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Mardi 11 février 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

Étude de la Loi sur l'intégration du système de santé local

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 11 February 2014

Mardi 11 février 2014

The committee met at 0902 at the Holiday Inn Kingston Waterfront Hotel, Kingston.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): We'll call the committee of social policy to order and say good morning to the committee and to our audience. It's great to be here in Kingston to continue our public consultation on the review of the Local Health System Integration Act, and the regulations made under it, as provided for in section 39 of the act. We've been travelling all around the province. This is the eighth day and the ninth city, or should I say the eighth city and a smaller town? But we're very happy to be here.

SOUTH EAST COMMUNITY CARE ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): Our first presentation this morning is the South East Community Care Access Centre: David Vigar, chair of the board, and Joanne Billing, senior director, client services. Are they here? If you would come to the front table here. Thank you very much for taking the time to come talk to us this morning. As you're sitting down to get comfortable, you will have 15 minutes to make your presentation. You can use any or all of it for your presentation. If there's time left, we'll have some questions from the committee, but from now until 15 minutes from now—all that time is yours to use as you see fit. Thank you very much for being here.

Mr. David Vigar: Thank you very much, Mr. Chair. My name is Dave Vigar. I'm the chair of the board of the South East Community Care Access Centre. Before retirement, I worked for over 20 years as a CEO in the health care system in Ontario and Manitoba, most recently leading the amalgamation of three hospitals in Lambton county and prior to that the formation of a new hospital entity in the Cobourg-Port Hope area. I was also a surveyor for Accreditation Canada for 12 years and have conducted accreditation reviews across Canada, in South America and in the Middle East.

With me is Joanne Billing, the clinical lead for South East CCAC client services. Joanne has worked in health care in the Kingston area for over 25 years. She has been involved with both the administrative and clinical operations of home care and has participated in numerous initiatives associated with the transformation of the health care system.

In our presentation today we'd like to talk to you about how our work with our LHIN and our health care partners is improving care to our patients and the community. We'll share some suggestions for improving LHSIA and the local delivery of health care services.

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

First, a little bit about the South East: A variety of population-specific characteristics in the South East have an impact on the provision of care in the community. The South East has the highest proportion of population aged 65 and older in Ontario: 16.7%, compared to the provincial average of 12.9%. Residents of the South East have higher-than-usual prevalence of diseases such as arthritis, rheumatism, asthma, diabetes and chronic bronchitis, and the highest prevalence of heart diseases in the province. The burden of illness is so significant that it results in a life expectancy approximately 1.8 years lower than the Canadian average.

I'd now like to ask Joanne to provide you with some additional information about the South East CCAC.

Ms. Joanne Billing: Thank you, David. As an accredited organization, the South East CCAC coordinates care for more than 12,500 individuals on any given day. Last year, we provided over one million hours of personal support—more than 100,000 more personal support hours than the year before—and we helped 3,451 children attend school.

Care coordination is our core service; not administration. It is patient care, and it is essential. Our care coordinators are all health care professionals and are mostly nurses. They work directly with our patients, their families and other health care providers to identify each person's individual needs, develop care plans, and ensure that people get the right care at the right time and in the right place to meet their needs.

Our care coordinators work in seven hospitals and all of the emergency departments across the South East. They work with family physicians, schools, every community agency and every long-term-care home. This

network of care coordinators helps to ensure consistent care and practices across the South East and the province, and that must be done to support the many families who rely on our help.

I will share an example of how our care coordination helps people receive the right care at the right time and in the right place. Ivy Bennett struggled with living in a secure unit in a long-term-care home. She ended up there after she was brought to the hospital with an infection and the antibiotics she was given were not working. The infection was causing Ivy's already-compromised memory to decline. She became confused and started to wander, which caused concerns with respect to her safety. She was deemed unable to return home safely. As a result, she was placed, as a crisis, in a long-term-care home. That home was not close to her family. After falling in the long-term-care home, Ivy's granddaughter Lorraine wanted to bring her closer to home. Lorraine worked with the South East CCAC to relocate Ivy to a nearby long-term-care home, and ultimately to return to living at home, in the community. With a focus on providing the right care in the right place at the right time, the CCAC care coordinator worked with the family to develop an individualized plan and provided system navigation to help the family access home care services such as personal support and occupational therapy, as well as services such as an adult day program one day a week.

Ivy is happy to be back at home. In the words of the family caregiver, "The government is on the right track trying to keep people at home as long as possible. It delivers good value and enhances the family experience. The care in the long-term-care home was good, but the support of the CCAC has helped us to feel empowered, and Nana is much happier at home."

We think the LHIN is on the right track in the South East too. The South East LHIN has led a number of initiatives that have improved the efficiencies and effectiveness of the local health system to meet local needs. Increased access to information empowers patients and their families to learn about health and their health care options. Technology is a critical enabler of high-quality care and cost efficiencies. An example of this lies in the introduction of the integrated community assessment and referral team, or iCART, which is an important part of the South East LHIN's Clinical Services Roadmap initiative and aligns with Ontario's Action Plan for Health Care in providing the right care at the right time and in the right place.

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The iCART team is made up of hospital staff, CCAC care coordinators and community support service workers. They share their assessments of high-risk patients to ensure they develop a coordinated care plan. The objective is to avoid duplication of services, reduce delays in receiving services and minimize client and caregiver confusion. A vitally important part of the plan will also be to make sure the client is visited often enough at home to diminish their anxiety, prevent social isolation and avoid their seeking help through the emergency room for non-acute needs.

The South East LHIN has a goal of using technology as an enabler for improved care outcomes for patients. Over the past year, the LHIN has supported the CCAC's adoption of an electronic notification system which alerts CCAC care coordinators to the presentation of one of their patients in a hospital emergency department. By alerting CCAC care coordinators that one of their clients has gone to an emergency department for treatment, the care coordinator can intervene to get the patient back home safely and efficiently.

By connecting patients back to their care coordinator as efficiently as possible, we are ensuring that more people are receiving less costly care at home, where they want to be. This leads to improved health outcomes and makes efficient use of health system resources.

Another focus for the South East LHIN has been reducing alternate-level-of-care rates across the South East. A noticeable reduction in alternate level of care reflects how patients in the South East are transitioning towards community-based services faster. Repeat visits within 30 days and readmissions have also been maintained within targets, revealing that the care being provided to the patient has been effective in keeping the patient from returning to hospital.

In the past year, the development and expansion of health links has been fully embraced across the South East LHIN, where there is a specific focus on the 5% of Ontarians who account for 66% of health care spending. Working more closely with primary care through health links, we, as a system, can provide increased focus on innovative, coordinated care delivery for the most complex patients.

Health links across the South East have already started to encourage greater collaboration between existing local health care providers, including family physicians, nurse practitioners, specialists, hospitals, long-term care and other community supports.

Health links put family care providers at the centre of the health care system. By bringing local health care providers together as a team, health links will help family doctors to connect patients more quickly with specialists, home care services and other community supports, including mental health services.

In order to establish a health link, strong representation from local primary care providers and the CCAC is required. Working closely with the South East LHIN primary care lead, the South East CCAC has actively been involved in the development of the seven health links in the South East LHIN.

To conclude our presentation today, David will share our recommendations to strengthen LHSIA.

Mr. David Vigar: Our population expects the health care system to be integrated, well coordinated and easy to navigate. Working with our LHIN, we are making important changes to improve the care that people receive, but we know that there is more to be done. Our population is aging, and our health care system is in the midst of

a significant transformation to prepare for the future needs of our communities. We believe that LHINs and LHSIA provide the right foundation to support this transformation.

We believe the following three recommendations will strengthen LHSIA and provide better health integration to the communities we serve.

The first recommendation is that public health and primary care should be brought under LHSIA to ensure we deliver seamless, coordinated care across the continuum, including health promotion and prevention. Clearly, the inclusion of primary care in the LHIN mandate is a key to the complete and effective integration of health services and the resulting quality and effectiveness of the patient experience.

Our second recommendation relates to how services are funded. Opportunities exist within the system to improve funding processes. It is difficult to plan how to best meet the needs of those we provide care for when funding announcements are fragmented over the course of the fiscal year. It would be beneficial to know our operating budget prior to the beginning of our operating year. Additionally, multi-year funding would allow us to plan and build out the system with more confidence.

Our third recommendation is that, beyond expanding the LHIN mandate to include primary care and public health, any conversation regarding possible structural changes has to take into account the disruptive effects of those changes. CCACs underwent a major structural change eight years ago to create the alignment with LHIN boundaries. While it was the right thing to do, we know, based on our experience about the time lost, the cost to the taxpayer and the uncertainty within the health care system which accompanies major system change.

The energy required to make this level of change takes focus away from efforts to bring real improvements to the services that Ontarians require. Before change based on random anecdotal events is undertaken, it is essential to ensure that the outcome is worth the cost and disruption.

In summary, we believe that the Local Health System Integration Act works well overall and sets out a strong framework for local health system planning, funding and accountability. The system changes that were made eight years ago are beginning to bear fruit, but can be improved.

To recap, we have three recommendations:

(1) We recommend that public health and primary care be brought under LHSIA;

(2) LHINs should provide multi-year funding; and

(3) While modifications to LHSIA can provide more integrated and stable health care, we must ensure that any changes are not disruptive to the communities who we serve by working within existing structures.

Only in this way can we deliver a health system our communities can rely on that is integrated, well-coordinated and easy to navigate.

Thank you for the opportunity to speak with you today, and we would be pleased to answer your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about a minute and a half. It'll be the government caucus: Ms. Jaczek.

Ms. Helena Jaczek: Thank you for coming. Thank you for yet again trying to explain the role of the care coordinator, and acknowledging that people look at it as administration. I think those of us who were on the Select Committee on Mental Health and Addictions certainly heard during that process that system navigation is a very important component, and care coordination seems to be part of that.

Now, many people coming out of hospital have very standard needs: You've got a wound, you've got a drain, you've got a joint that needs to be mobilized or you're frail. How have you streamlined your protocols to make sure that that care coordination is done in an efficient way?

Ms. Joanne Billing: Thank you for your question. One of the things that, as a sector, we've been working on is care pathways, outcome-based pathways that clearly articulate the expectations of our service provider and, indeed, what results a patient should anticipate receiving within a prescribed period of time. In order to effectively care for an individual in the most efficient possible way, we've introduced care pathways.

When you speak of wounds, for example, wound care in particular is a feature within the outcome-based pathway development that we have done as a sector, and indeed, we are introducing that across our LHIN and across the province.

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

OASIS SENIOR SUPPORTIVE LIVING INC.

The Chair (Mr. Ernie Hardeman): Our next presenter is Oasis Senior Supportive Living Inc.: Christine McMillan, secretary of the board of directors, and Rodger James, director of the board. Good morning, and thank you very much for taking the time to come and talk to us this morning.

Mr. Rodger James: And good morning to you.

The Chair (Mr. Ernie Hardeman): As with the previous delegation, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's any time left at the end of the presentation, we will have questions or comments from our committee members. With that, starting now is your 15 minutes.

Mr. Rodger James: Thank you very much. My name is Rodger James. I'm an investment and insurance adviser here in Kingston. I was a previous PC candidate in the last provincial election—unsuccessfully, obviously—but I'm also on the board of the Oasis program. This is our secretary, Christine McMillan, and we also have two board members in the background.

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I want to make apologies on behalf of our president—chairman, actually. Dan Corbett was called away on business, so Christine and I are going to handle the questions that may arise out of this. There will be a handout afterwards. There was far too much detail to try and cover in my presentation, so I'm going to highlight what we feel is important and give some history and certainly the savings that are available to the government.

John Gerretsen, our existing MPP, is certainly well aware of it, and we have made a presentation to him. The current health minister, Deb Matthews, has been down, I believe, twice to visit the Oasis program, which is in operation right now.

I'll do a summary here, and then questions and the handout will be later.

We appreciate the opportunity to tell you about an innovative assisted-living program called Oasis in one location in Kingston. The statistics submitted to the South East LHIN show that Oasis is saving the government over half a million dollars in health-care-cost dollars each year, and that's just from 11 seniors who are currently eligible for long-term care. Imagine what the opportunity is as we age.

Oasis is a registered not-for-profit organization in partnership with Homestead Land Holdings Ltd., the owner of a 60-unit accessible apartment building located in the Bowling Green apartments in Kingston. Oasis is providing the lifestyle found in retirement homes, but at an affordable price, to 59 seniors ranging in age from 70 to 97.

Oasis was developed by seniors, members of the Frontenac-Kingston Council on Aging. It was developed for seniors and with seniors who are active members of and in the program.

Oasis is different from other assisted-living programs. First, Oasis is not based on the medical model but rather on community development, where the seniors who are members of Oasis are the decision-makers in deciding what they want and how their needs can best be met. The community development model ensures that members who are seniors have the dignity of making decisions about their own care. The ability to make decisions about their own care provides a meaning for their life.

Second, Oasis is in partnership with a private owner of an accessible apartment building, Homestead Land Holdings Ltd., the largest owner of apartment buildings in Ontario.

Third, capital start-up costs are negligible since Oasis does not need to build a special building or furnish it.

Fourth, operational and maintenance costs are low since Oasis members pay their own rent, and regular building maintenance and cleaning costs are part of the general expense by the owner.

Fifth, the seniors are active participants in the Oasis program. By paying a user fee of $8 for a three-course dinner served in a dining room by our volunteers, they have ownership of the food served. There are activities and social events each day, many initiated and resourced by members or our volunteers.

Homestead sees value in our concept of bringing retirement home amenities into their apartment buildings, where normal-occurring retirement communities have developed. There is always a waiting list for this building.

Funding is the issue. When we had short-term demonstration funding—from the United Way, serving Kingston, Frontenac, Lennox and Addington, and the city of Kingston's Healthy Community Fund—we issued a contract to the VON, greater Kingston, for the provision of on-site personal support workers while maintaining the community-development philosophy. When this funding was depleted, the VON, as a registered health care provider, agreed to submit a funding application for this program to the South East LHIN. Since 2009, the South East LHIN has provided an annual grant of $130,000 to the VON for the Aging at Home Strategy.

As a recipient of this annual funding, the VON must operate within their own policy guidelines, which sometimes are inconsistent with the community-development philosophy of Oasis, where we do things with our members' consent. Health care providers do things for clients, not for members.

Oasis is a driving force behind this community-development model. The fact that the LHIN, under the current regulations, is unable to flow funds through not-for-profit organizations providing a comprehensive assisted-living program complicates, if not wholly negates, the opportunity for expansion of the Oasis concept.

Similarly, we are not eligible to apply for funding from the supportive-living allocation made by the South East CCAC, even though they were instrumental in the establishment of Oasis and in choosing the building.

At the same time, the opportunity to expand this cost-saving, quality-of-life option for older seniors appears to be limitless. Homestead has requested that Oasis expand to other buildings in the same complex, where there is a large population of older seniors. The board of the Pine Street seniors' apartments, a United Church program offering some rent-geared-to-income apartments, want to partner with Oasis, and a group in Toronto wants to initiate an Oasis program.

The administrative functions for this one Oasis site are performed by a volunteer board as well as site volunteers. We recognize that this is not a sustainable model. If we were to expand to other sites where there was a naturally occurring retirement community, called a NORC in research literature, employing a small administrative staff will be necessary to supplement the vital volunteer component. For this vibrant and innovative cost-saving program to expand, we are asking that a new regulation be developed that will allow a funding stream from a LHIN to a not-for-profit organization who is in partnership with an approved owner of an accessible building. In the formal presentation, which we are leaving with you, we have proposed an amendment as one suggestion that will

allow Oasis to expand, thereby setting a new standard for assisted living.

In closing, I want to share with you the motto that the Oasis members accepted as their own. It is taken from the report of the federal seniors' advisory committee: "Oasis: Adding years to life and life to years." Thank you.

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

We have about seven and a half minutes left. The questions will start with the PC Party.

Mr. Rob E. Milligan: Thank you very much for taking the time to come here today and present some, I find, quite intriguing facts.

I do have a couple of questions. How long has Oasis been functioning, up and operational?

Mr. Rodger James: Five years.

Mr. Rob E. Milligan: Five years. And what was the initial idea of forming Oasis to provide that service in the community?

Ms. Christine McMillan: I was working with the Council on Aging at the time—our local council. We had dealt with some seniors who were being abused in rental housing. We held 12 focus groups for seniors who were in rental housing to find out if there was any abuse going on by the management or the staff. What came out of every one of those was that seniors were fearful of dying alone in their apartment. Many didn't have families who lived in Kingston. But they couldn't afford to go into a retirement home. Their only option as they aged was to apply for long-term care. That is not a sensible option for competent older seniors.

We looked at the models of what was provided in retirement homes and thought we could do the same, but in a regular apartment building. It took some time for the board to come to terms with it because we knew this was going to be a huge project for a small organization. We were—Brian Brophy, who's here now—at a meeting where the Minister of Health at that time was present, and he announced 98 more long-term-care beds. I happened to be standing beside the executive director—CCAC at that time—and she said to me, "Isn't this wonderful? Ninety-eight more long-term-care beds." And I said, "I think it's terrible." She said, "Terrible?" And I said, "Yes; 60 of those 99 beds will be filled by seniors who don't want to be there." So that was the motivation.

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

M^me^ France Gélinas: Thank you so much for coming, Ms. McMillan and Mr. James. Why is it that you have to go through VON and you cannot have a contract directly with your LHIN to provide the support?

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Ms. Christine McMillan: There is no regulation under the act that we could find. We thought we had found one, but then we found out that it didn't really apply. The only people the LHINs can fund are registered health care providers.

M^me^ France Gélinas: Given that you don't qualify as this, you can't. Why is it that you cannot get a contract with your CCAC, your community care access centre?

Ms. Christine McMillan: Because they're under the same terms of reference. We're innovative, so there is no funding for innovation that will allow the South East LHIN to even do it on a three-year basis and then evaluate it while a regulation might be developed that would cover us.

M^me^ France Gélinas: So if we were to make changes, if it was possible, how would it look?

Ms. Christine McMillan: We've made a recommendation. By the way, I was a policy adviser with the Ministry of Labour before I retired. I looked at it, and I thought there would be a possibility of providing innovation funding to the South East LHIN.

M^me^ France Gélinas: No, I mean on the ground. For the clients you serve, how would it change?

Ms. Christine McMillan: Right now, a health care provider makes decisions for people. For example, the caterer who provides the meals wanted to go on holidays, so without any consultation he went on holidays for a week, leaving the seniors without meals for 12 days.

M^me^ France Gélinas: Not good.

Ms. Christine McMillan: Not good.

M^me^ France Gélinas: Basically, if you had the money, you would hire your own staff? Your members would have more oversight as to who does what?

Ms. Christine McMillan: Yes. I think the model we envision is, when we go into a partnership with an apartment owner, that the seniors form their own executive committee and board, and they make the decisions and work with—there will always have to be a health care provider. But if the contract is with the health care provider, it makes a difference about who is in control.

M^me^ France Gélinas: Thank you.

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

Ms. Helena Jaczek: Thank you so much for coming in. We've heard from a number of providers of assisted-living services from across the province, and I think we have got the message loud and clear.

I'm just wondering, to what extent—obviously, this is a technical issue here—are the LHIN and the CCAC here in the southeast supportive of your desire for regulation changes?

Ms. Christine McMillan: I think they've been very supportive. In fact, we did meet with the board chair last year and with the executive director of the CCAC, and they were very interested in having the funding flow through them, and then we would work in partnership with them. But they were told that there was no regulation that would allow that to happen.

Ms. Helena Jaczek: Presumably, they would be supportive of a regulation change, since they've—

Ms. Christine McMillan: I would expect so.

Ms. Helena Jaczek: Well, we hope we'll hear from them that they are. Thank you.

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

Ms. Christine McMillan: There will be a package that will be delivered to you. Thank you.

SOUTH EAST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presenter is the South East Local Health Integration Network: Donna Segal, chair. Thank you very much for coming in this morning. As with the previous delegations, you will have 15 minutes to make your presentation. You can use all or any part of that for your presentation. If there's any time left over at the end of the presentation, we'll have questions from our committee. Again, thank you very much for being here. The clock starts ticking now.

Ms. Donna Segal: Thank you, Mr. Chair and members of the standing committee. My name is Donna Segal. I appear today as chair of the South East LHIN board of directors, a position which I have held for one year. Thank you for the opportunity to present to you today.

The LHIN believes that your mandate to review LHINs and their enabling legislation is really timely, and we look forward to the outcome of your review, to identify areas for strengthening this important element of what we see as local governance.

I hope to speak for about 10 minutes or so, leaving the opportunity for a question or two.

I'll start with an indication of some of my experience with the health care system. For more than 25 years, I was with the Ministry of Health and Long-Term Care, and then after with the Health Council of Canada, both providing me with experience that gives me some important context in assessing how and what our LHIN is doing as we move forward.

I began in the ministry, lo, many years ago as an area planning coordinator in the District Health Councils Program. I enjoyed assisting the councils to plan and advise regarding local health care services in keeping with government policy and direction and, conversely, interpreting local aspirations and experiences back to a ministry centralized in and managed from Toronto. But the DHCs were advisory; they had no funding or decision-making authority, and the larger organizations continued to invest more strongly in their relationships directly with the ministry rather than locally with the DHC.

Much later, the ministry established regional offices when other provinces were turning to variations of decentralizing and devolving planning and administration to introduce order, local sensitivity and accountability in order to address the fragmentation of service management and spiralling growth in health care expenditures.

What I observed then from my then-current position as the CEO of the Ontario Family Health Network were the difficult decisions regarding the balancing of the scope of the services to be covered by the regional office, the health care provider community's frustration with their engagement with the office, and a level of decision-making authority which, frankly, still had funding decisions finalized by the ministry in Toronto.

This model demonstrated the weakness of half measures. It didn't achieve the predicted administrative cost savings; it didn't create closer relationships with the community and decision-makers; and didn't render planning and administration decisions to be more timely, more nimble or more responsive to the local context.

On another tangent, during this time when I was with the Ontario Family Health Network, I had the opportunity to appreciate the pivotal and underdeveloped position that family doctors had, not only in providing primary care, but also in enabling their patients to access needed services—again, a reference to patient navigation. It's this patient-navigation support role that is so important in helping to drive forward a system of care wrapped around the patient.

I draw on this experience as I watch the leadership and committed involvement of the primary health physicians in our region as they participate and collaborate in the development work of the seven health links, which entirely cover our region. We are one of the two regions in Ontario which have achieved this. We've had a rapid take-up of this approach, and the drive to make it work speaks to the local commitment and the willingness of the health care providers, including family doctors, to collaborate, to address the needs of the most complex patients within each health link. We have at least 85% of physicians in each link region collaborating, and in some links we've achieved 100% of family doctors, so there's terrific interest.

From 2004 to 2007, I spent three years with the Health Council of Canada. There, I witnessed the functional differences between regional authority models of health service management, which were in effect in many of Canada's provinces, and the LHIN model. The intent of Ontario's model was clear: to grow the capacity for system transformation in a manner which meets provincial expectations yet considers local needs; where the ministry sets policy and health system priorities and the LHIN, through system and service integration, promotes the improvement of the patient experience and ensures service value for money.

Lastly, and a key difference, the LHIN system retains local boards of directors for all funded health service providers as a means to ensure local oversight, local input and responsiveness to the local community.

Fast-forward through my term on the board of directors at Kingston General Hospital to now—as my husband refers to it, my failure in retirement as chair of the LHIN board. I remain convinced of the importance of the role of a local entity such as the LHIN, with appropriate authority and having engaged its community, including its patients and their families as well as health service providers, to:

(1) Plan in a manner which is patient-centred, not functionally provider-centred, and which promotes patient and family access and quality of service.

