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Monday 13 May 2013

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Lundi 13 mai 2013

Standing Committee on Social Policy

Oversight of pharmaceutical companies

Comité permanent de la politique sociale

La surveillance, le contrôle et la réglementation des entreprises pharmaceutiques

Chair: Ernie Hardeman
Clerk: William Short

Président : Ernie Hardeman
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 13 May 2013

Lundi 13 mai 2013

The committee met at 1440 in committee room 1.

OVERSIGHT OF PHARMACEUTICAL COMPANIES

The Chair (Mr. Ernie Hardeman): I'll call the Standing Committee on Social Policy to order. We're meeting for a study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies.

Just one announcement: Obviously, because of the length of the routine proceedings today, we will be short of time for the three delegations. So rather than have one delegation be cut tremendously short, we will, with the committee's indulgence, have the same length of presentations from each members and then we'll have the parties—each caucus will have 15 minutes rather than 20 to ask questions. That way, we'll treat everybody fairly and we will get the most we can out of all the delegates that are here.

ERIE ST. CLAIR LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): With that, we thank you very much. Before we start, the committee does work on sworn testimony, so we will ask the Clerk to swear in the delegates.

The Clerk of the Committee (Mr. William Short): Mr. Switzer, you wanted to be affirmed, correct?

Mr. Gary Switzer: Correct.

The Clerk of the Committee (Mr. William Short): If you could just raise your right hand, please. Mr. Switzer, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Mr. Gary Switzer: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for coming in today, Mr. Switzer. As you just heard, we will give you a 20-minute opportunity to make your statement, and then we will start with questions from each caucus.

Interruption.

The Clerk of the Committee (Mr. William Short): It's just a quorum call. It's okay. We can keep going.

The Chair (Mr. Ernie Hardeman): We can keep going, thankfully. Which caucus do we start with? We'll start with the opposition caucus for the questions—after the presentation. Okay?

Mrs. Christine Elliott: Okay. All right. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. The floor is yours to make your presentation.

Mr. Gary Switzer: Thank you for inviting me here today to speak about LHINs and our role within the health care system. I am Gary Switzer, the chief executive officer of the Erie St. Clair Local Health Integration Network, or LHIN, as we are commonly known. I am proud to be a charter member CEO, joining the LHINs in August 2005. Our acting chair, Dr. Michael Hoare, was invited to be here today; however, he is out of the country.

I report to a local board of directors with representatives from all three of our counties: Windsor-Essex, Chatham-Kent and Sarnia-Lambton. Being in this role for eight years, I've seen first-hand the evolution of the LHINs and the improvement in the delivery of health care in Erie St. Clair and in Ontario.

Prior to coming into the health care sector, I held senior executive roles in the telecom and broadcast industry in Canada and the Middle East. I applied for this role at the Erie St. Clair LHIN; I was not recruited or head-hunted. It was a conscious decision on my part to plan a career move into the health care sector. I consider my experience within industry to be an asset that could assist in the transformation of health care in our province. My experience in the private sector has served me well through my career transition.

In my time at the LHIN, I have worked provincially on committees such as the hospital working funds deficit committee; the MLPA, which is the ministry-LHIN performance agreement joint advisory committee; the hospice palliative care provincial steering committee; and the neurosurgery Ontario performance management working group, to name a few.

Cancer and cancer treatment is a serious issue. Cancer, in one form or another, has profoundly touched the lives of most of us in this room. My heart goes out to those patients, their family and their friends because during a difficult time they had to endure further anxiety over the uncertainty of their chemotherapy treatment.

The LHIN role: The 14 LHINs were established in 2005 to build a stronger health care system in Ontario. Each LHIN covers an identified geographic region and

works at the local level with health service providers and the community.

In my region of Erie St. Clair, we have 87 health service providers that serve a population of approximately 640,000 people and we fund over a billion dollars to local health care providers.

Across the province, the LHINs believe that local health care needs are best understood by people who live and work in our communities and who are able to engage the people who live there.

The word "local" is well placed in our name, local health integration network. LHINs are responsible for planning, integrating and funding local health services, and ensuring the accountability of local health service providers, including public hospitals, community care access centres, community support service organizations, mental health and addiction agencies, community health centres and long-term-care homes. Therefore, we do not have responsibility, nor accountability, for the funding of physicians, public health, ambulance services, laboratories or the provincial drug programs.

The LHINs operate within an accountability framework that is comprised of the Local Health System Integration Act, a memorandum of understanding with the Ministry of Health and Long-Term Care and the ministry-LHIN performance agreement, also known as the MLPA. This agreement outlines strategic-level targets that we must meet and relate to the improvement of the local health care system.

Erie St. Clair LHIN's strategic directions of better care, better experiences and better value guide all of our decision-making.

Our integrated health service plan is our three-year regional planning document that provides a snapshot of our population health and clearly outlines what our priorities are in how we will measure improved care. In arriving at our priorities we engaged our communities in conversations and workshops, and spoke with front-line care providers, physicians and many stakeholders to make sure we were on the right track, with the confidence that our local health care system is in agreement on where we need to focus our resources. We can work with our partners to accelerate system transformation.

Our LHIN's priorities are improved outcomes in alternative level of care; improved outcomes in the emergency department; improved outcomes in chronic disease management; improved outcomes in mental health and addictions; and certainly continuing to focus on better care for seniors and helping our older adults to age at home, surrounded by their life's memories and where they are most comfortable.

We have accountability agreements with all of our health service providers that outline their specific accountabilities and performance metrics. These agreements are publicly available.

Simply put, LHINs are able to translate the provincial strategies by localizing them, so you can see a straight line from the Premier right through to the patient. Our accountability agreements with all of our health service providers ensure there is alignment and performance measures.

Each health service provider organization is responsible for overseeing their own operations and service delivery and is governed by their own board of directors.

We therefore maintain a strategic and overseeing role in health care transformation and administration. I am proud of the work the Erie St. Clair LHIN has done in improving local health care. We build positive relationships with our health service providers, and it is because of our local connection to these agencies and hospitals that I can stand before you today and share my knowledge of, and intersection with, the chemotherapy issue. It is because we work closely with our hospitals that our internal issues management protocol worked.

We are able to share and receive information such as the situation we are all here today to discuss. In regard to the chemotherapy issue we are discussing today, as stated, we have a system-level accountability. Therefore, we did not have a clinical role, but rather, assisted our hospitals in coordinating a response.

LHINs work at the system level. We have confidence in our funded agencies to provide the direct clinical services and management of their day-to-day operations. In this particular case, we did not have a role in the procurement, distribution, administration or monitoring of chemotherapy pharmaceuticals. The clinical expertise and decision-making in regard to life-altering cancer treatment rests properly with our hospitals and health care providers.

As I'll elaborate later in my address, you'll see that the hospital led their response to their staff and patients, and on behalf of our LHIN, I coordinated a provincial discussion.

Timeline: With that in mind, I'll brief you on my knowledge of, and involvement in, the chemotherapy issue. The following is my recollection on how events unfolded.

On Saturday, March 30 of this year, I first became aware of a challenge with certain chemotherapy medications through our issues management protocol with Windsor Regional Hospital. The issues management protocol is a process that we have with all of our health service providers that encourages open communication and the sharing of sentinel events with the LHIN for information, support and/or possible action.

The same day, on March 30, I was informed by telephone from Windsor Regional Hospital CEO David Musyj that they had learned of an under-dosing issue with chemotherapy medications through London Health Sciences Centre that affected an estimated 289 local Erie St. Clair patients. After he explained the issue and his action plan, he asked for my help. I realized that he needed his organization to focus on their plan to reach out to patients and mobilize their response, and that I could assist in coordinating a provincial discussion.

Mr. Musyj also provided me with Windsor Regional Hospital's plan for informing their staff and patients. He outlined the steps they were going to undertake, includ-

ing a copy of the draft letter they were hand-delivering to patients; information on the hotline and information walk-in centre they were establishing; information on the process for the phone calls they were going to make; and a plan to engage the media through a coordinated approach.

Mr. Musyj asked for the Erie St. Clair LHIN's support on this issue, and I certainly agreed to assist where we could. I also offered to take on a provincial coordination role with other LHINs and Cancer Care Ontario. By doing this, I was able to help reduce the pressure on the hospital and move action along by coordinating the information sharing and provincial conversation. This meant that the hospital was able to apply their clinical and operational expertise and begin their patient and staff outreach.

LHINs have the ability to act both locally and provincially, and play a coordinating role to help connect all the parties.

Immediately after my discussion with Mr. Musyj, I contacted the CEO of the South West LHIN to inquire as to their involvement and plan. I asked for their assistance to coordinate activities as Windsor Regional Hospital was preparing to reach out to their patients on April 2.

As part of our issues management process, I reached out to our Erie St. Clair LHIN senior staff who was on call that weekend for after-hours issues and emergencies. I provided information to him and explained the hospital plan in place to communicate to patients and staff. In my coordination role, I also spoke with Claudia den Boer, Windsor Regional Hospital's and Hôtel-Dieu Grace Hospital's regional vice-president, cancer services, to inquire further about the involvement of Cancer Care Ontario and London Health Sciences Centre. I also wanted to further my understanding of the situation and update her on the actions I was taking.

1450

In speaking with Mr. Musyj and Ms. den Boer, it was apparent to me the provincial implications of this issue, and I requested a conference call for April 1. There would be representation from the three affected hospitals, three LHIN CEOs and Cancer Care Ontario.

On April 1, the conference call was facilitated by Cancer Care Ontario's president and CEO, Michael Sherar. Information was shared on the coordinated efforts to inform patients and the broader community. During that conversation, we were all made aware of the strategies each of the organizations were already taking, or were planning to take, to address the issue with their staff and patients.

Discussion around timing of the announcement for patients and the public sharing of the situation and information on where patients and their families could go to for answers—we were focused on alignment to ensure that each organization would be prepared to support their patients.

Later in the day on April 1, I spoke with our director of communications and public affairs and updated her on the situation. Our director of communications and public affairs also informed me that our office had received concerns from members of the public regarding this issue.

Our communications staff shared Windsor Regional Hospital's messaging on our website and directed concerned community members to the Windsor Regional Hospital hotline and website for more information, as well as to Cancer Care Ontario.

During this time, Windsor Regional Hospital was holding town hall meetings for their affected patients and families, as well as their staff. Since those initial meetings, I kept in regular contact with Windsor Regional Hospital and Cancer Care Ontario.

At this time, I want to acknowledge the outstanding work done by Windsor Regional Hospital and their staff: Christine Donaldson, regional pharmacy director, Hôtel-Dieu Grace Hospital, Leamington District Memorial Hospital and Windsor Regional Hospital; Claudia den Boer, regional vice-president, cancer services, Windsor Regional Hospital and Hôtel-Dieu Grace Hospital; Dr. Gary Ing, chief of staff at Windsor Regional Hospital; Dr. Ken Schneider, chief of oncology at Windsor Regional Hospital; and David Musyj, president and CEO at Windsor Regional Hospital.

Windsor Regional Hospital responded quickly, informatively and compassionately to the patients affected within Erie St. Clair. When I initially spoke with Mr. Musyj on March 30, 2013, he shared with me his plan for responding to the issue and he had all hands on deck during the weekend to work on this issue. I was confident in his strategy and ability to reach out to his hospital staff, patients and their families, to do whatever he and his team could do to help ease anxiety and provide a compassionate response to a very difficult situation.

I read Mr. Musyj's opening statement when he appeared in front of this committee on April 22. He referenced the "just culture" at Windsor Regional Hospital. As Mr. Musyj explained, a just culture is about mutual trust. I've experienced this as an administrator and as a patient at Windsor Regional Hospital. When you work with the staff at Windsor Regional Hospital and walk the hallways, as I do, you sense the culture of mutual trust, and know that "outstanding care, no exceptions" is much more than a tag line.

In closing, for the patients and their families, I wish that this never happened, but it has.

I'm a cancer survivor myself, and when you're first diagnosed and after the initial shock, you put your entire trust into your physician, the hospital and the system they work within. It is the most vulnerable I have ever felt. However, I had faith in my physician and the system, which I still do.

I can only imagine the impact that the patients who were affected by this issue must have felt. I do know that each organization felt the same way and put in measures to address all patient concerns.

Now we need to find real answers. Now is the time to understand what system changes need to take place to help restore confidence in our excellent health care

system and reassure all cancer patients that they are receiving the care they are expecting. This is not the time to point fingers, assign blame and create divisions amongst partners. No, now is the time for the health care system, our politicians and our leaders to come together and find solutions to ensure that this can never happen again.

Thank you. I'd be pleased to take your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. With that, we'll start with the official opposition. Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Mr. Switzer, for joining us today. We agree that we're all trying to find out what happened here to make sure that it doesn't happen again, and so I have a few questions for you just regarding some of the agreements that were entered into.

You mentioned on page 3 of your presentation that you have an accountability agreement with all of your health care providers, and I'm assuming you would have had one with the hospitals that were affected here?

Mr. Gary Switzer: That's correct.

Mrs. Christine Elliott: Do you recall what year those agreements were entered into?

Mr. Gary Switzer: They're entered into annually, and they're signed annually.

Mrs. Christine Elliott: Would you be able to provide us with a copy of the—have you signed one for 2013, as well as 2012?

Mr. Gary Switzer: Yes. They're on our website—

Mrs. Christine Elliott: Are they? Okay.

Mr. Gary Switzer: —and they're on each agency's website as well, but I'd be prepared to provide them as well.

Mrs. Christine Elliott: All right. If you could, that would be great. Thank you.

You also mention, on page 4, I believe, of your statement, that you didn't have anything to do with the procurement of drugs and so on. Would responsibility for that have been outlined in the accountability agreement that you had with the health care providers?

Mr. Gary Switzer: No. We don't outline what their responsibility is with respect to procurement. It's covered that they have to followed broader public service procurement rules, but beyond that with specifics, no.

Mrs. Christine Elliott: So you didn't have any specific requirements with respect to procurement of any drugs?

Mr. Gary Switzer: None.

Mrs. Christine Elliott: Okay. Were you aware that some of the hospitals were outsourcing the admixtures of chemotherapy products?

Mr. Gary Switzer: I was aware that various hospitals produced some of the pharmaceutical treatments in-house and some of it is outsourced to a third party. It's their decision based on quality, process and effectiveness. I wasn't aware specifically of any specific treatments.

Mrs. Christine Elliott: So you left that up to the individual hospitals to negotiate in their best judgment about how to manage their resources and what was best for the patients?

Mr. Gary Switzer: Exactly. That's where the expertise is.

Mrs. Christine Elliott: Okay. Are you familiar with Medbuy as an organization?

Mr. Gary Switzer: Yes, I am.

Mrs. Christine Elliott: And were you aware that Medbuy was involved in this particular situation?

Mr. Gary Switzer: I found that out after the fact. As more information became available, I was aware of Medbuy with this specific purchase, yes.

Mrs. Christine Elliott: The hospitals wouldn't have been required to provide you with copies of any of those agreements, would they?

Mr. Gary Switzer: No.

Mrs. Christine Elliott: Before this happened, were you familiar with the contents of any of those agreements?

Mr. Gary Switzer: The contents? No, I've never seen one of their agreements.

Mrs. Christine Elliott: All right. Thank you.

Mr. Gary Switzer: Thank you.

Mrs. Christine Elliott: My colleague may have some questions.

The Chair (Mr. Ernie Hardeman): Mrs. McKenna?

Mrs. Jane McKenna: Hi. Were you aware that there was a grey area with what was going on with the brokering between Medbuy and Marchese?

Mr. Gary Switzer: Not at all.

Mrs. Jane McKenna: No? So there was never any mention at any time that there was any issues at all with Health Canada and the Ontario pharmaceutical—with the overlap, with neither of them regulating the—

Mr. Gary Switzer: The first time I heard about Marchese as a pharmaceutical supplier was when this occurred. I'd never heard of them before.

Mrs. Jane McKenna: So you were familiar with Baxter, then?

Mr. Gary Switzer: Oh, Baxter I'm aware of. I'm aware of that brand, yes.

Mrs. Jane McKenna: Okay. That's fine for me right now.

The Chair (Mr. Ernie Hardeman): With that, we'll go to the third party. Ms. Gélinas?

