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Lundi 25 novembre 2013

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

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

Chair: Ernie Hardeman
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 25 November 2013

Lundi 25 novembre 2013

The committee met at 1402 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Vice-Chair (Mr. Ted Chudleigh): We'll call the meeting to order, the Standing Committee on Social Policy. We're here to resume our study on the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act, pursuant to the order of the House dated November 7, 2013.

LOCAL HEALTH INTEGRATION NETWORK LEADERSHIP COUNCIL

The Vice-Chair (Mr. Ted Chudleigh): Today we have the Local Health Integration Network Leadership Council. Robert Morton is the vice-chair. Mr. Morton, if you'd join us, you will have 30 minutes for your presentation. That will be followed by 30 minutes of questions from each party.

Mr. Robert Morton: Thank you, Mr. Chudleigh. It's my pleasure to be here this afternoon.

The Vice-Chair (Mr. Ted Chudleigh): I'm sorry, sir, could you identify yourself for the purpose of Hansard.

Mr. Robert Morton: My name is Robert Morton. I wear a couple of hats. One is chair of the North Simcoe Muskoka Local Health Integration Network. I also chair the chair's council, when the 14 chairs come together, and I chair that group and work as co-chair with the leadership council when the chairs and CEOs come together.

The Vice-Chair (Mr. Ted Chudleigh): Mr. Goebelle brought me up to date on all that stuff the other day.

Mr. Robert Morton: Good. I know. He told me. So you're just back from holidays, he said.

Interjection.

Mr. Robert Morton: So my presentation has been prepared and I believe will be distributed, but I won't stick right to the script. You don't want to hear me just read something for a half an hour, but I'll try and hit the high points and then move into the question periods as we move forward.

Of course, thank you for the opportunity to be here. I'm going to try and give a provincial perspective in my remarks, knowing that the standing committee will be meeting as the months unfold and maybe making a decision to meet in other communities. If that's the case, then certainly my colleagues, wherever you're going to be meeting, will be anxious to appear before you and give you the local flavour. My goal is a provincial flavour, but I will pepper my remarks with some provincial, but certainly lots of North Simcoe/Muskoka examples.

This is a pretty exciting time for me. In fact, yesterday as I was doing my final prep for today, I thought it would be wise for me to pull out the legislation and have a look at it one more time. What really jumped out at me was under the "objects", section 5(c):

"(c) To engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation."

I have worked in the health system for many years. I stopped my full-time work five years ago. But that is a most important piece, because it's saying that our communities have a stake and now have a vehicle for having significant input into the decisions of their community. That's gigantic and really important, and I'll try to illustrate how the LHINs have tried to live up to the spirit and the letter of the legislation as we've moved forward.

What I'll talk about is a little bit about who LHINs are and how we work. I'll talk a little bit about governance and accountability and give a bit of a perspective on how we've done over the last eight years since the legislation was first proclaimed. More importantly, I'll try to give you insight into ways that the LHINs and their partner health service providers are making a difference for the people in our communities and to share with you the LHINs' perspectives on opportunities to strengthen the current regional system and to strengthen the act that we're working with.

I need to say that the LHINs welcome this review. Whenever you start something as dramatically different as LHINs or the regionalization of a health care system, that's a gigantic change. When we look at the principles of complex adaptive change, we know that you'll never get it right the first time. If you did, you probably didn't go far enough. So this is a very important opportunity for us to take a look at the framework and make adjustments to it in order for the system to continue its journey to be improved.

While it is a review of the legislation, there's no doubt that many will look at this as an opportunity to review the

performance of the LHINs, and of course we welcome that. In this journey towards excellence, to improve the quality in the health system, we can always do better than we've done in the past.

With that, I think it's clear that LHINs play a crucial role in the system. We're required to listen to what our communities have to say, like no one has ever done before. LHINs need to be champions for the needs of our communities and the people who depend on our vast array of health care services.

A key piece of our mandate is holding providers accountable for the care that they deliver. Our job is to make the system work better for people, not just with one care provider but as people move from one care provider to another. Nobody owns the patient. I use the word "patient" knowing that in some cases it's "client," in some cases it's "consumer" and in some cases it's "resident." No one owns the patient.

The other significant shift that comes from the legislation allows us to put the patient first and to engage the patient in decisions about their care, like we've never done before. The act is powerful and has enabled us to do quite a lot in a short period of time. LHINs are making a difference in our communities, and I'll talk a little bit more about that.

How are we making a difference? We're trying to make the system work more like a system. It's clear that we're not there yet, but there have been significant gains. I say that as a health care provider for years, working in various parts of the system: This system is vastly different than it was when I stopped full-time work five years ago and when I started in the health care system in 1979—do the math; I'm 65. We're ensuring better value for money, we're improving access to care, and we're taking a population perspective in promoting equity, one of the issues that has been important for us to deal with.

It's all about change—changing the behaviour of front-line providers: changing the behaviours of professionals, including physicians; having them work in an interprofessional mode rather than as sole practitioners working within their silo. It's changing how organizations work within themselves and across organizations, and it's changing the behaviour of our patients too, though in some ways patients are ahead of us; their expectations of the health system are somewhat ahead of where we as providers have been.

These are changes that are taking time. This is a journey, and from my view we've made some significant progress, but we've got a ways to go.

In my presentation, I have a section on who we are and how we work. I understand, having looked at Deputy Minister Rafi's presentation, that I don't need to review that information, but let me talk to that key point that I mentioned as I began: listening to our communities. One of the greatest strengths of LHINs is our commitment to listening to the people in our communities in every aspect of our work, or the work of the system, because the LHIN is an entity, but the LHIN is also a system. It's that coming together of all of the providers within a jurisdiction, and the LHIN helps facilitate their working together in better ways. Community engagement is a core value, an object of the legislation, as I read. LHINs have worked together to develop common community engagement guidelines, and each LHIN posts an annual community engagement plan.

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Now, let me give you the scope of this. North Simcoe Muskoka is Muskoka, Orillia, Gravenhurst, Bracebridge, Midland, Penetanguishene, Collingwood, a chunk of the town of Blue Mountains and Barrie. We're one of the smaller LHINs, actually, with just under half a million people.

In order to kind of get a sense of what we needed to do to improve the system, we engaged in a broad community consultation. We recorded how many people were involved: Over 5,000 individuals, over 20,000 hours of dialogue and over 160 organizations were involved. Now, that's an important number because less than half of those are funded health service providers. They included municipalities, they included school boards, and they included the children's mental health providers—a number of people who are in that human services space but who are keenly interested, and their work is keenly tied to the health services system. That process gave us hundreds of opportunities to improve, so we've organized our work and are moving forward on that.

In order to remain true to that community engagement principle, it's a commitment that we have made that every one of our improvement teams or projects will have a person or persons on that team who have lived experience, because we know that if we listen to the patient, we'll get it right. Our successes to date have shown that there is incredible value that comes from listening in ways we never have before to the patients we serve.

The other point that I would make is that LHINs are highly transparent organizations. Our board meetings are all open to the public. Some LHINs, especially those that are spread over really big geographic distances, are using webcasts to reach out to people. We routinely post detailed information about our operations in our reports, in addition to our annual community engagement plan.

Governance: As you're aware, each LHIN is governed by a board of directors that is directly accountable to the minister through the MLPA, ministry-LHIN performance agreement, and the board members are appointed by order in council. Each board has up to nine directors, who bring a rich mix of skills and experience to the LHIN and have a deep understanding of their community. Indeed, one of the strengths of Ontario's approach is that LHIN governors do not come with a hat on, representing a particular sector or community. They come with the goal of representing all of the people in our communities.

The emphasis on the MLPA is on the patient's experience, so our financial sustainability and on our performance. LHINs are measured under 15 indicators, including how long patients wait, how our emergency rooms are performing, rates of readmission and alternative-level-of-care days. As we move forward with a quality agenda, we'll be anticipating that many of the indicators that

Health Quality Ontario have focused on as they've looked at the quality agenda for all of Ontario will be built into those.