(2) Encourage, facilitate and build on collaborative relationships between health service and community partners to promote local systems of care that are integrated as seamlessly as possible from the patient's perspective and which optimize value for money.

(3) Make funding decisions and allocate funds according to government policy in a way which is sensitive to the overall design of services in the region, best meets local needs, aligns the priorities of diverse stakeholders, addresses key areas for improvement based on the analysis of local demographics and performance data, and highlights populations within the region as a focus for new programs. It strives to ensure that all individuals have equitable access to high-quality care.

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(4) Monitor and track health service provider fiduciary and service performance, ensuring their accountability for the appropriate management of funds and delivery of services that were funded.

You've already heard from Paul Huras at the outset of your hearings. Paul is the long-standing CEO of the LHIN. He has a long history and has been a guiding force in the maturation of the LHIN model. I won't repeat what he told you; I think we don't have the time for that, but I do want to reflect. In your version of notes that I've provided you, I have built in his comments and some further reflections on the South East LHIN's performance.

You will note that there are clear indications that the system's performance has improved. In short, the system's successes are in the realm of access to care, continuing integration of care and financial performance. The one thing I do want to point out with respect to the current financial stability of hospitals is that all seven hospital corporations in the South East LHIN's area have submitted balanced budgets for 2013-14, and several are projected to end the year in a surplus position.

Hospitals are to be congratulated for their efforts to systematically eliminate operating deficits without materially compromising access, quality and safety of patient care. But that's not to say that, from time to time, some hospitals haven't been challenged to live within their budgets.

The following is also worthy of comment. Far different from what I observed in my days with the ministry, it's clear to me that this region's health service providers have acknowledged that new funds will be scarce and that a pitch for special consideration to fund a deficit is unlikely to be successful. I observed a renewed determination to perform within funded levels and to work collectively to meet financial imperatives.

How have these successes been achieved? First, I want to give credit to the health service provider boards and senior leadership. In the end, it is their hard work, determination and commitment, which delivers the success. But I also want to suggest that the local yet objective relationship of the LHIN to its health service providers has been instrumental in assisting them to achieve such successes.

Again, how? Well, I don't have a lot of time left, so I want to be brief:

—through capable LHIN board governance representing its community and committed to fostering patient-centred planning and service management;

—through capable staff: We have a complement of 50 staff;

—through structured and facilitative processes to manage accountability and introduce efficiencies;

—through engagement and addressing emerging patient demands: Particularly, a new emerging demand is now being evidenced through measuring the quality of patient care. We've been in discussions with Health Quality Ontario to determine how best to complement Health Quality Ontario's health-quality leadership and to support the delivery of quality services in our region; and

—through collaboration and support.

Three ventures come to mind. One example is of cross-border collaboration involving the Royal Ottawa Hospital and the Brockville General, for the divestment of psychiatric services provided in Brockville from the Royal Ottawa to Brockville. Through the collaborative efforts of the Royal Ottawa and Brockville General community mental health providers and the ministry, the two LHINs worked together to steer a successful outcome, and the services have been divested at this time.

A second venture I'd like to talk about is our Clinical Services Roadmap. It's a collaborative and detailed effort undertaken over the past three years with our hospital and CCAC partners, with the objective to address fragmented yet priority clinical services across the region. It hasn't been an easy exercise, but there have been some successes, one of the major ones being the learning opportunity provided in the development of regional thinking, trust and respect for mutual dependency.

The third area of collaboration is support to our health service providers. At the request of providers to help them develop the type of leadership skills required to work in partnerships, the LHIN has partnered with the Rotman School of Management to offer an advanced system leadership program. The intent is to support the providers to find the balance between their own organizational priorities and regional and system priorities, and to build the relationships necessary to enable the integration of services.

The last element that I'd like to identify is our achievements through integration. These are the opportunities which have been my priority in my brief tenure as chair. The first, which I don't want to belabour, is around health links, an important venture. I am amazed and encouraged by the cross-sector response to take part. We've been a stimulus, a seed and a catalyst for collective planning around the needs of the most complex patients.

The second initiative is around addictions and mental health redesign. We recognize through engagement that

there were significant gaps in our addiction and mental health systems in the region. We wanted, in that, effective redesign. We wanted to keep the redesign process patient-focused, so we enabled a task force comprised of patients, providers, clinicians and community service providers, who were supported by experts to identify the ideal patient journey. The intent was to replace the current episodic and truncated approach with an overarching, holistic and regional approach. Through a series of discussions, amplified by extensive engagement with patients and providers, the task force assessed a series of options for the redesign of the planning and delivery of services which might better address the ideal journey. Extensive engagement continues.

The third element is around hospital sustainability. The introduction of a new hospital funding formula will encourage more fairness in hospital funding levels across the province, but it will cause the South East to lose about $30 million to $40 million from its collective hospital allocation. That's a lot of money. In an effort to meet the imperatives of the reform, the hospitals are about to undertake a collaborative project to review the distribution and availability of hospital services across the region, in an effort to streamline service delivery.

I have deliberately focused on these strategic and important planning efforts, which have been in play since my involvement with the LHIN. This is the LHIN that I know, the LHIN that is committed to improving access to high-quality care for its residents, in collaboration with, and through the efforts of, its health service provider partners.

But, as with all systems, the capacity of LHINs can be improved, and we hope that you consider, in your review, amendments to LHSIA which will foster these improvements. In the absence of time, I won't elaborate.

Thank you very much for the opportunity to present.

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

We have just over two minutes left, and it will go to the opposition. Mr. Milligan.

Mr. Rob E. Milligan: Thank you very much, Ms. Segal, for coming in today. It's always a pleasure to see you.

I guess you weren't able to elaborate on some of the implementations that you would like to see brought forward by government concerning improvements to the LHINs. Could you perhaps just take a quick couple of seconds to highlight those?

Ms. Donna Segal: Sure. They don't differ from many of the observations that have been put forward by others. We'd like to see greater involvement with primary care physicians, particularly the organized primary care physician corporations or processes—in particular, relating to their performance, not necessarily relating to their OHIP funding in that matter.

We don't have a position on public health, and I know that came up earlier. We have remained silent on that. Without question, we work closely with public health, and the notion of working with them to continue or further efforts around health promotion would be fine.

Some of the issues that were expressed earlier were some changes in regulation or procedures regarding financial funding. I'm very sympathetic to the Oasis comments that were made previously. I'm also sympathetic to the comments that were put forward by the CCAC. Multi-year funding would be helpful, as would some of the easing of some of the regulations that, I don't think, were intended to be as strict and narrow as they have been interpreted.

Those are the two major ones but there are others.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much for taking the time to make your presentation. We very much appreciate it.

Ms. Donna Segal: My pleasure.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair (Mr. Ernie Hardeman): Our next presenter is the Ontario Public Service Employees Union, OPSEU: Rick Janson, campaigns officer, and Warren Thomas, president.

Good morning, gentlemen, and thank you very much for sharing your time with us this morning. You will have 15 minutes to make your presentation; you can use all or any of that for your presentation. If there's any time left at the end of the presentation, we'll have questions and comments from the committee. With that, the floor is yours for the next 15 minutes.

Mr. Warren Thomas: We'll talk fast so we'll have time for questions. Rick Janson is with me. He's our health care expert, and many here probably follow his blog. I know the government does because they phone, bitching about him, all the time.

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We represent 130,000 members. About a third work in a variety of health care settings, including hospitals, long-term-care homes, ambulance, home care, mental health, independent diagnostics, community health centres, public health, and Canadian Blood Services. We were the first union to sign up members at an Ontario family health team. We also represent health professionals in the province's corrections system and the Ontario public service members at the Ministry of Health and Long-Term Care. As a result, we believe we have a unique 360-degree perspective on health integration.

OPSEU was among the first trade unions to warn of impending issues with the local health integration networks. In 2006, we warned that the LHINs would be used to deflect public criticism from the real decision-makers. That not only came true but did much to damage the brand of the LHINs.

We warned that the LHINs would be used to implement the same kind of race-to-the-bottom competitive bidding we witnessed in home care and hospitals. The government said we were scaremongering, yet we note that the government now plans to have independent

health facilities enter into competitions this year with hospitals to perform such services as cataract surgeries and endoscopies. We are told this is only the beginning.

We warned that the LHINs would drive down wages as services got divested to community-based agencies. We should note that the Ontario Hospital Association recently advocated that the Public Sector Labour Relations Transition Act not require agencies to pay hospital wages to employees transferred to such community health providers. That's a declaration of war, folks.

The LHINs have gotten around such requirements by not publicly stating where hospital services were going, after permitting outpatient clinics to close under the auspices of hospital accountability agreements. Every time, we are told that these services will reopen in the community, but are never told when, where or on what scale. That makes it very difficult to assert workers' legitimate rights under PSLRTA.

We warned that the LHINs would help the government rationalize services and require patients to travel further to access care. We have seen this repeatedly in the decision to create so-called centres of excellence, even when there was no evidence to suggest that lower volumes performed closer to home threatened quality. The Windsor Regional Hospital recently fought and won this issue when Cancer Care Ontario tried to defund the hospital to make it stop performing thoracic cancer surgery. Windsor residents didn't want to travel to London when they could get the surgery done closer to home. Critical to the victory was the absence of any evidence by Cancer Care Ontario that quality or outcome would differ.

You may very well say that most of these decisions really reflect the direction of the Ministry of Health, and you'd be absolutely correct.

To create the LHINs, the government shut down seven regional ministry offices and effectively turned around and opened 14 in their place. OPSEU members lost more than 2,000 jobs at the Ministry of Health, only to see about 500 newly established at the LHINs. That's a quarter of the staff to provide oversight to 149 hospital corporations, more than 600 long-term-care homes, 14 community care access centres and hundreds of smaller community-based health providers. That's a quarter of the staff to do health system planning; a quarter of the staff to provide expertise and to seek public input. Make no mistake: This was doomed to failure.

To create the veneer that real decisions were happening locally, the government appointed nine-member boards to each of the regional LHINs when no board existed to oversee the provincial decision-making.

Where the key provincial decisions take place, there is no board. Where the key decisions simply get implemented, there is a board. We're not sure that this makes much sense. Anybody who attends a LHIN board meeting will quickly realize that any local decisions are being made by senior staff under the direction of the Ministry of Health, so why do we pretend otherwise? This is likely not news to you.

I'll note that during your briefing with the departing deputy minister, Saäd Rafi, government MPP Donna Cansfield said, "The LHINs tell me time after time that they do not have the autonomy you say they do. They do as you tell them to do." That is also our perspective. I note that Donna is not on the committee for the Liberals.

Our own hope for the LHINs was that the process around system transformation would be an open one and that there would be an opportunity for the public to have meaningful input into the decision-making process.

While the definition of integration is clearly spelled out, few of the substantive changes to local health delivery get treated with any kind of open process.

We're told there is no integration process if the services transfer outside the scope of the LHINs. We're told that there is no integration process if a health provider transfers services between two of its own sites, even if they are geographically distant from one another. We are told that there is no integration process if the changes are a result of a hospital meeting its accountability agreement. We are told that there is no integration process if a health provider independently chooses to close its doors.

When you think about it, there are very few opportunities to actually go through the integration process—not that it is particularly rigorous.

When we do have an integration process, often the details are so vague it would be nearly impossible for anyone to reasonably evaluate the merits of the plan. Often, we don't even know why the integration is taking place: What is it that the LHIN is trying to solve?

To give such an example, we were recently asked for input on an integration plan that would bring nurses from the Port Hope CHC to provide education and support to patients and staff at the Northumberland Hills Hospital dialysis unit. We were not told how many CHC staff that represented or what education would be conducted, especially when the hospital had existing certified diabetes educators already doing this work. The plan, which we received in December, was set to be implemented in January. The plan lacked any human resources component, leaving us to wonder how this was supposed to work, given OPSEU and ONA held bargaining rights for professional staff on this unit; nor was it clear who was paying the bill or what this cost. How is any stakeholder to reasonably evaluate such a proposal?

I'll turn it over to Rick now.

Mr. Rick Janson: We also note that infrastructure planning is not well integrated with the LHIN service-planning process. While the province continues to sink billions into new hospital infrastructure, the LHINs have been given the challenge of essentially emptying those buildings of services and patients.

We presented a report to the South West LHIN in 2010, suggesting the capacity planning for two new psychiatric hospitals in London and St. Thomas was both out of date and inadequate to local need. We pointed out that the existing aging facilities were working at capacity and couldn't understand how the new buildings could

open with fewer beds, amid an aging and growing population base.

What happened? Despite our intervention, the hospitals went ahead as originally planned.

The first, St. Joseph's Southwest Centre for Forensic Mental Health Care, opened in St. Thomas last year. When we visited a few weeks ago, we were told that all 80 funded beds were full and that patients remained waiting in the region's crowded corrections centres for lack of capacity. The only provision for the future was nine additional beds, which the centre could happily fill right now if the funding existed.

I should point out that here in Kingston, the province is about to make exactly the same mistake with the replacement hospital for Providence Care's mental health and rehab facilities. What we are presently seeing is not capacity planning, but wishful thinking.

Similarly, the Ajax and Pickering Hospital underwent an $80-million expansion that opened in 2010. It increased the overall size of the hospital by 25%. That expansion is now full, and the Rouge Valley and the Scarborough hospitals are proposing another major expansion at the west Durham hospital as part of their merger plan. They feel the space needs to double. They argue an expanded west Durham facility is needed because so many Ajax and Pickering residents travel to Toronto for care in the absence of local capacity. With the new funding formula that follows the patient, that means health care dollars are also travelling away from the community where the services are actually needed.

So what are we recommending?

(1) That the LHINs themselves formally integrate with the Ministry of Health by becoming 14 regional offices responsible for all health care planning, not just the sectors presently identified under LHSIA. These regional offices should also include responsibility for establishing local service and capital planning. The goal of these regional offices should be to place an emphasis on equitable provincial access to quality care, as well as assessing regional need to establish reasonable capacity targets. Expert staff should be available to assist health care providers in resolving performance issues, both quality and financial, and to ensure public accountability. All accountability agreements should be with the Ministry of Health and posted online.

(2) That an expert panel be appointed by the ministry in each region to review integration proposals and seek community and stakeholder input, publicly reporting their final recommendations, along with the results of their consultations, back to the ministry. The public should have a period of no less than 60 days to respond to an integration proposal.

(3) That a process be established for provider integrations, including a template that establishes the purpose of the integration, timelines, cost comparisons, the impact on volumes, quality and access, as well as how the proposed changes will impact other health service providers and fit within the regional plan. The proposal should also include a report on the results of public engagement, that not only establishes the who, when and where, but a summary of the substance of what was heard. Any proposal should clearly establish whether the recipient of any transfer process is for-profit or not-for-profit, especially in circumstances where the ministry is establishing a not-for-profit criteria, such has been the promise of the action plan around community-based speciality clinics.

(4) The integrations process should include any substantive change in service delivery, whether that be a closure, a transfer, a merger or new partnership agreement.

(5) Transparency is the best disinfectant. Accountability works best when all business is conducted in public, including posting of the integration proposals and all relevant documentation in a way that is easy to find.

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(6) We would also strongly recommend that any public disclosure be accompanied by a "popular" summary of the proposal written in plain language. Similarly, the websites should be reviewed to make them more user-friendly.

(7) We would urge the government to strengthen accountability agreements to require health service providers to give reasonable notice of closure, except under circumstances that may be beyond their control, such as bankruptcy or fire. The ministry should be able to order such providers to remain open until such time services can be reasonably transferred.

(8) The ministry should undertake an evaluation of staffing needs at these regional offices to ensure that they have the capacity to undertake service and capital planning, accountability, integration and provider support. Ultimate accountability should reside with the elected representatives, including the Minister of Health.

Mr. Warren Thomas: So in closing, I'd just like to say that better than a decade of mismanagement has created what I would consider to be a horrible mess in health care in Ontario. The government should be ashamed of themselves, and the previous Tory government should be ashamed of themselves too, because they started down this road.

I hope that in your planning process you actually do a little more consultation with front-line workers—because if you're a patient and you can get a service, you get really good care. The trick is to get that service, because there's just not enough of it. There's probably one manager for every five workers in hospitals, which Dalton McGuinty recognized and still did nothing about, so the health care system, even out in the communities, is grossly over-managed.

Anyway, I hope you make some reasonably good decisions, but frankly, I don't have much confidence you will.

Thanks for listening, and time for comments—

Interjection.

Mr. Warren Thomas: Hey, sister, you gave us 10 years to be skeptical.

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

We have just less than three minutes left, so the questions will go to the third party. Ms. Gélinas?

M^me^ France Gélinas: Good morning, and thank you so much for coming. You have given us a different sound, and I very much appreciate that you took the time to come and present to us today.

The model going forward would be with 14 regional offices, no more boards of directors, but the regional planning would be planning for the entire spectrum. Do you include fee-for-service physicians in there? Do you include public health units? Do you include EMS—everything?

Mr. Rick Janson: Yes, I think it would include the full range, because if you want an integrated health system, how can we just put half of it under the LHINs? It doesn't make much sense. If you look at the role of primary care providers, for example, it's key to the health system in terms of how it functions. They often are the gatekeeper to the system, and if they're not included in the discussions, it doesn't seem to make much sense.

M^me^ France Gélinas: We've heard over and over that it's the Ministry of Health that makes the decisions. The LHINs hold consultation or engagement, but we fail to see how whatever was told to the LHINs had an impact on the final decision. You're not the only one telling us that. In what you have put forward, how is it different? How do we make sure that if people mobilize and tell their new regional office that this plan needs to change—how do you make sure that it's active listening that leads to different decisions?

Mr. Rick Janson: I don't think we could ever guarantee that as long as there are elected officials, they'll follow exactly what people want to do. But I think there would be increased pressure to do the right thing if there was full disclosure. If we knew, for example, what costs were involved in any kind of transfer, which employees were going where, how this would impact local services, and this were all up online and publicly reported, and then the ministry decides to make the wrong decision, then I think there would be increased pressure to basically turn around that decision.

Right now, the LHINs make the decision, and there is really no avenue of appeal. When it happens, we get very little information up front, the decisions get made, and we have nowhere to turn. In fact, some LHINs specifically have requirements that if you're going to make a deputation to them, you can't bring up something that a decision has already been made on. So it's the opposite of appeal; you can't even talk about a decision that has already been made.

M^me^ France Gélinas: And the idea of appeal—is this something that you would see, a formal process for communities to appeal decisions?

Mr. Rick Janson: I think so. I think there should be some appeal process. I mean, ultimately, no matter what, it's going to be a political process at the end of the day, and I think as long as the politics is there, that people will—

The Chair (Mr. Ernie Hardeman): We have reached the end of our time, and we thank you very much.

Mr. Warren Thomas: Can I just say—

The Chair (Mr. Ernie Hardeman): The reason you couldn't finish your answer is because the questioner took too long to put the question. Thank you.

Mr. Warren Thomas: Whatever, Ernie. All I know is this: 15 minutes for such an important issue is an insult to democracy—

The Chair (Mr. Ernie Hardeman): Thank you very much. We are trying to hear from as many people as possible. We thank you very much for taking the time to make the presentation.

FRONTENAC COMMUNITY MENTAL HEALTH AND ADDICTION SERVICES

The Chair (Mr. Ernie Hardeman): Our next presenter is the Frontenac Community Mental Health and Addiction Services: Leonore Foster, member of the board. Thank you very much for being here. As with the previous delegation, you will have 15 minutes to make your presentation. You can use any or all of that for your presentation. Any time left after the presentation, if you so decide, will be used for questions and comments from the committee. Thank you again for being here, and the clock starts now.

Ms. Leonore Foster: Thank you, and good morning, and welcome to Kingston, to all of you. Thank you for this opportunity to provide to your committee our take on the effects of the act and on what we do in the Frontenac community in support of the recovery of people suffering from mental health and addictions problems.

In outline, I will introduce ourselves; give you an overview of our agency, to give you an understanding of what we do; give you our take on the effects of the act; and lastly, make some observations on our interaction with the local LHIN.

I'm Leonore Foster, as you heard, and I'm a board member with the Frontenac Community Mental Health and Addiction Services. I have over 20 years' experience of service to the community as an elected councillor for the former Pittsburgh township and the city of Kingston. I was a board member of the local board of health for five years and, while chair of the Federation of Canadian Municipalities' standing committee on social-economic development, I served on the Canadian Reference Group on Social Determinants of Health.

I'm a default presenter, as Dr. Duncan Sinclair, another board member instrumental in preparing this presentation, sends his regrets as he is out of town. Duncan was a senior administrative officer at Queen's University, retiring as dean of medicine, and vice-principal for the health sciences. He subsequently chaired Ontario's Health Services Restructuring Commission in the late 1990s.

Our chief executive officer, Vicky Huehn, is unable to be here today. She would answer most of your questions, but she is also out of town, at a business meeting in Toronto.

I'm speaking for a board of 10 directors, drawn from the community, and that includes four directors elected by the members who receive services from our organization.

Our agency began in 1972 as an experiment by two staff members of the former Kingston Psychiatric Hospital, who believed that, given the opportunity to live in the community with a bit of support, their patients would thrive. They rented student houses for the summer and found that the hypothesis was correct. In 1976, the agency was incorporated as Friends of the Kingston Psychiatric Hospital, with several rented houses, and by 1981, 24 people were housed in rental accommodations.

The social supports available to these tenants were scarce, and in 1982, funding was secured to assist the members with their daily living skills. As tenants' needs grew, so did funding, and the agency grew to an integrated addictions and mental health organization that provides a wide umbrella of services, including assertive community treatment teams, crisis services, case management, court support, support for those with addictions and problem gambling, and vocational services. We have over 200 staff members serving 3,000 people a year, and a budget of $14 million. The building equity of the corporation is over $14 million in 17 buildings.

In 2005, Frontenac Community Mental Health and Addiction Services became one of the first community mental health organizations to be successfully accredited by Accreditation Canada. In 2007, the organization was awarded the Award of Excellence by the Ontario Non-Profit Housing Association.

I'd also like to say that our executive director, Vicky Huehn, received the Queen's Jubilee Medal and also the Paul Harris award for her services to mental health and addictions.

Now to our take on the act: We recognize that our take is essentially confined to our experience with the LHIN for southeastern Ontario, but in conversations with other providers of health and health care services in the region, we believe our experiences with the LHIN over the past seven years are typical of other agencies like ours, whose services are community-based as opposed to institutionally based.

First, establishment of the 14 LHINs throughout Ontario has been a good thing. Collectively, they are slowly diluting the propensity of a central, Toronto-based bureaucracy to micromanage the different ways in which services are delivered in this diverse province.

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It was recognized, when the act was passed, that one size will not fit all and that regional sub-governances, LHINs, should be established to develop a variety of policy frameworks, with the objective of meeting province-wide goals related to the health and health care of the whole population.

Meeting those goals best demands that a variety of approaches be tailored to the environment and circumstances of each of Ontario's diverse regions. That tailoring cannot be done from the centre; it can only be done effectively by those who know and live in the regional environment. LHINs, in principle, were set up to fill this role. We say "in principle" because the act you are reviewing has yet to be more than fractionally implemented.

Ontario's LHINs remain very much under the thumb of the Ministry of Health and Long-Term Care in Toronto. LHINs still do not have the powers, the resources or the authority needed to do their specific job. Nevertheless, we believe that the devolved governance LHIN model should be retained in Ontario and that the LHINs should be given more authority and funding by the ministry to do what the act intends them to do.