M^me^ France Gélinas: Good afternoon, and thank you for coming to Queen's Park. I have a few questions that I want to ask, but first, I want to clarify a few things that you said during your presentation. You sit on quite a few of the provincial LHIN committees. Do you know if the LHINs have ever looked at subcontracting of health care services?

Mr. Gary Switzer: Subcontracting—that's a broad statement. To my knowledge, no. With respect to pharmacy?

M^me^ France Gélinas: No, with respect to outsourcing in general.

Mr. Gary Switzer: Not at the committee level, but's it been discussed at the CEO level.

M^me^ France Gélinas: In what context?

Mr. Gary Switzer: With respect to the CCAC when they contract services. With respect to—a number of our organizations come together to pool their resources for shared services, for example. And then, internally—the 14 LHINs—we subcontract out our IT support.

M^me^ France Gélinas: Very good. You give out the list of agencies that are under the purview of the LHINs; I think they're the same in all 14 LHINs. In the accountability agreement you have with those agencies, do you ask for accreditations for all of them?

Mr. Gary Switzer: We don't ask for it. I know a number of them proceed to be accredited.

M^me^ France Gélinas: So could you give me an example of who could not be accredited in the list of agencies that—

Mr. Gary Switzer: Well, when I'm thinking of our agencies that we fund, the majority, to my knowledge, have been accredited. Some of the smaller community agencies—it might be a Meals on Wheels, or a small transportation provider—to my knowledge, have not pursued that path. But I know, for example, our community health centres; our CMHAs; our CCAC, of course; our hospitals, of course; our long-term-care homes—more likely, it's the smaller agencies that haven't.

M^me^ France Gélinas: Okay. And what is the value added of—if you already have an accountability agreement with them, what is the value added of doing this accreditation?

1500

Mr. Gary Switzer: It demonstrates that they're adhering to industry best practice with respect to safety and patient care and a number of other indicators.

M^me^ France Gélinas: Okay. And is this something that is mentioned? Once they reach accreditation, do they have to maintain it as part of their accountability agreement with you?

Mr. Gary Switzer: It's not part of the accountability agreement, to my knowledge. The agencies that have achieved accreditation, they usually go on a three- to four-year cycle to repeat it.

M^me^ France Gélinas: The strategic direction for your LHIN is better care, better experiences and better value. What do you mean by better value?

Mr. Gary Switzer: When we talk to residents in Erie St. Clair, they all want to make sure that we're good custodians of the public purse. They want to make sure that there's value for every dollar that we invest, so we ensure that we use—we look through the lens of quality to ensure that every investment is for quality care, and it's efficient and it's effective.

M^me^ France Gélinas: Would you say we have value in the services that you presently fund?

Mr. Gary Switzer: Yes, I would.

M^me^ France Gélinas: So when you set out for better value, you set out for—

Mr. Gary Switzer: Improving. We're in a race that never ends. Health care is a $48-billion business or industry in Ontario, and there's always room to constantly improve the service that we deliver.

M^me^ France Gélinas: Okay. I'm on page 3. I don't think we have the same pages because I saw you flip not at the same time I did, but you say, "Simply put, LHINs are able to translate the provincial strategies by localizing them; so you can see a straight line right from the Premier right through to the patient." I'm quoting from what you just read.

What happens when the provincial strategies are not what—because you also say you believe that the LHINs are there to listen to the people they serve. So what happens when you have a disconnect, where the people you serve do not agree with the provincial strategy?

Mr. Gary Switzer: You know, we engage the public in a number of areas in a number of different locations, and a lot of this is education to identify what we're working on and to try to address their local issues as much as possible and how the provincial strategies are there to improve access and quality of care.

In some instances, the community wants something specifically that's outside the strategic plan for the province, and so we meet with them to try to understand what their needs are and try to reach at least an understanding, that we both understand each other's issues and the differences that we may have.

M^me^ France Gélinas: So when it comes to making a decision between the community wanting something that is outside of the provincial strategies, you're there to listen to your community, but you're basically there to translate the provincial strategies and localize them—which one wins, which one loses?

Mr. Gary Switzer: It's an interesting question. I'd say that everybody wins with respect to having local representation, managing the health care planning locally. I'd say that everybody wins. We may not be 100% all the time, but having been in these community events locally, just being there to discuss their issues with them I think is a far better position to be in than we were in previous years when they had nobody to talk to.

M^me^ France Gélinas: Okay. But at the end of the day, you maintain that your job is there to bring the strategies and implement them at the local level?

Mr. Gary Switzer: Yes, and through our integrated health service plan, which is our three-year plan for our community, we develop services around that as well. So with our region—you know, we're pretty unhealthy. We have the obese capital of Ontario in our region. We have higher diabetes, higher arthritis. We need plans locally to address those issues, and they do tie into the provincial strategies, for example, to reduce chronic disease across the province.

M^me^ France Gélinas: I thought we were the—I'm not going to fight you for it. You can keep the title. I'm more than happy—

Mr. Gary Switzer: Every LHIN wants to say, "We're the oldest and the sickest," but I'm proud to say that—well, not proud to say, but we are the most obese.

M^me^ France Gélinas: Oh, no. Nothing good; sorry about that.

All right. Does the LHIN have anything to do at all with protecting patient safety? You say better care, better experience, better value. Where do safety and quality fit in?

Mr. Gary Switzer: Each hospital has a quality improvement plan, and they have key indicators and they're all referenced back to the attributes of quality. We work with Health Quality Ontario on that as well, so we receive a copy of their annual plan.

The senior executives—a portion of their compensation is applied to achieving those quality indicators. For example, hospital infection rates would be an indicator which impacts safety. Hospital falls resulting in a fracture impact safety. Hand hygiene is another safety indicator. That's how we get at it through the QIPs, the quality improvement plans.

M^me^ France Gélinas: Now that we've seen what has happened with chemotherapy, where 1,000 people got a diluted dosage—that happens to be a drug that had been outsourced through Medbuy. When Cancer Care Ontario was here, they made it clear that every time there is a handoff, there is a possibility of error. It doesn't matter how good the health care system is; we are human, no matter the job we do. By having outsourcing, by having Medbuys, we've just added four hand-offs right off the bat. We've increased risk just by the mere fact that Medbuy exists and outsourcing exists and all of this. How do you reconcile this with your goal of better care?

Mr. Gary Switzer: I read some of the previous transcripts. Christine Donaldson, the director of pharmacy—I know Christine quite well. The process that they go through in-house to produce this chemotherapy treatment—based on their own analysis, they didn't have enough of an internal quality control to do this, and that's why it was outsourced, to certain standards of care, for the mixing of this drug.

You go to where the expertise is. In their review of the situation through Medbuy and their RFP for services, it was quite clear that they had instructions and they were based on best practices.

M^me^ France Gélinas: Not enough quality in-house, but they are doing it in-house now. Are you telling us that we don't have quality, now that they've started doing it in-house?

Mr. Gary Switzer: No. At the time that decision was made to outsource it, they felt at the time that they didn't have sufficient quality checks to do that one specific drug mix. As I understand it, they mix anywhere from 1,500 to 2,000 prescriptions daily in that hospital, so it's quite a busy spot. Now that they've brought it in-house, they've put extra due diligence on the process to double- and triple-check every step along the way. I agree with you: Transactions are where issues occur.

M^me^ France Gélinas: So why couldn't they have done this before, if it became quite easy and fast? I mean, the day that the thing was shelved, they started doing it in-house, and they all assured us that they are doing it in a quality way.

Mr. Gary Switzer: I'd have to defer that to the hospital to answer.

M^me^ France Gélinas: Okay. You've agreed that every time there's a hand-off, there's a risk. Is this something under your "better care" lens? Is this something that you're interested in looking at: How much outsourcing is being done, how much hand-off, how much increased risk is happening?

Mr. Gary Switzer: When we look at the system level with our system partners—let's call it our 87 providers—we want to make sure that they're following best practice, that they're following procurement guidelines and that they adhere to the quality programs that they put in place.

Many of their organizations have become lean experts. It's an engineering process to take waste out of the system but also to catch the quality issues. We have ongoing discussions with them on that area, and we look at their patient satisfaction and patient experience feedback as well.

M^me^ France Gélinas: You said that you had looked at outsourcing and contracting out at the level of the CEO. Do you intend to have those discussions now with your hospitals?

Mr. Gary Switzer: As part of our agendas with our hospitals, we talk about outsourcing or third party shared services through an organization that we've set up with the five hospitals. They have an organization called Transform, and that manages procurement, logistics, IT, IM and IS. That's the type of outsource; they outsource to this third party organization that they already own. Those are the conversations we have.

1510

M^me^ France Gélinas: And is this something you encourage?

Mr. Gary Switzer: Yes.

M^me^ France Gélinas: I'll let it go.

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

Ms. Helena Jaczek: Thank you, Chair.

Thank you, Mr. Switzer, for coming in today. You've talked a fair bit about accountability agreements with service providers in the geographic area of the Erie St. Clair LHIN. You also have a relationship with Cancer Care Ontario. How does that work? Is there an accountability agreement, or how do the two of you relate?

Mr. Gary Switzer: Cancer Care Ontario has an agreement with the regional cancer centres; they have a direct relationship there. We do not have an agreement with Cancer Care Ontario.

Ms. Helena Jaczek: In the situation that you faced, you've outlined very clearly, really, how you got the phone call, and you acknowledged that the LHIN didn't have the clinical expertise, perhaps, to get involved in the issue itself—the clinical issue—but you offered to provide a provincial coordination role. Is this something that is an expectation of the CEO of LHINs?

Mr. Gary Switzer: It's the expectation of the LHIN, and me being the CEO, yes, it is.

Ms. Helena Jaczek: That you would reach out and you would try and—

Mr. Gary Switzer: By all means. When David Musyj called me that morning, he had all hands on deck with his staff preparing for the patients. I said, "I'll take on the responsibility to work with Cancer Care Ontario, putting more of a provincial view on this and organizing that."

Ms. Helena Jaczek: Through this specific incident, there was an immediate response to handle the issue appropriately. Did you find that people were being collaborative in terms of Cancer Care Ontario, other LHIN CEOs, the hospitals?

Mr. Gary Switzer: Yes.

Ms. Helena Jaczek: We've heard from you that you were one of the original CEOs when LHINs were established in 2005. Have you had challenges somewhat similar to this, where your position as CEO of your LHIN has had to cross jurisdictional boundaries perhaps to have some coordination of response? Have there been other challenges?

Mr. Gary Switzer: I've worked very closely with the South West LHIN, for example—my neighbour—with respect to patient concerns. Residents of both of those counties will cross over for care, and sometimes it's not as smooth as possible. So we work together to ensure that it's seamless for the patients.

Ms. Helena Jaczek: What about across the province? Any other issues or challenges that you've faced in your role as CEO of your LHIN?

Mr. Gary Switzer: The 14 LHINs work very closely together. We meet on a weekly basis on the telephone and monthly in person. When there are provincial issues, to launch new programs, for example—with the drug shortage issue that was recently, within the last six or seven months, we—

Ms. Helena Jaczek: The Sandoz?

Mr. Gary Switzer: Sandoz. We've identified one of our CEOs to sit on that committee for the province and feed that information back to us.

Ms. Helena Jaczek: In your role as CEO of the LHIN, do you feel confident in your role to manage these issues as they arise?

Mr. Gary Switzer: Yes. We're the system managers. We're responsible for the planning and the funding of the system, and it's really joint accountability and lateral accountability, as I say it, as well.

Ms. Helena Jaczek: You've talked quite a bit about the accountability agreements with your 87 health service providers, and my colleague from Nickel Belt has alluded to your role in terms of ensuring patient safety. Is this something that's done through the quality improvement plan? How exactly do you feel confident in your 87 health service providers that the proper kind of quality assurance/patient safety measures are in place?

Mr. Gary Switzer: I'll start at the micro level. We have concerns in some of our regions with respect to patient transportation and how critical it is for a patient to be transported for dialysis, let's say. When patients would reach out to us, because they know who we are, and talk about the challenges they had, we were able to bring all the agencies together to get uniform practices and a system to pick up patients so that nobody would be missed, especially for critical transportation like that. So that's a patient safety issue.

With respect to safety issues in our accountability agreements, there are key performance indicators for specific things for each agency with respect to safety.

Ms. Helena Jaczek: It has been said that the LHIN, in a way, functions as the middleman between local service provision and the Ministry of Health. As you review quality improvement plans from your various health service providers, I presume if you have an issue you go to that health service provider and try to work out the issue—as an example, if wait time started increasing or something like that.

If those issues are not readily resolved, do you turn to the ministry? Can you just sort of explain to us what we believe is a very important role that you play? Can you sort of illustrate that for us?

Mr. Gary Switzer: It means we work directly with the agency. We identify what the patient issue or safety issue is, and we work with them so that there is a mutual understanding. We ask them for a performance improvement plan on how they're going to close the gap, and this is all done at the CEO and staff level.

If that fails and we don't get the results that we want, we'll have a board-to-board consultation, and we will go back to our board if we feel that we need to go deeper on this one and do an operational review. We have the powers, through legislation, to bring in somebody to do an operational review to determine what the current state is and the desired state, and put an improvement plan in place to reach that. We'll keep the ministry informed on these based on the progress of our discussions.

Ms. Helena Jaczek: And, therefore, there would be the potential to have that dialogue with the ministry if there was an issue that seemed to be very difficult to resolve.

Mr. Gary Switzer: Yes, if it's very difficult to resolve I have a regular interface with the ministry at my level with the ADM, and the DM, on occasion. My staff are always interacting with ministry staff through the LHIN liaison branch.

Ms. Helena Jaczek: Which ADM do you relate to, actually?

Mr. Gary Switzer: Catherine Brown.

Ms. Helena Jaczek: Health accountability?

Mr. Gary Switzer: Yes.

Ms. Helena Jaczek: Okay. We heard from Catherine. In your opinion—you're the CEO; you're trying to bring local issues forward—do you feel that the LHIN is working well? Are you satisfied with this kind of relationship, bridging between local communities and the Ministry of Health?

Mr. Gary Switzer: As I said in my opening statements, I'm from industry, so health care is new to me.

When I joined, the level of accountability that we had eight years ago compared to now—now we have signed agreements with everyone. They have specific targets that are tied to a strategic plan that the government approves. They balance their budgets.

Ms. Helena Jaczek: So you've seen progress? Would you say—

Mr. Gary Switzer: I've seen significant progress. I mean, our wait times have improved significantly; they are a specific focus. I'm used to measuring things in industry, and when I came in we didn't have any specific measurements. Now we do. We have clear accountability. Services cannot be changed in the system unless the LHIN signs off on it, so in the past we would have agencies balancing their budget by extending a wait time or cancelling a service. That does not happen anymore. They have to have it signed off by the LHIN if they want to change a service, because that will impact patient safety somewhere. Health care is like a large spider web. If it moves over here, you know that you're going to get a ripple effect somewhere else. It's a very complex system.

Ms. Helena Jaczek: Finally, in terms of administrative costs, in terms of the money that is received from the ministry and what is transferred out to your service providers, what is spent in administration at the Erie St. Clair LHIN?

Mr. Gary Switzer: We fund just over $1 billion and our operating budget is around $4.9 million.

Ms. Helena Jaczek: So a very small percentage.

Mr. Gary Switzer: Yes.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Ernie Hardeman): The official opposition, Ms. Elliott?

Mrs. Christine Elliott: We don't have any further questions. Thank you, Mr. Switzer.

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

M^me^ France Gélinas: You talked about your personal experience and how vulnerable you feel when you get a diagnosis of cancer; you look healthy, so I guess the treatment worked. There are a lot of people whose trust in the health care system has been shaken. What do you suggest, or is there anything that you can do in your position at the LHIN to rebuild that trust?

Mr. Gary Switzer: As I said in my statement, I have all the confidence and trust in the system that we have. Working in this industry—and I've worked with Dr. David Ng and Dr. Ken Schneider—these folks are very committed. My advice to any patient who is concerned is to listen to their care provider and to do some research on their own—but listen to their care provider. Nobody's intent is to do any harm at all—at all. Their interests are genuine, and it's all patient-centred.