What's key, as we look at these measures, is to know that they're not necessarily specifically assigned to a particular organization. No organization, solely, can change the result. Alternate level of care: Yes, those are patient days in a hospital, but the solution to alternate level of care involves families; it involves community support service providers; it involves the community care access centre and the home care program; it involves the long-term-care sector; it involves complex continuing care and rehab; and a whole host of other parts of the system. So to solve the ALC problem requires systems solutions, not just specific agency solutions. So each of the targets that were set were initially set by the ministry. In many cases they were very much stretch targets; communities were a long way from the targets that were set. It's my understanding that the government relied on external experts from across Canada to set those initial targets. As we've made progress on them, we've seen targets lowered. As different communities have a different set of challenges and a different set of providers, we know that the targets may be a little different from one community to another. That recognizes the uniqueness of Ontario.

Our governance structure: Because LHIN board members are accountable to the members of the community we serve and can have direct contact with other health service provider boards, it creates a unique opportunity for the LHIN to work with the service provider organizations at the governance level, in addition to traditional work that has occurred at the leadership or service provider level, to find ways of changing. It is, as I've said, all about change. By working collaboratively with other health care governors, we are changing the way that our health service providers think about their role in the community and the patients that they serve.

I've used the language about the made-in-Ontario solution. Deputy Rafi talked about the other provinces and their approach to regionalization and the number of regions, but what was a key feature in the rest of the country was that they wiped out local governance. Local boards did not exist; we ended up with a superboard with responsibility over a large number of organizations or different parts of the system. In Ontario, we've left local governance in place. So what is its unique role?

When we have these discussions—and our governance journey in North Simcoe Muskoka and indeed the governance journey in the rest of the province in the LHINs is focused in part on how governors continue to play a role. The place that we've landed in north Simcoe, and it's a place that many others are following up on, is that boards of directors have, yes, their accountability, their fiduciary, their strategic and generative—using kind of the new language of governance—responsibility for their organization, but in addition to that, they have a responsibility to the system. So the challenge is for them to find the balance between their responsibilities as governors for their hospital, their community care access centre, their long-term-care facility, and their responsibility to the whole system.

This is a significant shift for governors and it's part of the change process that's under way. But I think that is an incredible strength, because governors who are committed to serving their community are better able to focus on the patient that we're serving. The real, right reason for doing this is, with due respect to all of my colleagues over the years in leadership positions, it's hard to move away from the status quo. Boards are in a position of a more neutral and governing position that can help us move faster and more collaboratively to new ways.

I'd like to talk more about our communities and how we make a difference for the people and families who receive care.

First point: Geography makes a big difference. I mean, the language of "one size doesn't fit all" was clearly recognized when 14 LHINs were established, that what worked in Toronto wouldn't work in Wawa or London or, and my directions—I should be pointing to Penetanguishene this way. So as we've moved forward, it's pretty clear that there are differences within each of our communities: differences demographically, socio-economically, and there are cultural factors. These all play a role and have an impact on access, equity and efficiency of the system.

For example, in North Simcoe Muskoka, we've recognized that the way in which the system needs to be organized in Muskoka will be very different than the sub-geography of Barrie, a larger urban area. So this model, the LHIN model, gives us the opportunity, within the provincial framework and within the regional priorities and strategies, to respond on a local basis. We're kind of going right back to the legislation, when communities have the ability to set priorities for the communities in which they live.

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How are we doing it? This is about making the system work more like a system, taking these provincial priorities and objectives and making them work locally. It's about breaking down the traditional barriers between providers—who have worked in silos, and indeed we've organized it so that they would work in silos—to improve the experience of clients and patients.

Lots of health care organizations have looked very closely at industrial organization and have found that using Lean Six Sigma approaches to system improvement have really helped us find efficiencies. Indeed, the emergency room work that occurred that has significantly reduced wait times all used that Lean methodology that involved front-line workers and their patients in re-describing how work would be done and then sustaining those gains, using metrics to help us move forward.

When we take that kind of methodology and approach and apply it at a system level, now it's time for us to get the front-line workers from the hospital, from the community and from primary care working together to find those new care pathways and move the system forward. That's where change is occurring.

I bring to the table a really good example of how that approach has made a really big difference for a vulnerable population. Some of you may be aware that in Simcoe-York there's an initiative called the Children's Treatment Network of Simcoe York. It began with a missing piece, and the missing piece was a children's treatment centre, funding for children's rehab services in the Waterloo area: Waterloo–Wellington, KidsAbility in Mississauga, Halton, Erinoak—a bricks-and-mortar solution to provide services for these very high-needs kids.

In Simcoe and York, the community took that funding and said, "We're not going to create another bricks-and-mortar silo; we'll use that money to increase service capacity in schools, in hospitals, in early intervention programs and in children's mental health, and we'll build the tools to make it possible for front-line workers to work across the human services spectrum and do it with a single plan of care." That was an enormous piece of work, but it was all about change, with the patient and family at the centre and with front-line workers informing—as I said, you can't reform a system in a boardroom; you've got to do it on a shop floor. That's the granular nature of the change that's occurring through LHINs as we try and make the system a better system.

LHINs have become very good at learning from each other. In fact, it's one of the topics that regularly occurs at the chair's table and the leadership table when leadership gets together: How do we leverage good things that are happening in one part of the province with good things that are happening in another? I think about the Home First initiative, where we're clearly trying to change behaviours of practitioners from focusing that when a person gets old, long-term care is the only option for them. The first option should be care in the home. So the Home First program, which changed behaviours and reallocated investments into providing a broader range of community supports, more intensive supports up front, has moved lots of people back to home where they should be instead of waiting in a backlog to get into the scarce-resource long-term-care facilities—so, really good things that we've learned from that.

Convalescent care program: All LHINs now have a component of this, and I'll tell you a story. In Collingwood, a small nursing home, they were able to carve out space for four convalescent care beds. I visited it shortly after they opened, and I saw this one—I'll use "little old lady," and she was hanging onto the handrail. She had a kinesiologist beside her, and he could have been her grandson and maybe even great-grandson. He was having her do knee bends while he's holding on and he's kind of supporting her and encouraging her. I saw her a little bit later, after I visited some others. She had a balloon between her legs and he was helping her squeeze her legs together against the balloon.

She had been in hospital. It was a diagnosis of failure to thrive. It was pretty clear that she was on a downhill slide of aging. She really did want to go home, but really needed that jump start. Three months in convalescent care in the long-term-care facility built up her strength and her capacity and her self-esteem so that she was able to go home. It's an incredible success story that's occurring time and time again. That's a new program, existing resources, but it's a different way of using the resources that's having some really good results.

Access to care: All health care providers are part of an interdependent system. No one provider meets all of the care needs of the people in our communities. I believe that all of these organizations are clearly committed to making it better for the patients, but the reality of their day-to-day operations sometimes makes it hard for them to focus on the bigger picture.

With the LHIN: Because no one hospital or community agency or long-term-care home can make an impact on their own, these improvements that come from engaging workers together to focus on the things that are important for people are a way of moving the system forward.

On the point of equity, LHINs are committed to ensuring that every individual, regardless of their gender, race, income or social status, has the same access to high-quality health care. We've seen across the province great challenges meeting the needs of First Nations and Métis people. A number of LHINs—I look to the northeast; I look even to the southwest—have specific programs focusing on those vulnerable populations that have really started to make a difference as we've brought the system together. Notwithstanding the bigger system problems of federal and provincial jurisdictions, on the ground there's a clear commitment to make services better for some of our most vulnerable people.

In terms of partnerships, because that's what it's all about, LHINs have also established strong partnerships provincially, working with the sector associations, working with research organizations, and very clearly working with Health Quality Ontario, which has a very unique role to play in supporting the quality agenda, giving us the tools and giving us the evidence as we try to apply best practices to our clinical processes.