Second, LHINs were established as planning and funding bodies, not as entities charged with operating any service-providing component within the health care system. Unlike regional health authorities in other provinces, Ontario's LHINs are free of the inherent conflicts of interest that are inevitable when a funding agency also carries selective operational responsibility for such things as regional hospitals and home care agencies.

There have been times in the past seven years when LHIN staff members seem to have wanted to cross the line and to provide direction on how to implement a given policy thrust. It is worthwhile, in your review, to emphasize the point that LHINs are to be sub-governances for the province in their particular regions, with the role to provide leadership in reaching decisions on what to do to best provide the regional population with the health and health care services they need. Under the act, it is the responsibility of the regional providers, in all their diversity, to figure out how best to do it for the people they serve. We recommend that the wisdom of continuing to separate the different functions of governing the regional system—a function of the LHIN—from the operation or management of its variety of components—a responsibility of the components—be featured prominently in the committee's report to the Ontario Legislature.

Third, it is apparent that the LHIN in southeastern Ontario—and probably all LHINs—has been seriously handicapped in its mandate by three factors:

The hand-off of responsibility from the ministry for decisions relating to regional planning and the implementation of those plans has been too tentative and too slow. That was undoubtedly wise at the start, while the LHINs were being organized, staffed and learning how to deal with their new responsibilities. But it is seven years later and now over time for the ministry to loosen, if not cut, the apron strings and let the LHINs have the authority necessary to discharge their mandates.

While responsible for leading regional integration of health and health care services, the LHINs' mandate for planning and funding those services extends only to some of them. This is akin to giving the coach of a hockey

team the authority to direct the play of only half the players on the ice and, at the same time, holding him or her entirely responsible for the outcome of the games. To a considerable degree, coupled with having the necessary resources flow to the team from sources separate from the locus of responsibility, that's mission impossible.

Lastly, the LHINs continue to be seriously handicapped by the very slow progress by the ministry to develop and implement the capacity to collect, store, share, analyze and otherwise manage health and health care data and information. Until you can get a handle on the data and information bearing on the work of an enterprise, coordination of the activities of its components—that is, optimal integration of its activities for optimum outcomes—is virtually impossible. To be successful in what they are charged to do, the LHINs must have the tools they need to do the job. Those tools are: a centrally determined policy framework providing the authority necessary for the LHINs to lead in the implementation of health information management within their regions; the necessary technical resources and personnel to support implementation of that policy framework; and the data and information essential for all of us to know the extent to which we are getting our money's worth, measured in terms of the health of the regional populations for which LHINs, under the act, are to be held accountable.

Finally, our observations on some interactions with our LHIN that have need for improvement—our LHIN in southeastern Ontario has a new chair, a very passionate chair, as you've heard earlier, and we are very hopeful.

First, we need time for consideration. We have experienced several instances in which our board has been required to sign off or respond to inquiries from the LHIN on very short notice. Like most such boards, we hold monthly meetings. Receiving material for consideration that arrives too late for inclusion on our regularly scheduled agendas or is required to be returned in the interval between regular meetings inevitably leads to rushed decision-making, and often by less than a full complement of the board.

Second, timely responses: We have experienced occasions when the turnaround by LHIN staff of urgently required material for a decision—that material can be material that the LHIN requires itself—has been delayed for overly long periods.

Third, there are poorly defined requirements at times. Our board has been required to sign documents which have very open-ended articles, such as committing the agency to comply with a policy which has not yet been formulated or defined. All requirements in the multi-sector service agreements we are required to sign should be finalized prior to our being asked to commit to them, or a process provided to later negotiate further additions.

Fourth, there are vague measurements and expectations. We find that what the LHIN expects by way of measurement of outcomes, in conjunction with evidence-based information and best practices, in partnership with people with lived experience, family members and providers, is ill-defined to the point of vagueness. We are properly expected to produce the required results, but the LHINs are not content experts and should work more closely with the front-line organizations to develop appropriate ways of measuring progress towards these results. We have no problem with implementing the principle that those organizations that fail to meet the clearly defined outcomes adopted by the LHIN should not be funded.

In conclusion, the provision of the range of health and health care services the people in each of Ontario's regions need to optimize their health and well-being requires teamwork by the whole range of organizations who provide the necessary services; leadership from a governing body sensitive and responsive to regional diversity, and with the authority to allocate resources most appropriate to establish and maintain a genuinely integrated system of health and health care services; and effective and efficient management of the operation of each provider organization, like Frontenac Community Mental Health and Addiction Services, to serve those who depend on it.

The Local Health System Integration Act has as its purpose meeting these requirements. Full implementation of the act is essential in meeting its goals, and we hope you will recommend that the act be fully implemented, and soon.

Our sincere thank you for your time.

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

We have about a minute and half for the government side. Mr. Fraser.

Ms. Leonore Foster: I don't know if I can answer your questions, but I have one for you.

Mr. John Fraser: Thank you very much for your presentation. It's very clear, very well thought out, and really does speak to the evolution of the LHINs. We've heard a lot over the course of the hearings about the LHINs assuming more responsibility for things like the CCAC, public health, ambulance and primary care. I can see that in your submission here you spoke about inherent conflicts, which I think is very clearly expressed. Can you elaborate on that a little bit in the context of what I've just mentioned, in terms of those additional responsibilities that people suggested?

Ms. Leonore Foster: Well, the conflicts we suggested could happen were if the LHIN stepped over its line as governance in the area and tried to implement service itself.

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The people who do the service in the region are the ones who know. Anybody doing a job knows best how to do that job. We certainly do in our organization. That was the conflict that we were describing could happen, because we know what our job is; we do our job extremely well. For somebody else to step in and say how to do that job would require a lot of consultation with us. Consultation is, I think, key.

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

Ms. Leonore Foster: Oh, you are good on time.

The Chair (Mr. Ernie Hardeman): The time has run out. We very much appreciated your presentation.

Ms. Leonore Foster: Thank you.

ONTARIO COMMUNITY SUPPORT ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next delegation is not here yet, but the following one is, so we'll ask the Ontario Community Support Association, Terry Richmond, to come forward. Thank you very much for taking the time to come and talk to us this morning. As with the other delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for the presentation. If there's any time left over at the end, we will have questions from the committee. With that, the clock starts ticking now.

Ms. Terry Richmond: Thank you. Good morning, Chair and honourable members of the Standing Committee on Social Policy. My name is Terry Richmond. I am the executive director of Cheshire Homes (Hastings-Prince Edward). As well, I am the president and chair of the board of the Ontario Community Support Association.

Cheshire is a community support service agency providing attendant care services to people who live with permanent physical disabilities. Our services are provided in the western boundaries of the South East LHIN. Cheshire is also a member of the Ontario Community Support Association.

OCSA represents the home and community support sector in Ontario. Many members of OCSA are community-based, not-for-profit organizations that provide a wide variety of services that enable people to live in their own homes and help avoid inappropriate and costly placements of individuals in acute-care or nursing home settings. OCSA represents approximately 400 not-for-profit agencies across the province, including and not limited to home care providers, home support agencies, acquired brain injury services, hospice agencies, Alzheimer's programs, in-home respite programs, and attendant care services through outreach and supportive housing.

It has been widely established that maintaining individuals in their homes despite physical challenges, complex needs, or age-related issues is a goal well worth striving for, both in financial aspects and in terms of individual health and well-being.

OCSA supports a strong, sustainable health system where clients are the focal point, and it remains supportive of the principles that were laid out by the government when the LHINs were established. While there is more work to be done on LHINs, OCSA is prepared to and wants to work within the current structure. Dissolution of the LHINs would not improve the health system and could potentially cost a large amount of money to do so. It could also serve to distract from more immediate issues that impact the delivery of home and community care.

One of the key priorities of the health system has been the move in care from acute-care facilities to the community. The LHINs are best suited to plan this as they are much closer to the community.

In the South East—which is where most of my experience has been—much has been done to consult with all stakeholders and to look at opportunities for efficiencies. For example, several years ago the South East LHIN funded a consultant to look at back office efficiencies with approximately 52 agencies from community health centres, mental health and addictions, and community support. A community working group was put together, made up of service providers from the four sectors. A consulting firm was hired to put together a report on where and how efficiencies could be made. At the end of the report, the stakeholders involved questioned some of the report's findings and estimates of savings and refused to support the recommendations. The South East LHIN listened and allowed the group to use the report only as a reference document.

Between the agencies and the South East LHIN, several working groups were put together to address key areas. Today, a number of agencies have become hosts to other agencies for their financial, payroll and reporting needs. As well, after several RFPs, there are vendors of record for IT and for office supplies. This process illustrates the success we achieved as we worked with the LHIN as a team to address issues and to find efficiencies.

OCSA believes in smart integration and not just integration for the sake of it. Presently, there are a number of agencies working together in the South East to co-locate their services in one place with the intent that this will be better for the client. Within our LHIN, there are five stand-alone hospice agencies whose long-term sustainability was being questioned. Over the past year, the LHIN has worked with these agencies to try and come up with a solution that would ensure they would be there for the clients in the years to come. The agencies, with guidance, came up with a solution that will not affect client care but will take pressure off the agencies and allow them to focus on what is important for them: their palliative clients.

In the South East, before the development of the LHINs, agencies did not always have opportunities to collaborate or even share information with the rest of the system. In the past years, community support has been included at far more tables where they would not have been present in the past. This has been important for sharing visions of health care, best practices and for planning.

I think there is still much to be done to ensure better coordination and consistency among LHINs themselves. We believe it is important that each LHIN develop what is best for their part of the province. However, there may be programs that have worked well in other LHINs that might be beneficial for others to look at to determine viability in their area. For example, a service called Seniors Managing Independent Living Easily—the acronym is SMILE—was developed in the South East

several years ago. Clients who are eligible are able to decide who they want to provide these services. It may be a local service provider, but it also may be a neighbor. Around 1,700 seniors are remaining in their homes through this program, at a cost of approximately $3,000 per client. In an area that is quite rural, from a client's perspective, this has worked well. To my knowledge, no other LHIN has looked at this or tried a variation of it. When something is showing success, why, then, would others not want to look at it?

We believe that having a regional perspective is of the utmost importance. A one-size-fits-all viewpoint is not the answer, nor is bigger always better. Currently, acute care seems to drive all planning. For many community support services, providing services such as attendant care, Meals on Wheels and volunteer drivers for appointments etc. is serving to keep people healthy and at home, but it may not be as measurable as the numbers of hips and knees that are being done in hospitals.

In my own agency, for example, the average length of service for attendant care for someone who lives with a permanent physical disability is 15 years. We have had clients on service for 30-plus years and who are not in and out of hospitals. Why is that? The reason is, they are receiving service, perhaps daily for a few hours, by a personal support worker who provides the consistency and stability that puts the clients' needs first. Without these services, these people would be unnecessarily placed and taking up space in acute-care beds, as many have needs greater than what can be managed in nursing homes. Within the South East LHIN, they have made an effort to understand these client-directed services and have funded a needs study to determine the future direction of this population. Unfortunately, with new money only going to seniors' services, there are limitations to what can be done, and with the ministry still setting the direction, the LHINs can only plan so far.

It is important to allow LHINs to more appropriately resource all not-for-profit community support services. The ministry needs to invest in community-based services in order to increase the capacity and infrastructure of community support services. These services can be the answer to getting and keeping people out of acute-care beds, but the agencies providing necessary care cannot continue to do what they do with no funding increases.

I think it is time to allow LHINs to exercise the authority that was set out in the current legislation. LHINs were supposed to be able to allocate and reallocate resources to provide the goals of an integrated health services system plan and, to date, these things have not taken place.

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It is essential not only for our clients but for the entire system that we continue to strengthen and promote community support. The maintenance of the LHINs, encouraging ongoing growth in the existing networks, and communication with the agencies within each geographic area and beyond will surely serve to preserve and improve our health care system. Thank you.

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

M^me^ France Gélinas: Thank you for coming.

What I get is that you are quite satisfied that the LHINs are there. For the community support services, it has met—things are better. You're included at the table; you're more respected as an agency. You still struggle with some funding issues.

I would like to bring something to you that has been shared with us elsewhere, if you're comfortable to answer. Some people have been suggesting that we do away with individual boards of agencies and go from the ministry to the LHINs to regional boards. Were those for sub-regions of your LHIN, you would have a board responsible for every agency within that geographical area. Have you given thought to boards versus no boards? What would that mean for you, for your agency, and is this something you would support?

Ms. Terry Richmond: I think that for our agency personally and for OCSA, we would continue to support the individual boards across the province. We're not interested in having no boards for agencies to answer to. I think those boards are in tune with what each individual home support or attendant care program or hospice agency actually provides. And they do a lot of work. They do many, many volunteer hours beyond being board members. In some agencies, those very same board members may be delivering Meals on Wheels and assisting with service provision. So I don't think it makes sense to cut them out of the picture.

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

Ms. Helena Jaczek: Thank you so much for coming. I think I can probably speak for all members of the committee in saying that we've been so impressed by the number of people we've heard in support of community support, keeping people out of acute care and long-term care, and by all the work that you do in bringing our attention to that really important work.

There have been some suggestions also to integrate primary care more into the LHIN and the LHIN having more responsibility for public health and some other agencies. I'm wondering: As community support service agencies, to what extent do you liaise, in fact, with primary care physicians and perhaps with the local public health unit? Could you elaborate on any connections you have existing?

Ms. Terry Richmond: I think that there's probably limited liaising with those groups, other than the work that is now being done through health links.

Ms. Helena Jaczek: Do you think that would be helpful?

Ms. Terry Richmond: I think that the health links piece is starting to put those pieces together in terms of doctors discovering and understanding better what it is that community support does. The doctors, I think, have been one of the greatest complications in revamping the health care system.

Ms. Helena Jaczek: Nothing has changed over time. Do you think, though, that this movement might assist in terms of trying to bring them more into being part of a continuum?

Ms. Terry Richmond: I think there's hope there. I'm hopeful for that.

The Chair (Mr. Ernie Hardeman): Okay; thank you very much. Mr. Milligan?

Mr. Rob E. Milligan: Thank you for coming this morning. I've had this conversation before with many other individuals in the health care system regarding the LHINs. I agree: One size doesn't fit all. One of the challenges I see with the LHINs, though, from a local flavour, is that—and I'll give you an example. The Central East LHIN, which encompasses my riding, from Trenton all the way into Scarborough, and encompasses Scarborough, up to Haliburton—it's a rather large geographical region. One of the criticisms that I've heard is that the board doesn't necessarily reflect stakeholders from a local standpoint. What would you suggest that would actually give them a little more local input at the board level?

Ms. Terry Richmond: I'm not sure, for Central East. It certainly has not been my experience in South East. Our LHIN has been very engaged with agencies. They're involved in local networks. They meet with the variety of the people that they fund on a regular basis. They really have gotten quite a good insight into what it is that we all do, as diverse as the health care system is. Perhaps Central East could look to their neighbours to see how they've accomplished and achieved those things.

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

HOTEL DIEU HOSPITAL

The Chair (Mr. Ernie Hardeman): Our next presentation is from the Hotel Dieu Hospital. Michael McDonald, the chief of patient care and chief nursing executive, is here. Thank you very much for joining us this morning. As with all delegations, you'll have 15 minutes to make your presentation. You can use all or any of that for your presentation. If there's any time left at the end, we'll have some questions and comments from the committee. With that, the clock starts ticking now.

Mr. Michael McDonald: Thank you, Mr. Chair, and thank you to the committee for letting me present today. I am the chief of patient care at Hotel Dieu Hospital. Hotel Dieu Hospital is located within the city. It's an ambulatory care hospital located just a short distance from this hotel. We see about 500,000 patients annually, and we provide a wide range of programs.

Today, I'd like to speak to you about one particular program at Hotel Dieu: the Total Joint Replacement program, a collaboration between Hotel Dieu and the South East LHIN, which is really successfully balancing local and regional health care needs and providing superior orthopaedic care to patients of the region. Hotel Dieu had the idea of implementing an innovative short-stay joint-replacement program in order to accomplish three goals—this is for many of the patients of our region requiring hip and knee replacement: to improve surgical wait times; to improve the quality of care and outcomes; and to boost patients' satisfaction with their health care experience. The South East LHIN supported our plan and invested seed money to launch the program in 2009.

Since that time, the Total Joint Replacement program has delivered striking results. We started out quite small, actually, with about 60 or 70 joints per year. Over the last five years, it has grown to about 180 joints. At the outset, surgical wait times for hip and knee replacements in the region dropped, and the average length of stay for a patient at Hotel Dieu was two days, compared to other hospitals which had a length of stay of four to five days in hospital. Our intensive pre- and post-op physiotherapy means that none of our patients are admitted to rehab hospitals for rehabilitation.

The level of patient satisfaction is extremely high. This past November, Hotel Dieu topped a list of small, large, academic and community hospitals where patients were surveyed by NRC Canada about the quality of care they received during an overnight stay. One hundred per cent of the overnight patients at Hotel Dieu surveyed between April 1, 2011, and March 31, 2012, rated their overall care as good, very good or excellent.

We also know, through orthopaedic reviews conducted by our CEO and orthopaedic surgeon, Dr. David Pichora, that the program has achieved a more integrated role within the regional health care system than comparable programs in other provinces.

Given this success, accomplished with the South East LHIN's support, we are leaders in this model of care, demonstrating that it can improve access to surgical care for patients, improve wait times and maximize our efficiency as an outpatient care centre.

We are well positioned to share our clinical pathway with other hospitals in the South East LHIN, which we have done. We're also translating components of that, such as the centralized intake system, into a regional model for surgical intake. This is what integration is all about.

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This system is an important step toward building a regional hip-and-knee program across the South East LHIN. It shows how balancing local and regional needs can translate into structural changes that benefit patients in our own community and across the region. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have considerable time; we have 11 minutes left. We'll start the comments with the government: Mr. Flynn.

Mr. Kevin Daniel Flynn: Thank you, Mr. Chair, and thank you, Mike, for your presentation. My own experience in my own LHIN has been a very good one. I'm from the riding of Oakville, where the Mississauga Halton LHIN is.

You've given what I think is a very good example of a kind of micro-project that was performed, where the co-operation between the LHIN and the hospital was a very good one. Are there are other areas that you're planning on working on, or are there other examples of where you think that this type of co-operation would be the sort of thing we should be following up on? These numbers are impressive; that's what I'm saying. Could you apply this to other areas, and what would you suggest going forward for this committee that would make the LHINs work better?

Mr. Michael McDonald: Another program that we're working on with the LHINs is the bariatric program. Prior to last year, we did not have a bariatric program in the South East LHIN, so there were patients—approximately 300 of them—leaving our region and going to Toronto and Ottawa to get their surgery.

We started a program approximately a year ago—an intake centre. We handled the pre-surgery and post-op follow-up with the patients. The patients still do go to Toronto and Ottawa, but they don't have to go as many times, and they can be followed here.

That program was so successful that the ministry, with the LHIN working—we were able to get the medical program. So now we have two parts to the bariatric program. The last part would be the surgical part. The idea would be that we'd be able to provide that service to this entire region so that patients would not need to leave our region to go to Toronto and those places to work.

Working with the LHIN is working on new ways of models of care and looking at ways of improving access to the health care system. With new techniques on anaesthesia—things like that—we're able to now provide things on short-stay programs, so giving patients better access.

Mr. Kevin Daniel Flynn: Still time?

The Chair (Mr. Ernie Hardeman): You have about a minute left.

Mr. Kevin Daniel Flynn: Okay, great. This will be a short one, then. There are people who believe that the LHIN is a sound organizational concept, but it could be improved upon, or it's time to review it and see if there are ways to improve upon it. What advice would you give to this committee as to ways it could be improved?

Mr. Michael McDonald: We work very closely with the LHINs. One of the issues that has come up many times is that when we're working with QBPs, for instance, and we're trying to deliver the care, and we're working with the LHINs to—we have questions for the ministry, and sometimes those questions take a long time to be answered. So the LHINs are putting the questions out there, but sometimes the response back from the ministry with the answer is delayed. So improving that time for communication, especially when it comes to things like the quality-based procedures, would be a great improvement.

The Chair (Mr. Ernie Hardeman): Thank you very much for your questions. Mr. Milligan?

Mr. Rob E. Milligan: I'm fine. I don't have any.

The Chair (Mr. Ernie Hardeman): Okay. Ms. Gélinas.

M^me^ France Gélinas: I thought I knew your hospital way better than I realized. You're an ambulatory care hospital, but how many beds do you have?

Mr. Michael McDonald: We don't have any beds, per se. We do have a short-stay surgical program, so patients do have a short stay between one day and two days. But the balance of that is ambulatory. So we don't really have any beds, like in-patient beds to stay.

M^me^ France Gélinas: That's what I thought.

Mr. Michael McDonald: Yes. So we're not like St. Joseph's, for instance, where they have 30 beds and they're an ambulatory centre. We don't really have any beds, but we do run short-stay programs—preliminarily, the short-stay hip-and-knee program.

M^me^ France Gélinas: Okay. So, basically, you came up with this idea and, through seed funding from the LHIN, it came to fruition and got the good results you shared with us. I'm trying to see the value added at the LHINs. Do you think you couldn't have been able to convince the ministry to invest into seed money to do something like that?

Mr. Michael McDonald: I don't know. I know that the LHIN really believed in this and could see the regional effects of it, so we were able to get the money that way. I can't answer your question of whether I could have convinced the ministry or not.

M^me^ France Gélinas: That's okay. Piggybacking: I really want to see what the value added of a LHIN is for a hospital like yours. What is the role of the LHIN? Does it help to have a LHIN here, except for the seed money that you talked about?

Mr. Michael McDonald: Yes, I think as we move forward as an ambulatory centre, building on what is possible in the health care system, working with the LHIN, they have a very good understanding of what we are and where we're going. I think that, working closely with them, there's an understanding. And so, when we come up with ideas and we present our ideas, they listen, and they always have kind of a regional look to it as well as a local lookout. We have a very good relationship working with the LHIN, and I really do see the value in working with them.

M^me^ France Gélinas: Has your relationship with other parts of the health care system changed because of the LHINs, either with home care, long-term care, community care or mental health?

Mr. Michael McDonald: Yes. I think that the LHIN is bringing a lot of those organizations—especially with health links, for instance—to the table, and then encouraging us to work together to understand the system as a whole.

M^me^ France Gélinas: You mentioned when you were asked how you make things better that sometimes it takes a long time to get answers. Do you put this delay at the level of the LHINs, at the level of the government, at the level of communication between the two, or all of the—

Mr. Michael McDonald: The level of communication between the two, I would think. For instance, recently we were looking at cataracts, trying to find out if we're able to get more cataracts and so on. There have been a number of calls placed to the ministry, but we have not heard back from the ministry with regard to an answer on that.

M^me^ France Gélinas: Not heard back, or did they redirect you to the LHIN, or simply—

Mr. Michael McDonald: No, the LHINs made the call to the ministry.

M^me^ France Gélinas: Oh, it's the LHIN who made the call on your behalf?

Mr. Michael McDonald: Yes.

M^me^ France Gélinas: Did you try calling the ministry yourself?

Mr. Michael McDonald: We have not.

M^me^ France Gélinas: No? You go through the LHINs?

Mr. Michael McDonald: We go through the LHIN.

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

Mr. Michael McDonald: Thank you.

PRINCE EDWARD COUNTY COMMUNITY CARE FOR SENIORS ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next presentation is the Prince Edward County Community Care for Seniors Association: Debbie MacDonald Moynes, executive director, and Margaret Werkhoven, president and chair.

I guess I must have introduced someone in their absence—but thank you very much for being here. If you would be so kind in your opening presentation to make sure that Hansard knows which one of the two arrived today. You will have 15 minutes to make your presentation. You can use any or all of that to make your presentation. If there's any time left over, we will have questions and comments.