1520

Ms. Cindy Forster: Welcome, Mr. Switzer. On page 2 of the report that you read from, in the third or fourth paragraph, you said, "LHINs are responsible for planning, integrating and funding local health services and ensuring accountability of local health service providers, including: public hospitals...." How do you go about ensuring that accountability, particularly around the procurement piece? Because I don't see that as being excluded.

Mr. Gary Switzer: In procurement, we work with our hospitals on an annual basis. They have to sign an attestation that they're in compliance with the broader public service act with respect to procurement.

Ms. Cindy Forster: When they send those agreements in, what is the LHIN's responsibility to ensure that whoever they are procuring with is meeting standards that would protect patient safety?

Mr. Gary Switzer: The way we operate in our LHIN, we have a management team that interfaces with each agency at a working level. That elevates up to the CFO level and the CEO level. When we meet, on occasion—not every agenda—we talk about procurement issues and compliance with respect to the broader public service. Their individual boards have to sign off on that attestation. When it comes to us, we forward that in to the ministry, and we advise our board that they are in compliance.

Ms. Cindy Forster: Has there ever been a time, since you've been the CEO of the LHIN, when you've had a local community conflict with the Ministry of Health where you sided with the local community with respect to something that they thought they needed in health care in their community, and you had to go and advocate with the ministry for some changes? How did that work out?

Mr. Gary Switzer: I'm just trying to think of a potential conflict. I know we advocate on behalf of our providers all the time in their communities. Most recently, we supported the supervisor who was in the Hôtel-Dieu, because there was a structural deficit in that hospital. We'd like to say they were fighting above their weight. It was a structural deficit, and we went to the ministry and supported a base funding increase for them. That's what the community needed to provide those services in that trauma centre.

Ms. Cindy Forster: We've heard this year that there have been hundreds of patient complaints to the Ombudsman of Ontario, but he has no oversight over public hospitals or health care. What is the LHIN's role in actually dealing with those types of patient complaints, or do they even get to the LHIN level?

Mr. Gary Switzer: Patients call me, I'd say, on a weekly basis, not every day. We have a process in place where we respond to patients individually, and we ask them to please go back to the provider. The providers have their internal ombudsman or patient-advocate groups to go through.

If they still do not get satisfaction, we ask them to come back to us. We discuss every complaint that comes through that we forward on. We do have a discussion with the agency about it because, as you can appreciate, there are many sides to a story.

Ms. Cindy Forster: Thank you.

The Chair (Mr. Ernie Hardeman): That concludes the time. Thank you very much. More from the government?

Ms. Helena Jaczek: If we have some time, my colleague Mr. Flynn, would like to—

The Chair (Mr. Ernie Hardeman): Okay. Mr. Flynn?

Mr. Kevin Daniel Flynn: Thank you, Mr. Switzer, for your presentation. My riding is Oakville, so I'm in the Mississauga Halton LHIN. There's a variety of opinions about LHINs throughout the province. Some of the criticisms, I think, are sincere, and some of them, I think, are driven from a partisan perspective. But the relationship that I've had with my own specific LHIN has been extremely positive.

I look at some of the changes that have taken place, and like you, I'm someone that looks, as an individual, to quantitative measures when we're trying to change or reform the system. Where I've seen some real success in my own LHIN is in the field of ALC; emergency room wait times; bringing together all the mental health providers so that the people in my communities know where to go when that time comes, if that time comes. Most recently, there was a great initiative that was led by the local LHIN around the abuse of and the addiction to opioids.

A lot of these things seem to involve a strategy, the implementation of a strategy, that was going to work throughout the local system. So when you look at the reason that you're here today, one of the biggest successes that I've seen, or the reasons for the success of the LHIN in my own community, has been around its ability to be transparent, both with the patients and with the service providers themselves, and the accountability that they have to the community.

Based on those two strengths that I think the LHINs have, certainly in my own experience, how would you apply those two strengths to the issue that's here today?

Mr. Gary Switzer: The issue here today—we're totally transparent, as you said, and we have engaged our website with Windsor Regional's to direct patients there as a complete link, so we make sure everybody is aware of it. We work with the local community, when they do phone us about this issue, in providing them the material for it as well.

From a planning perspective—I'm just trying to recall back. What were the two points? You wanted—

Mr. Kevin Daniel Flynn: Well, there's one on transparency, and the other was on accountability.

Mr. Gary Switzer: Accountability: recognizing when the people of Erie St. Clair call us to identify our level of accountability with agreements with our agencies and the hospital's accountability or the agency's accountability—and we direct them to there. So it's totally transparent. All our meetings are open, and everything is on our website with respect to the agreements.

Mr. Kevin Daniel Flynn: And out of this, do you expect to have some learnings? Do you expect to learn something that would guide your future decisions?

Mr. Gary Switzer: We learn every day in health care. When you put the patient at the centre of every discussion and consider them in the room when you're talking about it, you become acutely aware of how important it is to improve communication, especially in the transactions of care.

When patients call me, they usually have a complaint about the transaction, going from agency A to agency B, to doctor A to doctor B, and it's that hand-off that causes the grief. They say they get great care. We're working very hard on these transitions of care, trying to improve that, such as the launch of Health Links—you've heard of Health Links in Mississauga, and Halton as well—as one way to wraparound care with the patient.

Mr. Kevin Daniel Flynn: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation, and that concludes all the time—holding you up at the start, but we cleaned it up just in time, so thank you.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Ernie Hardeman): Our next delegation or presentation is from the Ontario Hospital Association. Welcome. We are doing these committees under oath, so we'll ask the Clerk to either affirm or swear each one of you in before we start the presentation.

The Clerk of the Committee (Mr. William Short): Ms. Campbell, if you'd like to swear an oath, the Bible is in front of you. If you want to affirm, just raise your right hand, please.

Ms. Campbell, do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Ms. Pat Campbell: I will.

The Clerk of the Committee (Mr. William Short): Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. As with previous presenters, you will have 20 minutes to make a presentation, and then we will have questions. This time the questions will be 15 minutes from each caucus, and this time it will start with the third party. With that, the floor is yours, and thank you again for coming in.

Ms. Pat Campbell: Good afternoon, everyone. My name is Pat Campbell, and I'm the president and CEO of the Ontario Hospital Association. I'm joined here by Sudha Kutty, OHA's director of patient safety, physician and professional issues, and Amy Clark, the OHA's manager of issues management and media relations.

By way of introduction and background, the OHA is a voluntary, not-for-profit member association that represents Ontario's 149 public hospitals. Although we work with hospitals, the government and other health system partners to improve the quality of patient care provided by Ontario's health system, we do not have a formal or informal health system regulatory or standards-setting role like, say, Accreditation Canada, the College of Pharmacists or the government of Ontario.

In terms of my own background, I am a nurse and a former CEO of Women's College Hospital and of Grey

Bruce Health Services, so I have some direct insight into what it's like to deliver front-line care and to manage an academic hospital or a large, rural multi-site hospital. That said, I am not a pharmacist, and so my ability to answer certain scientific or technical questions you may have about pharmacy generally, or chemotherapy specifically, is limited. However, I will endeavor to obtain for the committee answers to any questions that I am unable to answer as soon as possible after my testimony today.

1530

On behalf of the OHA and Ontario's hospitals, I'd like to thank this committee for the opportunity to appear before you today. It likely comes as no surprise that we've been following these hearings closely, and we believe that important issues have been aired here. I view this as an opportunity to advance that discussion.

And on behalf of the OHA and Ontario's hospitals, I offer our deepest sympathies to the patients affected by this issue and to their families.

I also offer our apologies to the people of this province, because this issue strikes directly at the trust Ontarians have in their hospitals and health care system, the trust that is the foundation of our system: trust that the health care services we need will be there when we need them; trust that those services will be provided safely, effectively and efficiently; trust that the doctors and nurses, pharmacists and pharmacy technicians who work in hospitals, and the people and businesses outside the hospitals whose work supports them, are committed and capable of doing the job they were hired to do; and trust that when mistakes are made or issues identified, they'll be addressed quickly, transparently and in a meaningful, rational way.

These problems with the chemotherapy should never have happened, but I can assure every member of this committee and every Ontarian that the OHA and hospitals are committed to re-earning their trust by helping to determine why they happened and acting to ensure that they never happen again.

I'll note that these problems were discovered by hospital pharmacy technicians, who felt empowered and safe enough to bring their concerns about product quality forward to hospital management. This kind of thoughtful initiative is only possible when you have what is known as a "culture of safety" in hospitals, when staff understand that their first priority is identifying and addressing issues rather than blaming and shaming. Hospitals across Ontario have worked hard to build that kind of culture, and it is very much in the public interest.

I mentioned a moment ago that the OHA is not a hospital or health system regulator. However, we are often asked to assist the Ministry of Health and Long-Term Care with managing system-level issues that pertain to hospitals. Generally speaking, in these situations, we provide communications, information-gathering and policy advice and support to hospitals and the ministry.

The OHA first learned about this problem on April 2, effectively the same time that Cancer Care Ontario issued its first public notice. We circulated CCO's notice to every hospital in Ontario and offered our support to the ministry in terms of managing the issue.

The ministry invited OHA representatives to participate in daily, multi-stakeholder calls about this issue, and the OHA has participated fully ever since.

When it became clear that a knowledge gap existed about which companies provide chemotherapy to hospitals, and about hospital pharmacy practices, the OHA surveyed its members on April 16 with a requested turnaround time of 24 hours. The survey results, which we received from 88 acute care hospitals representing 94% of acute care beds and 95% of acute care patient days, were verified and shared in full with the ministry and the public on April 22. I have brought copies of the survey results for the information and use of the committee today.

When the ministry requested that hospitals attest that the oversight and quality assurance policies and practices they have in place for the procurement, storage and administration of all compounded drugs are sufficient to ensure patient safety, the OHA held a member teleconference to explain the nature of the attestation and encourage hospitals to submit the attestations as quickly as possible. All hospitals have submitted these attestations to the ministry.

The OHA has also carefully reviewed the draft regulations proposed by the College of Pharmacists and the ministry, and formally submitted our recommendations based on discussions with hospital pharmacy leaders from across Ontario. I will comment more on them in a moment.

The OHA will continue assisting where we can to resolve this issue. We are looking forward to Dr. Thiessen's report and to helping ensure that hospitals have the tools and knowledge they need to implement his recommendations.

Any members of the public watching today or reading Hansard should also know that every hospital has taken this issue very seriously and has looked inward at their processes in order to ensure that their pharmacy processes are safe and effective.

As I stated earlier, we believe these hearings are valuable in terms of airing important issues regarding the current regulatory environment and hospital procurement practices. I'd like to speak about these issues for a few moments.

Obviously, questions about chemotherapy have shone a spotlight on a regulatory grey area when it comes to pharmacy practice. I have no issues with saying that, as a former hospital CEO, I knew that these services were not new in hospitals but had no idea that a regulatory gap existed, until it was brought to light seven weeks ago. This was not an issue that's been raised before.

The OHA believes there should be formal regulatory oversight of the companies that produce pharmacy products—all pharmacy products—for hospitals, and that this oversight should be clear, thoughtful and consistent across Canada. Let me explain what I mean by "thoughtful" and "consistent."

Even in the absence of formal regulation by Health Canada or the ministry, compounding has, to the best of our knowledge, been performed safely and effectively outside of hospitals for many years, in part because the companies that performed this work were generally very responsible, fully understood the needs of hospitals and pharmacists, and took their quality assurance practices very seriously. We believe that as legislators consider how to fill the regulatory gap, they should seriously consider how to reinforce and build on the best of those practices, and also the downstream implications of the new regulations in terms of their effects on the health system supply chain, even if this consideration takes some time. This issue is sufficiently complex and important that we do need to get it right.

First and foremost, any regulations that are created must actually achieve what they're intended to achieve. Secondly, we must minimize unintended consequences. For example, in our written submission to the ministry regarding its proposed amendment to the Public Hospitals Act, we noted that a number of Ontario hospitals are in communities that border other provinces or the United States—places like the Ottawa Hospital, bordering Quebec, and the Windsor Regional Hospital, bordering Michigan. We spoke with these hospitals and learned there have been situations where they have had to obtain drugs—authorized by Health Canada with a drug identification number and approved for sale in Canada—from hospitals in other provinces or in the United States.

Generally speaking, hospitals manage ongoing supply shortages pharmacist-to-pharmacist. Supply shortages can range from a back order on one product in one hospital, to a major shortage like we saw last year involving products made by Sandoz. Given the unpredictable nature of these types of situations, it's difficult to assess the frequency or how much advance notice hospitals will have before a shortage occurs.

Our concern is that the language in the draft regulation would limit an Ontario hospital's ability to manage ongoing supply situations at a local level. For that reason, we have recommended that the draft regulation be amended to allow for hospitals to purchase or otherwise obtain drugs from hospitals outside of Ontario.

We also strongly recommend that care be taken to ensure that the College of Pharmacists actually has the capacity, knowledge and resources necessary to do any work it is given by new regulations, and that this capacity be carefully considered when decisions about when the new regulations come into force are made.

In terms of consistent regulations and approaches, evidence from across the health care system shows us how important consistency is, whether it's consistency in hand-washing processes or consistency in open-heart surgery. Consistency of practice based on evidence is the driving principle behind the Excellent Care for All Act and almost all quality improvement initiatives. Consistency is also important from a trust perspective. Patients and their families and, frankly, regulators should be able to trust that, within reasonable variation based on specific needs, health care services will be provided in a consistent manner, regardless of where they are in the province or the country.

This applies to medication, obviously. That's why we strongly believe that clear, national standards regarding the labelling of all medication should be considered. Ideally, a pharmacist in a hospital in PEI who picks up a 100-millilitre bag of chemotherapy should have the exact same understanding of its contents as a pharmacist in the Yukon or Ontario. Although we are waiting to review Dr. Thiessen's report, we do believe there is value in provincial and national regulators considering this kind of thing without delay.

Consistency is also important in terms of the legislative and policy frameworks hospitals and other health providers work in. For example, the draft regulation released for consultation by Ontario's College of Pharmacists includes a definition of "drug" that differs from the commonly understood one in the Drug and Pharmacies Regulation Act and also the federal Food and Drugs Act. We are concerned that applying different definitions to hospitals obtaining drugs and the persons or entities supplying them creates a potential for misinterpretation, and could lead to inconsistent practices. For these reasons, we have recommended that the definition of "drug" in the draft regulation be consistent with the definition being contemplated by the proposed regulation under the Public Hospitals Act and in existing and already well-understood legislative/regulatory language.

1540

Beyond these examples, it should be noted that the college, ministry and Health Canada are all working on regulations and policy changes in this area. We believe that any proposed regulatory changes should be considered within the broader existing legislative and regulatory framework and closely aligned with any other legislative and regulatory changes to minimize duplication of oversight and ensure uniform application across the sector. For that reason, we strongly urge all of the relevant legislators and regulators to work closely together and carefully consider the interplay and front-line implications of their proposed courses of action.

In discussion of hospital procurement practices here and elsewhere, a number of questions have been raised about the outsourcing of goods and services by hospitals. I'd like to focus on this for a few moments.

The fact is, almost everything used by a hospital, from medication to diagnostic equipment, from food to hand soap, is to one degree or another outsourced. These goods and services are brought to hospitals for use by health professionals, patients and their families. In some cases, hospitals contract directly with manufacturers. In other cases, depending upon the arrangement, a group of hospitals may share services to allow for greater expertise and collaboration in pursuit of the best solution.

Some of the reasons for this are obvious. Hospitals don't have the expertise or capacity to create medical equipment or, in most cases, basic medication, or to grow food for patient meals. But some of the reasons are less obvious, and it's important that they be fully understood.

This committee has heard that when it comes to the compounding of medications for chemotherapy, a number of hospitals outsource this practice. What hasn't come through clearly is why hospitals do this. Contrary to the assertions of some commentators and unions, the outsourcing of compounding by hospitals was not driven primarily or even secondarily by cost considerations in most cases. Rather, the OHA's survey of hospital pharmacy practices suggests that hospitals that outsource compounding do so primarily for reasons of occupational health and safety and adhering to accreditation standards related to medication management. This makes sense. The components of chemotherapy are toxic and require costly infrastructure in order to facilitate their safe compounding. Beyond that, evidence and leading practice holds that having a dedicated, external provider of chemotherapy or other medications can reduce the potential for variation and human error. Indeed, patient safety was cited as a reason for outsourcing by 31 out of 40 hospitals that purchase ready-to-administer intravenous medications.