One of the other important outcomes that the past eight years have shown is that there is an increased level of accountability with service providers to the province of Ontario for the services they deliver. Public dollars are being used more effectively. The service accountability agreements are a better monitoring tool than what was in place before with the previous mechanism. We've seen a significant drop. While health care costs are still increasing, they're not increasing at the rate they were. Indeed, I was reading some recent stats that Ontario has done a better job at bending the health care curve than any of the other jurisdictions have. We have a ways to go. The financial problems that we are facing as a community have not yet been solved, but there are mechanisms in place to help us get there.

I think it's important for the committee to understand that the improved quality of care, reducing waits and delays, results in lower costs. Endless pursuit of quality will result in better care. We won't be duplicating; we won't be readmitting. It is about quality, and so the quality agenda becomes really important to us.

Our ability to manage performance is growing as we get access to better, more current information. Traditionally, we've had very good information sources from the acute care system; the community care system is catching up with that. So as we manage the system, those clinical information points, when they get aggregated, become management information. When they become aggregated to the next level, they become system information. So we're becoming much more acute in our ability to use the data sources that are emerging to help us improve the health care system.

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Are we there yet? No. There are opportunities to improve our health care system, clearly.

The Vice-Chair (Mr. Ted Chudleigh): We have about three minutes left.

Mr. Robert Morton: Three minutes? Thank you.

First, I would talk about giving LHINs greater responsibility for managing the accountability of primary care. I was absolutely excited when the minister announced her action plan that talked about bringing primary care into the rest of the system. Primary care has always been there, and it's always been important, but we never established the links between primary care and the rest of the formal system. Health links gives us an opportunity to do that in a way in which I believe physicians will be much happier about the care they provide. Patients will be much happier. That's a key piece.

I think there's also an opportunity to improve the system by giving the LHINs greater responsibility for managing the accountability of independent health facilities. As we look at moving more and more procedures out of acute care centres and into the communities, into independent health facilities, we need to ensure that their accountability is managed. And so, it will require some changes to the legislation that include IHFs in the range of partners that are involved with LHINs; and for health service provider boards, defining responsibility to the systems, as well as their own organizations.

I talked earlier about the journey that we've been on in North Simcoe to understand the new role of boards. I think we need to take a bit of a step back, look at it provincially and clearly underscore that boards are a very significant part of our system. We need to think about ways of adjusting the legislation that underscores that responsibility, which is a joint responsibility, not just to their agency but also to the system as a whole.

It would help LHINs if we had greater flexibility to allocate funds and the ability to fund initiatives over multiple years. This would be a statement that would be made, I'm sure, in every ministry, but change takes time. When we look at new initiatives, you need to be able to build capacity. You need to move forward, and it would make life much easier—it's not about making life easier. It would ensure the transitions within the systems if we could use the limited amount of new investments in a way that can ensure that there will be sustainability for good ideas.

Then there are administrative barriers, not within the legislation, but within all of the siloed pieces of legislation that we have. I have to commend the work of the associate minister, Helen Angus, on kind of being the rule-buster—not breaking the rules, but finding ways around those rules that have emerged because of—

Mr. Mike Colle: The what-buster?

Mr. Robert Morton: The rule-buster.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Mr. Morton. We'll move into the question phase. We'll start with the official opposition. Mrs. McKenna?

Mrs. Jane McKenna: Thank you so much for coming with your detailed presentation. We do appreciate you being in here today.

On page 2 here, you have a question saying, "Ensuring value for money so that the system can be sustained for our children and grandchildren." Do you think it is sustainable now?

Mr. Robert Morton: Certainly it wasn't at the rate at which health care spending had been growing. When we compare our spend rates to the spend rates in other jurisdictions, in Canada and Ontario we're spending at greater rates. I think Ontario is doing better than other provinces, but I think we need to get a hold of it in different ways. We need to have better outcomes for the funds that we're expending.

We've had all kinds of money that we've thrown at the health care system. It hasn't turned into better health or better outcomes. In some ways, I think these tough economic times give us more pressure to use the scarce dollars correctly.

The minister talks about the 1% of our health care recipients who are using 34% of our health care dollars. In North Simcoe Muskoka, that translates into about $120,000 per person. That's not including OHIP billings. The provincial average is about $116,000. And as we are doing through health links, if you talk to those people, they're not really happy about the health care system. They're the ones going back to the ER time and time again. They're the ones who are going to multiple doctors because they can't get the answer they want. They're not happy with the system. So on a provincial basis, by reducing that cost by 10%, very much an achievable amount, it turns into about a $2-billion reinvestment fund.

So we're spending that money on the system. We're not getting good outcomes. Those people aren't happy. They're not getting quality care. If we can improve their care, we'll spend less money, and we'll have money to invest within the system.

So, bottom line, we are working towards—we're not there yet; we're not as efficient and effective as we could be. But we're chipping away at it, and I think we're making progress.

Mrs. Jane McKenna: When you say "chipping away," you have here that it's eight years you've been doing the LHINs. We were told six and I thought seven, so we're just going to say whatever number at this particular point—

Mr. Robert Morton: Somewhere in there. And I've only been at the LHIN table for just a little over two

years. But the legislation was proclaimed, and there was a start-up period as organizations were established, board members were recruited. It was some time after the legislation was proclaimed that the service accountability agreements were introduced, first for hospitals, then for long-term care, then for multi-service agencies. It wasn't sort of, everybody started out at the very beginning with all of the tools; the tools have emerged over time. There has been some ramping up as we moved forward.

Mrs. Jane McKenna: You keep talking about evidence-based outcomes and measuring. From when we were here with Mr. Rafi last week, Mrs. Cansfield brought up some wonderful points, one being very obvious to me—and I didn't speak for anybody else, but she reiterated that; she's not here today, sorry—about how the system is so hard for us to navigate. How in heaven's name anybody else can, I have no idea. You mentioned today how all 14 LHINs work together as a team and collaborate and give off information so everybody is working at a different level. Well, we don't see that at all here.

I'm trying to figure out, with your presentation here, how exactly, when you have performance measures for each LHIN—where do the targets come from, who measures those targets and who sees the outcomes of those targets? Because clearly, what you're saying right here, "Everybody working together and the people who need help get help," we don't see that at all—well, I'm not going to say anybody else; I'm saying I, as an MPP, don't see that at all. Your system is very hard to navigate. I know you say you go back and facilitate for the people in the community who have told you what their thoughts are, but we don't have any of that communication at all in Burlington. Who are these people from the LHINs going back to facilitate and who has the information that they're getting that from?

Mr. Robert Morton: Let me—

Mrs. Jane McKenna: Yes. I've asked about five questions. Sorry.

Mr. Robert Morton: No, that's okay—they're great questions, and they're really important questions. So let me kind of triage them, in a way.

I think we need to get into our heads that the LHINs play a very different role. They're not service providers. We're there as system managers, trying to hold all of the different partners accountable for what they're supposed to do. The traditional approach that looked at each provider individually—the accountability measures for Joseph Brant Hospital, for the—I'm struggling to think of local examples for you, but actually, I must say that I'm proud to say my grandfather was the founding chair of Joseph Brant, and I remember as a kid the sod-turning and the ribbon-cutting.

Mrs. Jane McKenna: Wonderful.

Mr. Robert Morton: Yes. It was an exceptional time in the 1950s—another indication of age. I digress.

The point is that holding Joseph Brant accountable for ALC is inappropriate, because the resolution of the ALC issues involves many partners. So it becomes that the LHIN comes, on the one hand, with the stick, saying, "Live within your budget. Manage your accountability. Meet these targets." But it also comes with a number of tools and processes to make it possible for that hospital to work with its partners in degrees of detail that it never had in the past. Hospitals didn't have to work with their partners—they just did what they did, and the people went home—because we didn't have the complexity of problems in our hospitals back when Joseph Brant opened in 1957 that we have now. The people in the hospitals then were very different than they are now. People in the hospital then had acute illnesses; now, most people in the hospital have chronic diseases that need multiple interventions, not just a surgery or—I'm trying to think of the language—patch and repair shop. It's a very different kind of service that we're providing, and people want their care at home.