Ms. Margaret Werkhoven: Thank you. Good morning, Chair Hardeman and honourable members of the Standing Committee on Social Policy. My name is Margaret Werkhoven, and I am the president and chair of the Prince Edward County Community Care for Seniors Association, a retired superintendent of education with the Hastings and Prince Edward District School Board and a founding member of the board of the South East Local Health Integration Network.

With me today was supposed to be Debbie MacDonald Moynes, who has been the executive director of this health service provider agency for over 30 years. I'm very sorry that she wasn't able to join us; she had a dental emergency and went to see the dentist this morning. She hoped to be here but, despite a fair bit of Tylenol, she has had to go home rather than coming. I know that you would have enjoyed having her, because she is someone who has been in community support services for a very long time and knows all the answers to any questions that you might have about our services.

Our agency, a member of the Ontario Community Support Association, exists to support seniors living at home. We operate with eight full-time staff members and seven contracted nurses, and with the support of 500-plus volunteers and a governing board of 10 elected members. Our annual budget is approximately $500,000; 60% of our budget is funded by the South East Local Health Integration Network, and the remaining 40% by fundraising, donations and client fees.

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A major source of our revenue comes from two thrift shops we operate in Picton which are staffed exclusively by volunteers. The community support services we offer throughout Prince Edward county include Meals on Wheels, congregate dining, transportation for medical appointments and shopping, foot care clinics, walking programs, home maintenance, respite, home help, rural route and telephone reassurance, friendly visiting, and help with forms, including income tax. In short, we provide whatever services seniors identify as needed to continue to live at home. On an annual basis, we provide support for about 1,000 seniors, using over 15,000 volunteer hours.

Your committee's task, as we see it, is to review the Local Health System Integration Act. Our task, as we see it, is to give you our perspective on our South East Local Health Integration Network and, by extension, on the LHIN model. This is a homegrown presentation. We don't have the resources to supply you with a comprehensive and sophisticated package of materials in support of the statements we make. Our views are based on the diverse personal experience of two individuals who are deeply involved in their communities and passionate about their agency's work, and who believe that the way to create a system of health care that is effective and sustainable is to pay more attention and provide more support to community-based health care and to foster a culture of disease prevention and wellness.

The basic question that we believe you are addressing is, "Do we keep the LHIN structure set up in 2005, modify it, or scrap it and start all over again?" Our response would be, "Keep it and tweak it." We have to say up front that it would be very helpful to all of us in the business of providing health-related services in our communities if you could all just speak with one voice on the matter of LHINs.

LHINs are not yet perfect in practice, but the basic concept of local management of health care, including planning, coordination and funding, vested in an organization which is independent of current health structures, makes good sense to us. Wondering from year to year and from election to election whether the LHIN structure will endure creates a level of uncertainty in the system that is counterproductive. It reminds me, frankly, of teachers who used to say, when new program initiatives were introduced, "Another bandwagon. This too shall pass."

The chaos that would inevitably ensue with a brand new approach would set us all back and would distract us from our main business of providing support for seniors. One thing I learned from 35 years in education is that you have to assume a five-year implementation cycle for a new program initiative. The LHINs have a huge challenge. They are not trying to implement a program or two; they are responsible for transforming a complex and multi-tiered health system. They need time and support from all of us to achieve that transformation.

We would give our local South East LHIN a strong B-plus. I'd venture an A-minus, but you might accuse me of having a bias. I can tell you from personal knowledge that the South East LHIN has a hard-working and dedicated chief executive officer and staff, along with a talented chair and board members that take their responsibilities very seriously.

We believe that together they have done a good job in a number of key areas. They have engaged local communities in meaningful ways in the development of three Integrated Health Service Plans through the use of citizens' forums, open houses, and Web-based surveys. They have found ways to involve primary care physicians not covered by LHSIA in developing a road map to coordinate hospital and clinical services across southeastern Ontario. They have given community support service agencies a place and a voice at tables to which these agencies had not been invited in the past. They have made collaborative governance a priority and have had, since 2006, a collaborative governance team with cross-sector representation. They have established seven health links which cover the whole of the LHIN and which are seen as a very positive step in care coordination for our most vulnerable citizens.

There are 120-plus health service provider agencies in the South East and about 1,000 board members associated with those agencies—volunteers who work hard to support their individual agencies and who have worked together in ways not thought of, let alone carried out before LHSIA, to achieve the vision for health care articulated by the ministry and by the LHINs.

The LHIN has made "accountability" a word with force and power among health service providers in southeastern Ontario. When our South East LHIN was first set up, its staff and its board had to work very hard to be taken seriously by the big players; that is, hospital and CCAC administration and boards. Hospitals especially were accustomed to running deficits and asking the ministry for bailouts, and seemed to believe initially that life shouldn't be any different under the LHIN. Because LHSIA gave the LHIN the power to make them comply through performance improvement plans and to make them balance their budgets, they did.

In the intervening years, the tone has changed significantly. Hospitals and the CCAC and their CEOs and boards make public statements about the direction of health care which echo those of the LHIN and its board. The collaborative relationships among the seven hospitals in the southeast are stronger.

The LHIN has also drawn community support agencies into discussions with hospitals and the community care access centre, which are now making far better use of our services than they once did. Emergency room diversion programs and hospital-to-home transition programs have helped get frail patients home from hospital and keep them out of emergency rooms. Those connections between hospitals, the CCAC and community agencies still have a long way to go, but they are well started, from our perspective.

What does our LHIN need to do to get an A-plus from us? First, they need some help from you, the legislators. They need to have the LHSIA implemented for real—and extended. Local health networks were intended to provide community-based decision-making. Central decision-making—that is, decisions made on behalf of local communities by the Ministry of Health and its regional offices—was to devolve to local integration networks. It doesn't seem to have played out that way. The regional offices were dismantled, but the ministry itself has grown significantly larger. Many of the big decisions—for example, re base funding—still come from the ministry. As a result, the flexibility of the LHIN in dealing with the funding needs of its health service providers seems more limited than it should be.

As well, two significant groups were not included in LHSIA: primary care physicians, except for those associated with community health centres; and health units. The South East LHIN has worked hard to cultivate good working relationships with physicians and the three health units in the region. We do not know if more formal relationships with these groups are necessary, or even possible, but we do believe that local system health planning will only be successful if there are strong connections among LHINs, physicians and health units.

Our focus is on keeping seniors in their own homes for as long as possible, through programs which support their good health and well-being, and which help them to continue to feel part of their local community. We hear much talk from both the ministry and our LHIN about the need to shift focus from acute care to community care. It feels mostly like talk, though. The indicators in our M-SAA, for example, are all derived from acute care targets. While we appreciate that our agency's work has an impact on wait times and alternate-level-of-care days and the number of emergency readmissions, we think that our work would be seen to have more value if some indicators referred specifically to the work we do.

A significant issue for us in our sector is reliable base funding. Although the ministry mandated a 4% increase in funding for community-based care, that money must be spent on specific projects identified by the LHIN to address provincial and local priorities. None of it can be used to support increased base funding for agencies like ours. The message is clear: Community support services agencies will have more to do, and will have to fundraise harder and recruit more volunteers to do it.

If the work of our agency were viewed more positively for the impact that it has on seniors living successfully

at home—and our staff, for the equally important work they do for those working in other parts of the health care system—then perhaps it would be easier for the ministry and the LHIN to see that funding of the CSS sector is just as important as funding for the hospital and CCAC sector. It might also make it easier for us to recruit staff into community-based health. The wage differential between equally qualified staff working in hospitals and CCAC settings and in community settings makes it difficult for us.

I'd like to introduce Debbie MacDonald Moynes, who—Tylenol-enhanced and all—is here. Thanks, Debbie, for getting here.

I was talking about the wage differential between qualified staff. Higher wages suggest higher value. We don't see a ready solution, but we want you to know of our dilemma. Essentially, base dollars have to shift, and LHINs need to be able to make that shift.

In the early years, our LHIN has, of necessity, given much of its time and energy to the organizations to which the bulk of health funding has traditionally gone. One of its challenges in shifting its focus to community-care-based organizations is that there are so many of us.

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One of the original selling points of the LHIN made-in-Ontario model was that it retained the governance structures already in place. We see our LHIN struggle with keeping track of 120-plus health service provider agencies and boards. While we believe that integration of both services and governance is sometimes a good option, we want to see integration happen only when it is clear that integration will lead to improved service for clients and not just to simpler administration for LHINs. Our staffs and boards have a wealth of experience and commitment. We would like to see our LHLN take better advantage of that experience, by setting up structures to ask for and take our advice more often. We are guided by the same vision and are pursuing similar objectives. We need to work more closely together, at both the staff and board level, as partners.

There have been tool kits created to help boards learn of their expanded responsibilities in a LHIN environment, but there are no guidebooks that we know of for how LHINs should work with their many providers and boards. Developing good relationships based on mutual respect is essential and requires exceptional skill and sensitivity on the part of the partner with more power; that is, the LHIN.

To summarize: We are proud of the work that our Prince Edward County Community Care for Seniors Association does in our community, with financial support from the taxpayer and with incredible support from volunteers in the community itself, support which often goes unnoticed and undervalued until it is put in jeopardy. We appreciate and value the work of our LHIN, as well, and believe that the better way forward for the province of Ontario is to work out the kinks in the LHIN model.

Thank you very much for listening to us this morning.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We do want to recognize the arrival of Debbie MacDonald Moynes, the executive director, who I'm sure was detained by a painful experience. It was mentioned that you'd had a dental appointment. With that, we just have a very short question from the PC Party. Mr. Clark.

Mr. Steve Clark: Thank you very much, Chair, and I apologize for being late. I was at one of my local chamber of commerce meetings. I want to extend to you best wishes from your member of provincial Parliament, Todd Smith—

Ms. Margaret Werkhoven: Thank you.

Mr. Steve Clark: —who was unable to be here, but he wanted me to make sure that I extended his best wishes on the work that you do in his riding.

One of the things that I did catch as part of your presentation was a reference to fundraising. Do you see that the LHIN model, the way it has been created in the province, has required that more community agencies have had to fundraise? I know in my own riding, in Leeds and Grenville, that's a big concern: the amount of health care dollars that now have to be fundraised in the local community. Is that something that is a big issue in Prince Edward?

Ms. Margaret Werkhoven: I think from a historical perspective, that's a question for Debbie to address.

Ms. Debbie MacDonald Moynes: Is that how we turn it on?

The Chair (Mr. Ernie Hardeman): It'll start on its own.

Ms. Debbie MacDonald Moynes: It comes on by itself?

Mr. Steve Clark: It's magical.

Ms. Debbie MacDonald Moynes: Thank you. Fundraising is something that we've always had to do in the community support services sector and those agencies that support seniors, primarily, to live at home, through Meals on Wheels and transportation and services such as that. Because of no increases to base funding, that's part of the reason why the fundraising has to continue and seemingly continues to grow.

Ms. Margaret Werkhoven: I just—

The Chair (Mr. Ernie Hardeman): Very quickly.

Ms. Margaret Werkhoven: Just to say that fundraising is significant for us, but it's also something that we wouldn't want to see disappear altogether, because fundraising in a local community gives a community a sense of ownership. When you see what happens with the sense that hospitals have when—

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

Ms. Margaret Werkhoven: Okay. Is that it?

The Chair (Mr. Ernie Hardeman): That does conclude the time.

Ms. Margaret Werkhoven: Thank you very much.

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

CENTRAL EAST REGIONAL SPECIALIZED GERIATRIC SERVICES

The Chair (Mr. Ernie Hardeman): Our next presenter is the Central East Regional Specialized Geriatric Services: Kelly Kay, interim executive director, and Glenna Raymond, chair of the board. Good morning, and thank you very much for being here. As with the previous presenters, you will have 15 minutes to make your presentation. You can use any or all of that time for that presentation. If there's any time left over, we will have questions from our committee. With that, your 15 minutes starts now.

Ms. Glenna Raymond: Thank you very much. Good morning, Mr. Chair and members of the committee. I'm Glenna Raymond. I'm pleased to be here along with Kelly to speak with you this morning.

Central East Regional Specialized Geriatric Services was actually created by the Central East LHIN to improve coordination and system-level planning of specialized geriatric services. Our current strategic priorities include fostering excellence among specialized geriatric service providers; improving care for frail older adults, with an aim to keeping them at home; and increasing awareness of age-related needs. We work as a regional system to create that person-centred system of care together.

The RSGS is pleased today to participate in your review. We would like to share some experiences and some examples that illustrate our work within the Central East LHIN to improve availability and coordination of services. These experiences and examples I hope will illustrate for you an effective partnering between older adults themselves, their care providers and the local health integration network, a network that is keenly aware of and responsive to the needs of its communities, which is possible within the umbrella of the current legislative framework.

Ms. Kelly Kay: Hello. My name is Kelly Kay. I will try to keep our comments fairly short so there's an opportunity for questions.

In the Central East LHIN, specialized geriatrics includes several formal programs that are listed as examples in your handout. To set the context for our region, we have shared some information from a local study of health needs and system capacity that was recently completed by our organization. This planning work has been critical to informing priority setting and service planning for frail older adults across the Central East LHIN. We have provided details about the population of frail seniors that is the focus of our work, and you'll find that on the front page and on the second page as well.

Recently, the advice of the RSGS was sought by the Central East LHIN to inform more than $27 million in community investments, including services for older adults. While the act empowers the LHINs with the responsibility for resource allocation, it also enables advice from the field to inform these decisions and provides the mechanism and flexibility for local innovation and implementation.

The expansion of geriatric assessment services illustrates service design and implementation that prioritizes community engagement. Our consultative approach involves multiple partners and prioritizes the input of older adults and primary care providers. As a result, access to coordinated interprofessional assessments and interventions for older adults experiencing frailty and complex health concerns is expanding in our region.

The focus on interprofessional teams and flexible funding parameters allows us to address both regional and local needs in a cost-effective manner. This optimizes health human resource capacity and leverages local support. I offer you an example of that leveraging in the handout, whereby there are 11 organizations involved in this network of providers offering geriatric assessment services that are hosting a total of 100 individuals who are providing direct service, and also supporting that work with an additional 20 providers coming from their own organizations.

The RSGS has also convened a senior-friendly hospital working group, which includes representation from all nine hospitals in our LHIN. The structure of the legislation enables such collective work, including, in our case, the development of plans that build on provincial priorities and impact the acute-care experience for older adults. This approach for collective action locally holds promise for knowledge exchange of best practices and efficient use of scarce resources and expertise.

Addressing the needs of frail seniors requires a diverse group of partners and contributors, some of whom are not within the current LHIN scope; for example, some primary care providers. We need to find continued ways to bring multiple stakeholders and sectors to the table for a shared purpose.

In collaborative arrangements, governance is complex, and time and attention is needed for stakeholder communication as not all are operating under the same parameters. System design and improvement initiatives require front-line caregiver involvement. Their presence is critical to informing the long-term plan; however, the short-term cost of their involvement is the availability of patient appointments.

Ms. Glenna Raymond: Some things that we want to pay attention to in driving for the future: We want to ensure that there is equitable access to specialized seniors' services across all areas of a very diverse geographic area and that the planning for those services is based on solid data and capacity- and needs-assessment studies like the ones that we've completed locally. Secondly, we need to help address the public's understanding of the options and opportunities that are available to them in services, and we need to advocate for the best care for older adults. We're very pleased that the public and providers together are engaged in advising the funding allocations that make those opportunities possible.

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Thirdly, while we have seen providers accept accountability beyond a single organizational focus and they have come together as a network with accountability, we need to find better ways to measure the impact of that work and the impact on the health of the population beyond service utilization measures, like system volumes or counting visits, for example.

In addition, the collective work enabled by the legislation has tremendous benefits, but it is essential that the challenges are best understood and addressed with local flexibility, with opportunity to leverage local relationships and build local capacity. Both users and providers have expertise to inform new programming and resource allocation, and they should be supported to participate at a system level.

The enabling framework needs to be strategically aligned with the provincial health care priorities, but we recognize that this engagement takes time and has implications for short-term service delivery. The governance complexity is because there are multiple partners and stakeholders involved in any initiative, and yet that collective action is where the tremendous benefit comes from.

We hope we've left time for your questions and discussion, and we hope that some of these examples stimulate your thinking about what's working well and where there may be a need for increased attention.

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

We do have about seven minutes left. It starts with the opposition. Mr. Milligan?

Mr. Rob E. Milligan: Thank you very much, ladies, for coming here today. It's always good to see you.

I guess you've sort of touched on one of the things that I hear consistently from patients or constituents who have loved ones who have received service. It's not necessarily the service that they've received per se, but what I'm hearing is this concern: that the current model that's in place for the LHINs—I don't know if the money flows are a problem or an issue. But it would seem that in the shift to community-based services, there isn't the money—even though the current government has said there is money and that's the focus. But what I'm hearing back is that those services aren't always necessarily in place to provide the services that are required. Of course, the area, given the demographics of Northumberland county, is quite an elderly, retirement community in a lot of senses. So this is what I'm hearing. Is this a concern that you have? How do we expedite, given the LHIN's role in how we get funding from the government, to make sure that those services are in the community and people are getting the care that they need?

Ms. Kelly Kay: I think you raise a very good example. Thank you very much. That's something that's of great concern to the people who live within our region. I think that that has helped to inform the decision-making that our LHIN recently went through to direct $27 million towards community investments. A large proportion will impact directly the care of frail seniors, which is really intended to help keep people at home. That was what we heard from seniors and their families: that they really want to stay at home as long as possible.

We worked to advise our LHIN, which responded by directing investment specifically for that purpose—so the creation of new positions, the expansion of geriatric assessment teams from four to 10, the creation of system navigation roles that will help to support people move through the system, which we also hear to be a challenge for individuals. Certainly there is a team that has been located in the county that you speak of. I think that that's where we've seen an example to have the opportunity—

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

The third party: Ms. Gélinas?

M^me^ France Gélinas: Two things that you mentioned: the first one having to do with bringing primary care providers into the tent; and the second one, not being happy with indicators. I'll start with the first. Locally, do the primary care providers feel that they're ready to come into the tent?

Ms. Glenna Raymond: I think that one of the very successful efforts that the RSGS has been able to engender is providing an opportunity and a forum for those providers to come together. That may not have happened previously. By inviting them, encouraging them and including them in the decision-making and the discussion at every stage of the design work, whether it's part of the governance board, where we have willing primary care providers sit as members of the governance team, right through to the programming and advisory work and design work that the staff are carrying out—I think there is a sense of readiness to participate very much.

M^me^ France Gélinas: My second, about indicators: Do you have input as to what kind of indicators you will be evaluated on? Some of them don't work for you, obviously.

Ms. Kelly Kay: Yes, we do. In fact, part of the task of our design work is to define the indicators that make a difference in terms of specialized geriatrics. While visit volumes do have relevance—not to say that that's not an important indicator—there are other indicators that are particularly important to a frail senior population, where visits are much longer, so volumes look a lot lower when you compare them against things like acute-care visits. We certainly do have that opportunity to influence the metrics that are to be collected.

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

Ms. Helena Jaczek: Thank you very much for coming in and explaining about the model that has been instituted here in Central East by the LHIN.

I'm just a little puzzled. What is your relation to the CCAC?

Ms. Glenna Raymond: The CCAC is a member of our network as well. They have a position on the RSGS board and are fully engaged in the work that we do as

well. But the RSGS is a broad collection of all providers, including community support, primary care, the acute-care hospitals, the specialized mental health sector and the CCAC.

Ms. Helena Jaczek: So you bring your collective wisdom to the LHIN board? Is it sort of board to board? How do you work together?

Ms. Kelly Kay: In a couple of different ways: certainly at the board level, but we also work directly with LHIN staff in providing oversight to their programs and actually doing the design work.

Ms. Helena Jaczek: One of the criticisms we've heard across the province is that there's too much administration. I think it could be perceived that somehow we've got an extra layer in here between dollars and front-line staff—the work on the ground. How would you react to that?

Ms. Glenna Raymond: I think it's an opportunity to bring together consumers, users of the service, the very broad range of service providers and the LHIN all together in one forum, in one table, with a mandate to do system planning, program design, and communication and advocacy in terms of older adults. There is tremendous value in that engagement that is happening with that collective and collaborative effort. It's not just an extra layer; it is adding tremendous value in programming, in design and in decision-making.

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

Thank you very much for your presentation. It's much appreciated.

LEEDS, GRENVILLE AND LANARK DISTRICT HEALTH UNIT

The Chair (Mr. Ernie Hardeman): Our next presenter will be the Leeds, Grenville and Lanark District Health Unit: Jennifer Labelle, public health nurse. Thank you very much for sharing your time with us this morning. As with the previous delegations, you'll have 15 minutes to make your presentation. You can use all or any of that for your presentation. In what time is left of the 15 minutes, we'll have questions and comments from the committee. With that, the clock starts now and the rest of the time is yours.

Ms. Jennifer Labelle: Thank you, Chair and committee. I'm here today to talk about my experience with the provincial Integrated Falls Prevention Framework and Toolkit of July 2011, which identified falls prevention as one of the key pan-local health integration networks' priorities in September 2010—and the ratification of it as a priority by every LHIN CEO in October 2010.

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The main objective of this document is to "improve the quality of life for Ontario seniors aged 65 years and over and lessen the burden of falls on the health care system by reducing the number and impact of falls." The report states that "A LHIN-wide integrated falls prevention program must be implemented in each LHIN catchment area." Supporting the integrated falls prevention document, the South East LHIN acknowledged the importance of falls prevention in its Integrated Health Service Plan for 2013 to 2016, stating that it would work with public health, community care access centres and long-term-care homes to develop a regional approach to falls prevention that aligns with the provincial falls prevention tool kit.

Both documents align well with the Ontario Public Health Standards of 2008. "Public health units are required to take action to reduce falls as articulated in the public health standards." There is an excellent match with the health units' requirement to work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs and the creation of safe and supportive environments to prevent falls in people 65 years and older and the integrated falls prevention program. It addresses the use of comprehensive health promotion approaches to increase the capacity of this population to prevent injury through collaboration with and engaging community partners, mobilizing and promoting access to community resources, providing skill-building opportunities and sharing best practices and evidence for the prevention of injury.

Public health units are experts in the application of communication and social marketing to educate the public on the issue of falls prevention, but there are challenges to reaching and influencing the intended audience. Health promotion and preventive measures mainly target healthy and low-risk seniors who may not necessarily be 65 years or older, promoting healthy lifestyles and the social determinants of health to prevent falls from occurring in the first place. The results from these interventions will not be realized for many years.

Research tell us that many older adults reject falls prevention advice because they view it as a hazard reduction, or the use of aids such as canes and walkers as a restriction on their activity or as not relevant to them because it is only necessary for older, disabled individuals. They find the messaging patronizing and a threat to their identity as well as their independence.

There is important work for health units to carry out, but the impact that can be made for individuals and the health care system is limited if we work alone. The burden to lessen the risk of falls cannot fall on the shoulders of the seniors themselves. For those with complex health issues, there is no amount of lifestyle change that can overcome the side effects of medications and declining function due to age.

With this in mind, the provincial Integrated Falls Prevention Framework and Toolkit explains the importance of ensuring that the majority of seniors aged 65 and older should be screened or assessed for risk of falls at multiple points, including self-assessments. To match appropriate interventions to individual needs, screening and assessment is the first step in determining the most appropriate individualized interventions. This crucial step

can only be achieved within the context of an integrated system to develop common screens and tools and to co-ordinate multiple partners to reach seniors at multiple points and a database of available interventions.