All of this is to say that outsourcing is a necessity in hospitals for reasons of practicality, safety and best practice, and that legislators considering legislative or regulatory changes that would affect hospitals' procurement processes should be cognizant of this reality.

That said, there are specific procurement issues which have come to the fore because of this issue that should be addressed. Ontario's hospitals, and the group purchasing organizations many of them are members of, procure goods within a rigorous regulatory environment from a process perspective. What is less clear is who in the procurement process is responsible for assuring quality—prior to contracts being signed and on an ongoing basis thereafter—in order to ensure that what is being delivered is what has been ordered and paid for.

In our opinion, this responsibility should properly rest with the persons or organizations that make the products being purchased. It is here that procurement links directly with regulatory oversight of the provider's activities, whether they are providing medication, medical equipment or something else. Hospitals are skilled at providing patient care. Generally speaking, they lack the capacity to conduct quality assurance tests on products coming into the facility, even on a select or periodic basis. They must be able to trust that the products they have purchased are as advertised and understood. This is why we believe that uniform standards for the labelling of medications should be considered, and why provincial regulations governing the work of medication manufacturers and compounding be carefully conceived and sufficient to ensure quality.

Put bluntly, in the absence of effective point-of-manufacture quality assurance, compliance mechanisms like attestations imposed on hospital boards or executives that relate to how a product is used by hospital staff will paint, at best, an incomplete picture for regulators and patients.

I'll end this portion of my presentation in this way: Earlier, I mentioned the importance of trust in our health care system. Hospitals are ready and willing to work with legislators and regulators to fully address the issues raised by this unfortunate issue, and re-earn the full trust of Ontarians. But our efforts to rebuild trust are also linked to the right decisions being made by legislators and regulators—fully informed decisions grounded in facts. For that reason, I urge all Ontarians to wait for Dr. Thiessen's report before speculating about causes, drawing conclusions about solutions or taking additional action in this complex area. For the sake of public trust in Ontario's hospitals and pharmacy practices, it's better for us all to be right about the root causes and the way forward than to be fast.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll start the questioning now with Ms. Gélinas.

M^me^ France Gélinas: Thank you for coming, Ms. Campbell. I will start where you left off, as in doing it right rather than doing it fast. Some of the comments that you have made about the regulation that the ministry has put forward—more specifically, when it comes to your members, the hospitals of Ontario, having to check who they are procuring drugs from as well as the attestation.

I think you said it well: that it should be done by whoever makes the products being purchased, not by the hospital. Given what we have in front of us and given that I represent an area where there are mainly small and rural hospitals, could you see it ever working out the way the regulations are being presented right now?

Ms. Pat Campbell: I do think that, at this point, we shouldn't be rushing to move to finger pointing or laying blame. We have a process in place that's about determining what went wrong and finding reasonable and appropriate steps to ensure that something like this never happens again.

M^me^ France Gélinas: What is the process for looking at what went wrong?

Ms. Pat Campbell: The review being completed by Dr. Thiessen that's under way will play a key role in understanding the facts, and we think it's important to allow Dr. Thiessen to complete his important work. That being said, when Dr. Thiessen's work is completed, it will be important to broadly disseminate the findings and the conclusions from that review, and to ensure that those changes are implemented going forward, complemented by appropriate education resources for hospitals, pharmacists and others to act on those recommendations.

M^me^ France Gélinas: I agree with what you just said. Two things: The mandate of Dr. Thiessen is not to find out what went wrong; it is to look at the supply chain—not to get your hopes too high there, because you could be disappointed. The second is that there is a draft regulation being circulated right now where the ministry makes the hospital responsible to make sure that whoever the deal is with is regulated. You've commented on it. My question is: Can you see it, the way it is now, ever working out? Think about the 52 small members that you have. How would it work for them?

Ms. Pat Campbell: They are an important constituency for us. At this point, we're welcoming the draft

regulations and we're welcoming the chance to comment on the draft regulations. We do think that it's important that people are being thoughtful about what to propose. We have commented on the recommendations to both the College of Pharmacists and the Ministry of Health, and we can certainly share with the committee what our comments are.

As you've pointed out, it is important that any proposed regulatory changes should be considered within the broader existing and proposed legislative and regulatory frameworks and should build on existing practices, incorporating common language and minimizing duplication. We want to ensure that we don't inadvertently impact the availability of medication.

M^me^ France Gélinas: That's good. What's the relationship between OHA and Medbuy?

Ms. Pat Campbell: The Ontario Hospital Association has a category of members that are called "associate members." Certainly Medbuy and the Ontario Hospital Association have an overlap in their membership, but we have no direct relationship with Medbuy. In terms of what it means to be an affiliate member of the OHA, it means they are eligible to apply for the healthcare of Ontario pension plan, they can have access to group benefit plans that we offer, and they can possibly receive reduced rates on some of our educational offerings.

1550

M^me^ France Gélinas: So you've never looked at the Medbuy procurement process, policies or contract? That's not something that the OHA ever looks at?

Ms. Pat Campbell: No.

M^me^ France Gélinas: Would you have concerns about the fact that points are awarded to different companies? When Medbuy reviews the different companies' bids for the procurement, they look at the size of the donations that will be made to the hospital in determining who should get the contract.

Ms. Pat Campbell: The idea of value-added offering by companies is not something that's unique in terms of the processes that Medbuy undertakes. The value-added practice employed by Medbuy, as I understand it, is compliant with the procurements directive, which gives you a sense of how pervasive or common those kinds of elements are.

In terms of what it means to be compliant with the procurement directive, it has to pass the test of being fair, open and transparent. From our perspective, it's better to ask about the value adds that a service provider might be considering as part of the RFP process than to not ask and have that conversation not be part of the formal process.

We think it's acceptable if this is transparent, and that's the only way it's acceptable under the procurement directive: if it's transparent and if you can appropriately and fairly evaluate the value add. In the case of the Medbuy RFP, the value add of the donation to their RED program was only used in the evaluation as a tiebreaker, but otherwise would not influence the scoring or decision on a successful bidder. So it was only a secondary consideration at best.

M^me^ France Gélinas: And how do you know that?

Ms. Pat Campbell: In terms of the conversations that have gone on since this activity came to light.

M^me^ France Gélinas: Okay. I'll let it go around.

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

Ms. Helena Jaczek: Thank you, Ms. Campbell, for your very clear presentation. I really appreciated it.

One of the areas that you've alluded to is the survey that you conducted on hospital usage of pre-compounded medications from an external provider. It is a fairly lengthy 16-page document. Could you just outline for us some of the highlights of what you found as a result of your survey?

Ms. Pat Campbell: Would it be acceptable for the committee for my colleague Sudha Kutty to address that question?

Ms. Helena Jaczek: I'm not quite sure whether there's a need for an oath, but that's a technical matter.

The Chair (Mr. Ernie Hardeman): Yes, I'm sorry; I was writing down my time here. But anyone who's going to testify must be sworn in.

The Clerk of the Committee (Mr. William Short): Did you want to be affirmed or swear an oath?

Ms. Sudha Kutty: I can swear.

The Clerk of the Committee (Mr. William Short): Swear? Okay, the Bible's there. It's Sudha Kutty, correct? OHA director of patient safety, physician and professional issues? Do you solemnly swear that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth, so help you God?

Ms. Sudha Kutty: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

The Chair (Mr. Ernie Hardeman): There we go. Thank you. Back to the questions.

Ms. Helena Jaczek: If we could have some highlights.

Ms. Sudha Kutty: Sure. The survey really looked at the use of two different categories of medication. The first was ready-to-administer IV solutions, and bulk IV medication. This category around chemotherapy drugs fell into the category of bulk IV medications.

What the survey showed was that a very small number of respondents actually purchase bulk IV medications from external providers. Actually, only 10 hospitals were using that over a variety of different drug classes. Six hospitals were purchasing chemotherapy, two narcotics and two epidurals. The vast majority of these hospitals—nine hospitals—were purchasing from an organization by the name of Baxter CIVA. At the time of completing the survey, only one hospital was purchasing from Marchese, and that hospital was purchasing for epidurals, not chemotherapy drugs.

As Pat alluded to, this practice of outsourcing is being done for a variety of drivers, most of them related to occupational health and safety and patient safety, and that's

what our survey revealed. So that's really the highlight on the bulk mixture.

On the ready-to-use mixture side, more hospitals are purchasing pre-compounded IV medications in a ready-to-administer format—40 hospitals, to be specific. Primarily, the types of drugs that are being purchased are: epidurals, 27 hospitals; narcotics, 21 hospitals; and antibiotics, 18 hospitals. Again, Baxter CIVA has the lion's share of—most hospitals are purchasing from Baxter CIVA for those particular products. Again, the drivers for outsourcing this purchase of pre-compounded medications: patient safety, Accreditation Canada standards and occupational health and safety.

Ms. Helena Jaczek: Thank you very much.

Back to Ms. Campbell: The Ontario Hospital Association exists, in essence, as an association for individual hospitals to belong to, to have their voices heard, I presume, with the Ministry of Health and Long-Term Care. Also, as you've alluded to, very much in terms of communications—you've emphasized consistency, and I really appreciated that. So your role is very much to communicate to ensure some consistency across hospitals. Is that how you would describe it? Could you sort of flesh out what the Ontario Hospital Association is there to do?

Ms. Pat Campbell: Sure. The Ontario Hospital Association is a member association, but several years ago, the OHA recognized that hospitals don't exist in a vacuum. So, in fact, our vision is to work toward a high-performing health system and to do that in a way that recognizes that hospitals are part of a broader community of health service providers and, indeed, community providers that are required to support hospital care.

So in terms of how we do that, we do that through a variety of mechanisms, some of which are educationally focused in terms of providing education, both for hospital members and for the broader health care community. About 30% of the folks who use our educational programs don't come from hospitals. Then, we work with both hospitals and government around steps to improve the health care system. Some of those are around advocacy positions. One of our current advocacy positions, which we've been really pushing on, is increased investment in community-based services, recognizing that patients want to be home and they want to spend as little time in hospital as possible. But that's only possible for them to do that if, in fact, there's an enhancement in community-based services.

So we do work on behalf of hospitals, but we do see that, in order for hospitals to do an effective job, it really is a component of a high-functioning health care system.

Ms. Helena Jaczek: And one of your sort of core principles, I'm sure, relates to patient safety, to ensuring quality assurance. We've heard quite a bit over the last few weeks about the Excellent Care for All Act and quality improvement plans. I presume that you're involved again in ensuring that these sorts of principles are consistently expressed to hospitals—your membership, in other words.

Ms. Pat Campbell: Ontario's hospitals are all about accountability, transparency and responsibility, and that's kind of the root of everything we do. I think one of the key challenges is that health care is changing, and it's changing pretty dramatically. So supports to hospitals and others to respond to this changing environment is a key element of the kinds of things that we provide—and help them to process new regulatory requirements, understand what the implications are, how they could incorporate those into practice and support them in doing that through the creation of tool kits or other resources, education programming or other mechanisms that allow them to do that.

Ms. Helena Jaczek: In terms of the working group that was put together by the Ministry of Health and Long-Term Care, you're involved with that working group on a regular basis?

Ms. Pat Campbell: Yes. We've been involved in the working group on a regular basis—the terms of reference for the quality assurance and review working group.

Ms. Helena Jaczek: And are you pleased with the way that's being handled and your ability to contribute and being listened to? Are you finding that a useful exercise?

1600

Ms. Pat Campbell: We are finding that a useful exercise. I think it was really important that the number one priority that was recognized by everybody when this first came to light was a focus and a priority on reaching out to patients and their families, and giving time and space for the important work of contacting those folks and having those folks work directly with their care provider teams in terms of understanding the implications and the ramifications of this issue. We've since gone on from then, of course, to talk about the multiple review processes that are under way and how things like the need for information can be supported. That has certainly been a role that we've played on behalf of that group.

Ms. Helena Jaczek: You've commented extensively on the regulation introduced by the Ministry of Health and Long-Term Care and the fact that you were able to comment, and that some time should be taken, obviously, to review those comment. And also the working of Dr. Thiessen's study—you're anxiously awaiting the results, presumably, from his review as well.

Ms. Pat Campbell: Yes. We do think it's very important that—and this is kind of one of the principles of the whole patient safety movement: to not rush to what we call in the patient safety world "shame and blame," but, in fact, to do root cause analysis to understand that we're applying the right remedy for the right purposes and not overlaying a whole lot of new process that adds an additional layer of complexity to what is already a very complex system.

Ms. Helena Jaczek: In terms of Health Canada, you haven't specifically mentioned them. Have you had ongoing dialogue with Health Canada on their appropriate role in this particular incident and in the future going forward?

Ms. Pat Campbell: Health Canada has also been part of that working group and participating in the working group. We don't get into the details on that working group; it's more about how to support the logistics of what needs to happen. But certainly there has been some discussion about Health Canada's role versus the College of Pharmacists' role going forward.

Ms. Helena Jaczek: Would one of those issues be this consistency of labelling nationally? You alluded to neighbouring provinces and other jurisdictions and so on. Would you see that as a role for Health Canada?

Ms. Pat Campbell: Well, certainly, of all of the people at the table, only Health Canada has a national role. The groups that we deal with on an ongoing basis around patient safety include Accreditation Canada and the Institute for Safe Medication Practices. They are both interested in and advocating for a national approach to this issue, recognizing that the challenges that have been uncovered in Ontario won't, in fact, be unique to Ontario. So we are supporting that approach.

Ms. Helena Jaczek: Thank you very much. We'll save the rest of our time.

The Chair (Mr. Ernie Hardeman): Thank you. We'll go to the opposition. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming out today. To start out the questioning, is the OHA in favour of the Ontario College of Pharmacists taking over inspecting and regulating hospital pharmacies in house?

Ms. Pat Campbell: We're certainly aware of the conversation that's going on around the appropriate role for the Ontario College of Pharmacists. Ontario pharmacies are already supported by a set of standards through Accreditation Canada that are applied as part of the overall accreditation of Ontario hospitals process. One of the core accreditation standards is around patient medication safety, so that's already in place. Ontario's pharmacists are all covered by the College of Pharmacists, so they already have a level of jurisdiction in Ontario's hospital pharmacies at the present time.

We do think that, going forward, we need to ensure that the public policy solution actually addresses the problem that's been identified, and that's the process we're currently in. In order for the public policy to be effective, we need to know what went wrong and what should accurately prevent it from happening. At this point in time, from our read of the situation, the problem isn't actually in hospital pharmacies; it relates to the manufacturing process or the process outside of the hospital systems.

Mr. Jeff Yurek: You've stated that "the OHA believes there should be formal regulatory oversight of the companies that produce pharmacy products—all pharmacy products—for hospitals," and I agree with that. But I think the regulatory oversight needs to have an understanding of the complete system, which would include hospital pharmacies.

We have an email between Marchese and OCP given to committee stating that OCP didn't know who Medbuy was. So how do you have OCP cover regulatory framework of just 80% of the system and ensure that there's compliance within the whole system? You're leaving out the hospital pharmacies when you take a look at excluding them from the oversight of the Ontario College of Pharmacists. How do you—

Ms. Pat Campbell: Well, I think the important piece, as we get through this phase, is to ensure that we have the right oversight in the right places by the right people. In our view, at this point, what's really needed in relation to this chemotherapy issue is that hospitals need assurances that they are receiving products of the highest quality. In our view, the role of hospitals is to provide quality patient care, not to provide oversight or to be regulators of pharmaceutical supplies, and in the area—

Mr. Jeff Yurek: That's not my question, though. My question's about the College of Pharmacists overseeing hospital pharmacies.

Ms. Pat Campbell: But it is related, in that for the public policy solution to be appropriate, it needs to address the root cause of what the issue is. From our point of view, the root cause of the issue was not in-hospital pharmacies; it was in relation to the products that were received from outside of the hospital.