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So the LHINs bring the tools—the carrots and the sticks—to get the health care providers working together to make the system more effective, so with the gigantic step forward of saying, "Primary care, you're part of the system. Family doctor, by working with your colleagues—physician, nurse practitioner, social worker—at your health link, through your family health team, you now have a broader responsibility for that patient." You can take that on and help them manage, navigate their way through the system. The LHIN can bring to the table the technology supports that are required in order to create that beautifully seamed system. I don't like the word "seamless," because the reality is, there are seams. What we want are beautiful seams within the system to help the patient be part of their care and to move in a coordinated way across the system. The technology, as I mentioned, plays a very significant piece in that journey.

I'll use an example of North Simcoe Muskoka. The hospitals were producing a report. They were printing it and faxing it to the family health team. The family health team staff took that fax, scanned it and then filed it in the patient's report. That took, on average, 16 days. By working collectively, that now takes 30 seconds from the time the report is generated and it's into the patient's EMR. These are gigantic improvements within the system, but it requires us to work together, and that process is rolling out across the province: much better access for the primary care provider to the information that comes from their other partners within the system.

Mrs. Jane McKenna: You mentioned health links and how people are happier, the physicians and the patients, so I just wonder: Because it's patient-centred and that's what we should be doing in the first place, where can we see the evidence-based outcomes where the actual patient is happy with what the outcomes are? I don't want—like it's easiest for us to see the actual data.

Mr. Robert Morton: Yes, I agree. So we've done a good job at developing some patient feedback information, particularly on the institutional side, the hospital—our LHIN was looking at the ER data, but we haven't gotten to the point of looking at system-wide data yet. Long-term-care facilities do client satisfaction. Community care access centres do client satisfaction, using similar

tools that help them compare CCAC to CCAC. We need to move—and this is another step that will come, needs to come, as the system moves forward—to the overall client, sort of their system experience.

In the past, with primary care being the way it was organized, sending out surveys about your family doctor isn't going to help. You don't get that body of information. You don't have the comparatives. You can't move the system forward with that. Now, when we're dealing with teams, when we're dealing with much better sources of clinical data, we can connect information from clients about their clinical results, which will come from the electronic medical record. But we also need to take the next step in getting client satisfaction, system satisfaction, rather than client satisfaction with silos.

Mrs. Jane McKenna: You see, to me, when you're doing your performance for your targets for your LHINs, the only way you could measure their success was by the patient in the system. So I'm just kind of wondering when—because we don't seem to have a good measure of performance of what the LHINs are doing: who's doing what; who's better than the other. But if the key component is measuring the success of the patient through the system, and that's what you're all about with legislation, why is it that you're not able to measure those outcomes for those patients?

Mr. Robert Morton: I would say we're not able yet.

Mrs. Jane McKenna: It's been seven years or whatever. So when is that? Is that not a target that you would want to achieve?

Mr. Robert Morton: It is a target, and I think that adjusting the legislation to make that a clear responsibility would really strengthen the tool and would get us moving even more aggressively in that direction.

Mrs. Jane McKenna: Two questions: If, right now, you had your wish list and you were able to tell us—because ultimately, in the end that's what we're doing here—what you would change in the legislation, what would that be?

Mr. Robert Morton: As I mentioned, as I rushed through my final points, with health links the accountability mechanism is not crystal clear yet. We're talking about agreements that the LHINs will manage for each of the health links. But a health link isn't an entity. It's not a legal entity. It's a collaboration of partners coming together and agreeing to work together in a collective way. So we need to be a little bit clearer about what the tools are that the LHINs will have to manage primary care accountability.

This is about the carrot, not about the stick part of managing. How do we leverage information of best practice from one health link and use that knowledge as we improve the next health link? This isn't about money. OHIP and the negotiations between the government and OMA I don't anticipate will change. This is about how physicians work, and I'm cautiously optimistic that we can move forward on both of these fronts, creating a funding environment—but again, that's a government responsibility; that's not an area of expertise that we would want to go into.

So that's a key piece of it: improving the accountability piece for primary care. Recognize that when LHINs started, primary care was way out there, and it's just in the last year that it's been said that you have to have primary care as part of the system.

The next piece is about independent health facilities. The government has committed to moving certain procedures out of acute care facilities into the community, so diagnostic procedures, surgical procedures—the cataract is a good one. The Kensington Eye Institute is an example that we frequently hear about. IHFs weren't contemplated to be part of the system when the legislation was first passed. As we start to grow and create more and more independent health facilities, we need to make sure that their accountability is managed. So adding that component to the LHIN legislation would help us ensure that they are responsive to the needs of the community and are providing good value for the investments that we're making in them.

The third area is about flexibility. We know, in working with the long-term-care act, the Public Hospitals Act—you know, a whole host of pieces of legislation that have been around long before, decades before, the LHSIA act—that there are pieces in each of those pieces of legislation that say, "You've got to do it this way." Well, the reality is, we're trying to move to an integrated system and we get a barrier that won't let you do it that way. I'll use an example in long-term-care facilities: Using space for convalescent care wasn't contemplated when the Long-Term Care Homes Act was created. It's easy for a bureaucrat to say, "You can't do that because that wasn't contemplated; it's not in the legislation. You can't have that style of short-stay bed. You can't offer that program because the legislation trumps everything." So we have to find ways to remove those—and I characterize them as administrative barriers that exist within a number of pieces of existing legislation.

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Mrs. Jane McKenna: So if we spend 46% of monies on health care, and we have a system right now where we can't actually measure the job description of a LHIN—and it's not clear to each individual LHIN what that is; and after seven years, we still are altering, measuring performance levels—to me we have a serious problem. If you have a system and people understand their job description and they go and they do it, then that's great. But when you're still, after seven years, and—Mr. Rafi—you have so many people who are setting these targets and looking—this isn't one individual person who's looking at all these 14 different LHINs.

I guess where I'm unclear is how long is it going to take before we actually can have some form of system in place that people know what they're doing and their performance measures are all at the place where they should be?

Mr. Robert Morton: We have it now through the 15 performance indicators, broken down looking at wait-time pieces, looking at emergency time waits. So those are the common pieces that we have that we can compare one LHIN's performance against another. And I want to

go back: This is about the performance of health care providers within a LHIN geography. We have those indicators. They're being refined as time goes forward. They were very much stretch targets for many of the health care providers in many of the jurisdictions. We've made significant progress. I may not have mentioned in what I said, but the script talks about Ontario making the most progress on wait times of any of the provinces in Canada.

So we do. They don't capture the patient experience adequately; I think that's work to be done. I don't think our indicators are sensitive enough to community variations and the mix that's there, some of the socio-demographics.

I'm really excited by the work Health Quality Ontario has done as it's worked with all of the silos to come up with the next iteration of quality targets, to moving to that common quality agenda. That's a very important step, and I would urge the committee to talk to HQO about the work they're doing on the common quality agenda.

Mrs. Jane McKenna: So do you think that with primary and then having the people stay at home longer as opposed to long-term care, is that because we don't have enough long-term-care facilities for people? And what exactly are we going to do when the baby boomers get into the system? Because we can't cope now.

Mr. Robert Morton: Baby boomers—me—even though I worked for a chunk of my career in long-term care, we don't want to go to long-term care. We want to remain at home. We want to be as independent as we possibly can be. We want the services—and I'll speak as a baby boomer—that I can afford, that I can pay for myself or I can access from the public system, that will allow me to stay at home.