An essential component of the LHIN-wide integrated falls prevention program is an understanding by health care providers and caregivers of the screening, assessment, referral and treatment protocols to follow when encountering people who are at risk of falling. Working individually and in isolation, no one will have the ability to connect all the pieces that make up a program such as this. This is why a LHIN-wide intervention is so important to leverage available resources. It will take the involvement of all the relevant health care organizations at a local level, including LHIN-funded, non-LHIN-funded and private organizations. There are many falls prevention initiatives being implemented by numerous organizations; therefore, it is crucial that each LHIN-wide integrated falls prevention program is aware of such initiatives to be able to appreciate, coordinate and integrate with them.

At this time, a database of such initiatives does not exist within the South East LHIN catchment area. One way to ensure this understanding is through a LHIN-wide referral algorithm that outlines agreed-upon protocols and all the interventions available to seniors within the LHIN in which they reside. All of this must be supported with targeted education directed not only at seniors, but also formal and informal caregivers, health care providers and community members.

The catchment area of Leeds, Grenville and Lanark District Health Unit falls within two local health integration networks: the Champlain region and the South East. Understandably, there are differences in the two LHINs. The Champlain LHIN approached us in November 2012 as it prepared to move forward with its integrated falls program. The Champlain program starting operating in one geographic sub-region, and, as it expanded outwards, the people of North Grenville and Lanark started questioning why they would not have access to falls prevention programs they'd heard about in regions closer to Ottawa.

Currently, the program is set to expand into the north Lanark and North Grenville areas, where many residents, their caregivers and health care providers are anxious to have access to the services provided through the falls prevention programs. When the expansion of the Champlain LHIN reaches it borders, that is where an integrated falls prevention program will end for the people under the catchment area of the Leeds, Grenville and Lanark District Health Unit, vastly limiting falls prevention intervention for parts of the community.

In the geography serviced by the South East LHIN, there are a number of individuals and organizations who are passionate about falls prevention. Organizations such as Community and Primary Health Care and Country Roads Community Health Centre are doing great work, such as providing exercise classes. As spelled out in the provincial Integrated Falls Prevention Framework, their ability to have an impact on the number of people suffering falls is greatly diminished with the lack of coordination and integration.

The health units of the South East LHIN—Leeds, Grenville and Lanark; Kingston, Frontenac, Lennox and Addington; and Hastings and Prince Edward counties—reached out to the South East LHIN in October 2012, hoping to initiate interest in the integrated falls prevention program. We were hoping to start with an assessment of the current falls prevention initiatives in the South East LHIN catchment area, but to date there has been no word of any progress. With new concerns, such as the changes in OHIP funding for physiotherapy exercise classes, we are concerned that the new priorities will compete with limited resources and there will never be an integrated falls prevention program in the region.

As part of the health unit's accountability agreement with the Ministry of Health and Long-Term Care, the Leeds, Grenville and Lanark District Health Unit will continue to monitor the rates of injuries related to falls that result in emergency visits in adults aged 65 years and older. It is foreseeable that the change will not be favourable for regions that will see no change in current interventions.

An additional concern is that if there's no LHIN-wide integration plan in place for the South East, the population will not be able to benefit from any provincial structure that may be created in the future. This lack of progress in implementing a LHIN-wide program will affect the quality of life for many seniors, as well as have a negative impact on health care in general and the costs associated with it. It's imperative to do more than to write about frameworks and tool kits for falls prevention. The programs must be developed and implemented.

As public health nurse practitioners, we are guided by the Ontario Public Health Standards. One of the requirements is to influence development and implementation of healthy policy and programs and the creation or enhancement of safe and supportive environments that address falls across a lifespan, including falls in people 65 years and older.

As a public health professional, I would advocate not only for the writing of the documents, such as the provincial Integrated Falls Prevention Framework and Toolkit, but the development and implementation of the falls programs for all citizens of Leeds, Grenville and Lanark. By presenting today, I'm hoping to encourage the implementation of the initiatives reported in the falls prevention document.

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

We have six minutes left, so we'll have two minutes from each party, starting with Ms. Gélinas.

M^me^ France Gélinas: This is really unbelievable, because we started the day being told that the South East LHIN had the highest population of people 65 and over. They described the region as being really focused on the needs of the elderly population, yet the South East LHIN did not implement the falls prevention, and the Central

East, that never presented to us for their high population of 65 and over, did. This is what you told us.

Ms. Jennifer Labelle: This has been my experience so far.

M^me^ France Gélinas: All right. We're here to look at the LHINs. Did you do things differently with Champlain than the South East that could lead to those different results?

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Ms. Jennifer Labelle: I did not do anything with the Champlain. They came in and invited us in. They've been quite open. They've been inviting us to any workshops, any programs that have been going on. They've been open about anything they've been doing. And even before they started expanding into our area, they came to us to invite us into that network.

M^me^ France Gélinas: The same thing did not happen with the South East?

Ms. Jennifer Labelle: In the South East, we contacted the LHIN, hoping to have a meeting. We had one meeting, and there was supposed to be a follow-up meeting in a few months. The person we had contact with—we're not sure what happened. That person is not there anymore, and there was no more contact. When we tried again, it was difficult to find who was responsible for this area.

M^me^ France Gélinas: Is this typical of health unit programs—

The Chair (Mr. Ernie Hardeman): Thank you. Next? Um, Ms. Jaczek.

Ms. Helena Jaczek: You should know me by now, Ernie. We've spent the last eight days together.

The Chair (Mr. Ernie Hardeman): It just got me so frustrated—flustered.

Ms. Helena Jaczek: Thank you so much. It's great to see a public health professional here. As a former medical officer of health, one of my great frustrations with the LHIN boundaries has been that they're not coincident with public health units. We've heard from many deputants that, in fact, they would like to see public health integrated within the LHIN, but given that kind of structural anomaly, that would be a major, major shift. So thank you for sharing the frustrations on the ground.

In terms of moving forward—I mean, obviously, this must be well known between the Champlain, South East and Central East—has anyone come up with solutions at the LHIN level to see how we can make sure that this important program gets disseminated?

Ms. Jennifer Labelle: We've made no headway. It's getting to be that maybe it would be better to work without the LHIN, because it's taking too much energy to be able to build those relationships.

Ms. Helena Jaczek: Okay, thank you.

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

Mr. Steve Clark: Thanks very much, Chair. Jennifer, I want to thank you for your presentation. I know you know that I share your frustration. I have to say something nice: Since Donna Segal took over at the LHIN, at least I'm able to get regular meetings with the LHIN, which I couldn't get with Ms. Thompson in the chair.

Mr. Huras is sitting there. He knows my feelings. It drives me crazy that I have two LHINs covering my riding, and there are two different standards. Dealing with Champlain and dealing with South East can be very, very different, and I think that's a challenge. When I challenged Mr. Huras, back when I got elected in 2010, to prove to me that the services that we get in Leeds–Grenville are comparable with other LHINs, that wasn't able to be given to me, and that's something that I think is very important for a member of provincial Parliament.

When they get these examples—I've gotten this example at my office several times from the folks in North Grenville: "Why can't we have these services in Brockville?" —or Gananoque or up in Portland, for example, in the rural area in Leeds. I think this is the frustration that I have with the LHIN system: You have these inconsistencies, LHIN-wide, where you have a health unit that covers the entire riding.

I think, really, if there's one good thing that can come out of this review, it's that we need that more consistent model moved forward—especially when I read in this presentation that the LHIN CEOs agreed with a pan-LHIN model across Ontario. To me, if you're going to agree, you have to provide the proposal.

Sorry that I'm rambling on, but I do want to thank you, and if you've got any other comments, I'd love to hear them. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. We didn't leave any time for that comment to be heard.

Mr. Steve Clark: Sorry.

The Chair (Mr. Ernie Hardeman): But we do thank you very much for your presentation. It's much appreciated.

PATRONS OF OUR COUNTY HOSPITAL

The Chair (Mr. Ernie Hardeman): Our next presenter is Patrons of Our County Hospital: Betsy Sinclair, vice-chair; Jane Wallenberg, secretary-treasurer; and Ian Batt, member.

As you're getting seated, thank you very much for joining us this morning. As with the previous delegations, you will have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's any time left at the end, we will have questions and comments from the committee. That's not necessarily a prerequisite. With that, we start the clock, and it's your 15 minutes.

Mr. Ian Batt: Thank you, Mr. Hardeman. Good morning, ladies and gentlemen. My name is Ian Batt, and I belong to a group called Patrons of Our County Hospital, or POOCH for short.

We are a community-based group of volunteers whose mission is to ensure the proper stewardship of the only hospital in rural Prince Edward county; namely, Prince Edward County Memorial.

In 1999, the Honourable Allan Rock said, "We can never accept the notion of limited access to health care for the one third of Canadians who live in rural and remote Canada. Geography cannot become an excuse for inequality."

While the challenges to the health care system are great, we hope our presentation today will cause you to address a continuing and singular lack of stewardship and response by the provincial government and its local bureaucrats to the voices of the residents and stakeholders of our county hospital.

Briefly stated, since 1998 our hospital has been subjected to a disproportionate number of cuts to acute-care beds, hospital services, nursing staff and support workers. The vast majority of these services have been relocated to Belleville General Hospital, and more are anticipated this fiscal year.

The South East LHIN is complicit in these reductions. The local health integration network act of 2006 requires the LHIN "to set up requirements for community engagement" while, at the same time, "it requires service providers to comply with LHIN decisions on integrating services." If that's not enough clout, the act "provides the minister with the power to integrate service providers in certain situations." Where is the participatory democracy in this structure?

We are calling on this committee to take action to accomplish the following: Reboot the LHINs—and the word "boot" is maybe appropriate—to clearly become the stewardship-oriented entity that they were reconfirmed to be by the provincial government in 2006. How?

Some highlights would include appointing a broadly based panel of elected municipal and provincial representatives and local doctors to report within six months to the cabinet with recommendations related to:

—reviewing the LHIN model and its functionality, particularly as it relates to its stewardship role;

—considering the implementation of a fully transparent and open process within all LHINs and their individual hospitals, including, but not limited to, planning, finance and administration;

—contemplating the thought that bonuses are not automatically paid for just doing the job or retiring on time;

—reviewing the benefit of putting all privatization opportunities through an independent vetting process, with the final say resting with the minister; and

—appointing a LHIN-focused ombudsperson with teeth.

Frankly, we lay all our issues and disappointments at the feet of the LHINs' masters. It is the provincial government which needs to give stewardship and transparency their rightful place in Ontario's health care system.

Thank you for your courtesy.

Ms. Betsy Sinclair: Good morning. My name is Betsy Sinclair.

By the spring of 2013, with more Prince Edward county hospital cuts on the way—politically referred to as service integration—most of the residents of Prince Edward county were fed up. Four busloads of ordinary citizens carrying a petition with well over 5,000 signatures headed to Toronto to meet with the minister, Deb Matthews.

The infamous letter from her that arrived in June basically said no to de-amalgamation and, in future, to get approval from Quinte Health Care and the South East LHIN before coming again.

Have no doubt: The LHIN is a corporate animal which, by its very nature and legislation, requires all to submit to its programs and initiatives, regardless of the human fallout.

In October 2013, POOCH became aware of a document entitled Local Health Hubs for Rural and Northern Communities, sponsored by the Ministry of Health. As per the minister's instructions, we approached Quinte Health Care. POOCH was supportive of the document because it contained new and innovative approaches to rural communities that the present system simply ignored. Was it perfect? No, but it certainly went a long way to improving relationships and issues of local governance which we believe any government must be sensitive to in dealing with a rural community.

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To our astonishment, we were informed that Prince Edward County Memorial Hospital is not a rural hospital; it is a "small" hospital. Prince Edward county is an agricultural, tourist-based, rural island economy, and we fit the definition of a rural hospital as outlined in the Hub document. Change a word and you change the outcome. Prince Edward County Memorial Hospital has been excluded from participation. In communications regarding "small" versus "rural," Quinte Health Care indicated that their decision to have Prince Edward County Memorial Hospital declared "small" versus "rural" was based on the 2006 Core Service Role of Small Hospitals document and the Hub document of 2012. We have these documents. "Small" refers to the number of weighted cases and does not exclude the use of the term "rural," which by definition is a geographic term. Prince Edward County Memorial Hospital has always been a small, rural, B2 hospital.

Further investigation indicated that Quinte Health Care, in April 2013, used both these sources for a motion at their board meeting to determine the future of the four Quinte Health Care hospitals. One has to ask why, if they had most of this information in 2006, they waited seven years to act on it. If one had a suspicious nature, one might conclude that with the publication of the Hub document imminent, they preferred a pre-emptive strike against any possibility of discussion or actions by the citizens of Prince Edward county.

Again, in the spring of 2013, Prince Edward County Memorial Hospital was refused funding while Bancroft, also a small rural hospital in Quinte Health Care, got $488,000. LHIN CEO Mr. Paul Huras indicated to the press that he would look into the matter. To date, we have had no update on his inquiries. As one hospital supporter remarked in the press, "What this really is, is

punishment for wanting to break away from Quinte Health Care. Read between the lines, everyone."

It is interesting to note that Mr. Paul Huras, on December 5, 2013, received an invitation by phone to participate on the Multi Sector Rural Health Hub Advisory Committee.

Ministry directive or not, the South East LHIN will be hearing from us.

Thank you for your attention.

Ms. Jane Wallenberg: Good morning. My name is Jane Wallenberg, and I'm also a member of POOCH. Unlike other members who have lived in the community for many years, I moved here quite recently from Saskatchewan, where people pay very, very close attention to health care matters.

What I've learned in the years that I've been away is that, in many ways, particularly in the rural parts of Ontario, it has not offered better and more innovative health care to its citizens; in fact, it has become excessively and insensitively bureaucratic. The people who know what's required in their communities, especially rural communities—i.e. the primary health care providers and those who need their services, the patients—have been ignored and in some cases disparaged.

These failings can be partly attributed to the federal and provincial governments for not providing stable, appropriate and adequate funding, as well as, in our case, the South East LHIN and QHC, who are especially complicit in this. Instead, the LHIN prevents the people who live locally and who are considered better able to plan, fund and integrate health care services in their own communities from doing just this, as it's stated in their purpose on their website. Rather, they have continued to issue short-sighted, ill-advised cuts, without providing the leadership and consultation required to address the gaps these cuts have caused. This is the crucial message: We can't sustain ourselves by fundraising and by volunteers alone.

The level of interest, knowledge and commitment this community has demonstrated over the past 18 months, not to mention since the early 1990s when the changes began in earnest, is formidable. In partnership with the family health team, Prince Edward County Memorial Hospital and many other local and province-wide groups, we, the citizens of the county, have made known our dissatisfaction with the continuous cuts to our hospital and the clear expectations for the levels of health care we require. But we aren't being heard.

I'm speaking for real people, seniors like my parents and others like them in our community who deserve to be treated with respect and receive the excellent health care that is possible if the right plans are put in place. It's also the elderly person, alone and disoriented, having been transferred by taxi from Picton for an appointment with a specialist now in Belleville that should have been available to him or to her in their own town, and that was, actually.

It is the senior desperately trying to maintain his or her independence with dignity, living alone with limited support in an apartment and not wanting to bother anyone regardless of the pain and difficulty living on their own causes them. And it's the people in our community who are poor and struggle with mental health issues and lack basic support in their lives which contributes to their living in poor health, who are just some of the victims of these short-sighted cuts. They need and deserve accessible, good health care and home care services in their own communities. Providing it not only makes sense, but it's also less costly.

According to the JPPC Multi-Site/Small Hospital Advisory Group in 2006, increasingly "place" is becoming identified as a determinant of health because people in predominantly rural regions have a lower life expectancy than the average Canadian; disability rates are higher in smaller communities; there's an increased prevalence of chronic disease in smaller communities; "place" particularly affects the health of the elderly; and there are fewer available community supports.

These are just a few of the challenges we and so many other rural communities face each and every day. We are offering you an opportunity to help us create community health care that's inclusive, effective and compassionate. Some of the frailer and weaker voices may not be able to sustain the fight, but we can and we will. We will not go away, and we would rather work with you to promote and insist that the agencies controlling health care funding and allocation make the changes that are necessary for our communities to live and continue to grow and prosper healthily. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you all for the presentation.

We have just over three minutes left so we will just go to one party, the third party.

Before we do, I'll just take a moment. I want to say that in the first presentation—appointing a committee to review the operation of the LHIN, that is why we're here today.

Mr. Ian Batt: Okay.

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

M^me^ France Gélinas: We both represent northern, small, rural communities and we live your pain each and every day. The policy coming from the Ministry of Health is to make small hospitals self-implode. They're not allowed to do baby deliveries anymore because they don't do enough. They're not allowed to do hips and knees because they don't do them as cheaply as the University Health Network. They're not allowed to do this, that and the other thing. Then they can't recruit, can't retain and they self-implode. You go to your LHIN and the LHIN doesn't listen.

We need good policy to make sure that northern, rural, remote, small—call them whatever you want—hospitals have a way to continue to serve the community that they were there to serve. This has not been happening.

The fact that you have tried to go to your LHIN and have not been heard is very disappointing but not that surprising. I have very little to offer to you. I'm not going

to give you false hope. We are here to review the LHINs. What you have said to us is really that you want some kind of a review process. You want to make sure that the LHIN not only takes the time and has the courtesy to listen to you, but actually acts upon what you have said, and none of this has happened.

The first thing that comes to mind is some kind of a process to review those decisions. I don't know if that would help. How would you like it to change?

Mr. Ian Batt: I think that just an open conversation—unfortunately, the leadership at the LHIN is not well liked. The doctors, for instance, who I talk to in the county really have very little time for the LHIN leadership, which is an unfortunate start to the whole conversation. There's just a total general attitude of negativity, just for starters. I think that was why we put in the thought about the ombudsperson because there are examples of good, local ombudsmen in Ontario, André Marin being one.

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The Chair (Mr. Ernie Hardeman): Thank you very much, but that's the end of that 15 minutes that I talked about.

Thank you very much for your presentation and bringing your concerns here. As I said earlier, it is part of what we're trying to accomplish through this committee.

OPSEU REGION 4

The Chair (Mr. Ernie Hardeman): Our next presentation is OPSEU Region 4: Dan Anderson, local president, and Hervé—

Mr. Hervé Cavanagh: Cavanagh.

The Chair (Mr. Ernie Hardeman): —Cavanagh, local president, yes. I don't know why it wouldn't come to me.

Welcome. We thank you for coming in and sharing your time with us this morning. As with previous delegations, you'll have 15 minutes to make your presentation. You can use all or part of it for your presentation. If there's any time left at the end, we'll have comments and questions from the committee relating to your presentation. With that, the 15 minutes start now. Thank you very much for coming.

Mr. Dan Anderson: Thank you very much for listening to us. Hello. My name is Dan Anderson. I'm currently the president of Local 431 OPSEU, which serves over 500 members working at Providence Care Mental Health Services. I am also a registered practical nurse at MHS, with over 40 years' experience in the mental health field.

I am here today to voice my and our members' concerns surrounding the LHINs' direction in mental health care. We as mental health providers have little to no voice to the bed cuts, staffing and placement of clients. We strongly believe that we can be part of the solution to providing the excellent care that the clients deserve and their families expect.

In the last couple of years we have seen a dramatic cut in mental health beds and reduction of staff in both outpatients and within the facilities. Our community has lost experienced and dedicated nurses and other mental health workers due to these cuts. Last October, in 2013, Providence Care Mental Health Services saw over $6 million cut out of their budget. Did that money go all back to outpatient services?

When asked why we are cutting beds and budgets, the answer always provided to the workers comes back to an outdated report of the Health Services Restructuring Commission. The data on which that report is based go back to the early 1990s. Things have changed. One of them is the closure of mentally delayed facilities like Rideau Regional. MHS now deals with these clients, who are aggressive and can't function in the community. This has further reduced mental health beds.

Why are the LHINs not having open meetings with the workers to get the ground-level view? Is that not why the LHINs are there—to make sure that the best possible care is provided to the citizens of this area?

One of the most glaring aspects of the change in mental health in the Kingston area is the fragmentation of services. You have two hospitals providing in-patient services. Outpatient services are provided by two: Providence Care and Frontenac Community Mental Health Services. On top of this you have funding for other mental health teams, such as Behavioural Supports Ontario and ACTT teams.

The more fragmentation, the more management and administrative supports are required. Considering the much higher level of compensation for these managers, it means less money for the front-line services. It makes you think: Are these services there to support managers or the mentally ill?

Placement of clients in long-term facilities in the community has to be the right fit. Mental health clients with aggression or other cognitive issues are rarely the right fit unless properly trained staff exist. As well, these clients require more nursing hours due to their illness. The staff in nursing homes—mostly PSWs—have little experience with these aggressive clients and their behaviours.

Understaffing in long-term-care facilities is common due to the funding formulas. A recent article from the Toronto Star highlights the crisis in our long-term-care facilities—and a plea from the 630 facilities that are under the Long Term Care Association and Association of Non-Profit Homes and Services for Seniors for more money to help train staff and hire more workers.

The care of aggressive elderly clients was part of the business of mental health services, formerly the Kingston Psychiatric Hospital and other hospitals, where you had trained staff and the experts. Is it really better to spread the problems from several facilities out to 630 facilities? Who does this really benefit? With the rush of the baby boomers in the next couple of decades, is this the right approach to meet their needs?

Clients in the community need more supports to be successful and productive in their community. Unfortunately, many more chronically mentally ill fall through the cracks, because beds are being closed and they're told that they can't get back into hospital.

If a client goes to KGH, they may face a six-to-eight-hour wait to be seen. This is usually unbearable to most schizophrenics and others, therefore they often don't get seen. Because of the deterioration of their mental state, some act out and end up in the court system or turn to illicit drugs. Some fall through the cracks and end up on the streets.

Respectfully, the system is broken. It does not fully serve the needs of our clients. I've talked with many psychiatrists, GPs and other health care professionals within and outside this province. We do not fully agree with the direction of the mental health care that is being provided in Ontario, but we do believe that the system can improve when the LHINs can work collectively with direct-care workers and reduce the fragmentation of the services.

Each LHIN is to be accountable to the communities that they serve. When can we have meaningful dialogue?

Mr. Hervé Cavanagh: Thank you, Dan.

My name is Hervé Cavanagh. I'm a resident of Tay Valley Township, and I've been a physiotherapist for 22 years now. I've worked both in the public and the private sectors; I've worked both in Canada and the United States in my profession. I'm also the president of OPSEU Local 466, which represents the hospital professionals at our local hospital in Perth and Smiths Falls, and also the support staff at the local retirement home in Carleton Place.

When it comes to hospitals, our residents are very sick, particularly in Lanark county, which has a high proportion of retired people, most of them in rural communities. If we look at Lanark county, we have three major communities: Perth, Smiths Falls and Carleton Place. All of them have a population under 10,000 people. We're the only hospital north of the 401 in the South East LHIN. The population has a higher need of health care and hospital resources, particularly for the stroke and the fracture patients. Those are the diseases of the elderly. It's in the industrialized countries that we see people falling because we live longer; we fall and we break our hips. We live longer, we have strokes. We live longer, we have congestive heart failure. This is what we see in our county.

It is important and crucial that we identify these risks that the people are facing, and this is what we see when we see these people in the hospital. For example, a patient suffering from congestive heart failure is at risk of losing 30% of their functional ability during a hospital admission. By taking away access to rehab services, the impact on mobility is extremely negative, only to increase the length of stay as a result.

However, rehab can be used to improve patient flow and outcomes. By providing early access to physiotherapy, occupational therapy and speech therapy, we can improve patient flow; maximize quality outcomes, which helps to reduce unnecessary readmission; and we can reduce health care spending. Let's face it: Therapy is cheap and the length of stay in hospital is not. When we look at stroke care, for every dollar that we invest in in-patient rehab, we save $4 in other hospital costs.