Mr. Jeff Yurek: That's your root cause analysis? So—

Ms. Pat Campbell: I think it's important to realize that everyone has a role to play as we move this forward, but in terms of the College of Pharmacists having overall inspection of hospital pharmacies, I think we need to be careful about overlaying multiple levels of accountability, multiple levels of review on any system, and make sure that we've got the right level of responsibility and accountability in the right places.

Hospitals are already subject to a great deal of oversight. They have boards that are in place to be accountable for the quality of the patient care that is provided within hospitals. So the question in our mind has to be: What would be the additional value that would be placed on the College of Pharmacists having jurisdiction to also inspect hospital pharmacies? That's an open question in our mind, at this point in time, as we work through the remainder of the review process.

Mr. Jeff Yurek: But you agree with the College of Pharmacists having oversight of the individual pharmacist—even though, I assume, the same things that you just said are in place in the hospital to oversee that their pharmacist is providing accurate patient care in doing their job?

Ms. Pat Campbell: Well, that's currently the system we have in place, where the regulated health professions are governed under their individual colleges. So the College of Pharmacists is very consistent with other regulated professionals within the hospital environment.

Mr. Jeff Yurek: So they could probably do the job of overseeing hospital pharmacies?

Ms. Pat Campbell: Hospital pharmacies are already overseen by hospitals and by hospital boards. So the question that we're asking is: What is the additional value added for the system in having an additional level

of oversight? It isn't a question of competence, although I think we would have to consider that as times goes forward, because that would be a new role for the College of Pharmacists.

I think the other piece, though, that all of the system—the health care system's a very complex environment, and one of the things that we do have is a lot of standards and a lot of regulation that is already in place.

In terms of drug therapy, Accreditation Canada has a series of standards that hospitals have to meet. One of four core standards is, in fact, the medication management standard. It's one of the four core things that is looked at in any accreditation survey that comes to any hospital.

I don't know if you're aware of the accreditation process, but it's very extensive. You have experts and leadership in different hospitals who come from outside the system and spend a number of days looking at the hospital's adherence to the different standards that apply to that particular facility, of which medication management is one of the four central ones. They spend a number of days providing that oversight, and that process is already in place and it supports continual advancement of the system, both through enhancements of the standards, as well as enhancement of the capacity to do the review and provide the feedback on where the hospital could continue to improve.

We actually think there's a need to examine the role that Accreditation Canada—the standards under which Accreditation Canada reviews hospitals now could potentially play a role as part of this overall review of how this incident took place.

1610

Mr. Jeff Yurek: You made note in your testimony here that "they must be able to trust that the products they have purchased are as advertised and understood." It's common knowledge that Health Canada allows for IV bags, pre-made, to have overfill in them—100 millilitres, 250 millilitres, 500 millilitres, one litre etc. Wouldn't you think it would have been wise for Medbuy to be as plain as day in their contract to specify the concentration of the drug they expected to receive?

Ms. Pat Campbell: The process that we are currently involved in right now will point to where things could have been more sufficiently addressed. Certainly, hospitals have a responsibility through their procurement processes to be clear about what they're procuring and at what standard. That being said, hospitals need to be able to count on the quality of the product as specified in the contract—

Mr. Jeff Yurek: That was my question.

Ms. Pat Campbell: —and on the information provided on the packaging. When packaging says that gloves inside are latex-free, the hospital needs to be able to assume that that is the case, and so too with compounded medications like those delivered in this instance. Hospitals need to be able to assume that the concentration and the volume specified on the bag is what's in the bag.

Mr. Jeff Yurek: But they didn't ask for concentration. That was my question. Don't you think that would have made sense, to actually put the concentration you expect to receive from the supplier on the bag you're going to be receiving?

Ms. Pat Campbell: You have information that I don't have in terms of what was specified. What we understand is that a concentration-specific request was made in terms of the procurement of those solutions.

Mr. Jeff Yurek: I have the contract. I don't know if I have it right here, but basically, it said "four grams in 100 millilitres," which isn't a concentration. Don't you think it would have made sense to put "37 milligrams per millilitre"? That way, it doesn't matter what overfill is in the bag; they know the bag they receive would be—I'm throwing out 37 milligrams per millilitre because that was the concentration that the hospital at Lakeridge had figured out. Do you not think that if you just put, "I want cyclophosphamide at 37 milligrams per millilitre," in 100 millilitres or 500 millilitres or whatever millilitres you wanted it to be in, you would never have to worry about overfill in the whole system?

Ms. Pat Campbell: The issue of overfill is something that pharmacists are well aware of in the system. As I understand it, four milligrams per 100 millilitres is still a concentration-specific requirement.

Mr. Jeff Yurek: It's not a concentration.

Anyway, you've also made note that procurement directive value adds were okay as per the procurement directive for breaking ties.

Ms. Pat Campbell: That's as we understand it, yes.

Mr. Jeff Yurek: Did you know that this government banned value adds in the pharmacy industry two years ago, but still allow it in the hospital? Do you think that maybe that's a double standard out there?

Ms. Pat Campbell: Well, clearly from the way you've identified it, it is a double standard. What we're responsible for is making sure that hospitals are operating in light of the procurement directive. Under the current procurement directive, it's acknowledged, and as long as it's dealt with in an open and transparent manner, it's not outside the directive.

Mr. Jeff Yurek: Do you think it made sense at the time—when they were reviewing how value adds were done in one sector of this province, that maybe they should have looked over the whole area? If it's bad in one area, do you not think it should have—I agree; I think it should have been banned across the board, across the whole province for every department. I don't really agree with value adds. Do you not think that would be—as the head of the OHA, do you think that's not a smart thing to do?

Ms. Pat Campbell: Well, I will comment on my understanding of the RED program that Medbuy runs. It does provide support to hospital staff to be able to access training. Hospitals are always challenged with being able to provide the amount of training that they need. The process for allocating the RED funds is separate from the procurement process, in that it's a totally separate competition.

So while I understand the concern about the question about value add, there is a real benefit to the hospital

community in some of these things—as long as it's done in an open and transparent manner, it's very clear what the rules of the game are and it complies with the required directives. That being said, if the rules of the game change and if their directives change, hospitals will be very open to adapting and changing their processes in that regard.

Mr. Jeff Yurek: I'll wait till the next—

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

M^me^ France Gélinas: Should I go ahead first? Okay.

The first thing I went to is a comment you made. It says, "There is value in provincial and national regulators considering this kind of thing without delay." I couldn't agree more. Can you think of a valid reason why it was not worked upon in 1998, when it was discovered; it was not worked upon in 2003 when there was a directive; it was not worked upon in 2008 when, here again, there was documentation between Health Canada and the Ministry of Health that there was a grey zone? But now you state that it needs to be looked at without delay. Can you think of a valid reason why now it needs to be looked at without delay, but six months ago it could have sat for another 11 years?

Ms. Pat Campbell: I think that those kinds of questions, I'm hoping, will be addressed as we go through these review processes that are under way. Certainly, from hospitals' perspective, it is our contention that all parts of the pharmaceutical chain need to be under regulatory oversight and that that should be addressed.

M^me^ France Gélinas: And you see that oversight not resting with you or your membership but resting with a level of government, either provincial or federal?

Ms. Pat Campbell: In terms of the regulation or the issue of oversight of outsourcing, certainly I don't think that hospitals should be trying to provide verification of the standards that manufacturers are to address independently. They should be able to rely on their suppliers to provide what they say that they are providing.

M^me^ France Gélinas: I agree. My next question: You say, "Contrary to the assertions of some commentators and unions, the outsourcing of compounding by hospitals was not driven primarily, or even secondarily, by cost considerations in most cases."

A couple of questions about this: Who are the unions that are saying this?

Ms. Pat Campbell: To be honest with you—apparently, it's OPSEU that has been saying this.

M^me^ France Gélinas: And in what forums did they say that?

Ms. Pat Campbell: I'm aware there's been some media reporting of that.

M^me^ France Gélinas: Okay. How about commentators?

Ms. Pat Campbell: I think it's media commentators that have made an assumption about the reasons why hospitals would go to outsource activities.

M^me^ France Gélinas: So we look at the website of Medbuy. Their entire front page—and it doesn't matter where you click on this, it always comes up that they will save you money: "Hospitals, join us. We will save you money." Why should we believe that they're not there to save money if this is what they say on every page of their website?

Ms. Pat Campbell: Certainly one of the benefits that hospitals look to accrue through group purchasing organizations can be savings through larger group contracts. However, you have to look at the reasons why any individual business decision is made, and in terms of this particular activity, the reason to move to group purchasing was not driven by cost savings. It wasn't—

M^me^ France Gélinas: Okay. I have a hard time with your answer, because the statement you make, that it was driven by occupational health and safety—they all brought it back in. They are all doing it now with the same staff, with the same training, with the same equipment they had before. So are you telling me that all of those workers are at risk?

Ms. Pat Campbell: Certainly, these drugs are toxic, and when you're mixing and addressing large volumes of them, there are two key risks: One is toxicity and the other repetitive strain injury. I know from personal experience that the issue of patient safety is paramount in terms of trying to address these particular drugs safely and effectively. So, yes, they will all—all hospital pharmacies are capable of producing these drugs. Is that the best way? No. Accreditation Canada and the Institute for Safe Medication Practices both have standards that say that that is not the best way for these drugs to be prepared and supplied on an ongoing basis.

1620

The Chair (Mr. Ernie Hardeman): One minute left.

M^me^ France Gélinas: So, if we go to those documents you just referred to, we will see that they suggest that you outsource the admix medication, although you're sending it to an unregulated field?

Ms. Pat Campbell: I don't think any of the accreditation standards contemplated that the supply source was unregulated. The standard under the Accreditation Canada program—the organization purchases commercially manufactured medications, when available, to minimize compounding—is in fact the standard of care that's identified as preferential under the Accreditation Canada standards.

M^me^ France Gélinas: If you could send us a copy of this, as well as a copy of—if it's not the same—adhering to accreditation standards related to medication management. That's under your hospital procurement practice statement. If you could table that with the Clerk, please.

Ms. Pat Campbell: We'd be happy to do that.

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

We will now go to the government side. Mr. Flynn.

Mr. Kevin Daniel Flynn: Thank you, Pat, for your presentation. I'm thinking now, when something like this happens, your thoughts turn, as a legislator, to your constituents and the variety of ways that they interact with the system. I suppose the average person's inter-

action with pharmaceuticals in general, the typical interaction: You feel sick, you go to the doctor, the doctor would prescribe a prescription, you'd take that prescription to somebody with the training of a Mr. Yurek, and you'd trust that that individual had given you the pill or the liquid or whatever it is that was going to make you feel better. There's a level of trust that runs throughout there that those professionals have served you in the way they should.

A visit to the hospital is a little different, in that you go in for a procedure—perhaps it's planned, perhaps it's unplanned—and a lot of that interaction with the pharmacist is very limited; in fact, it probably is non-existent. But you get administered a drug, you get given a drug. When I heard that, I thought, okay, I'm interested in my own hospital, so I went, and I've actually seen the attestation that came from Oakville Trafalgar Memorial Hospital, for example, because I wanted to be sure that in my own community things were being done the way they should be.

So, from a very practical level, from a patient perspective, what kind of reporting exists within the organizations that belong to you, the hospitals that are your members, that ensures that drugs are prepared properly and are administered appropriately?

Ms. Pat Campbell: There are many elements to that question, but I'll start with the two simplest. All hospitals in Ontario are accredited under Accreditation Canada. The medication safety standard is one of four core standards that all hospitals have to comply with, and any deficits in those core standards are seen very seriously as priorities for improvement.

The second I'd point to is the requirement that limits scope of practice for certain providers, limits the administration and distribution of medication to only a limited set of providers in our system. Under the scope of practice for those providers, there are specific requirements about what kind of training and expertise nurses, RPNs, in certain instances, and so on need to have to be able to deliver and administer medications, and that also applies, of course, to the pharmacists. So we rely very heavily on the fact that everybody plays a role and has a role to play and that they're trained and accountable for the role that they have within the system.

Mr. Kevin Daniel Flynn: I'm aware of a situation that exists now in Oakville. We're building a brand new hospital there in Oakville, and it's costing over $2.5 billion, and there are all sorts of improvements and best practices that are being put into place there. One of the things that the people who are building the hospital and the staff at the old Oakville hospital are saying about the new Oakville hospital, one of the major improvements they talk about is the use of vending machines on the actual floor for the medical professions to go and get the prescriptions they need for the people on the floor.

Is this a field that's constantly under review, how you can do better? Obviously, we want to save money in the system if we possibly can, but we don't for one minute ever want to jeopardize patient health or safety. Are there any other advances? Does this make the field more accountable, all these changes that I see taking place, that would involve, perhaps, the use of vending machines? Can patients in Ontario be confident in the safety of the drug supply in Ontario's hospitals?

Ms. Pat Campbell: I think patients can very much be confident of the drug supply in Ontario's hospitals. That being said, there are always things that we can do to improve any system, and Ontario's hospitals are open to the need to constantly improve.

I think one of challenges that we will all face is that hospital care and health care in general is changing and it's increasingly complex. Chemotherapy is a very good example of that, where increasingly the medication that's provided is individualized and identified for that patient alone.

So we will constantly be looking at our mechanisms for supporting effective delivery of patient care services, and the use of robots to support effective medication management is something that's just beginning to be looked at and used in Ontario's hospitals. It's very exciting, because it in fact increases the level of standardization that can happen and the systematization of the care delivery process in a way that supports more effective patient safety.

Mr. Kevin Daniel Flynn: Thank you. Do I have time left?

The Chair (Mr. Ernie Hardeman): Yes, you have about a minute.

Mr. Kevin Daniel Flynn: About a minute? Okay, this can be very brief—a very short answer.

Obviously, when we have an issue like this arise, there's a lot of interaction between the ministry, between the association, between the college, between patients. How would you characterize your relationship right now with the ministry on this issue?

Ms. Pat Campbell: I think we have a very mutually supportive relationship, in terms of just trying to get to the facts of what needs to be done and look at pragmatic solutions that can help move the system forward.

Mr. Kevin Daniel Flynn: Thank you, Mr. Chair.

The Chair (Mr. Ernie Hardeman): Thank you very much. We go to the opposition. Ms. Elliott.

Mrs. Christine Elliott: Good afternoon, Ms. Campbell. Thank you very much for appearing before the committee.

We've heard from your presentation that the OHA was aware that a number of hospitals were contracting out the preparation of certain admixtures for certain types of products. I'm just wondering if your association had ever issued any policy, directives or suggestions to hospitals with respect to procurement or with respect to this contracting out procedure at all.

Ms. Pat Campbell: Certainly, with the identification and initiation of the procurement directive, the OHA did a lot of member support around interpretation and understanding about what the procurement directive required of hospitals, and supported the implementation of that directive across the system.

Mrs. Christine Elliott: When would that have been done?

Ms. Pat Campbell: When the directive was first issued, but we could certainly clarify what exactly we did and when we did it and provide that back to the committee.

Mrs. Christine Elliott: If you could, and provide us with a copy of the directive, that would be great. Thank you.

The other question I have: It seems that when a number of hospitals were negotiating this whole process, they did use Medbuy as their broker or agent in the whole transaction. Could you explain to me, if you're aware, how this would happen and how that process would be initiated by the hospital, and the relationship between the hospital and Medbuy concerning what they were asking for and how that came to be reflected in an RFP, for example, such as was issued by Medbuy in the present case?

Ms. Pat Campbell: I can speak in general about how hospitals use group purchasing organizations, but in terms of the details about this specific contract and this specific engagement with Medbuy, we're really looking to Dr. Thiessen's review to highlight that. So I'm not going to speak to that.

1630

Really, hospitals use group purchasing to create efficiencies in the procurement process by performing commonly required tasks once and not having to do it hospital by hospital over and over again; also, the leveraging of purchasing power to drive costs down. But I think, more importantly, the group purchasing organizations have expertise in what is increasingly a more and more complicated procurement process, with many requirements for hospitals to navigate. GPOs not only streamline the process, they add an extra layer of confidence and reassurance that hospitals are meeting those strict accountability measures that are in place for procuring goods and services. So there's kind of a dual role that is played.

Mrs. Christine Elliott: How would that actually happen? Would there be a contract between the specific hospitals and with Medbuy, for example—

The Chair (Mr. Ernie Hardeman): Okay, that will be the last question, if you—

Mrs. Christine Elliott: —to act as their broker agent, and would that outline what their requirements were?