We will always have a need for long-term care. There's still some work to do on the distribution of long-term care. I was looking at some CCAC data over the weekend that shows that there is still a range of beds available for different jurisdictions, so we need to do some work there. We need to recognize that in some parts of the province, particularly the northwest and the northeast, there are real challenges around what's the right mix of community supports, home supports and long-term-care beds. So there needs to be a different answer. There needs to be some capacity work done to understand what the right capacity is.

But on Thursday last, I was in Penetanguishene. The county of Simcoe has really gotten serious about care of the elderly. They've rebuilt their long-term-care facility there. While it was an expansion of beds, they were interim beds that were already in the community. But they've added four other elements of housing to it, from rent-geared-to-income housing with supports, to more of a traditional retirement home, to life-lease housing in both apartment style as well as cottage style, to create this community that serves over 450 people.

So it's a recognition, again, for the baby boomer to be able to go into that semi-independent living environment, to have services provided to me, to use the technology—as we look at home care, CCACs are starting to introduce the electronic home care monitoring systems. I don't need to have somebody come in and take my blood pressure. I can have something hooked on me that tells the blood pressure all the time, and it can be monitored anywhere. There's a whole host of technologies that make it possible for people to be more independent.

But our long-term-care facilities will clearly need to be there for people who are cognitively impaired and can't manage their own care, people who—and we've seen some horrible outcomes of people with severe behaviours in our long-term-care system, and those are great tragedies. But 80% of the people in long-term care now have some form of cognitive impairment, and that will be a key piece of that system. But I think we need to continue to find better and better models, rather than building more and more beds or bigger and bigger homes.

Mrs. Jane McKenna: So if you could say one thing—LHINs are not a service provider, but they are a system manager. What is the best thing that they have offered for the communities as a service manager?

Mr. Robert Morton: They've brought the partners together to identify the challenges to the system and to create processes for working to solve those problems.

Mrs. Jane McKenna: And you have evidence that those are working?

Mr. Robert Morton: Yes. Every LHIN will have evidence of things that they're very excited about, where they've—I talked about the musculoskeletal, but there are a whole range of clinical things happening all over. There's lots of good news.

Mrs. Jane McKenna: If they're the facilitator of those and you're saying they've done a great job, where can we actually see the evidence that those are what they're doing and managing well as a system manager? Is there some place to see that?

Mr. Robert Morton: The broad indicator is that our costs aren't climbing at the rate they were, even though our population is growing and aging. We've bent the cost curve. We've come a long way at holding the line, and now it's time to really go looking for the gains to bring the curve down even further.

Mrs. Jane McKenna: But how do you measure those curves? I'm just curious. I know you're saying it, but where exactly did these numbers come from? There must be some place where you have some form of facts in front of you so that you can actually see that there is a difference.

Mr. Robert Morton: Well, I was referring to the study that was done by—was it the Fraser Institute or the OECD? It was comparing our health system performance to the others. So it is—ICES, the Canadian Institute for Health Information, all of those bodies that look at data collectively. I'm a chair; I'm not into the day-to-day workings. But that's a question that—as we brief our colleagues, I'll make sure that there are more robust answers than I'm able to give to that question, as the hearings proceed.

Mrs. Jane McKenna: Okay. Do you have any questions? No? That's it for me.

The Vice-Chair (Mr. Ted Chudleigh): Are you finished?

Mrs. Jane McKenna: Yes. Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Good. We'll move to the third party. Ms. Gélinas?

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M^me^ France Gélinas: Thank you so much for being here. I want to start with the comments that you've made on page 3 that I was really happy about. I come from northeastern Ontario. The LHINs are there to give people a voice in the health programs and services that will be available to them. When you come from northeastern Ontario, it's way better to have somebody up there than down in Toronto. What do they know about what we need? We get it.

Mr. Robert Morton: Absolutely.

M^me^ France Gélinas: So you make a comment that community engagement is both your core value and a legislative requirement, and you post community engagement plans, and I follow all this. But we're here to look at how we could make things better. There are areas of the province right now, which we will more than likely be visiting, where people actually got matching T-shirts to tell us how much they hate the LHINs. They know what you do. They do not feel like you listen to them. They do not feel like you engage them in changes. They hate you. How do we move this forward? What can you tell us that will help us bring those people into the tent, that will help us diffuse some of that tension that exists? We're open to your advice.

Mr. Robert Morton: I think it comes in many ways. I appreciate the frustration that you would have as a member of the Legislature when you have constituents who aren't happy with the system.

M^me^ France Gélinas: Not the system, the LHINs.

Mr. Robert Morton: The LHINS, the way in which the LHINs are performing. Dialogue, dialogue, dialogue—you've asked for advice; you need to hold your LHIN accountable for those things that I'm saying on their behalf in this presentation, that we have to engage our communities in our discussions. That discussion, that engagement, has to be done with the health service providers as well. It's not us and them, the health service providers against the LHIN and against the population. We've got to find that common ground. This is about the health system—that's our interest—and that common ground, then, has to be the patient that we're serving. So we've got to work harder to get the patient to the centre of the discussion. What's going to be better for the patient in your riding in the North East LHIN?

M^me^ France Gélinas: The example I was giving was not necessarily just for mine. But this is the core value of the LHIN. This is why you exist. You exist to give people a voice. You exist so that people have a chance to say which programs and services they want. And yet, in some parts of the province, you've failed. There is no other way to describe it. Some people really hate the LHINs. And yet, it's your core mandate. What have you, as a group, learned from this? What can you give us for the future that will change? You are the expert in community engagement. It has been years that those people are not happy and we haven't moved an inch to bringing them into the tent. They still hate you with more passion than before—not you, the system you represent.

Mr. Robert Morton: Yes, yes. I didn't take that personally, though I guess I do. I have spent my whole career working in the health care system. I'm as excited as I've ever been about the future for the health system. I see higher levels of collaboration. I see more levels of support. I see a much better understanding of the importance of community and patient engagement. I see a much better focus on the patient as being the centre of their care, patient-centred care. We're a long way from where we were. Clearly, based on your examples, we're not there yet in some communities. That doesn't mean we have to throw the baby out with the bathwater. I think we have to hold all of our providers—that includes the HSPs and the LHINs—to the standard, to the legislation, for engaging their communities in the discussion about the future.

Now, they have to be real discussions. The reality is, the existing system is not sustainable. The way in which we have provided care in the past doesn't meet current and future needs. We have to change the system, even though people don't like change. I'm going to use the example of: "What about the doctor who doesn't want to join health links and be that sole practitioner out there? What are you doing about them?" The answer is, well, we've got to focus on where we're going to make some gains. You can't fix everything at once, so let's work with the—in change management—low-hanging fruit. Let's go where we've got some motivations, some energy, some desire to change.

But the reality is, that doctor will change when his patients see that the better way of receiving care is not from the old-style family doctor, working independently, loving and caring for his patients. That doctor would have better tools if they were part of a team and working in a system approach, rather than as a sole practitioner. But that's a journey of change, and our communities have to be part of that journey.

M^me^ France Gélinas: You suggest that we hold all providers, including the LHINs, to the legislation. How would you suggest we do that?

Mr. Robert Morton: With respect, I don't sit in the Legislature. That's what the act is about. I think MPPs play a really unique role. I would encourage you to meet, if you're not meeting regularly with your LHIN and your HSPs, though I expect you are. You need to continually push that agenda. When I go to an MPP's office, it doesn't matter what colour their tie is; this is about the people we're serving. So MPPs play a particular role in communicating with the LHINs about issues.

In my regular meetings with MPPs, "What are you hearing from the community?" is a question that I ask, because it's a good temperature for me. Are they hearing lots about health issues or are they hearing less about health issues? I'm really pleased when an MPP says, as

last week, "No, things are trending down, even though this one hospital has proposed to make some significant changes in order to make its budget. I've had one call, but we're monitoring it. That hospital is working well with its community. It has its engagement strategy out there. It's supported. They're giving good evidence for why they're changing." So it can work, but it's hard work.