According to the magazine Physiotherapy Today, proper investment in rehab can reduce at least $20 million a year in the Ontario system. But for achieving these savings, we must provide rehab care to the patient as soon as possible once they are admitted in hospital. This is what we call "front loading" of rehab care.

The best practice guidelines provided by the stroke strategy of eastern Ontario recommends a minimum of three hours a day of therapy, seven days a week. We still run a hospital like a business, five days a week. When we're sick, we're sick on weekends; we're sick on weekdays.

This is a crucial time for stroke patients to benefit from rehab. When forced to wait for a long period of time, their brain begins to shrink and rapidly leads to atrophy of neural tissue, which reduces the potential of their recovery. But when you provide rehab services early after their admission, the brain tissue is known for recovering faster and even expands, facilitating the learning of new motor skills and therefore improving their mobility.

However, what I see in Ontario is going in the wrong direction. I'm concerned about the rehab services. In the last three years, at least 50% of hospitals have reduced physiotherapy and rehab services. This is happening without consultation. It has happened in Perth and Smiths Falls as well. Due to financial compression, we faced a reduction of 3.1 full-time equivalent in physiotherapy in the last budget in the Perth and Smiths Falls hospitals. Over the years, I've faced at least a loss of one full-time equivalent for occupational therapy and a 0.5 position for speech language pathologists. We're saying that if we invest in these professions, we can save money down the road, but we're taking them away, lengthening the length of stay in the hospital. This is happening, again, without consultation.

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With the rising costs of hydro and postage alone in the near future—our hospital is facing a freeze in their budget for the next four years, so am I to expect that physiotherapy and rehab services will be on the chopping block because we can't afford to pay for hydro, because we're not a priority—our services? Again, am I a scapegoat, just to say, "Okay, physio, you're out the door. We don't have the money anymore." Are we doing a favour to our residents in Lanark county? Have we been consulted on this issue?

It comes down basically to, when we have a patient who has either a stroke, a fractured hip or any other medical condition, if we deny them the service that they need, I think that's unethical. We have a responsibility to face. Let's face it together. We can bring solutions together.

Thank you.

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

We have about four and a half minutes, so we will have it go around. First is the government side: one minute and a quarter. Mr. Flynn.

Mr. Kevin Daniel Flynn: One minute and a quarter; okay, I'll make this quick. I'm from Oakville. We're from a different LHIN, obviously. The experience that I've had, particularly in the mental health field, has been almost the opposite to what you just outlined. We had very few services in our community. The LHIN became involved, and our services have improved tremendously over the past few years and continue to improve. The LHIN has become a very strong advocate for the local hospitals as well. They seem to go to bat for them.

You seem to be telling a different story. Is there a communications link missing? Have you spoken to the LHINs? Have you sent them information as to how it should work?

Mr. Dan Anderson: We've gone through our administration, requesting to speak with the LHINs, and we've not gotten any response.

As staff members, and also as the union president, we get very little information from the LHINs, and also from management, as to what the plans are until the last minute.

I can cite, as an example, the last cut that we had, part of the $6-million cut. We asked a year—

The Chair (Mr. Ernie Hardeman): I do have to stop it there. As I said, it's a very short time for each party.

Mr. Clark.

Mr. Steve Clark: Thanks very much for your presentation. I agree that consultation is pretty key, and I appreciate your frustration in not being involved in the process. Some of the ideas and suggestions you have, I think, are very valid and should be taken into consideration by the LHIN when making those service decisions.

The mental health piece is very important to me as well. We had a bit of a situation in my riding where we had the Champlain LHIN funding a mental health—the Brockville Mental Health Centre was like an island in Leeds–Grenville, so it was a bit of an anomaly.

You did talk about the piece of coordination. Is that another pretty key piece, seeing what's going on in Kingston with Providence and some of the other decisions? Could the system be coordinated better?

The Chair (Mr. Ernie Hardeman): If you want to give him time to answer, you're going to have to cut your question to the right length.

Mr. Steve Clark: I'm shutting up. I'll be quiet; I'm done.

Mr. Dan Anderson: Yes, part of it is coordination. For us, it's very much that we feel we can provide services. Most of the staff at my facility have in excess of 25 years' service—or did. We feel we can contribute. We believe in community services. The problem is that we're not getting opportunities to go out into the community, other than through our own ACT teams. Geriatrics is a fine example: We're finding, with nursing homes, that they have the BSO teams, but they're mostly provided by PSWs—

The Chair (Mr. Ernie Hardeman): Okay, we're going to have to cut it off there.

Ms. Gélinas.

M^me^ France Gélinas: As president of your local, have you ever been invited by the LHINs to come and talk to them?

Mr. Dan Anderson: Never.

Mr. Hervé Cavanagh: Me neither.

M^me^ France Gélinas: Have you ever reached out to the LHINs, on behalf of your membership, to say that you have something to contribute?

Mr. Dan Anderson: Through our management, we did.

Mr. Hervé Cavanagh: We've reached out to our local MP without success, and we reached out to the community, which raised a lot of meetings and stuff like that. But with the LHIN, being an employee of the hospital, I have to be careful when I go and I try to speak on behalf of a union for obvious reasons.

M^me^ France Gélinas: I can tell you that other LHINs do invite their unions, they do talk to the union membership, and there is a wealth of knowledge. You live in your community. You are a resident of your community. You need care just like every other human being, and you have something to say. There is no reason for your LHINs to deny you—not listening to you. Can you think of why?

Mr. Hervé Cavanagh: I don't think they're interested to hear what we want. What we want is to reinvest in the service again.

My impression with the LHIN so far—every time I talk through my managers in either an FAC management or a labour management committee, they tell us, "We don't have the money, and we need to rationalize what we need to do." So, again, we've been under pressure to squeeze services out.

The Chair (Mr. Ernie Hardeman): With that, thank you very much. Thank you very much for your presentation. That does conclude the time. We thank you very much for taking it.

That concludes our morning session. A couple of announcements: The committee will have lunch served in the Martello Room.

This afternoon, we have a unique experience: We have a substitution. At 1:45, the Mental Health Support Network South East Ontario will be making a presentation, instead of the one that's on your agenda. Just exchange the one.

With that, lunch.

The committee recessed from 1205 to 1259.

The Chair (Mr. Ernie Hardeman): We'll call the committee back to order. I hope everybody enjoyed their lunch and the break.

CANADIAN HEARING SOCIETY

The Chair (Mr. Ernie Hardeman): Our first presenter this afternoon is the Canadian Hearing Society: Karen McDonald, vice-president of program services. She has Katherine Hum-Antonopoulos with her. We want to welcome you both here this afternoon, taking the time to come to speak to us. You will have 15 minutes to make your presentation, and you can use any or all of that time to make your presentation. When you have finished, if there's time left, we will have questions from the committee. With that, the next 15 minutes is yours.

Ms. Karen McDonald: Thank you very much for inviting me to do a presentation on behalf of the Canadian Hearing Society and on behalf of OCSA. This is a great opportunity, and I really commend the committee for doing a review of the LHIN act.

A little bit of background about CHS: CHS is a multi-service agency. We are a member of OCSA, and we are a charitable agency that's been around since 1940. We are the leading provider of products and information that remove barriers to communication, advance hearing health care and promote equity for people who are culturally deaf, oral deaf, deafened and hard of hearing.

We are unique in North America—

Interruption.

Ms. Karen McDonald: Sorry. I'm always being told that I've got a soft voice.

We are unique in North America. We provide a complete roster of services, only some of which are directly funded by the LHINs. We provide sign language interpreting services and real-time captioning, which I could have asked for today, but it can be quite intrusive for organizations that are not familiar with it, so we did not do that.

We also provide employment consulting, educational support services for post-secondary students who are studying part-time, specialized counselling services, sign language instruction, hearing tests and hearing aids, and we are the largest provider of a range of communication devices, including TTYs, visual smoke alarms and baby monitors. We are certainly very grateful for the recent amendment to the legislation which has ordered visual fire alarms to be installed in residences going forward.

We are the largest agency of its kind in Canada, and we employ approximately 450 people who deliver about 17 different programs and services through 28 offices across the province. Our national advocacy initiatives and partnerships help us to remove communication barriers and promote equity for our consumers, and our organization's communication devices program has partnered with services in Manitoba, Nova Scotia and Saskatchewan to assist them in servicing consumers in their provinces.

Now I'll just move on to talk specifically about the LHIN-funded programs. We have a range of LHIN-funded programs. We have counselling services which include our Connect mental health services, our general support services, our hearing health care program and, in Toronto only, our audiology and oral rehab program.

The Connect mental health service provides mental health counselling, education and advocacy, and these are really for individuals who find the mainstream providers to be a barrier to them accessing it. That can be because the mainstream providers may not understand the unique cultural needs of individuals who are deaf, but it can also be because of the need for interpreting services and the costs of those. Most of our counsellors in the Connect mental health program—not all, but most of them—are either culturally deaf themselves, or if they're not, then they are fluent in sign language.

In terms of the stats, we saw 660 individual clients in 2012-13 who would fit our criteria, and we do have a number of communities in Ontario where we have significant waiting lists for this service.

Our general support services serve individuals 16 years of age and over and provide general counselling, advocacy and special assistance. You may wonder what the difference is between the two services. The main difference is that the general support services do things that you and I may take for granted. It would actually go with an individual to a bank to help them negotiate a mortgage. It might go with someone to court, if they were going to Small Claims Court, and facilitate the communication between the individual who was deaf and the service providers. The hearing care counselling program is a very unique service. We serve individuals who are 55 years of age, or younger individuals with multiple disabilities. This service is primarily given in the home, so it's counselling and assistance with communication strategies between the individual and their family or their community partners and also to assist them in accessing communication devices. These two programs are reported together to the LHINs, and we served approximately 8,000 clients last year.

Here is really the crux of our submission: CHS provides services in all 14 LHINs, but we have MSAAs with 11 LHINs. We do not have contracts with the Central West or the Waterloo Wellington LHINs, and we have a service level agreement through the North Simcoe Muskoka LHIN. We also have two separate MSAAs with the Central LHIN. We have two different funding models. We have a centralized funding contract, and we have regional contracts that are multiple, as I've just shown.

We think that there are many benefits to having a centralized LHIN contract. The Toronto Central LHIN, for instance, funds the Connect mental health program through the lead LHIN model, and this is very beneficial to CHS and, ultimately and most importantly, to our consumers. It allows us to have one contract. There's one set of targets, and there's one set of indicators. It gives us great flexibility to either add or reduce staffing in specific regions as the needs change, because needs do change. With the regional contracts, as you'll see, that can be very problematic at times.

The challenges of the regional LHIN contracts: We have regional contracts for general support services, for the hearing care counselling program and for audiology and aural rehab. Those contracts vary tremendously in size. Some are very small, at under $50,000, and others are very large, at over $600,000.

The regional LHIN contracts do present some unique challenges for organizations like CHS. Each LHIN has a different board of directors, different funding priorities and different performance indicators. Put yourselves in the shoes of an agency like CHS with one head office. We are very lean and efficient, yet we're having to deal with all of these multiple different expectations. There are multiple reports that must be completed and signed off every year for each LHIN. Staff and volunteer board members are expected to attend multiple meetings in each of the LHINs.

The LHIN priorities are often competing with each other for limited staff and financial resources. For example, one LHIN mandates accreditation and only provides financial support for that region, not recognizing that financial and corporate supports are for the entire province. One LHIN mandates that CHS work towards designation status under the French Language Services Act, but CHS is not a designated agency. This is a challenging process when it only applies to one region.

The LHIN priorities are often competing with each other for limited staff and financial resources. Another, different example is that sometimes even when the priority is the same, such as health equity, the expectations of the LHINs may be different. We recently completed three different health equity surveys. They were not even remotely similar. Some mandated that they be filled out by a member of the senior management team. Others mandated that they be filled out by front-line staff. Still another expected us to have designated staff for health equity.

1310

I'd just like to offer some reflections on the LHINs. The LHINs are not perfect, but they have given small agencies and agencies that focus on the health and well-being of persons with disabilities a voice and a seat at the table. This is very positive and it's very important. This is the second organization that I've worked in that has had LHIN contracts; the other organization also served a very specialized population: those with aphasia. Again, it was through the LHINs that we actually were able to find a voice for those consumers. I do think the LHINs offer a very valuable resource.

CHS has been privileged to be invited to be part of the health links in a few LHINs and also to sit at a few issue-specific tables for discussion.

Dissolution of the LHINs will not immediately improve the health system and may distract from more immediate issues.

A key priority of the health system right now is to move people from hospitals to home and community. The LHINs, working with agencies such as CHS, are well-placed to make this happen. However, no base-funding increases means that specialized agencies, again, like CHS, who do not qualify for funds designated to alleviate ALC and ER pressures, face increased costs and the pressures associated with the costs of salaries and infrastructure, and then we are in a position where we have to look at cutting services in order to maintain a balanced budget.

Under the LHIN funding mandate, budgets do not properly account for administrative costs. I'm sure that you've all heard the stories of organizations that have to keep their administrative costs to 10% or under. That is extremely challenging for an organization like CHS, where we provide services across the province. We have one centralized head office, but we actually have to charge back against the contracts and services of head office.

Provincial agencies like CHS that receive a significant amount of funding from the LHIN are well-positioned to improve efficiency within the LHIN because we already have back office integration. That's a battle that we are constantly fighting with the LHINs. They're constantly coming to us and saying, "We need you to go forward with back office integration with other agencies"—we've already got it—and making that case over and over.

We can address issues systematically across the province. We know the needs of the people that we serve throughout the province.

Finally, we have three key recommendations. Provincial agencies should be given centralized contracts for all LHIN services. This will reduce duplication and improve efficiency by allowing agencies to utilize resources across all regions. It also allows agencies to meet our governance requirements, and I can speak more to that in the question-and-answer session, if you would like.

We also recommend a coordinated approach to implementing LHIN initiatives across the province so that provincial agencies don't have to manage competing priorities with limited resources.

Third is sufficient investment in the CSS sector, which, as you know, is a very important and growing sector in this province, to ensure that community needs will be addressed well into the future.

Finally, I just want to thank you for giving me the opportunity to appear at the standing committee on behalf of both CHS and OCSA.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have one minute left. The government has the question. Ms. Jaczek.

Ms. Helena Jaczek: Thank you very much. Thank you for coming and educating us and sharing your frustrations. Have you brought this to the attention of the ministry through the years—in other words, the idea of having one centralized contract?

Ms. Karen McDonald: Yes, we have.

Ms. Helena Jaczek: And what response have you received?

Ms. Karen McDonald: Wonderful. They've been very supportive. I think the issue, as it was explained to me, really is that there's so much reorganization going on

at the ministry right now that they didn't feel that the business operation unit could take it on at that time.

Ms. Helena Jaczek: But they flagged it as something—

Ms. Karen McDonald: That they agreed with, yes.

Ms. Helena Jaczek: —that conceptually was the right thing to do.

Ms. Karen McDonald: Yes.

Ms. Helena Jaczek: Okay. Thank you very much.

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

MR. DUNCAN MEIKLE

The Chair (Mr. Ernie Hardeman): Our next presenter is Duncan Meikle.

Mr. Duncan Meikle: Congratulations. You got it right.

The Chair (Mr. Ernie Hardeman): There you go. I take the compliment. I'm not right on all of them, so the rare time that I do get it right—

Mr. Duncan Meikle: You must have been influenced by a Scot somewhere along the line.

The Chair (Mr. Ernie Hardeman): It could be. We thank you very much for being here to make a presentation. You will have 15 minutes to make your presentation. If you leave any time at the end of the presentation, we will have questions and comments from our committee members. With that, the next 15 minutes are yours, sir.

Mr. Duncan Meikle: Everybody should have a package of about 20 pages. I started to number them. Some of the pages got away, and I had to revise the numbering system, and then I had to revise it again, and then I had to put in a letter that I had somehow missed. My filing system is not what it should be.

I depend on community home support for a lot of things, particularly a drive to a doctor. The drive from my home to the doctor was, for a year and a half, $100. Suddenly it was changed to $116. I'm not complaining about the $16. I am complaining about the way I was treated after I started to ask, "How come?"

I asked, "Why?" and I got three or four different answers: a normal increase in fees; I went to the far side of Ottawa; I made extra stops—and one that was sent in a mumble; I don't know exactly whether it was a reason or not.

The second, that I went to the far side of Ottawa, was false.

Extra stops: There seems to be a fair number of choices: two extra stops, three extra stops, four extra stops. At one point, the four extra stops involved being let off at the bank, and then I would go to the pharmacy, the drugstore—sorry—lawyer, post office and grocery store. We negotiated what time to meet at the grocery store. That has worked fine. All of a sudden, I was charged for four stops: pharmacy, lawyer, drugstore, post office and so on. I don't understand that.

I asked three different people, "Who is in charge?" I got three different names. These are people in the organization; I didn't ask strangers on the street corner. I asked people who were there in the office, "Who's in charge?" It strikes me as odd that any organization of any size or importance would not know who's in charge.

So to get attention, I ignored the next two bills that came in. It worked: I got attention. It resulted in a meeting between two of the personnel and myself. It was a fairly long meeting. They agreed to withdraw the $16; that was minor. But what I insisted on was that I would pay in installments if they provided me with a set of rules.

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If you turn to the back of that package, you will see some examples of the questions that I asked regarding the rules: page 11 and page 12, to the community home support leader; an organization chart for the Ontario health system—for a certain distance, and then it stopped—and the letter to Randy Hillier, my MPP, asking: To whom are these people accountable? How is the LHIN funded? How much comes from the provincial government? Can you provide a breakdown? What screening tests are made of volunteers? What agencies are part of the network? How many of these are available in Lanark county? And where can I get a copy of the annual report or its equivalent? No answer. That was in September.

I keep wondering: Is somebody trying to hide something? Or are you all flying upside down, like the song at camp—"Up in the air, Junior Birdmen, / Up in the air, upside down"? I don't know, and I'm intelligent enough to follow an answer. But I don't know your system.

I think something is wrong—I don't know what; I don't know where. But when people give contradictory answers or when they give false answers, such as the letter labelled number 3—"I am writing in response to your concerns about the transportation service...." I'm not complaining about the transportation service. If I was, I would say so. It's at about the middle: I'm complaining about the way I was treated when I asked a question.

"Both my staff and Paul Huras ... have asked you to contact me directly...." The staff didn't; Paul Huras did, but only under a little bit of pressure. "You have ignored these requests"—that's not true; I went to a meeting, as requested—"and have continued to call and attempt to intimidate the agency staff."

"Intimidate"? I'm a little bunny rabbit. I don't know what's going on. I am not likely to intimidate the people who are providing transportation that I need. Personally, I'm wondering about a libel suit.

"[Y]ou have claimed not to know the 'rules'...." Paul Huras made a similar statement. The rules were never given to me when I went and said, "I need transportation." I was handed transportation in a basket: "Phone here. We will arrange it. Say where you want to go and when," etc. I was never given a set of rules. The rules that did come eventually—on pages 5 and 6: "Be dealt with in a courteous and respectful manner"—that's not a

rule; that's a value. If you want an example of the use of the word "value," turn over to page 7. A blurb from the Perth hospital: "Our Values ... where everyone is treated with dignity, respect and compassion." That's a value; it's not a rule. It's not a statement as to when the mileage begins and when it stops. It's not a statement as to how they measure mileage. Something that came up only a couple of weeks ago, after all of this was written: Mileage in some cases is measured from city boundary to city boundary. I've never heard of that one, but I present it as a possibility. I don't know how mileage is calculated.

I wrote back to the person who sent me this and said that it appears "that you have violated items one, four, seven and eight," most of which deal with financial abuse, receiving information and recommending changes without fear of interference or reprisal.

After several letters back and forth, I was cut off transportation. One of the reasons was that I was a threat to the volunteer drivers. I don't know where that comes from. I honestly don't know what's going on. When I saw the ad that this commission would be here, I said, "Fine. I will come and make a noise."

There are many errors in the letters sent to me. Nobody has pointed out an error in a letter that I sent.

The file is not complete, because my filing system is atrocious. But I urge you to pass this on to those who are not here to read it carefully and consider what $16 can do to your organization. I'm quite willing and quite capable of paying the $16 and the outstanding fee, but I want to know what the rules are.

The Chair (Mr. Ernie Hardeman): Very good. Thank you very much for the presentation. I think you are right. First of all, we will make sure it's passed on, and I wouldn't be surprised if the presentation, as you presented it to the committee, was likely heard by some of the people who would be involved with it. Maybe we could all get together and come up with some answers to your questions.

Mr. Duncan Meikle: Oh, boy. That'll be good.

The Chair (Mr. Ernie Hardeman): Well, I really hope that—obviously, our committee is not in the position to be able to deal with the directors. We are not the providers.

Mr. Duncan Meikle: No, but I don't know where to write. You do.

The Chair (Mr. Ernie Hardeman): Very good. And that's why we hope that we can get that message out. I'm sure some of the people who are involved in this are here for the same purpose we all are today: to hear about how the system works. Hopefully yours can be dealt with by the appropriate authorities to satisfy your needs. It seems—

Mr. Duncan Meikle: Well, I think I've shown how the system does not work.

The Chair (Mr. Ernie Hardeman): To get people to understand what the rules are shouldn't be that difficult.

Mr. Duncan Meikle: It shouldn't.

The Chair (Mr. Ernie Hardeman): No. And so, I do thank you for coming in and bringing it forward, and hopefully your presentation here this afternoon will have an impact on getting your problem solved.

Mr. Duncan Meikle: You're repeating yourself.

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

CARP, AJAX-PICKERING CHAPTER

The Chair (Mr. Ernie Hardeman): Our next presenter—where's my list? There it is. The Ajax-Pickering CARP chapter: Randy Filinski, consumer advocate—

Mr. Randy Filinski: Filinski.

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The Chair (Mr. Ernie Hardeman): Yes, you say it so much nicer than I do—and vice-president, program services. Thanks, Randy. As with all the delegations, you'll have 15 minutes in which to make your presentation—

Mr. Randy Filinski: He's just hooking me up.

The Chair (Mr. Ernie Hardeman): That's just fine. I will give you the instructions. You'll have 15 minutes to use as you see fit. You can use all or part of it. If there's any time left, we'll have questions from our committee. The clock starts when I push the button, which will be when you're ready. We won't let technology take away from your time.

Mr. Randy Filinski: Thank you very much. My name is Randy Filinski. I'm here, really, for two reasons. One is that, hopefully, I'm the proverbial consumer/patient/caregiver/resident—any name you want to put on me. I live in Pickering, Ontario. I happen to fall within the boundaries of the Central East LHIN. I've put the CARP message here because I'm going to transition my comments from "I," as an individual, to "we," and CARP is just one example of "we," being the community.

In focusing on the legislation, I really am here today to tell you about my activity, and then about "we," as a group, our activity pre-LHIN, so since I got involved in health care and then with the LHIN up until today, even, and the work that we've done, and, hopefully, give you a consumer view, a patient view, of the importance of the LHIN, and some suggestions on improving a lot of what you've heard today about what the LHIN can do.

Let me just click over here and hope this works.

Why me? I've sort of said it—if you jump to the bottom—I have 62 years of experience in health care. I was born in the Central East LHIN; I live in the Central East LHIN. I've travelled around the world, but I am a resident. I've also been a patient in the hospitals. I work with community care. I've got a family; they were born into the health system. People usually knock me, saying, "Well, you're not a service provider or a health service expert," but I am an expert, and you are experts once you step out of your job too. We have experience in health care. The consumer voice needs to be very strong.