Ms. Pat Campbell: It can happen a number of ways. Sometimes the hospitals sign on and the procurement is done for that group of hospitals. Sometimes a few hospitals sign on to start a procurement but then other hospitals can add in and take advantage of that group purchasing. It just depends how it's constructed as a process when it's initiated.

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

M^me^ France Gélinas: Before these good people go home, they were scheduled to stay till 4:40. Being respectful of their time, rather than calling them back, we still have a few questions. I was wondering if the time between now and the time that they were scheduled to stay until could be split evenly between the three caucuses?

The Chair (Mr. Ernie Hardeman): I stand to be overruled. I mean, it was agreed as to the time that we were going to use. The time isn't always necessarily—in this case it was—used equally by everyone. The time that was saved from the start was in fact very disproportional to which party it saved time from. But I stand here at the will of the committee. If you wish unanimous consent to carry on, we can carry on and divide the time that's left till 4:40 equally among the parties.

M^me^ France Gélinas: Thank you.

Interjection: Agreed.

The Chair (Mr. Ernie Hardeman): We have agreed. With that, we will start with the third party.

Ms. Cindy Forster: Thank you for being here, Ms. Campbell.

The Chair (Mr. Ernie Hardeman): We're dividing about eight minutes equally.

Ms. Cindy Forster: We've heard from a number of people who have come and made presentations over the last couple of weeks about the increased risk to patient safety with multiple more hand-offs in this procurement practice. Where meds are actually mixed in the hospital, you get a doctor's order, it goes to the pharmacy, it comes back to the nurse, and that's the end of it, right? But through this procurement process, the hand-off may be multiplied by four times. What is the OHA's position on that inherent risk to patient safety?

Ms. Pat Campbell: Again, it becomes a question of are we clear about what problem we're trying to solve and do we have the right mechanisms to solve the problem. Certainly, in terms of hand-offs, we know from patient activity that more hand-offs can create challenges. What solves that problem is effective communication and the need for effective communication processes. I go back to, in this instance, the need for effective labelling as being one of the solutions that could really help with the challenges in this particular process going forward. I think that that would go a long way to helping with the issues or the potential risks in this kind of process.

I think we need to understand that hospitals will need to procure good services on an ongoing basis. We need to have effective mechanisms to do that. There are good public policy reasons for the broader public sector accountability—

Ms. Cindy Forster: I have one more question. I just have one minute, so my next question is that we heard from Ms. Gélinas about the fact that the federal government had made the province aware, on a number of times over the last 20 or 25 years, of the lack of oversight and there was no action. Do you believe that if we had Ombudsman oversight, like every other province in this country, that perhaps the Ombudsman would have picked up on this with a review much earlier than in 2013?

Ms. Pat Campbell: Certainly, we're aware of the conversation around the role of the Ombudsman, but

actually, in this particular case, we don't believe that the Ombudsman would have played a role in terms of this. This wasn't initiated as a result of a patient complaint; this was initiated as a result of a concern raised by a hospital staff member who moved it up the chain. It immediately triggered the minister to exercise her power pursuant to the Public Hospitals Act to appoint an inspector. There was no gap in response relative to any gap in oversight.

Ms. Cindy Forster: So just the OHA—

The Chair (Mr. Ernie Hardeman): Okay, thank you. Your time is up. The government: Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Mr. Chair. You explained to my colleague Mr. Flynn that the relationship with the Ministry of Health and Long-Term Care is a positive one in terms of dialogue and so on. You sent the letter to ADM Catherine Brown of May 6 on your concerns about perhaps acting in too much haste related to the regulation, the clarification around definitions and so on. That was May 6. We're only at May 13, so I don't suppose you've received any formal response, or have you had any verbal communication in relation to your comments on the draft regulation?

Ms. Pat Campbell: As I understand it, and I look to my colleagues, the response of the public consultation on these regulations is just getting initiated and being started. So no, I don't believe we've heard any response, and neither would we expect to in that immediate term.

Ms. Helena Jaczek: But would you say that you would expect to be listened to very seriously as the representative for Ontario's hospitals? Is that the kind of experience that you've had in the past?

Ms. Pat Campbell: That has certainly been our experience: an openness to dialogue and to really understanding and unpacking the issues so that we end up in a place that actually supports improved patient care.

Ms. Helena Jaczek: Thank you for your very detailed response in the letter to Catherine Brown; I'm sure it will be looked at very closely.

The Chair (Mr. Ernie Hardeman): The official opposition: Ms. Elliott.

Mrs. Christine Elliott: Thank you. I'd like to quickly get back to the relationship between the hospitals and Medbuy since they were going to be acting as the hospitals' agent. Would you be able to advise us if, in the present case, there was a contract between the hospitals involved and Medbuy? If so, could you provide us with copies of those documents?

Ms. Pat Campbell: It is my understanding that there was a contract between Medbuy and the hospitals. We can certainly look into that; I don't know if we can provide it to you, but—

Mrs. Christine Elliott: All right. If you are able, I'd appreciate it if you could provide it. Also, was there someone who would have been designated from a hospital to work with Medbuy to make sure that the product that they wanted to have procured actually was procured?

Ms. Pat Campbell: Certainly in the initial bid process, hospitals would have been part of that initial evaluation team. Sometimes in doing a collaborative process, some hospitals participate and some don't, but they rely on their colleagues from the other hospitals to participate and be a proxy in the evaluation process. It is the hospitals' responsibility to review the product specifications and perform due diligence when the product is received and to ensure that it meets the identified clinical requirements. But this typically wouldn't include a re-evaluation of the quality of the products or the qualifications of the supplier; that would have been done as part of the procurement process.

Mrs. Christine Elliott: Okay. We certainly heard that there was a discrepancy between Medbuy and Marchese as to the product that was to be supplied. Do you suppose there could have been any discrepancy between the hospital and Medbuy in the first place as to what it was that they wanted to have procured?

Ms. Pat Campbell: I don't believe that to be the case because what was being procured was very much understood within the hospital community to be used in the way that it was used, so I don't believe that that would be the case. But communication is always something that can be addressed and improved. Looking to labelling specifications would be our recommendation as to how to improve this particular situation going forward.

Mrs. Christine Elliott: Okay. Thank you.

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

Ms. Pat Campbell: Thank you. Good luck.

CENTRAL EAST LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): The next presentation is from the Central East Local Health Integration Network. For clarification, since we are right back on time to the original schedule, I guess I want it understood that we will then revert back to the original schedule, which would be the full time for all the committees.

Interjections.

The Chair (Mr. Ernie Hardeman): Okay. Just wanted to make sure.

Thank you very much for coming in to talk to us this afternoon. As we are doing this under oath, we'll ask the Clerk to administer the oath first.

1640

The Clerk of the Committee (Mr. William Short): Ms. Hammons, I'll start with you. Oath? Okay, great.

Ms. Hammons, do you solemnly swear that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth, so help you God?

Ms. Deborah Hammons: I do.

The Clerk of the Committee (Mr. William Short): Thank you. And Mr. Gladstone?

Mr. Wayne Gladstone: Yes.

The Clerk of the Committee (Mr. William Short): Same thing. Mr. Gladstone, do you solemnly swear that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth, so help you God?

Mr. Wayne Gladstone: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

The Chair (Mr. Ernie Hardeman): With that, thank you very much for coming in. As we do with all the delegations coming in, you'll have 20 minutes to make a presentation. At the conclusion of the presentation, we will have 20 minutes of questions from each caucus. This time, I think we start with the government caucus. With that, thank you again, and the floor is yours.

Ms. Deborah Hammons: Good afternoon. My name is Deborah Hammons, and I am the CEO of the Central East Local Health Integration Network, a position I've held since 2007.

I began my career in health care as a nurse and have held senior positions in health care organizations throughout Canada, including the Vancouver General Hospital, the Ottawa General Hospital, the Toronto Hospital and the Hamilton Health Sciences Corp.

As executive director of Fairhaven, a 256-bed long-term-care home in Peterborough, I oversaw the development of a new $25.5-million facility, led the organization in achieving their first three-year Canadian Council on Health Services Accreditation—Accreditation Canada now—and implemented an information strategic plan to create a state-of-the-art computerized environment.

I am joined by Wayne Gladstone, chair of the Central East LHIN board of directors. Wayne joined our board in June 2010, becoming board chair in June 2011. As senior vice-president of finance and administration at OMERS, the Ontario municipal employees retirement system, for 15 years, Wayne's responsibilities included corporate strategic planning, financial controls and reporting, the risk management framework, and financial and technology support.

I would like to thank the members of the Standing Committee on Social Policy for inviting us to appear before you today as you undertake a study relating to the oversight, monitoring and regulation of non-accredited pharmaceutical companies.

Wayne and I would like to begin by speaking as local residents of the Central East LHIN and acknowledge the worry and anxiety felt by patients receiving care at our hospitals when it was discovered that there had been an underdosing of chemotherapy drugs at hospitals in Ontario and New Brunswick.

As a former nurse, long-term-care home administrator and hospital administrator, I know how challenging the journey can be for patients and their family members as they undergo treatment for cancer. It is vitally important that they have trust in the system, and as LHINs we share in the responsibility of ensuring that their trust remains strong.

That is why, when this issue first came to our LHIN's attention, we immediately participated in a process of connecting with our provincial colleagues and our local health care providers involved in the Central East regional systemic therapy treatment program to ensure that, from the patients' and family members' perspective, their concerns and their questions were addressed as quickly as possible.

Mr. Wayne Gladstone: I would like to give part of the presentation now. As part of our statement today, we would like to take a few moments to tell you about the Central East Local Health Integration Network and the role we play in managing the local health care system.

The Central East LHIN, as a geographic region, is a mixture of urban and rural geography and includes Scarborough, Durham region, Northumberland county, Peterborough city and county, the city of Kawartha Lakes and Haliburton county.

Created by the Ontario government in March 2006, the Central East LHIN is one of 14 not-for-profit agencies that works with local health providers and community members to determine the local health service priorities of our regions.

As LHINs, we work with our with local health service providers, patients, consumers, clients, caregivers, doctors, nurses, front-line staff, volunteer boards, and municipal and provincial representatives to plan, integrate and fund local health services delivered by hospitals, community care access centres, community support services, long-term-care homes, community-based mental health and addictions services and community health centres.

As you know, at the present time, while we do not have direct responsibility for the funding and accountability for doctors, public health and emergency management services, we do work closely with these groups in our day-to-day work, engaging them in our activities and seeking their input and advice. We are also not responsible for the oversight of the provincial laboratory system or the provincial drug program.

While we do not directly provide services, our mandate is to plan, integrate and fund health care services. As LHINs, we oversee nearly two thirds of the $48.9 billion being invested in health care in Ontario in fiscal 2013-14. At the present time, over 140 health service provider organizations are funded by and accountable to our Central East LHIN for providing health care services based on signed accountability agreements. These accountability agreements reflect both provincial priorities and our local strategic directions and priorities for the health care system.

Since 2007, our LHIN has been focused on the achievement of four strategic directions: transformational leadership, quality and safety, service and system integration, and fiscal responsibility. I would like to briefly comment on each of those.

"Transformational leadership" means that the Central East LHIN board will lead the transformation of our local health care system into a culture of interdependence. We do this by demonstrating accountability and systems thinking in all decision-making and leadership actions,

rewarding innovation which is aligned with the LHIN's integrated health services plan, and modelling fair, transparent and honest interaction with one another and with our health service providers.

In turn, we expect our health service providers to bring forth integration opportunities aligned with our integrated health services plan, self-organize to solve problems, and proactively manage their organizations beyond organizational boundaries.

"Quality and safety" means that the LHIN board will ensure that health care will be person-centred in safe environments of quality care. We do this by considering quality and safety as a filter for LHIN decision-making, ensuring that no LHIN actions or decisions will impact negatively on the quality or safety of the health system. We measure and monitor the public's confidence in the health system, and we have established a health professional advisory committee with an added mandate for safety and quality.

Again, in turn, we expect our health service providers to be accountable for demonstrating improved quality and safety of clients and their caregivers, to achieve standards and targets for safety and quality of services in their service accountability agreements, and to demonstrate that patient satisfaction indicators are routinely collected and monitored.

Talking a bit about "service and system integration," it means that the board will create an integrated system of care that is easily accessed, sustainable and achieves good outcomes. To achieve this direction, the LHIN board ensures that the community is engaged to identify opportunities to enhance their health care experience. With input from our communities, we also create and implement strategic plans, such as the integrated health services plan, or IHSP, that will serve as a guide for local decisions on health care.

We expect health service providers to align their service and strategic plans with the goals and objectives identified in the integrated health services plan, participate in LHIN planning activities, support implementation, and self-identify opportunities that advance the performance of the local health system.

Finally, "fiscal responsibility" means that resource investments in the Central East LHIN will be fiscally responsible and prudent.

1650

As a board, we maintain a primary focus on quality as a driver for cost-effectiveness; measure cost-efficiency against our strategic priorities; evaluate investments against return on investment and the long-term sustainability of the public health system; make investments in community-based programs that prevent or shorten hospital admissions; and ensure that the LHIN is appropriately resourced. For our health service providers, this means they are to maintain a primary focus on quality as a driver for cost-effectiveness, measure cost-efficiency against strategic priorities, and make budgetary and programmatic decisions with a clear understanding of the impacts on other health service providers.

Ms. Deborah Hammons: I'm going to go ahead.

As a LHIN, we recently released our third integrated health service plan. This document sets out a shared goal for the local health care system to help Central East LHIN residents spend more time in their homes and in their communities. The integrated health service plan provides the road map for Central East LHIN hospitals, long-term-care homes, community health centres, community mental health and addictions agencies, the community care access centre and community support services to follow as they work together to create an integrated community-based health care system that can respond to changing demographics, financial challenges, updated evidence-based clinical practice and new technology.

As the LHIN works with the system towards the achievement of our strategic directions and integrated health service plan goal, we are very aware that each health service provider organization is governed by its own board of directors and is responsible for overseeing its own operations and service delivery to ensure that they meet the performance and service obligations outlined in their signed accountability agreements and the various legislation overseeing their operations.

Copies of each of the health service providers' current accountability agreement are posted on the Central East LHIN website, along with a breakdown of the funding they receive from the LHIN and a report on the system's quarterly performance. In all cases, it is the responsibility of the LHIN to ensure that the organization is aware of and complies with our expectations as defined in the accountability agreement.

The actual day-to-day operational processes that a health service provider organization puts in place to run its organization are the role of that organization. The accountability agreement only remains in place if the LHIN is satisfied that the actions of the health service provider will achieve the contracted outcomes.

Since our creation in 2006, we have exercised the word "integration" in our name numerous times to support and endorse a number of partnerships, transfers, mergers and amalgamations between health service providers that have led to better health, better care and better value for money. Examples include the merger of the Canadian Mental Health Association in Lindsay with the Canadian Mental Health Association in Peterborough. This was the result of a facilitated integration process supported by the LHIN. The new CMHA Haliburton, Kawartha, Pine Ridge now consists of 138 full-time employees who support the delivery of community-based mental health services across the four counties. With a combined operating budget of $11.1 million, over $230,000 in back office savings have been realized and are being redirected into front-line care.

To ensure the sustainability and the continued provision of vital palliative and end-of-life services to local residents, the LHIN supported two facilitated integration processes, the first between two hospice service providers in Northumberland county and Community Care

Northumberland, and the second between Hospice Kawartha Lakes and Community Care City of Kawartha Lakes. Front-line staff from the three hospice organizations were retained, the strong leadership base for this type of specialized service stayed in place, and the integrations occurred without any disruption in service to hospice and palliative patients.

Working with hospitals, we have streamlined access to vascular and thoracic surgery, cardiac rehabilitation, and supported the expansion of Rouge Valley Health System's Code STEMI program to Lakeridge Health in Oshawa and the Scarborough Hospital.

We also built a unified stroke system across the Central East LHIN. We obtained the funding to have Lakeridge Health Oshawa designated as a district stroke centre, partnering them with the stroke centre already in place at Peterborough Regional Health Centre. This allowed Lakeridge to hire specialized clinical staff and begin administering clot-busting drugs, commonly called TPAs, that minimize the effects of a stroke.