M^me^ France Gélinas: All right. My colleague before me talked about indicators of success. When you put forward health indicators for success, such as the wait time for cataract surgery went down and the wait time for hip-and-knee went down, it would be pretty easy to say that had nothing to do with the LHINs. The wait time went down because the ministry invested a tonne of money in getting more ophthalmologists to do cataract surgery. Whether you would have been there or not, or not even thought of, give ophthalmology more money to do more cataract surgeries and the wait times will go down.

Mr. Robert Morton: I use the experience in North Simcoe Muskoka, where we didn't get more hip-and-knee wait time money, but the result of moving from three separate sites providing orthopedic surgery—hip replacement, knee replacement, hips being the more critical one. They each had their own staff of physicians. They each had their own standards of practice. They each served their local community, and if someone from north Huntsville needed that surgery, then they kind of had to wait-list against the program. By creating an orthopedic program that used the three hospital sites, that moved them to common standards, that put in place a bed registry which made sure that in the emergent case—a person falls—they get their hip replaced within 24 hours, there were incredible gains in that system, because we got rid of the waste, we got rid of the waits, we got people working together. As a result, without an investment in a whole bunch of new hip-and-knee funding, we used what we had in a more effective way. That's the kind of change that needs to occur.

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M^me^ France Gélinas: There are 14 of you right now. If you look at the geographical boundaries, you are an example of a very small LHIN, with half a million people. Do you figure the boundaries are at the right place? Do you figure the number is the right number?

Mr. Robert Morton: It's an interesting question. When LHINs were created, it was clearly stated that the boundaries shouldn't be boundaries for people; they're really administrative boundaries. For example, in North Simcoe Muskoka: Parry Sound is technically in the northeast, but 60% to 70% of the people in Parry Sound, when they look for other services, are getting them from North Simcoe Muskoka. It doesn't matter. For a patient, the LHIN boundary shouldn't be a boundary to their access to service.

M^me^ France Gélinas: I'm asking you administratively, is 14 the right amount? Are the geographical boundaries for the work that you have to do—did we get it right? Does it need any changes? Do you have any suggestions?

Mr. Robert Morton: I think, by and large, we got it right. Lines were drawn on a piece of paper. They were based upon hospital utilization. Hospital utilization changes over time. Hospital utilization is only an episodic use of the health care system. People use other parts of the system on a continuing basis. I think any boundary change would have to be weighed against the impact that forcing reorganization and restructuring of the rest of the system would create. On balance, I think, we have a model that can work because we're not creating barriers for people in crossing the boundaries, that we can make it work.

M^me^ France Gélinas: As far as you know, there are no areas of the province that would really like to see a LHIN boundary change?

Mr. Robert Morton: Personally, I'm not aware of any, though there may be. I'm not aware of any.

M^me^ France Gélinas: Okay. If we look at the part of the health care system that you fund—whether we look at CCACs, CHCs, long-term care, mental health etc.—did we get that right? You do mention on page 11 that I think you would like to have funding ability for more of the primary care sector. Would that be limited to—

Mr. Robert Morton: Well, I—sorry, I interrupted.

M^me^ France Gélinas: Go ahead. What did you mean by that?

Mr. Robert Morton: When we talk about the primary care sector—remember, when LHINs were established, primary care was another part of the ministry. It was funded in a very different way. There was a great deal of energy spent over time to change the funding models—negotiations between government and OMA. We talked about FHNs, family health networks. We talked about FHGs, family health groups. We talked about FHOs, family health organizations. And then we sort of landed on FHTs, family health teams. So there's lots of work going on there.

Let me talk just a little bit about community care access centres and I'll kind of bring the things together. Community care access centres were started in the late 1990s. It recognized that if we wanted to have an improved health care system, we needed to have a consistent framework for home care delivery across the province. While we did have home care across the province, it was very different. In fact, the spend rate was 4 to 1. Some parts of the province were spending four times as much as other parts of the province. Part of that came from the structure of home care.

M^me^ France Gélinas: And to my question?

Mr. Robert Morton: Yes, I'm getting there. So they were very different. When CCACs were created, moving from either a hospital-sponsored, a municipally sponsored, a health-unit-sponsored or a stand-alone-agency-sponsored, to create kind of a single model, more like the hospital model for governance of that part of the system, it would have been really good at that time if we'd been able to bring primary care into that part of the system,

because primary care and home care are absolutely related. But it could not have happened. Primary care wasn't at a place in time that it could have allowed—the age demographic, the understanding of the critical mass of physicians about the value of interprofessional care wouldn't have made it possible for us to bring primary care into the system.

Now the time has arisen. It's not about funding primary care; it's about managing accountability. If a health link says its goal is to keep people out of emerg; to deal with the complex people; to drive the cost of the 1% down by some target, so we have money to reinvest in the system, then it's about managing their performance. Working with them to manage performance rather than funding primary care is the basis of this request. It's a big challenge.

M^me^ France Gélinas: Why wouldn't that principle apply to everybody else? You just need to manage the accountability of a hospital; you don't need to fund them. You just need to manage the accountability of long-term-care homes; you don't need to fund them. Why is primary care so different that you can manage the accountability without funding them?

Mr. Robert Morton: Funding is a good tool to use to get there. I'm just suggesting that the reality is that the funding tool isn't going to be on the table for the LHINs to use, but the other tools can be used effectively and we can get much better performance out of our primary care system. In doing so, we'll have much better performance of the entire health care system.

M^me^ France Gélinas: So it's not there now. If we were to change it to make it there, what would be wrong with that?

Mr. Robert Morton: I'm sorry—change?

M^me^ France Gélinas: As in, you don't fund primary care organizations or providers now. If we were to increase your mandate so that you were to fund primary care organizations and individuals, what would be wrong with that?

Mr. Robert Morton: I would say there would be nothing wrong with that. I'm just thinking about the realities of any government's ability to make that very significant shift from the historic way in which we funded. If it happened, great; but if it doesn't happen, I think we have to work with what we can do. We already do fund community health centres; they're part of the primary care system.

M^me^ France Gélinas: But what's the difference between a community health centre and an Aboriginal Health Access Centre? What's the difference between a community-led nurse practitioner clinic? Am I missing something here?

Mr. Robert Morton: Those that are outside of the OHIP envelope—and I don't pretend to understand the nature of the agreement between physicians and the province of Ontario. Any of those programs—in North Simcoe Muskoka LHIN, when we're talking about primary care, they're all there. They're at the table; they're working; they're building their relationships with the FHTs, the family health teams, and the health links. We're very pleased. We're one of the first LHINs to have our entire geography covered by health links, and so the models are emerging.

Here is a little story about an aboriginal health centre in Wahta, a First Nations community. I was visiting them, talking with the nurse practitioner, asking about the patients that she serves. She said, "Some 22% of my patients live on reserve." So I said, "Okay, so 78% of your patients are off-reserve First Nations people." She said, "No, 72% of my patients live off reserve." They serve the broader community along the 400 corridor. She knows that her work has to be with the mainstream. We can't silo the aboriginals and First Nations people with a parallel health system.

M^me^ France Gélinas: Unfortunately, Chair, I see that my turn is up to go talk to this motion. Can we save our time? Cindy, are you ready for more questions? Or can I save the time for the next round after the Liberals?

The Vice-Chair (Mr. Ted Chudleigh): Sure.

M^me^ France Gélinas: Yes?

The Vice-Chair (Mr. Ted Chudleigh): There seems to be some agreement.

M^me^ France Gélinas: Okay. I'm running up there and I will run right back. Sorry.

The Vice-Chair (Mr. Ted Chudleigh): Shall we move to the government side?

M^me^ France Gélinas: Yes.

The Vice-Chair (Mr. Ted Chudleigh): Very good.

M^me^ France Gélinas: Sorry.

Mr. Robert Morton: Thank you for your questions.

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The Vice-Chair (Mr. Ted Chudleigh): Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair. Mr. Morton, thank you for being here. You've given us little hints about your background. Could you just explain your experience within the health care system prior to becoming the chair of the North Simcoe Muskoka LHIN?