Some of the other background here: I retired from IBM early, early, early, thank goodness. It was a great job, but I've become a professional volunteer, working with—although they're not up here—about 10 to 12

organizations in health care. I will admit, it started off with a local mayor tapping me, saying, "Could you go talk to VON? They need some help with their marketing plan and strategic plan," early in the year 2000. That led to becoming a friendly visitor, a transportation driver for the—similar to the gentleman who just left—volunteering with the Special Olympics—just a whole rack of things, but health care become my intellectual capital. It's the thing that I've examined, looked at—the LHIN tells me I'm a consumer expert—but from a consumer point of view. This is only important for the next little bit of the presentation, not necessarily for me in itself.

Now, I did say "I." When I first started getting into health care—and if you just read some of the key words down here, I'll make a couple of points.

It was about me, "I," my family. Everything we did was anecdotal. If I had a problem, I wrote a letter to the ministry. I didn't know what a district health council was. I knew who my MPP was. I knew that health was a provincial issue. But it was very, very reactive. I'd write my letters to the ministry. I'll be very frank with you: Most times I didn't get a letter back. I got a form letter saying, "Go to this website; thank you," but no real dialogue, no real feedback as a community member.

When I joined boards—again, this is pre-LHIN days—I would be representative of an organization. As a board member, we would do the same thing: We'd try and look at—but in cases, they were still anecdotal. They were Mrs. Smith had a story, so-and-so had a story, and we'd try and present those coming forward—again, very reactive, and usually because you were personally involved—

Interjection.

Mr. Randy Filinski: Too close?

Mr. Christopher Beesley: Yes. It's okay.

Mr. Randy Filinski: Can you hear that okay? Okay, sorry. I'm just excited about this.

Usually they're very reactive stories and usually there was a personal involvement with the thing.

So as I was doing all this work with these organizations, I think it was Hugh MacLeod in Ontario who was given the mission to step back and look at what can be done in health care from a funding/planning model. Only because I was on a board did I get invited to The Barn in Markham, Ontario, where 400 service providers got together to talk about what health care was and what it could do.

Again, as a consumer—there were no consumers there. We were there as volunteers, but primarily through boards of service providers. It really twigged my interest in health care. Following this—let me just go to the next page—the formation of the LHIN came out and it gave me the opportunity to switch from "I" to "we."

The Central East LHIN—and I'm talking only about community engagement; I'm not here to tell you about all the things they've done. I'm talking about the engagement to the community, to the resident, to the patient, to the caregiver. If they've done a couple of things extremely well, they've done a job right from day one of engaging the community, and I mean the resident and the patient. So we were invited to the table.

I happened to be on boards and moved in with this, but I found myself sitting with service providers in the community, in hospital, in long-term care, in mental health and addictions. There was never enough time that they wouldn't ask us to come and participate in what they were thinking about and the design of enhanced services.

One of the very first things that happened was that I, representing the "we" in the groups I was with—we were invited down to Queen's Park as consumers to meet George Smitherman or the staff who were thinking about aging at home at the time. As you probably know, it was all about community care, enhanced services, capacity building, integration etc. This was the transition point between reactive to being proactive. We had a chance to step back and talk to the community. We had a chance to gather our thoughts. We had a chance to put all the anecdotal things on the table and we soon found out they became systemic things where we could actually build a recommendation to the health care system.

At the time, what it also allowed the consumer to do, it allowed the consumer—I think, for one of the first times—to see what a health care system is.

Prior to the LHIN, health care was just a bunch of pieces. You call them silos; you call them a lot of things. At least with in the Central East LHIN, our community is seeing more end-to-end services. The gentleman who was here before me—I'm also a volunteer driver. Community Care Durham is a phenomenal community care organization with about seven to 12 different services, and through this type of action with the consumer and the patient-built services like Home First and Home at Last. That included multiple organizations coming from hospital, getting to a hospital, leaving the acute system but actually getting to the home, checking the home for safety, checking for prescriptions etc.

Again, I've witnessed as a consumer my reactive things to now-systemic items where I'm able to gather groups into the community and actually look and examine the health care system and make recommendations back. Again, the Central East, from day one, has had us at the table. If this was a Central East meeting, one of us from the community would be sitting out there with you participating in that review and being part of not only the listening but the design of what comes next. That's what's happened in the Central East LHIN.

I said I'd use CARP as an example. Well, let me come back here. The Central East LHIN is a facilitator. The best word I can give you is that they have facilitated the process. I think they recognize the value as we speak, and I know there was an RSGS presentation here earlier. There are community members on the design team redesigning those services, so specialized geriatrics are out in the community now to be in 10 community locations, including the hospitals. But as we speak, the residents are working on the redesign of those services because they've been invited to the table.

I probably said a lot of this: The one key point here, because I've heard this today—the other thing it's done for the consumer is it's given us this urban, rural, remote—really, a demographic positioning. When we go to these meetings, it's really relative to the local, local, local, where the people are and where they live. Again, it allows the person from Haliburton or wherever to be part of that service design. It's not Toronto or GTA saying, "This is how it should be," but it actually reflects the capabilities in and out of the areas that we're working.

CARP is just an organization. I don't want to go into it too much, but a friend of mine and myself started up a chapter three years ago in Ajax–Pickering. We've got 2,000 members. There are 4,000 members in Durham. Because of our involvement with the LHIN, we invited the LHIN in and started up a health advocacy group, and quarterly we meet with every CEO. We meet with the line staff, so the gentleman who was here from the union—we invite the union in to talk about their perspective to the community. We have a constant renewal with the community, with leaders in health care who want to come and have a dialogue. They come not to present but they come to talk, discuss, learn from the community and then feed back.

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Some of you may know the name Susan Eng. Everything we do in Ajax-Pickering and in Durham, we feed up to Susan Eng. We develop policies on health care, one patient brief—and obviously back to the politicians, currently Joe Dickson and—oh, heck, I can't remember. It slipped my mind. It's a senior thing here; I'm getting close to it. We feed back to the politicians and the community and up to our national organization to formulate our policy.

My recommendation is really simple: Don't stop. We've been invited in. We're at the table. We're a big component of service change, of health change. It used to be—and pardon my English—more of a bitch session. Everybody would come in with a bad story. When you come to these meetings now with the community, it's very productive: "Here are the things that are wrong, but here's the things that are working." We can name names. We see patients and we see neighbours who are delivering these enhanced services. Their quality of life and health is much better than it was two years, five years and 10 years ago.

My simple view of life is that there are two dialogues. There's the external dialogue to the community, to us. It needs to be simplified. We have to admit that health care is complex, but it can be branded and reshaped back to the community in a much better way. I would see the LHINs as being more empowered, not less empowered, bringing those pieces in under one single funding and planning umbrella and allowing the ministry, whoever's in power at the time, to do the strategic job of looking out over the top from a Canadian perspective and making sure that all the things required are there. But give the authority to the LHIN to pull the pieces, break those barriers down and keep delivering a newly branded health care system.

The last piece on here I think that I would improve: Use the intellectual capital that you've built up by allowing the consumer in. We are a powerful voice; we do know health care. We have groups and organizations that are on the street. We work with front-line service delivery people. The LHIN could invite us in as intellectual capital as they redesign—and, by the way, quite frankly to the ministry as well on branding.

My thank-you here: These are real names of real people. I just pulled them off a list of 1,500 people that we've talked to in the last two years. Those people on the top line are people who have received enhanced services, either through community care, acute care, Home First, all the programs that have been driven out—GEM nurses, GAIN clinics etc. We need to rebrand them all, but they are benefactors of better health care in the last five years. The bottom line is a thank you to the LHIN staff because they invited us in.

Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We have a little over three minutes left, and it's the PCs. Mr. Milligan.

Mr. Rob E. Milligan: Thank you very much for coming here this afternoon. I know it's a fair trek to come all the way from Ajax-Pickering.

I guess what I'm hearing more and more is that it's nice that you've been brought in with the Central East LHIN. It's the matter of providing different services within each LHIN. It seems to be that there's an inconsistency. That could be a direct result of demographic needs in certain regions within a LHIN. For instance, we heard from the Canadian Hearing Society that some—

Mr. Randy Filinski: But is the question on inconsistent services?

Mr. Rob E. Milligan: Yes.

Mr. Randy Filinski: Let me just—because I know my time will run out. All right? So that's the question.

I think the answer is enhanced capability. My third bullet, which I didn't really get to, is that it's a quality practice across the LHINs of consistent engagement and then a review of best practices on services. That includes branding. What tends to happen now is, everybody does something differently. Somebody needs to step back and brand these things so that whether I'm in Thunder Bay, Sudbury or Peterborough—I made a comment over here: If I get the flu in Pickering, it's probably the same flu I get in Thunder Bay, but I don't have to be told it's different or go to a different resource. This is a very important thing, but I think this is an enhancement to the LHINs: There are best practices that the 14 LHINs could adhere to.

Next question?

The Chair (Mr. Ernie Hardeman): That's it?

Mr. Rob E. Milligan: Yes.

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

Mr. Randy Filinski: That's it? I get to go home?

The Chair (Mr. Ernie Hardeman): I didn't know that the flu was consistent everywhere, but now I do. Thanks, Randy.

MENTAL HEALTH SUPPORT NETWORK SOUTH EAST ONTARIO CORP.

The Chair (Mr. Ernie Hardeman): Our next presenter is the Mental Health Support Network South East Ontario: Garry Laws. Thank you very much for making the time to come and see us this afternoon. As with other presenters, you will have 15 minutes to make your presentation. You can use all or part of that for your presentation. If there's some time left over after the presentation, we will have some questions and comments from the committee. With that, the next 15 minutes are yours.

Mr. Garry Laws: Thank you for your attention. I am the system leader, or executive director, for Mental Health Support Network South East Ontario. I'm representing approximately 1,500 consumer-survivors, people living with mental health challenges, across this LHIN. We don't serve the Lanark area; we serve all other catchment areas of the southeast.

I wanted to sort of trace back a bit in terms of the LHIN, and the LHIN act specifically, and how this LHIN has been able to assist the consumer-survivors of the southeast. I came in as the executive director in 2009, which was the last of a second involuntary integration order. It was taking four very small consumer-survivor initiatives across the southeast and amalgamating them into one large organization, a regional organization.

At the time, of course, for the small organizations, I imagine it was a bit upsetting. I came in, again, with just the tail end of it to take on the Leeds-Grenville area. But what it did was give the consumers a very strong voice. I think, hindsight being what it is, it has really elevated our organization. It has elevated our board.

We have a regional board from across the southeast, representatives from all the different communities that we serve. We are a consumer-driven, consumer-led organization, which means that many to most of our board members are also self-disclosed folks living in recovery with a mental health and/or addiction issue. It really gave us an opportunity, as consumer-survivors, to provide peer support in each community as a cookie-cutter approach, however, having our own autonomy within each of the communities.

Each of our support centres—and we have eight of them across the southeast—didn't really change so much as the policy and good governance that has been provided by having one large organization. Standardized evidence-based practices are now the cornerstone of what we do. We only work with evidence-based programs such as the Wellness Recovery Action Plan and Intentional Peer Support. We really now have a strong organization that's very much supported, we feel, by this LHIN.

Initiatives such as the back-office integration project saved our organization about $30,000 right off the top, and in a small organization, that is a lot of dollars that went directly back into peer support. That actually represents almost two staff in one of our centres, so it really went to good use. It has facilitated many service integrations, and I think that one of the fine pieces of the act is that it really pushes us to that boundary of integrating our services into one system so that we're acting more as one and not as in the typical silo effect.

Reputably, we are shoulder-to-shoulder with our clinical partners and at the table. In fact, we were one of the consumer-survivor groups that was selected for our recent—we're still in the process—addiction and mental health redesign here in the southeast. The consumer voice was included at that table. That was, by the way, not just selected by our board but nominated by our peers from across the southeast, our clinical peers who saw the value in having the consumer voice heard at the table, so much so that our peer support is seen in the redesigned process as a very important foundational aspect of the care, treatment and recovery of people living with addictions and mental health issues. That was a huge, huge step for what was four small organizations that were really kind of fumbling along trying to organize themselves, within the communities that they were in, into one larger organization that spanned across the region and was one, solid, unified voice.

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It's brought performance indicators in. While they may not seem that exciting when you first get your arms around, it has actually really assisted and supported one particular area for our organization that was crafted into our board strategic plan, the reduction of stigma. That is pretty much what you see on a lot of the vision statements that the LHIN or the community coalitions set out: reducing stigma, eliminating stigma.

Mental Health Support Network put together a very cost-effective plan supported by the LHIN. We now have what's called the Elephant in the Room program, not just in the southeast, but it has trickled into three other LHINs. It's a very much asked-for program. We're out talking about mental illness and addiction issues in schools, through companies, to the military. CFB Trenton has adopted the program. Five thousand elephants across, really now, the province, which was really the foresight of putting stigma as a performance indicator, asking people to reduce and train our folks on stigma reduction, and taking it out to the public. It wasn't just an indicator for mental health and addictions agencies; we were able to take it and make it something of its own.

I guess one of the most important pieces of that is, it has allowed this organization, through the stigma reduction program, through the redesign process, to really become a forerunner in terms of peer support. We also have started, through a research project with Providence Care, a transitional discharge model, and that is actually just being launched formally today through Providence Care, where peer support is going to be matched up with someone being discharged from the hospital. The evidence proves that if it's done correctly and the match is a good match, that the person will be repatriated and not

have to go through the readmission process, and that the person will be supported and navigated through the system upon their discharge from hospital.

Just a few of the high points that I wanted to bring forward to this standing committee of what the LHIN act has done—and in this area, the South East LHIN has really strongly embraced and ensured that we, as an organization, a consumer, are very much heard. I would like to ensure that the folks here know that that is probably one of the highest pieces of respect that you can afford the folks in the southeast, people living with mental health and addictions—is to be heard. That is the greatest thing. We don't feel comfortable, perhaps, in other areas of our lives, so to have a LHIN respect the fact that we have a voice and we have patient experience that we can share with you as a system—that really begins to change not just the organization but people's lives.

With that, I will rest, and if you have any questions—

The Chair (Mr. Ernie Hardeman): Thank you very much. We have about two minutes for each caucus. It starts with the third party. Ms. Gélinas.

M^me^ France Gélinas: Thank you so much for coming. As you know, we're reviewing the LHINs. I fully understand that because of the integration, you have a stronger voice. It's a very good story that you told us. What I want to know is: In the future, now that the integration piece has been done, do we still need the LHINs?

Mr. Garry Laws: Oh, yes. I mean, the integration piece was just one small part of the process. We have a LHIN here that encourages and enhances professional development. They're partners in the delivery of service, really, not necessarily just around integration orders.

M^me^ France Gélinas: Because other people talk about being clear as to where one's mandate ends and where, in your case, the service provider's mandate starts. You seem quite comfortable to have a bit of a grey zone there, where the LHINs also talk about human resources and community development etc., where others really want clear boundaries as to, "This is the LHIN's mandate. This is where it ends, and let us run our shop the way we want." You don't subscribe to that.

Mr. Garry Laws: What I subscribe to is that the LHIN does allow us to operate our organizations. As organizations, the board is the employer. What I do subscribe to is the global systems thinking and global unification of the LHINs as partners in the delivery, not in the actual service delivery but in ensuring that those performance indicators are met and upholding the values that come out of, in our case, the M-SAAs.

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

Ms. Helena Jaczek: Thank you so much for coming and for all the good work that you do, especially around the peer support piece. Many of us are very enthusiastic about the potential there.

Mr. Garry Laws: Good.

Ms. Helena Jaczek: Earlier today, we did hear from Providence Care mental health services, from front-line workers. There was a concern there about, in essence, the move from institutional care to the community. You mentioned that you work with Providence Care. Have you seen, from your perspective, that the LHIN is aware of the difficulties in the system in terms of capacity, whether it be institutional or community-based? From what we've heard from you, you are a fan of the LHIN. But do you feel there really are sufficient opportunities to ensure that the LHIN hears concerns across mental health and addictions?

Mr. Garry Laws: Yes, I do.

Ms. Helena Jaczek: So you would say that if there is a move from institution to community, every effort is made to make that seamless?

Mr. Garry Laws: Every effort is made to make it seamless; every effort is made to ensure that the system is integrated, that the person is not left out there without the right supports and services. I think that is a major reason why we're looking at the redesign of addiction and mental health in the southeast and what is the best model. We're still in that stage, but I was on the redesign task force and the LHIN was excellent. I have to say, it was one of the—I've been a leader of non-profits for many, many years. I will say that the expert panellists we were able to have connection to, the folks that they brought in to assist us in making decisions around the patient experience, were really first-rate. I do think that they don't make arbitrary decisions, if that's what you're suggesting. I think whenever we've done a depopulation—and I've done three of them in the developmental world—there's always, always a lot of anxiety, especially from the move from institution to community. It may not work out as best for a particular individual, but if the right care and the right leadership is there and the right planning has been done, we've done it. I feel very comfortable.

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

Mr. Rob E. Milligan: Thank you very much again for coming. I heard you speak of some overlap: some of the work that you're doing in your LHIN has spilled over into three other LHINs, I believe you said. To what extent does your organization within your LHIN work in partnership with other LHINs and other service providers in those jurisdictions? What's the scope of the partnerships there? And is that a valued thing that you think your organization—or is this an initiative that you think the LHIN should take?

Mr. Garry Laws: To answer the question in terms of what the LHIN does with the other LHINs, that would be a long answer; I don't have enough time. I sit on a provincial—I'm actually the chair of the Provincial Consumer/Survivor LHIN Leads Network, so that's how they got involved with our Elephant in the Room program. They took it back to their LHIN catchment area, and their LHINs were supporting it.

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To answer that—how did they get connected to it?—we meet on a quarterly basis, as a provincial network. It

was actually a network that was developed many, many years ago. It was mandated by a minister at the time, so we were actually mandated to meet at least twice and up to four times a year.

It's a knowledge exchange; it's information-sharing so that in the mental health and addictions world, at a peer level, that information is shared. Many, many good things are being shared across, at that level.

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

Mr. Garry Laws: Thank you.

MS. DEBORAH JODOIN

The Chair (Mr. Ernie Hardeman): Our next presenter is Deborah Jodoin. Welcome, and thank you very much for being here. You'll have 15 minutes to make your presentation. You can use any or all of that time for your presentation. If there's any time left over at the end of the presentation, we will have some questions and comments from the committee. With that, the next 15 minutes is yours.

Ms. Deborah Jodoin: Thank you very much. The surname is Jodoin.

I come from quite a different perspective than the presenters that I've heard. I don't read well from notes, so I'm just going to kind of talk off the cuff, and I might ramble a bit.

I'm a retired nurse. I nursed for 36 years, and that's partly what brought me here. I have worked on the front line. My last employment was 14 years with an assertive community treatment team—not in this LHIN; in another one.

I have concerns. I also have had experience with the LHIN. I was at some hearings in Ottawa in 2006, I guess it was, discussing the LHIN mandate. I remember that at the time, folks expressed concern that the changes that were coming about would lead to a lot of privatization and delisting and that there would be an erosion of the health care system that we know Canadians are so proud of and hold dear.

At that time, there was a lot of reassuring of the people who had concerns about the for-profit delivery of health care making inroads, that we really should relax, that that wasn't going to happen, and that there would be continuing dialogue with the community and with people who advocate for community members.

Exactly the concerns that were expressed by people at that time, and that I shared—those fears have come true with a vengeance.

The other situation I had, talking with the LHIN, was in another LHIN, the Champlain LHIN, and it was a community hall meeting. I don't remember how long ago it was. It was an exercise in frustration. It became apparent to the members of the community who were there, quite early in the evening, that it was more of a show than anything. We weren't listened to, and in fact, the whole emphasis seemed to be to steer the community members to some kind of a goal of support of the LHIN. It was very frustrating. I remember, after that, reading the report; the LHIN had some kind of written report. It didn't reflect at all what happened that night.

I understand as well that this review of the LHINs is two years late. It was supposed to happen two years ago. So maybe, from my perspective, and that's just from listening today—I've got a lot of other things to say, and 15 minutes isn't long—this is not a bad start, but if the public input is three weeks, after something has been delayed for two years, you're not going to get a good sense of what's happening, not from people like me, but—I hate the word "consumers"—from community members, people who receive the care.

I just moved into the South East LHIN, and I have to say this: I changed family doctors, so I'm now a patient of the Country Roads health clinic. It's fantastic. I met with the director, and he has a really good relationship with the LHIN. He kind of made me promise that today I wouldn't badmouth that relationship.

It's an example of best practice, I would think. There are nurse practitioners, there's a dietitian, and they even have a program where folks who can't afford it can come in and have some dental work done. There are some good things. He tells me that his relationship with this gentleman back here is really good, so that's the South East LHIN.

Also, in terms of what happens in this area, I just moved in in August, and I became aware that there's a new Providence Care hospital—it's a P3—that is going to be built. This leads to another one of my concerns. The community was informed—often, I'm sure, people learned about what was happening with this new hospital by what they read in the paper. What was in the paper was a price tag of $300 million. That's what people were told—or maybe as much as $400 million for this new P3 hospital. After the contract was signed—and I have a copy here of the document—the price tag isn't $300 million; it's $900 million.

I wrote a letter to the editor that didn't get printed. When I go out to buy a car and somebody tells me that it's going to cost something, and then when I get the bill it's three times that amount, that's not right. It was not accurately portrayed to the community. I guess that's an example. There needs to really be an opportunity to go out and get the information from people.

The other thing I wanted to say, and I don't want to run out of time: My experience with the assertive community treatment team was amazing. It's a really good program. We made a difference in people's lives because we got to work with them over a long period. Some of the clients I worked with, I worked with for 14 years.

The change in the quality of life for those people was amazing. If they did go into hospital, they weren't in for as long. We would accompany them to emergency or wherever they needed to go. The program works. You've got to fund it properly.

There are times, too—there are a lot of bed cuts, and there's this moving people into the community and treating them into the community. Sometimes what's

needed for somebody who has a serious psychiatric illness is time—time in hospital. I'm not talking about a couple of weeks; for some people, it's a couple of years for them to stabilize in a safe place with meals, where they're not going to be vulnerable to all kinds of horrible things happening.

That's kind of gone. There's too much of an emphasis on pharmacology when some kind of supportive therapy is probably more effective and a whole lot cheaper. That was one of the other things I wanted to make sure that I said to you.

The big picture, stepping back: I read the Canada Health Act. I read the LHIN mandate. What else did I read? A letter from the doctors for publicly funded health care, recommendations for where changes could happen and what to be aware of in any kind of changes.

When you deliver health care for a profit, somebody is going to miss out. There's going to be money taken off for profit. Oftentimes it ends up being that the provider—the nurse or the practical nurse who provides care—doesn't get a decent wage.

The situation in home care is a mess. I actually didn't have a South East LHIN story to tell until last Saturday. I apologize for rambling, but this really is important. My son's friend is a nurse, and he works in the States. He works for an insurance company. We got talking, and I wanted to defend our Canadian system as being superior to the American system. Hopefully you all know that that, really, their outcomes are poorer; they spend more.

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He said, "You know what? I came up here. I had to see my"—his mother lives in Tweed. Her common-law partner, who's in his mid-80s, had some kind of hernia; I think he had an inguinal hernia. He had surgery, and he was sent home. He was sent home with no follow-up at home. The next appointment with his doctor was in a three-week period, and nobody gave him instructions about what he needed to do when he went home. He said, "That's deplorable." He's right; it is. The man ended up in a very serious condition, back in emergency. Hopefully, he was hospitalized, but he might not be, in today's situation. He might be sent home from hospital, and the follow-up might be inappropriate. There are stories like that all over, and you need to invite people in to tell you those stories.