Most recently, we worked with 10 community-based agencies in our Durham cluster to develop an integration plan that aims to provide or improve client access to high-quality services, create readiness for future health system transformation and make the best use of the public's investment.

We are just starting a process in our Scarborough cluster that involves two hospital corporations working in partnership with our physicians, front-line staff and local communities. Their deliverable is to design and implement a Scarborough cluster hospital services delivery model, again to improve client access to high-quality services, create a readiness for future health system transformation and make the best use of the public investment.

Wayne and I are both very proud of the work being done by the LHIN staff and, indeed, the staff, leadership and boards of all of our Central East LHIN health service providers to improve the health of our communities through innovation and collaboration while recognizing the need to sustain and enhance the delivery of vital health care services in a challenging fiscal environment.

Two of our Central East LHIN hospitals have appeared before you already—Lakeridge Health on April 23 and Peterborough Regional Health Centre on April 30 and May 7. As Lakeridge Health's CEO stated during his presentation, every one of us is involved in health care in order to improve the lives of our patients. The same holds true for the team at the Central East LHIN.

As a LHIN, we first became aware of the underdosing issue through an email sent to us by Cancer Care Ontario on Saturday, March 30, that referred to an issue related to chemotherapy drug underdosing with the regional cancer programs in London, Lakeridge and Windsor. As our colleagues from Lakeridge told you when they were here on April 23, this led to a table being established by Cancer Care Ontario, the affected hospitals and the LHINs to share information and coordinate efforts to inform patients and the broader community.

The LHIN participated in two telephone conversations on Monday, April 1.

The first conversation, led by Cancer Care Ontario, included the three LHIN CEOs—myself, Gary Switzer from the Erie St. Clair LHIN and Michael Barrett from the South West LHIN—along with representatives from Lakeridge Health, Windsor Regional and London Health Sciences Centre.

The conversation was focused on developing a coordinated outreach plan to effectively communicate with affected patients and their families. During that conversation, we were made aware of the formal processes that each of the organizations were already taking or were planning to take to reach as many people as possible, including couriered letters and phone calls, setting up face-to-face meetings between affected patients and hospital staff and affected patients and their physicians, the opening of a dedicated 1-800 number to answer questions and concerns, and posters in treatment areas.

The group also talked about engaging with the media to ensure that people were aware and knew who to contact for more information, and shortly thereafter news releases and updates were sent out to patients and the media and posted on the hospitals' websites.

Based on our previous experiences in managing health system issues, we asked if other providers beyond those on the call had been notified.

The team from Lakeridge Health confirmed that they were reaching out to other systemic therapy providers in our LHIN, which include the Scarborough Hospital, Rouge Valley Health System, Northumberland Hills Hospital, and, as you are aware, Peterborough Regional Health Centre, which had one affected patient as well.

The second conversation that the LHIN was involved in on April 1 was called by Lakeridge and included the LHIN, Lakeridge Health leadership and their colleagues at Peterborough Regional Health Centre, and again focused on effectively communicating with patients and their families.

In the days that followed, staff at the Central East LHIN have continued to monitor the efforts of our hospitals—Lakeridge Health, Peterborough Regional and others—in responding to their patients, supporting their physicians, nurses and pharmacy staff, and ensuring that everyone has access to the most up-to-date information on the impact of this situation.

I am extremely proud of the steps that the hospitals in the Central East LHIN took to identify the issue, alert their provincial and local colleagues, partner in the development of a coordinated outreach strategy, and take the very necessary and personal steps to contact patients and their families as quickly as possible.

Mr. Wayne Gladstone: In conclusion, I would like to state again that we have a very strong system of health care providers in the Central East LHIN region who are working together to improve access to quality care for local residents.

By working with our providers, the LHIN is ensuring that local decisions are being made to respond to local

health care needs. Health service providers are being held accountable for the taxpayer dollars they are given, and with the support and direction of the LHIN, the health care needs of the people in our communities are being identified, coordinated and addressed as a truly integrated system.

Thank you very much for allowing us to make this statement. We would be pleased to answer any questions you may have.

1700

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We'll begin with the government caucus. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Ms. Hammons and Mr. Gladstone. That's what I would call a very comprehensive report. As you were going through, I was ticking off a lot of the questions that I had for you.

To get back to this particular incident and issue, as we know, the discovery in Peterborough was on March 20 by those splendid pharmacist technicians—or assistants, as they are now, soon to be technicians, no doubt. Is it surprising to you in any way that you first heard about the incident on March 30? In other words, that was 10 days later.

Ms. Deborah Hammons: I think what the hospitals—or I know what the hospitals did. They wanted to do their due diligence before notifying the LHIN. In the case of Peterborough, obviously, it was only the one patient. But when it came to Lakeridge and the other hospitals, there were many more that were involved. In the case of Lakeridge, they wanted to go through all of the files to make sure that they had an accurate count and could come to us and tell us exactly the extent of the problem. I appreciated the fact that they were alerting us to what they had done so that we could make sure that we understood and we could discuss what we would do on a go-forward basis.

Ms. Helena Jaczek: And of course they had contacted Cancer Care Ontario—

Ms. Deborah Hammons: Yes.

Ms. Helena Jaczek: —through the Durham region cancer service, essentially.

Ms. Deborah Hammons: They have. Their relationship to Cancer Care Ontario is unique. They have their funding agreement and accountability directly with CCO. They're funded directly by CCO, and their performance agreement is directly with them, so it's not a surprise to me that they would have reached out and made that call first to CCO.

Ms. Helena Jaczek: And as we heard—as you just described and as we heard from Mr. Switzer from the Erie St. Clair LHIN, there's no direct relationship between the LHIN and CCO; it's between the hospitals and CCO.

Ms. Deborah Hammons: That is correct.

Ms. Helena Jaczek: So when you started getting involved, you saw your role—how would you describe your role as CEO of the Central East LHIN?

Ms. Deborah Hammons: In these cases, it's more of a coordinating and facilitating role. Oftentimes, when we are involved in these cases, we will make sure that the communication is effective, that it has been broad, as I mentioned in my statement. We also always have connectivity with the ministry so that they are fully briefed on what the issue is, and we already knew that that had taken place. It was more of a coordinating and facilitating role in this particular instance.

Ms. Helena Jaczek: And you've given us many examples of what has occurred within the Central East LHIN over the last few years. Ms. Hammons, you've got a long history in health care, as you've detailed to us. Maybe you're not the most objective person to ask, but do you think the LHIN's role is a valuable one? Can you, through your experience through the years, encapsulate for us what you see as the critical role of the LHIN?

Ms. Deborah Hammons: I've been at the—not the very first CEO at our LHIN but the second. I've been in the position for six years. It is phenomenal to me, the changes that I've seen, the fact that all of our health service providers have accountability agreements and that we are keeping them accountable with performance measurements that they have to report to us on a quarterly basis.

Before the LHINs were in place, there were many instances where hospitals were not balancing their budget. I'm proud to say that I think across the province we've had an excellent record. All of the health service providers in our LHIN, of which there are over 140, are all balanced. That was not the case when we first came into our role. Many facilities were not balanced. That's a significant change.

The other change is integration of the system. We've heard as we've been out talking to the public that transitioning our system is difficult, that it's very difficult for them to understand the role of different health service providers, so we've spent a lot of time looking at how we can better integrate the health care system. How can we clarify that for the public? We've spent a lot of time doing it, and we've been quite successful.

Ms. Helena Jaczek: One of the issues that has come up in conversations we've had as colleagues on the government side is that sometimes there appears to be a lack of consistency across the various LHINs. Services are provided in ways possibly to meet local needs, but sometimes it's rather hard to discern. Can you describe how LHINs communicate with each other and what role the ministry plays to ensure some degree of consistency and sharing best practices, the forums that you use for that?

Ms. Deborah Hammons: Three questions in one.

First of all, there shouldn't be an assumption that across the province everything was equal at the beginning when LHINs were first formed, because it wasn't. There are differences across the province. We've got the north, where we have a lot of rural hospitals and agencies. In the south, we've got an urban setting. It's very different. As far as providing consistency, we are there as

local health integration networks, so we're really trying to focus on the local issues that we find, and they're very different. For instance, in the Central East LHIN, because we have that rural and urban, what is needed in, say, the Scarborough area, is very different in the north. So we have to take into consideration the local needs.

As far as providing consistency, the LHIN CEOs actually meet either by telephone or by OTN or face to face at least weekly. We have these conversations on an ongoing basis as we're dealing with issues or we're dealing with the plans that the ministry is rolling out—their direction to us and how we will implement it. Those kinds of discussions go on on a regular basis.

We also relate to the LHIN liaison branch. That is an organization that we're in constant contact with. I can list many, many reasons why we make contact with them.

We also have meetings once a month with the ministry. This is with all the ADMs, the deputy minister and all 14 LHINs. That's how we communicate what's happening in the province, and also, we can report back to the ministry about what we're doing so that they can keep in constant contact with us.

As well, as you've heard, Catherine Brown is our ADM. She meets with the LHINs on a regular basis, on a one-on-one basis at our meetings, or we also have quarterly meetings with her when we're talking to her about our performance. We do have an accountability agreement with the ministry. They're monitoring to ensure that we're meeting our performance obligations with the ministry.

There's a lot of dialogue going on day-to-day—many ways that we keep in contact.

Ms. Helena Jaczek: We heard a little bit about a shortage of supply, the Sandoz situation, earlier. Were you involved? Did you have a role—

Ms. Deborah Hammons: I happened to be the provincial lead with the Sandoz shortage, so I worked very closely with the ministry on that. There was a special branch that helped support that process with us. We had a small working group.

Our LHIN was actually very instrumental in developing some of the protocols that were used provincially. We made sure that there was a web of call-outs so that we were ensuring that all of the LHINs were kept apprised.

As well, in our LHIN particularly, we had close contact with all of our pharmacy directors. That was very instrumental, because we were able to quickly know where there were issues. We actually moved drugs from one LHIN to another if there were shortages. That's the kind of thing that we would do in an issue management type of situation.

Ms. Helena Jaczek: So you feel that the structure as it exists at the moment is working well—the LHINs structure?

Ms. Deborah Hammons: That would be my opinion, yes.

Ms. Helena Jaczek: We've heard about the accountability agreements with individual hospitals. Again, you're going to have some people performing really, really well, and perhaps not performing as well in other areas. Describe for us, if you would, how that works out. Supposing you have someone whose wait times or an organization whose wait times are increasing. How do you handle that?

Ms. Deborah Hammons: In the accountability agreement, it's outlined that if they're not meeting their performance, the LHIN can issue a performance factor. We have done that where we have had instances—we give them a couple of months, and of course through dialogue, but if there isn't an improvement, we will actually write to them and suggest that they come up with a plan of improvement to improve that specific performance factor. They usually come back to us—if we've issued a performance factor, that's something that we expect: The CEO would come and present to our board with a plan. That has happened where they have come in and talked about what the issue was, what their plan is for improvement, and we would monitor that.

1710

If there still isn't satisfaction in moving forward for whatever reason, we do have the capability to bring in somebody to do an operational review. We have had instances in certain hospitals where we've asked for an external review to come in, and they have presented a report. The hospital or whatever organization would work on the directions that the external review would expect, and the LHIN would monitor that.

Ms. Helena Jaczek: Then, as a recourse, in case of ongoing difficulties, as you said, you can rely on the ministry—you have that dialogue—to step in if required.

Ms. Deborah Hammons: That's true.

Ms. Helena Jaczek: And then how do you engage the public in the Central East LHIN? How do you engage stakeholders, the public? How do you make yourselves accountable to the population?

Ms. Deborah Hammons: Well, we've used various techniques. Certainly through our integrated health services plan, we've used face-to-face groups, focus groups. We actually did an Ipsos Reid study where we did—through a random sample across our LHIN—telephone surveys. We've also used the Internet where we've had the capability of the public to respond to certain issues.

Certainly, whenever we've done our integrations, it's important for the public to be engaged in that, so there's a process of communication either electronically allowing them to provide input into what we're doing. Whatever we do, that's a requirement: that we must engage the community. Of course, we have to set out opportunities to do that, and the timing of that varies.

Ms. Helena Jaczek: To Mr. Gladstone, do you feel confident, as chair of the board, and your board of directors, that everything that Ms. Hammons is doing is to ensure transparency and accountability to the population you serve?

Mr. Wayne Gladstone: Absolutely. We find at the board level that there is an openness conveyed by the staff to share information at a good level. They're

working very hard to make sure that they are delivering on their responsibilities. The board is very satisfied.

Ms. Helena Jaczek: Just one last question, at least from me. This was something I posed to Mr. Switzer. In terms of administrative costs, of the amount of revenue that you receive from the Ministry of Health that you transfer out, what percentage is used for administrative costs?

Ms. Deborah Hammons: Our budget is about $2.2 billion, and our administrative overhead for our LHIN is just over $5 million.

Ms. Helena Jaczek: So a very small percentage.

Ms. Deborah Hammons: A very small percentage.

Ms. Helena Jaczek: I think we'll reserve any time we have left, Mr. Chair.

The Chair (Mr. Ernie Hardeman): To the opposition. Ms. Elliott.

Mrs. Christine Elliott: Good afternoon, Ms. Hammons and Mr. Gladstone. It's good to see you again, and thank you very much for appearing before the committee.

I have some questions just based on your submission. On page 5, you talk about quality and safety and having a health professional advisory committee with an added mandate for safety and quality. I'm just wondering if you could explain a little bit about what the committee does and what kinds of inquiries it undertakes.

Ms. Deborah Hammons: This is a committee that was set out in our legislation. It's an expectation as part of the LHSIA that there be a health professional advisory committee set up. On that committee, there are six physicians and representation from a lot of the regulated health professionals, but there are some that are actually specified in the act. So physicians, nurses, pharmacists, dietitians and physiotherapists are on that committee. We meet on a quarterly basis. We look at a number of issues. They actually reviewed the quality improvement plans that the hospitals were expected to implement so that they were aware.

They're an advisory committee to the boards. We ask them for their input. They look at things like the human resource impact within our LHIN, how we are doing as far as ensuring that our patients are connected to a family physician, so that we have statistics that we can show in relationship to that.

We also make them aware of what's happening in the LHIN, keeping them apprised of the activities. So when we developed our integrated health services plan and we were going out for community engagement, they were one of the committees that we asked for their input on the directions that we're going: Is it the right way from their perspective? So we've asked for their input. So anything that we do, we keep them apprised and ask their advice on it.

Mrs. Christine Elliott: Would the hospitals be required to report to the committee a departure from their normal procedure? For example, contracting out the preparation of admixtures? Would anything that specific come before them?

Ms. Deborah Hammons: Well, one of the members—actually, the co-chair is a pharmacist, and so depending on who sits at the table, they actually bring to the table interest from their perspective. We didn't have a meeting. Our meeting was held before, so it may have come up at our meeting, but I can tell you that when we had the Sandoz issue, I actually heard about the problems because she was working in one of our pharmacy departments. I heard about the shortages before that, before the Sandoz issues became so critical. I actually had conversations with the ministry about this because this was an ongoing concern. So they alerted me of the fact, and then very shortly after that, the Sandoz issue became quite difficult, actually, in the province. So there are some fairly granular issues and questions that come up at the table, but it varies depending on the individual.

Mrs. Christine Elliott: Do you know if this particular issue ever did come before the committee? I ask that question because Lakeridge had only recently adopted that procedure.

Ms. Deborah Hammons: There were no issues about this that came forward, no.

Mrs. Christine Elliott: But would you have expected anything like this to have come forward to the committee?

Ms. Deborah Hammons: If, after the—it'll be interesting at our next meeting what comes up. There may be some questions that would be asked of us. It's hard to say. I don't know. It may have come up

Mrs. Christine Elliott: Were you aware as a LHIN that this procedure had been adopted by Lakeridge?

Ms. Deborah Hammons: No, I was not. We were not aware, no.

Mrs. Christine Elliott: Would you have expected to have been made aware of it overall?

Ms. Deborah Hammons: Well, this is quite an operational issue, and it's the expectation that this type of operational issue would be managed through the various committee structures and the board.