Mr. Robert Morton: Thank you. For my first job in health care, I was hired as the personnel manager at what was to become Huronia District Hospital in Midland. I then left being a little fish in a big pond to become a big fish in a little pond, and I moved to the Georgian Manor home for the aged in Penetanguishene, where I spent a number of years.

During that time, I had some phenomenal experiences. I did a year-and-a-half—almost two-year—secondment to the then-Ministry of Community and Social Services and the Ministry of Health, as we were bringing services for seniors together under the umbrella of long-term-care reform—the beginnings of the long-term-care system and the enhancement of the community care system.

During that time, I chaired the Simcoe County District Health Council. I was also fortunate to be chair of OANHSS, the provincial organization representing not-for-profit homes for seniors. In 1997, after 18 years at the county, I was chosen to lead the establishment of the community care access centre in Simcoe county. I spent a

number of years there, and was chair of the Ontario Association of Community Care Access Centres.

There was a shuffle within the CCACs around 2001, and I was asked to take on the responsibilities at Peel's CCAC, so moving from a medium-sized CCAC to one of the largest CCACs in the province. I was there at the time that the LHINs were being planned and ready to be implemented, and I was of an age thinking that that's going to be for some younger people and that I was going to finish my career there. But I was approached by the Children's Treatment Network of Simcoe York, an example that I gave earlier, and I was asked to become the founding CEO of that. That was a phenomenal journey for me and for our communities, as we really made a difference in the lives of kids with multiple disabilities. That program was recognized with a couple of national awards for pediatric home care innovation and with an innovation award from IPAC/Deloitte.

I reached the end of the time that I thought I wanted to work, and just at that time, my local hospital was in trouble. Huronia District Hospital, in partnership with Penetanguishene General Hospital, were under supervision because the community had come to disagree with positions that the board was preparing to take. So the board resigned and a supervisor was appointed. After his work and recommendations, a new board was selected, and I was chosen to chair the newly-merged Midland and Penetanguishene hospitals, which have since become Georgian Bay General Hospital. That was a very unique experience, and during that time I did a number of consulting contracts with Deloitte, KPMG and some other firms.

As my tenure as chair at GBGH was coming to an end, I was approached to move to the LHIN. For me, going to the LHIN was an opportunity to bring the significant learnings I'd had in all of my work, in particular at the Children's Treatment Network: that you can create an integrated system not by merging organizations or forcing marriages; if you really focus on who you're serving, you can do incredible things and you can end up creating an integrated system.

If you give the power to front-line workers and give them the tools to redesign how work is done, you'll come up with better examples. As I said in my presentation, that's exactly what we're doing in north Simcoe, within organizations and across organizations, as we try to redesign our system.

Ms. Helena Jaczek: Thank you. So you obviously had experience with the previous system of regional offices of the ministry—both the Ministry of Health and ComSoc—as well as district health councils. Now, obviously, as LHIN chair, you're seeing the new way of managing health care providers in the community. So can you tell us what exactly is the difference? I think I've heard, through what we've heard already, that you like the new system, so can you really encapsulate for us just what the advantage of having LHINs versus the previous organization actually is?

Mr. Robert Morton: The LHINs have the ability—I wouldn't use the word "power," but the ability—to facilitate collaborative work amongst providers. They do have the power, but I don't believe that using it as power gets you where you want to go. You can't force people to work together; you have to lay the foundation for people to be able to focus on who they're serving and to find a better way. So that's the unique role that LHINs play, that they have this—yes, they're managing accountabilities and they are holding people accountable to their HSAA, making sure that they balance their budget, but once that is in place, then it's about improving the system. As I say, when I talk to health service provider boards, I say, "The LHIN's goal here is to make you as successful as you possibly can be, and you'll get there with robust collaborative partnerships, getting together with your partner organizations at the board level, at the leadership level and at the front-line level to find new ways, better ways, of serving the vulnerable people in our community."

Ms. Helena Jaczek: I was obviously interested in your reference to the Children's Treatment Network of Simcoe York. I'm very familiar with that organization, and the office piece is in my riding. But what role did the LHIN play? I was very much under the impression that there were a lot of service providers very concerned about care of children with developmental disabilities and that they came together voluntarily, in essence, and created what we see now. Can you again just sort of outline why we need a LHIN for that to happen?

Mr. Robert Morton: Well, just a little bit about that context. The envelope of funding for children's treatment centres: Even though the roots of it are under the Public Hospitals Act, the administration of those fundings fell under the Ministry of Children and Youth Services. But the reality is that kids looking to the MCYS for service are the same kids who are looking to the health system, the education system, the child protection system—you know, the whole system. So the model there said, "It doesn't matter who the front-line worker works for; these kids need help across the continuum, so let's make it possible for these kids"—and this isn't about serving every kid. There are thousands in York, in Simcoe, who are—the south end of Simcoe are particularly young compared to the rest of the province. But this is about 4,800 kids in those two jurisdictions with multiple disabilities. It wasn't trying to fix the system for every kid; it was just trying to fix the system for kids with high needs, just like at this stage with health links we're not trying to fix the system for everybody; we're focusing on those most in need of the system and giving the tools to make that happen.

So while some of our partners were funded by LHINs—the CCAC piece, the hospital piece—the majority of partners were outside of that envelope, were MCYS- or MCSS-funded, or Ministry of Education. So we needed to go beyond that, but there was much that we learned that has been very helpful to the rest of the system.

For example, when we started Children's Treatment Network, we said, "We don't want a back office." Yes,

you need to pay the small number of people who work for you when you need to do your submissions to the ministry. "Who can we contract with for that?" So we actually went to the Simcoe CCAC at the time, now North Simcoe Muskoka CCAC, because they were in an initiative of saying to all of the community support agencies, including the community health centres, "We'll come together and we'll create a back office for all of us."

Now that back-office integration—15 or maybe 18 organizations, all of their reporting, recording, payroll and finance—is done in a centralized office at much lower cost and with much higher quality than could ever have been done, had each of those agencies had their own—

Ms. Helena Jaczek: I understand, but you haven't mentioned the word "LHIN"—

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Mr. Robert Morton: Okay. That was work that we did with the LHIN to support that. We became the poster child for back-office integration for the LHIN.

In Central LHIN—in order to share information on the single plan of care, you have to deal with several pieces of privacy legislation, including the Municipal Act, the Education Act, and the privacy act, of course. All of the work that we did was very appropriate, and the Central LHIN used those tools, that suite of work, to help build their palliative care network. It's exactly the same thing: a very high-needs group of people, people who are at the end stage of their life.

While Children's Treatment Network isn't a funded HSP, it's very much a part of—when we look at our work at a LHIN, if you are only focusing on your HSPs, not enough people are at the table. I talked about our consultation: 20,000 hours, 5,000 people and 160 organizations. Only 75 or 76 of them are HSPs. The system is much bigger.

If we're dealing with children's mental health, and you have to, particularly around the transition age, where you move from—if you're hospitalized as a kid for a mental health issue, that involves the hospital system, it usually involves the school system, and it may involve the home system. But when we do the transition, then all of your mental health needs need to be met by the health care system. An effective LHIN recognizes that the partners are much broader than just the funded HSPs.

Again, using the North Simcoe Muskoka example—and this would be repeated time and time again in other LHINs, some to a greater extent, and perhaps some to a lesser extent—you can't do it if public health isn't at the table. They're the partners on the integrated falls program. You can't do it without EMS at the table, so that involves the municipalities, because you're doing urgent transfers and you're doing non-urgent transfers. That can be a horrendous bottleneck within the system. You can't improve ER wait times unless you're involving EMS with that discussion

Ms. Helena Jaczek: So at the end of the day, you're saying LHINs are providing a vital function in the facilitation of integration, and kind of being a driving force to make it happen.