Also, the issue of extra billing: I'm told, "Well, nobody's faced with extra billing." I know they are. I've been through it with clients with the ACT team. I suggest that if you really want to find out about extra billing, have a hotline and publicize it so people know. If you've had a problem, we need to know, because that's somebody breaking the law.

We really are going to be losing our system. The priority needs to be—I guess we have to be aware of costs. If you give billions of dollars away to big corporations in tax cuts, it does reduce the amount you have to spend on health care. But it's quality; we've got to be looking at quality and not just cutting. "Ever-increasing efficiencies": I remember when that was the mantra of the LHIN. It meant cutting, and sometimes cutting indiscriminately, and giving money and being able to take from a not-for-profit and giving to a for-profit. How much profit are they making? I guess that's one thing: As a taxpayer, if my tax money is going into a for-profit corporation—and often now, it's big corporations from the States providing some care—I want to know where my money's going. I want to know how much money is spent on advertising and what their profit margins are.

The LHIN, I guess, is here. It would be nice if it actually did what it was set out to do, and if there was public input and there were people on the board, maybe, who were elected—if consumer groups that advocate for patients were invited to the table. I guess the South East LHIN does do some of that. There needs to be more. We really do need to guard our system.

I could talk for hours. I guess I come back to the first point: Please don't let this be the last time. If you've got nine months to evaluate the LHINs, and this is the last time that people like me have a chance to communicate with you, you've got a problem. You need to hear; you need to listen and go out and invite people in.

The Chair (Mr. Ernie Hardeman): Okay.

Ms. Deborah Jodoin: Yes.

The Chair (Mr. Ernie Hardeman): We have about three minutes. The third party.

M^me^ France Gélinas: I'm most interested in the example that you gave us where the LHINs had held a meeting. There were consumers there so, obviously, people came—

Ms. Deborah Jodoin: I hate that word "consumers" too. I'm a citizen—

M^me^ France Gélinas: Okay, there were people there.

Ms. Deborah Jodoin: Yes.

M^me^ France Gélinas: There were people there so, obviously, whatever invitation went out, people got the invitation and came. But you felt that you were not listened to. What proof have you got that you were not?

Ms. Deborah Jodoin: Oh, you could talk with anybody that was at that meeting. It was in Cornwall. I could find out exactly when it was. I was talking yesterday, actually, with somebody else who was at the table with me about how frustrating it was.

M^me^ France Gélinas: What was the issue that you were talking about?

Ms. Deborah Jodoin: It was feedback to the LHIN.

M^me^ France Gélinas: On?

Ms. Deborah Jodoin: It's quite a while ago now. I guess we expressed concerns, probably, about things like competitive bidding for home care and how it's a race to the bottom and the service has just deteriorated. It might have been that. It might have been just closing beds and amalgamating services without a proper look at whether that was, in the long run, wise—probably a number of issues.

M^me^ France Gélinas: Okay, on a number of issues. You read the report, and you saw that your comments had not been captured adequately?

Ms. Deborah Jodoin: It was almost funny, if it hadn't been so serious. There was—I can't remember, quite frankly; that was quite a long time ago—but reference to the fact that there was a lot of criticism. You know how you can neutralize language, and something can be made so confusing that it's hard to not know it wasn't positive. It was that kind of minimizing the—

M^me^ France Gélinas: Has it improved since? Have you had the opportunity—did you receive other invitations to participate in a LHIN-led—

Ms. Deborah Jodoin: No, no.

M^me^ France Gélinas: You're off the list now?

Ms. Deborah Jodoin: Well, I don't know. I don't know. That was quite some time ago.

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

TOWN OF SMITHS FALLS

The Chair (Mr. Ernie Hardeman): The next presentation is the town of Smiths Falls. There was one cancellation prior to that—Kingston, Frontenac and Lennox and Addington Public Health—so the next one is the town of Smiths Falls: Dennis Staples, Mr. Mayor, sir. Your Worship, welcome. As with all the other delegations—the mayor is no different—you have 15 minutes to make your presentation. You can use any or all of your time—

Mr. Dennis Staples: I want to thank the Clerk for allowing me to have standing today. I just found out about this late Friday for another purpose, and thank you for the opportunity. I haven't had a chance to prepare notes. Normally, I speak, but I have some notes I'd like to read to the committee. I should add a thank you for allowing me to provide this input.

The others have provided some background in terms of our involvement with health care. Mine goes back to 1968, which is just about 46 years ago, and my involvement with my council is 29 years. So if you add that up, that's 75 years—not all together. Thank you for this opportunity.

My comments are going to be very general. I'm in support of the LHIN community model—whatever you want to call it; it's now known as LHIN—for a variety of reasons. In my humble view, in terms of my involvement with health care over a long period of time, the current model we have provides better planning, much better decision-making and public engagement at the local level, and that's the key in terms of meeting the needs of our communities. The needs of our communities are all different; I'm sure everyone would agree with that. It also provides greater opportunity for collaboration and finding best or great solutions of the many health care providers that exist in our areas. It's a complex area, as you probably all know. I expect that this same comment would be true of the other 13 LHINs in the province, of the total of 14.

The health care map is complex and daunting, especially for those who have to access it, have to navigate within the system. I firmly believe that the LHIN model provides an important remedy for system improvement, service response and good decision-making related to health care for the customer, client, patient, consumer—whatever the current terminology is—and also for the family as well, which is part of this navigation.

I also have a comment that is individualized in my case. Could this objective be successfully achieved in a centralized model? I worked in the centralized many years ago when I worked for the OPS as part of the Ministry of Health and, subsequent to that, community and social services. My humble view as a citizen and as a mayor and as one who has had experience with the current model—could this be successfully achieved in the corporate model, i.e. a centralized or Queen's Park model? It's my opinion that, no, we wouldn't do it as well.

The community model, i.e. the 14 LHINs, has been, in my view, truly effective and in my opinion, well and increasingly effective in determining the services required by our citizens. They differ in our various regions, even within our LHIN. It responds to local needs and priorities and also addresses the health care challenges and deals with the critical issue that I think we're all painfully aware of: allocating and determining the allocation of scarce health care resources.

The second part of my presentation is to give you an example of something that Smiths Falls has been involved with and I've been involved with personally.

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Our community is well known for job loss and all those other challenges, which I won't go into today. This is not the time for that. But about three or four years ago, when we were dealing with some significant economic challenges, in addition to that we had three local doctors who decided to leave. Two retired and one passed away. Smiths Falls is a community halfway between here in Ottawa. It's a community of 9,000. When I talk about Smiths Falls, I'm talking about Smiths Falls and area.

We had two local doctors retire and one unfortunately passed away. That impact created 5,000 to 7,000 citizens in Smiths Falls and area who found themselves without a doctor. That put a tremendous strain on our emergency room. One of our local doctors—I'm not proud to say this—had a plaque in their office, a poster, that said, "If you need a doctor, go to see the mayor of Smiths Falls. He has to solve that problem."

Well, we've done a good job of solving that problem by working with our LHIN and the other partners, and I'll tell you about that. It has put a tremendous strain on our community. A lot of those individuals are still without a doctor. We've had individuals who have chosen to leave Smiths Falls because their doctor is in another area. From an economic point of view we've had citizens choose not to live in Smiths Falls because they can't find a doctor. So I wanted to point that out as well.

The South East LHIN—when I first became aware of this, I made a phone call. It was on a cold day in January three or maybe four years ago, the day after January 1. My phone call was responded to within about 30 minutes by the gentleman sitting behind me—his staff. We said, "We have to solve this problem." And we've done a good job of solving that problem.

Extra support has been provided for our emergency room to get us through this challenge—our emergency department at the Smiths Falls site, or Perth and Smiths Falls District Hospital. Our community health centre, located in Smiths Falls, was resourced to take on some vulnerable clients who are part of that 5,000 to 7,000.

We've also found a way that we can hopefully attract new doctors to our area. The young grads are looking at working in a practice where there are other doctors there in terms of mentoring, consultation and not faced with the challenge of setting up their own practice because of the tuition debt that they have going through medical school. So we've created, with the support of our local communities, our municipalities, a local developer and some funding from the South East LHIN, a turnkey operation that would hopefully be able to attract up to six or eight new doctors. That's almost completed. That wouldn't have happened without the support of what I've just described.

The final obstacle is recruiting new doctors, and we're working on that as well. But what I wanted to say and allow some time for questions is that the model that we currently have in place, the LHIN, and in our particular case the South East LHIN, has absolutely been critical in assisting us working through those situations in terms of support, assistance and understanding. They continue to work with us as well.

My final plug for this is to say that this model provides an opportunity, an obligation and a responsibility to our citizens to work within the LHIN structure to ensure that good plans are developed, priorities are identified, responsible decisions are made and the various local health agencies are at the table to allow this to occur—our hospitals, community care access centres, mental health and palliative care.

Recently, within the last month, I attended a meeting in Smiths Falls of all these groups coming together looking at another initiative that's under way that's absolutely critical called health links. For some of these leaders it was the first time they had been in a room together. Would that have occurred without the structure that's in place? In my opinion, no, it wouldn't have.

I think this is an effective model to ensure that we continue to look at system improvement opportunities and local response to needs that are different throughout the province. That's what I wanted to tell you this afternoon.

The Chair (Mr. Ernie Hardeman): Thank you very much. With that, we have about seven minutes left. We'll start with the government. Mr. Fraser.

Mr. John Fraser: Thank you, Mayor Staples. Thanks for coming to present today. What I'm really interested in hearing, though, is a little bit more about this solution that you came up with around having family doctors. Now you're at the recruitment stage, so how are you connecting with everybody on that?

Mr. Dennis Staples: For the past 20 years I've been mayor, I'm contacted three or four times a year to meet with a prospective new doc—these young docs. What we've discovered is that in terms of the doctors who are retiring, now they have huge caseloads of maybe 1,500, 2,000. In fact, one of our doctors who passed away had a huge caseload; we're told 3,000 to 4,000.

The new docs want caseloads of 800 to 1,200. They want to have a life. They don't want to incur debt. So we've heard consistently from these new docs in the last number of years that if there was a place where they could go and set up shop—it's already there; the overhead is there; the diagnostic equipment, computers, technology; and, by the way, they work with other established doctors. It's been described to us as a turnkey. That's exactly what we've created. It's just about to open.

Mr. John Fraser: How do you advertise, in terms of how do you connect with those potential doctors out there?

Mr. Dennis Staples: Well, recently—our director of economic development just retired. For the past four or five years, our town, through our economic development department, which we've totally supported, goes to these recruitment fairs. It's called PARO fairs—the young grads. Currently, we have a list of about 125 potential graduates we're working on to try and entice them to come to Smiths Falls, come and serve our area. So that's one of the ways we're doing it.

Also, the existing docs, through word of mouth, have their points of contact to say, "If you're thinking about graduating, you might want to come to our community and have a look at what we have available."

The other thing that's really to our advantage is that through the Ontario government—we thank you all for your support in this—we've had a significant redevelopment of the Smiths Falls site of the Perth and Smiths Falls District Hospital, close to $50 million. It's wonderful, so that's another attraction for us.

It's a variety of efforts we're doing to try to attract new grads and even existing doctors to consider our lifestyle, our way of life; and, by the way, we have a place for you to work in.

The Chair (Mr. Ernie Hardeman): Thank you very much. We have to cut it there. Mr. Milligan?

Mr. Rob E. Milligan: Thank you very much for coming in. It's always great to see that local municipal individuals like yourself, who represent the people, are as active as you are in recruiting health care providers. I guess that was sort of an area that I wanted to dive into as well. We've heard that, obviously, you're in favour of the LHINs. Is there anything that you would recommend to improve upon, something that you feel obviously needs to be addressed within the LHIN model itself, not necessarily for just the southeast, but the rest of the province?

Mr. Dennis Staples: I'm going to answer that in a very general way. I would hope that there's continued support for this community or regional approach to health care. Now that's described as the LHIN.

The other thing I would hope, and I'm sure this communication linkage is there, is that if issues arise within a LHIN—I'll use the South East LHIN as an example—in terms of a pressure point, that those issues get forwarded to the Ministry of Health and Long-Term Care at a very senior level in terms of making adjustments and remedies in terms of a particular challenge within our LHIN that we can't address with existing resourcing, and hopefully that gets dealt with at a higher level. I think I would just ask that the system be supported and continued, because, in my view, with the examples that I've been involved with, it is serving a very useful purpose and making a much-needed difference.

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

Mr. John Vanthof: Thank you, Mayor Staples, for coming in and giving us some of your insight. Coming from northern Ontario, we face a continuous shortage of doctors. I really appreciate your advocacy on that issue.

One thing I'd like to dig a little bit deeper on: your new turnkey facility, which I commend you on. How will the doctors be funded? Is it a family health team or a community health care centre?

Mr. Dennis Staples: I believe it's a family health team. But we also have a community health centre as well, a CHC in Smiths Falls. I should also add: A couple of years ago we were provided with the nurse practitioners' clinic as well. So we're looking at a variety of things to try to provide for the needs of our community and area.

Mr. John Vanthof: Because if there's one thing that we're still trying to get our heads around, and in my community we're trying to get our heads around, and I believe this committee as well, it's: What is the funding model that's best for doctors, for the community? A family health team is quite a bit different than a community health care centre.

Mr. Dennis Staples: I'm going to answer that by saying I'm not sure, and I would not make a guess. My concern is trying to provide the resources to our community to meet the needs, and then sort out the chapter and verse as a result of that.

Mr. John Vanthof: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much, Mr. Mayor, for being here and making your presentation.

We're slightly ahead of time, and our last delegation is not yet here, so we will call a recess for a health break while we wait for the next deputation.

The committee recessed from 1429 to 1438.

ONTARIO HEALTH COALITION

The Chair (Mr. Ernie Hardeman): I call the meeting back to order. I was going to say that I believe our late delegation has arrived, but that would be totally inappropriate. We're still ahead of time, but we very much appreciate that you have arrived and we can get on with having this delegation. Thank you very much for taking the time to come and talk to us today. We very much appreciate your willingness to do that.

As with all our delegations, you'll have 15 minutes to make your presentation. You can use any or all of that time as you see fit. If at the end of your presentation there's some time left, we'll have some questions and comments from the committee. With that, the clock starts now and the next 15 minutes are all yours.

Ms. Natalie Mehra: Thank you very much.

The Chair (Mr. Ernie Hardeman): Before you start—we'll restart the clock—the delegation is the Ontario Health Coalition: Natalie Mehra, executive director. I should have introduced our guest; I totally forgot. With that, the clock starts now.

Ms. Natalie Mehra: Okay. Thanks for having me. I apologize for not being able to be at the hearing yesterday. Thank you for hearing from me today instead.

The Ontario Health Coalition's mandate is to protect public health care under the principles of the Canada Health Act. We have a network of local health coalitions across Ontario, 400 member organizations, and thousands of individuals committed to protecting public medicare. We've had extensive experience, both prior to the passage of the Local Health System Integration Act and since, in trying to work to preserve and improve single-tier public health care services across Ontario.

I struggled a little bit with this presentation because I didn't want to be too negative. Although there are obviously people within the local health integration networks who have great expertise and although there are individual projects within LHINs that do have the potential to—or do, actually—improve health care, overall we are concerned that since the passage of the local health integration network act, the fundamental principles of the public health care system have been eroded.

The other day, Bob Hepburn, one of the editorial opinion writers for the Toronto Star, wrote a column—it was rather a shocking column—in which he said that health care services have not been eroded in the way that they are now in more than a decade, since the deep cuts of the mid-1990s. That's a really big statement to make. I sat back and thought about it and tried to quantify: Where are we seeing cuts? To what extent is public access to services being eroded? In truth, that statement is justifiable by the evidence. Unfortunately, part of this, although not all of it, is under the purview of the LHINs and part of it is under the ministry's planning. I'm going to try and separate out what we see happening—quickly.

From our perspective, the fundamental role of a public health care system is to measure and try to plan to meet population need for health care. That's a fundamental role of the public system. We pool our resources through our taxes; we redistribute them out through free services at the point of need. The idea of that is that cost should not be a barrier to needed care. That, I believe, is sup-

ported by almost all Canadians and certainly all political parties in Canada. Therefore, the design of the public health system is supposed to meet these fundamental goals and principles.

However, what we've seen is that under the planning regime instituted and the extraordinary restructuring powers under the Local Health System Integration Act, these principles have been subverted to a command-and-control structure that has removed, in many cases, meaningful public input from decisions that affect the community; that institutes a planning system that actually bears no relation to community need for services; and has adopted an arbitrary integration imperative that is more ideological than it is evidence-based. In fact, while the LHINs are currently making some moves towards restructuring community health services, the prime accomplishment that they have made over the years has really been to enforce hospital cutbacks. These are very, very significant hospital cutbacks.

The LHINs' own accountability mechanisms to the ministry are themselves quite convoluted. The performance indicators are very few for the LHINs. There are 15 of them, actually, and they themselves are not enforceable. Many of them, actually, fall out of the LHINs' powers to actually address in a concrete way, but they're not enforced and they're not really enforceable. The LHINs also have a secondary process of integrated health services plans with a whole separate set of goals that they're also supposed to follow in their communities. Those goals don't necessarily match with the performance indicators. None of those flow from any kind of plan to measure and try and meet population need for health services.

This is what we've seen, in short: We've seen that in Ontario's health care system now, there is no capacity planning. This is a really fundamental problem. The last capacity planning that was done was in the 1990s under the health restructuring commission. Although we had issues with the bed targets at that time—they were set on Australian benchmarks—certainly, the process was one in which there was a clear plan for each community. The plan was published; there was opportunity for meaningful public input. The plan could be appealed on the basis of evidence. There was a whole process around that. None of that currently exists under the local health integration network planning system.

To date, the LHINs have engaged, and, without actual integration orders from the LHINs, hospitals themselves have engaged in an array of cutbacks that are ad hoc, that are not associated with population and need. What we've seen put at most risk now across Ontario are rural hospitals and rural health care services in particular; chronic care, or what they now call complex continuing care hospital beds; physiotherapy and rehabilitation services; an array of outpatient clinics, like pain clinics, that have been closed for entire regions; and the whole gamut of care that is longer-term care, which is now very severely rationed and very deeply privatized.

Our first concern is that under the LHINs legislation, the minister is supposed to have created a strategic plan for the health system. That strategic plan is supposed to have guided the LHINs' strategic plans for their own areas. So, like a pyramid, the vision and goals of the health system are supposed to flow out across the province. There should be central standards set, and then each of the regions follows those standards and develops its own health care system to meet the unique needs of their communities. There is a lot of good wording in the LHINs legislation around coordinating care and measuring and meting care and flowing the plans from this strategic plan.

However, the minister's strategic plan for health care—there was supposed to be a 10-year strategic plan created in 2004 after the legislation was passed. That plan never materialized. We were told by Elizabeth Witmer's staff at the time that Elizabeth Witmer had done a freedom-of-information request for that strategic plan and was told that it would not be released publicly, despite the fact that the legislation calls expressly for public release of the strategic plan. They were told that it was a cabinet document. We never found or were able to get a copy of that 10-year strategic plan. This was when George Smitherman was health minister.

Currently, there is another plan for health care: Ontario's Action Plan for Health Care. I don't know if that is supposed to be the strategic plan for health care, but if it is, it has very few concrete, actionable items in it. It has very few concrete goals. It doesn't follow the format set out in the LHINs legislation, with a vision and strategic goals to meet it, and so on, and in fact, isn't strong enough or clear enough or even concrete enough of a document to guide a health system for a province.

If you compare our planning regime to other jurisdictions—I'm going to run out of time—you'll see that other jurisdictions actually have bed studies for long-term care; they actually have bed studies for hospital care; they have benchmarks; they have occupancy rates that they try to meet. None of that exists in Ontario's health system.

In Ontario, we've seen an entire hospital closed in Shelburne. That decision never even went through the local health integration network. It didn't go through the integration process, where there's supposed to be a board motion—integrations, of course, defined as coordination, right through to closures and dissolution of health care services.

We've seen the entire closure of the health centre, the hospital—what remained of the hospital—in Burk's Falls, similarly treated as a department of the larger hospital, not recognized under the LHINs legislation as an entity unto itself because it's not a separate corporation. The whole community lost those services.

We've seen a so-called Hospital Improvement Plan required by the budget deficit in Niagara, which was prior to the requirement for the cuts plan—euphemistically called the Hospital Improvement Plan—a $15-million deficit. The plan cost $60 million. At the end of the day, this year, that hospital, after closing all of the

acute care beds, all the services and the emergency departments in two entire communities of 20,000 and 40,000 people—Port Colborne and Fort Erie—that hospital now faces a $13-million deficit. The plan was never properly costed by the LHIN. There was no measure of new patient risk as a result of closing the vitally needed services in those community hospitals. There was no measure of increased costs on the municipalities. Tax increases had to actually be brought in in Niagara to pay for the increased ambulance costs in that community. There was no real, proper planning, and Niagara still has huge backlogs because of a lack of long-term-care beds and now a severe shortage of hospital beds.

We've seen in communities like Wallaceburg and Petrolia, where the local small and rural community hospitals are under constant risk of closure, again treated as departments of the larger hospitals because small and rural hospitals that are amalgamated to larger hospitals, under the LHINs' regime, are not considered to be separate entities.

And so, without any process whatsoever, either an unelected board of people in the LHINs, in the cases of Petrolia and Wallaceburg where the LHINs have intervened, or the hospital board itself, also an unelected group of people in the case of Shelburne and Burk's Falls, have arbitrarily decided to close down entire health care services for entire regions, with very superficial—if any—consideration for the consequence of cutting those services.

What we're seeing is that, at the bottom line, health system planning is now divorced from population need for care. That is a real problem. If regionalization was about measuring and trying to meet population need for care, about strong provincial standards and enforcing those, about embracing the uniqueness of each region of Ontario in the local health system and empowering local people to make decisions about that, and to give feedback about what's working and what's not, we could support it, but none of those things are actually happening under the local health integration networks.

We think that reform needs to follow a principled track that flows from the notion that the fundamental goal of the health system is to measure and try to meet population need for care. So what we're recommending is that the extraordinary powers for restructuring be removed from the LHIN legislation—that nobody should be able to restructure or required to restructure in perpetuity anyway. It doesn't make any sense. It's demoralizing. It's damaging to the health system, and the LHINs have not shown that they have the capacity or the proper processes to engage in permanent health care restructuring. Even the Health Services Restructuring Commission in the 1990s had a sunset clause. It restructured for a number of years, and then it ended, and the system was able to rebuild to some extent again.

It should be needs-based, focused on the core goal of the health system. It should focus on equity. Public ownership and non-profit control should be embodied in the act; currently, the LHINs are able to transfer services to for-profit entities—the minister, under the act, is not, but the LHINs are able to.

They should be democratic, in keeping with our democratic traditions in terms of school boards, in terms of municipalities and, in fact, in terms of the provincial government. There should be concrete protections for patients against user fees, extra billing and cuts to medically needed health care services.

We don't have time to go into the rest of the details, so I will be happy to provide them in a written submission.

The Chair (Mr. Ernie Hardeman): Thank you very much for that. We have less than a minute left, so we will leave it at that.

We thank you very much for making your presentation. If you do leave a copy of your presentation, we will make sure that the committee has that in its entirety, so that it can be read for their deliberations.

Ms. Natalie Mehra: Thanks.

The Chair (Mr. Ernie Hardeman): Thank you again for being here. We very much appreciate the time you took.

That's the end of the deputations this afternoon. If there's nothing further, for the good of Rotary, this committee stands adjourned.

The committee adjourned at 1454.

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