Mrs. Christine Elliott: Thank you. I'll just hold on to any further questions for the moment.

The Chair (Mr. Ernie Hardeman): And the third party: Ms. Forster.

Ms. Cindy Forster: Thank you. Good afternoon. I just want to go back to the quality and safety issue and kind of the accountability of the LHIN board. Your presentation said that "the LHIN board will ensure that health care will be person-centred in safe environments of quality care." How do you actually accomplish that through your LHIN? How do you monitor it? How do you evaluate it?

Mr. Wayne Gladstone: Thank you very much. The LHIN board relies on the accountability agreements, and part of the accountability agreements include performance standards and metrics that we have for hospitals. We have 14 major metrics that we use, and they report to us on a regular basis on them. I'll just give you some examples: the 90th percentile wait time for cancer surgery; the 90th percentile wait time for cataract sur-

gery; the 90th percentile wait time for hip replacement—I can go through all of them, but we have those kinds of measures in place so that we can see whether the hospitals are meeting those requirements or not. If they're not, then we go into the process which Ms. Hammons described, wherein if there's a significant deviation, particularly, they'll be asked to remedy it. We have had that experience at the board level, where we've had hospitals coming in under performance improvement plans to remedy a specific measurement that was off track.

1720

Ms. Cindy Forster: And do you do any periodic audits to ensure that the information you are receiving is actually accurate?

Ms. Deborah Hammons: Yes, we do audits. I can say that most of the audits we've done have been more financially related. As you know, there is an attestation that the hospitals do on a regular basis. We receive the information quarterly from them—not directly from them, but through different agencies. I have not had a concern about the information that the hospitals share—that it was inaccurate.

Ms. Cindy Forster: We've heard from the Auditor General and we've heard from certainly the public that there have been hundreds of patient complaints in the last fiscal year. How does your LHIN actually deal with patient complaints, or do they even get to your level?

Ms. Deborah Hammons: We do get patient complaints; fortunately, not many. But we do have a very robust issues management process that we use. Any complaint that comes to us is immediately responded to, and then there is follow-up on any of the complaints.

If it is an issue that's related to one of our organizations, in fairness to them, we write to them and ask them to respond to the issue and copy the LHIN so that we know they've responded. Obviously, if the public is not satisfied with the response, we'll hear back from them.

Ms. Cindy Forster: You said that you actually meet with your counterparts in the other LHINs across the province in a variety of ways throughout the year. Has there ever been any discussion about Ombudsman oversight of health care in this province, as happens across the rest of this country?

Ms. Deborah Hammons: There has not been any discussion.

Ms. Cindy Forster: And would your LHIN actually support Ombudsman oversight of health care?

Ms. Deborah Hammons: On occasion, we've had a few calls from the Ombudsman on issues where they do not have jurisdiction. What they have done in the past is, if there is an issue that's in relationship to an organization they do not have jurisdiction over, we'll have a discussion about the problem and I will approach the organization and get back to the Ombudsman. That has been a very successful way of managing whatever issue the Ombudsman has, to have that dialogue with the Ombudsman's office—not the Ombudsman particularly, but with the office—and then rectify the issue. It has been very successful.

Ms. Cindy Forster: So based on that, you wouldn't be opposed to Ombudsman oversight of health care in this province?

Ms. Deborah Hammons: I think that the system right now seems to be working okay. Any concerns that have been brought to my attention through the Ombudsman or any complaints that we've had from the patients or relatives that are dealt with in our LHIN—we have had good success. We track everything that we've addressed, so it seems to be working.

Ms. Cindy Forster: The Ombudsman's office thinks they need oversight of the health care system in this province. I just wanted to get your views. Thank you.

M^me^ France Gélinas: Actually, I'll use this as an example: I have that thick of petitions from people—about that thick of it comes from your LHINs—who want Ombudsman oversight. How are you going to handle something like this, where the people in the geographical area that you serve want something—they want Ombudsman oversight—but the ministry does not? You are there to implement the policies of the ministry but you're also there to listen to the people who live in the geographical area of your LHIN. How do you handle that?

Ms. Deborah Hammons: I have never had anybody come to me saying that they want Ombudsman oversight. What they come to me about is what their concern is, and what we have done in every instance where we have received a concern is to address it, either directly, if we can, or through the health service provider.

If there are MPPs in our LHIN who have issues, we encourage them to bring those issues forward to us and let us know. We have a very robust relationship on those kinds of issues and try to resolve them with the MPP offices.

M^me^ France Gélinas: What kind of investigative power have you got when you go into a problem like this with an agency? Are you allowed to do investigations of practices of the different transfer payment agencies that you supervise, like the Ombudsman would do?

Ms. Deborah Hammons: That is a very broad question. Could you be a bit more specific?

M^me^ France Gélinas: Sure. Do you have a team that knows how to do investigations of complaints of third parties?

Ms. Deborah Hammons: It depends on what the complaint is. I said that we do have and have done audits, for instance, on financial matters, and we do have people on our staff that have the designation to do that, so—

M^me^ France Gélinas: How about when it has to do with care?

Ms. Deborah Hammons: There is a process—I mean, the hospitals or the agencies, if there are issues of care, if they have come to our attention, we have dealt with them, as I have mentioned.

M^me^ France Gélinas: But do you have investigative powers of care issues within the hospital?

Ms. Deborah Hammons: If there was a complaint, normally we would turn it back to the hospital to respond to that complaint, and they would investigate the com-

plaint at the hospital level and respond back to us. We look at the response that they've given us. I can't recall an incident where the patient who has complained, or the family member, hasn't been satisfied, or at least they haven't informed us.

M^me^ France Gélinas: I will share about 30,000 of them with you just so that you have—

Ms. Deborah Hammons: All from the Central East LHIN?

M^me^ France Gélinas: No. About that thick are from the Central East LHIN. I'll share them with you—

Ms. Deborah Hammons: I would like to see those, actually.

M^me^ France Gélinas: —but basically, there are people who have gone through the internal process of the hospital. They have not found closure, they are not happy with the outcome of the care they have received, and they turn towards the Ombudsman to complain and the Ombudsman answers, "I cannot. I don't have jurisdiction over the hospital." But I'll leave it at that.

That was one example of the community wanting something. I want to know: How do you handle the community's wish for something versus government policies for something? Because when people complain about the LHINs, including yours, they complain about, "You are there to implement the wish of the ministry; you are not there to listen to us." If you have not heard that before, then I would be quite surprised, because we hear it all the time. First, have you ever heard anybody say, "Your LHIN is there to implement ministry policy; it's not there to listen to us"?

Ms. Deborah Hammons: I don't recall that.

M^me^ France Gélinas: I have heard it. How would you answer me?

Ms. Deborah Hammons: Well, I would want to talk to the individual who talked to you and understand more about what the issue is that they're concerned about. You know, not knowing what they're speaking about in broad terms, it would be difficult for me to respond.

M^me^ France Gélinas: So you cannot foresee a situation where the wish of the population won't be the same as the wish of the ministry?

Ms. Deborah Hammons: Well, the ministry does a lot of engagement on their own to come up with what their directions are across the province, and I think that the directions that they are giving are quite in line to what we're hearing locally.

M^me^ France Gélinas: I want to come back to the procurement. Right now, the LHINs don't do anything with the local hospital in terms of their procurement policy?

Ms. Deborah Hammons: We don't. That's really a governance issue at the local board level.

M^me^ France Gélinas: Okay. But you do admit that there is a part of procurement policy that has to do with protecting patient safety. We've just seen that drugs being procured had a little bit of a patient safety issue, as in 1,000 people did not get what they were supposed to.

Ms. Deborah Hammons: There is a directive that the hospitals are expected to follow as far as procurement is concerned.

M^me^ France Gélinas: That deals with the money side of the procurement. How about the safety side?

1730

Ms. Deborah Hammons: Well, I don't have the procurement directive memorized, but I'd be surprised if it didn't say something in there about safety and quality.

M^me^ France Gélinas: So you trust that what was in there about safety and quality is sufficient and worked?

Ms. Deborah Hammons: Obviously in this case it didn't, because it actually revealed that there was a grey area that was not covered by regulation.

M^me^ France Gélinas: Whose job is it to put those regulations in place?

Ms. Deborah Hammons: Dr. Thiessen is doing his study. I think he's going to look at the supply chain process and give some recommendations to who should be regulating it, whether it's Health Canada, whether it's the College of Pharmacists or if it's a regulatory change that the government puts in place. It could be any number of those.

M^me^ France Gélinas: Could you see yourself as having a role?

Ms. Deborah Hammons: We're not an expert in pharmaceuticals. The procedures in pharmaceuticals—I think that should be left up to people who are experts.

M^me^ France Gélinas: You both talked about the trust issue. What are you doing right now to help rebuild the trust within the geographical area you serve?

Ms. Deborah Hammons: I think the most important part in this is to ensure that communication is robust and getting out—I think it will be absolutely essential that, once there is the report from Dr. Thiessen and perhaps the results from this group, we need to make sure that the public is aware of what we're doing about this issue that has just come up. We need to make sure that the grey area is resolved. So I think communicating is the most important thing. We have been in discussions with Lakeridge and Peterborough—in their case, it was fairly simple—to make sure that the people were communicated with and that there is ongoing communication within the hospital to support the families and the patients who were involved in this.

M^me^ France Gélinas: I'm assuming that yourself and everybody else involved in the health care system has done a little bit of soul-searching right now as to what has happened. Can you see any role that your LHIN could play in preventing a situation like this from happening in the future?

Ms. Deborah Hammons: There are regulations that the organizations are to follow. They could be specifically incorporated into our accountability agreements, perhaps, and there is the attestation which is expected. In this case, the hospitals weren't aware that there was a grey area. So it wasn't done maliciously or on purpose.

M^me^ France Gélinas: They didn't know.

Ms. Deborah Hammons: They didn't know.

M^me^ France Gélinas: We've talked a lot about every time there's a handoff, there's an increased risk in the health care system. It's well known. Do you agree?

Ms. Deborah Hammons: Yes.

M^me^ France Gélinas: The RNAO has put forward a position that says that the handling of the home care contract should be done directly by the LHINs rather than by the CCAC. What do you think of that idea?

Ms. Deborah Hammons: I can speak for myself, not for all the other LHINs.

M^me^ France Gélinas: You're the one I'm questioning, so go ahead.

Ms. Deborah Hammons: I just want to be clear that this is my opinion on this. I don't want to become a direct service provider, and I think this would take us into the realm of getting too close to that. I think the role that we're playing as far as system leaders and trying to ensure that the system is working well, that the transitions are being dealt with appropriately, is a good role for us. I do know that in other provinces where they have, say, for instance, eliminated boards, their regional authorities get very involved in the day-to-day operations.

Certainly, if my opinion was asked—and you've asked my opinion—I'm quite happy with the relationship that we have with our CCAC. It's working very effectively. They have very good expertise in the management of contracts. As a matter of fact, when we go out—the LHIN itself, we actually rely on them to help support us in the absolute development of RFSs if we do, and they work with us very closely. So they're quite expert in doing that.

M^me^ France Gélinas: If we look at that expertise, why do you figure hospitals go through Medbuy and other group purchasing agencies rather than simply: take all of your hospitals within your LHIN, have their purchasing departments work together and develop the expertise in-house to do the subcontracting out? Why is a third party involved?

Ms. Deborah Hammons: Well, not all of the hospitals are equal. Some are smaller and would not have the expertise. They rely heavily on group purchasing agencies like HealthPRO and Medbuy to help support them. They have built up the expertise on how to properly contract out, so it's a way of extending their resources, if you will, by working with a supply chain organization.

M^me^ France Gélinas: It can be viewed that the supply chain organization, the group purchasing organization, is very good at doing procurement, but maybe not so much at ensuring patient safety and ensuring care. Don't you figure the LHIN has a role to play in this?

Ms. Deborah Hammons: When they're developing the RFPs or RFSs, the people who are sitting around the table developing the contracts are people who are experts in the area. In the case, for instance, of this incident that we're talking about, there were pharmacists who were developing the contracts. There were pharmacists who were actually rating the responses to the RFSs—

M^me^ France Gélinas: How do you know that?

Ms. Deborah Hammons: Because that's the process that Medbuy uses.

M^me^ France Gélinas: And the pharmacists would be pharmacists from the hospitals?

Ms. Deborah Hammons: They're pharmacists, so they're a regulated profession.

M^me^ France Gélinas: I realize, but—

Ms. Deborah Hammons: I don't know which pharmacist, who they were. Maybe I shouldn't make the assumption that they were pharmacists from the hospitals. It could be pharmacists from hospitals, it could be a pharmacist working in a number of organizations.

M^me^ France Gélinas: Not necessarily the one who knows patient care, who knows the security of—

Ms. Deborah Hammons: I don't know in this instance. My assumption would be they would be experts.

M^me^ France Gélinas: That's good.

The Chair (Mr. Ernie Hardeman): Okay. The government side: Mr. Flynn.

Mr. Kevin Daniel Flynn: Thank you, Deborah, thank you, Wayne, for your presentation.

My experience with my LHIN—my riding is Oakville and my LHIN is the Mississauga Halton LHIN. I have a very positive experience with my LHIN. The work that I've seen them undertake I think has really spoken to the value that we hoped LHINs would be able to provide when we went to that system.

What I've specifically seen is the advances they've made in things like off-premise day surgery, ALC days of care. They were able to bring a lot of the mental health providers—we found out that we had a lot of people providing mental health services. The people in the community were having a hard time trying to find those services or were finding the wrong service. They were able to get those people into a room and ask them to look at it through a patient-centred lens and to amalgamate, to go to a lead provider. Things like opioid abuse—they've got plans in place now that are being generated through the LHIN. So I find the consultations that the LHINs have done in my own community have been very, very positive ones. They've worked really well.

I'm wondering, in this case, there appears to be a concern over the quality of a service that was provided in a number of hospitals. I'm looking at this from a quality assurance perspective. What's the best thing that LHINs around the province, and your LHIN specifically, could bring as a positive to this issue? What's the best thing you could do?

Ms. Deborah Hammons: In my view, there are steps being taken right now. The report that Dr. Thiessen is going to be providing and which will be made public will be—he's a very respected individual. I would like to see the recommendations that he brings forward implemented.

Mr. Kevin Daniel Flynn: Do you play a role in that? Do you see yourself as part of the accountability agreements or whatever? In the future, do you see the LHINs playing a role in whatever comes out of this committee? Do you see yourself and your brother and sister LHINs implementing them somehow in their own communities?

Ms. Deborah Hammons: There could be something that comes out of his report that we may have a role in. We want to ensure that the quality of care and safety is maintained across our LHIN. It's important; it's one of our strategic directions. So if we can play a role that would help with this, we'd be more than pleased to do that.

Mr. Kevin Daniel Flynn: Thank you, Mr. Chair.

The Chair (Mr. Ernie Hardeman): Thank you. Does the opposition have any further questions?

Mrs. Christine Elliott: No further questions. Thank you, Chair.

The Chair (Mr. Ernie Hardeman): No further questions. We have one minute left on the time for the third party. Ms. Gélinas.

M^me^ France Gélinas: I'm just going to come back to Ombudsman oversight. Do you know if the Ombudsman has oversight of your LHIN?

Ms. Deborah Hammons: Do they have oversight of our LHIN?

M^me^ France Gélinas: Of your LHIN.

Ms. Deborah Hammons: Like if there's a problem with our LHIN, they would have—

M^me^ France Gélinas: Oversight?

Ms. Deborah Hammons: I'm not aware of that.

M^me^ France Gélinas: I'll let you know that he does, just so that you know. Thank you.

Ms. Deborah Hammons: Thank you.

The Chair (Mr. Ernie Hardeman): That's it? No further questions? That concludes the hearing. You didn't want to use any more of your time? That's very good. That concludes it. We thank you very much for your participation this afternoon.

With that, before we all rush out, the next meeting is tomorrow at 4 o'clock. Anything else for the good of—one of those service clubs—for the good of Rotary? If not, we stand adjourned.

The committee adjourned at 1741.

CONTENTS

Monday 13 May 2013

STANDING COMMITTEE ON SOCIAL POLICY

Chair / Président
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Ms. Cindy Forster (Welland ND)
M^{me} France Gélinas (Nickel Belt ND)

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