done. The transition will be that that will be moved over to, I'm going to say, the OHTs. If that is the case, then I would simply say that's great, because the OHTs will bring about—and I will say this again, that it is to bring about a flavour of the local needs that are required within your community.

Ms. Jo Wood: I can say a little something on that.

Mr. Wayne Gates: Go ahead.

Ms. Jo Wood: My concern about going locally focused is that poorer neighbourhoods will end up with poorer service; I don't know that much about how the structure works, but it seems to me that that happens quite often in various situations—even schools.

Mr. Wayne Gates: I'll ask the next question to the two of you as well, so it will make it easy.

I think we need to have a community-driven, evidence-based, transparent process to determine care hours. By the looks of this legislation, that process will not meet any of those requirements. Are you concerned with home care services' decision lacking any form of transparency?

Ms. Jo Wood: Go ahead.

Mr. Denis Boileau: That's a really good question, and I really—

Mr. Wayne Gates: I wrote it last night. I'm glad you liked it.

Mr. Denis Boileau: I really can't speak to that because I do not have the knowledge to actually respond to this, and I apologize.

In terms of transparency, we are part of, certainly, the Ottawa Health Team—and more around that we're going to be involved with. I think one of the things about OHTs—it is service providers that are getting together and really looking at the care coordination. So if you are going to ask me, am I going to be concerned about the transparency, I will say probably not, because we're all going to be in the same boat. We all have respect for one another, and we're all working together to provide the best service we can to our clients or patients.

Ms. Jo Wood: I guess the only thing I would say to that is that, certainly, some kind of transparency is required for accountability. You can't have accountability without some kind of transparency.

Mr. Wayne Gates: I appreciate that.

I have another question. We have noticed that there is little guidance in this legislation to ensure there is appropriate representation from the community on the Ontario health advisory board. For us, that is very concerning. We believe community voices need to be heard to ensure that care is properly being delivered.

Could the two presenters expand on their thoughts regarding community representation on the board and how important that should be? The two of you can answer it.

Nice cat.

Ms. Jo Wood: I'll say, I agree with you 100%.

You and your cat go ahead.

Mr. Denis Boileau: I apologize. The cat is a star in my home.

Mr. Wayne Gates: We know who runs the house, buddy.

Ms. Denis Boileau: I would totally agree, but I would probably go a little bit further in regard to not only talking about committee, but also having the voice—and this is important for me—of not only clients, but also caregivers in regard to that.

Mr. Wayne Gates: Okay, that's fair.

Raging Grannies, got anything to add to that?

Ms. Jo Wood: That's about it. I tend to agree with what Denis said.

Mr. Wayne Gates: I just want to finish by saying, keep up the good work. There are a lot of people who need your services for brain injuries, particularly workers—a lot of workers. I came out of a plant where we had a lot of people get hurt on the job with brain injuries. So please keep up the work. Hopefully, we will keep raising the issue that you need more funding. You never have enough funding, particularly to pay your staff, to keep your staff too. That's important, because we see that right across the sector. You can't have your staff leave. They're hard to replace.

To the Raging Grannies, thanks very much for all the work you do. Like I said, I've got a very good rapport with the Raging Grannies down in Niagara. I enjoy getting my picture with them every year at the Prince of Wales. Again, a lot of their stuff is done with song, and it comes from the heart. It is a lot of fun, but a lot of times, there's a serious message. So please keep that up as well, and thanks for being here today. I appreciate it.

The Chair (Mr. Brian Riddell): I'd like to thank everyone for their comments today. If you would like to submit any written materials to the committee in addition to your presentation today, the deadline for written submissions is on Wednesday, November 15, 2023, at 7 p.m.

This concludes our business for today. Thank you again to all presenters.

As a reminder to the committee, the deadline for filing amendments to the bill is 5 p.m. Eastern Standard Time on Thursday, November 16, 2023.

The committee will now stand adjourned until 9 a.m. on Tuesday, November 21, 2023, when we will resume consideration of Bill 135.

The committee adjourned at 1814.

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