Mr. Robert Morton: Yes, and holding the system accountable to work within the funds that they have, to drive better value for money.

Ms. Helena Jaczek: Mr. Morton, you're here today, though, because you are co-chair of this leadership council. This is where the 14 chairs and the 14 CEOs come together. Do you elect your co-chairs? Or do you—

Mr. Robert Morton: I'm trying to think how I got this job. It must have been a short straw.

Ms. Helena Jaczek: For how long are you co-chair of this leadership council?

Mr. Robert Morton: It's a two-year period. One year, you support the other chair. I'm in my second year, so I'm the big chair or, I guess, the major spokesperson. This term will end at the end of the fiscal period.

Ms. Helena Jaczek: This leadership council is made up of board members?

Mr. Robert Morton: It's the 14 LHIN chairs and the 14 CEOs. The CEOs meet on a more regular basis. We meet four times a year. We're trying to do three times a year face to face, and one by video teleconference. In the off months, we'll do a teleconference call. We're exploring ways in which we can use webinars and other technology to improve the communication between and amongst us.

We're recognizing that we have a lot to learn from each other. At the last chairs' council meeting, we invited two chairs—and we'll continue to do it—to do a best-practice case study on what's happening in your LHIN and what we can learn from that—good-news stories or bad-news stories. That's how we're using that structure to help advance the agenda.

The leadership council and chairs' council don't exist between the LHINs and the minister. The accountability is between the LHIN boards and their chairs to the minister. The leadership council and chairs council are mechanisms that we've agreed upon to help us do our work, but we're not like a provincial association that's sort of in between.

Ms. Helena Jaczek: Right. I was pleased to receive from my board chair of the Central LHIN, John Langs, some 17 recommendations in terms of this LHSIA review, making very precise—he is a lawyer—recommendations in terms of looking at the legislation and certain areas where, in the Central LHIN's view, there might be some need for change. Is your leadership council coordinating suggestions coming in and will we be the recipient of the combined wisdom, the integrated wisdom of the 14 LHINs?

Mr. Robert Morton: Yes. The timing of today meant that we didn't have—even though we knew it was coming, we didn't know when the timing was. We knew we needed to come at the first day to speak as broadly as we could. So my goal was to introduce a range of themes that will be picked up on by my colleagues. We'll be working with the questions you've asked today where I've not been able to provide fulsome answers. We'll make sure that as further presentations, both verbal and written, are made, we'll pick up on the gaps that I have in my knowledge and understanding.

Ms. Helena Jaczek: I think it would be very useful for all of us to have certainly the combined wisdom from the field, from the LHINs themselves. Of course, we're going to be listening to many other associations and stakeholders as well—and we certainly asked the deputy last week in terms of the ministry's thinking after many years now, because, as has been said many times, with regionalization across the country there has been several iterations; there have been changes over time. We may not have got it absolutely right the first time, but we would welcome that input. So we would be very interested in receiving that in as timely a fashion as you can provide it.

Turning to an area that my colleague Ms. Gélinas came up with: boundaries—certainly from health service providers, those who have accountability agreements with the Central LHIN, it has come to my attention that they are not happy about the boundaries, especially in the GTA. We heard last week from our colleague Ms. Cansfield, whose riding actually has four different LHINs that serve her community. The difference in terms of the service provided is very readily apparent. This is something that I believe we will be hearing from health service providers in terms of boundaries.

From your perspective, this isn't something that has come up in your leadership council discussions?

Mr. Robert Morton: The only extent to which we've discussed it as leads were, we're working with the structure that was given to us. We're doing everything we can to make it work as effectively as possible. We recognize that LHIN boundaries are not meant to be boundaries for individuals in how they receive service, but we do recognize that for some of our health service providers it means they're dealing with multiple LHINs.

I think of the country of Simcoe. Three of their long-term-care facilities are in North Simcoe Muskoka; one is in Central. The Parry Sound-Muskoka mental health agency has offices in Parry Sound as well as Huntsville. So they're between North East and North Simcoe-Muskoka.

As we look at a comprehensive review of the legislation, it may be something that needs to be addressed, but I don't find it a burning platform at this stage. There are other things that could be dealt with in the short term with a potential longer-term look at that as a piece of it. However, I'm really pleased that you're in a position to hear from the health service providers, particularly those who are challenged by working with more than one LHIN. From a patient perspective, however, it shouldn't matter where they live what LHIN they're receiving service from.

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Ms. Helena Jaczek: Well, it does impact considerably, certainly on my constituents, and I hear from them all the time.

You said this is not a burning issue for you. Are there any burning issues for you?

Mr. Robert Morton: I'll come back to primary care and how health links are going to evolve. It's very exciting. There are some columnists and bloggers I read who say, "In this kind of change, we can expect only 20% of them to succeed." We can't have that kind of success rate on change. We need 100% success in that. So the burning platform for me would be to design accountability mechanisms within the legislation that allow us to support and help the growth and development of health links. As it is now—and I go back to the other member's comments about funding—I'm not expecting significant change in the funding model. health links that are sponsored by a family health team are directly funded. For health links that are led by a community health centre, the funding flows through the LHIN. It doesn't really matter. It's public money, and we need to hold them accountable to their business plans and for the targets that they're approaching. So it's those tools to hold the collaborative health links accountable that are really important.

Ms. Helena Jaczek: We asked the deputy last week if there were any other areas, from the ministry's perspective, that they were looking at including in the responsibilities of the LHINs, and I think the legal counsel mentioned independent health facilities. Do you see any other areas that you would like to see included within the responsibilities of the LHINs?

Mr. Robert Morton: As we move to a more population-based agenda, as we look at not just the repair shop part of the health care system, as we look at injury prevention, as we look at disease prevention, health promotion, that continuum has to be connected to the health care system. That would suggest that when we look at how public health is organized, that's another area that—again, I wouldn't say this is a burning platform, because in many places, locally, our medical officer of health is actively involved in the LHINs' change processes. He and the board of health—we have this mechanism called the governance coordinating council that's giving advice to all of our governing bodies as we establish the right way to govern integrated initiatives, the programs that cross organizations. One of the very active members of that is the vice-chair of the board of health, so he comes wearing a different hat, but he's part of the governance picture. So they don't have to be there.

I wouldn't try to answer the question, "Are public health units accountable?" I don't know the mechanisms that are in place, but I know that they're a very critically important part of the health care system.

Ms. Helena Jaczek: And of course, their boundaries are completely different—

Mr. Robert Morton: And their boundaries are different, as well.

Ms. Helena Jaczek: And there is municipal money in public health.

Mr. Robert Morton: Yes.

Ms. Helena Jaczek: So that would, I suggest, be an incredible difficulty.

Mr. Robert Morton: So let's keep them at the table and let's not necessarily get too excited about where their funding comes from.

Ms. Helena Jaczek: In terms of bringing people to the table, you've talked quite a bit about primary care, and I guess the first crack is through health links. But you do have something called a Health Professionals Advisory Committee. I believe we heard, legislatively, there is a provision that each LHIN establish that group. Do you find that a useful group?

Mr. Robert Morton: Not particularly. I can understand why it was included in the legislation at the beginning, because we didn't know where we were going. We had this grand view that we needed to engage communities more in discussions about change; we needed to change how service providers worked. So it was all about change going in. And so there was significant push-back from a number of provider organizations and some of the professional organizations as well. So as an attempt to bring them forward, the professional advisory councils were established as a way to engage them.

As time has unfolded, the need for that in—certainly in North Simcoe Muskoka, we don't need that anymore. There's confidence and comfort that professional interests are dealt with in a most comprehensive way, and to continue to have it would be to create another silo that we don't need.

Ms. Helena Jaczek: Okay. I have five more minutes, Chair?

The Vice-Chair (Mr. Ted Chudleigh): Yes, just under.

Ms. Helena Jaczek: Okay. Service accountability agreements: In terms of funding, I understand that sometimes the health service provider delays in signing the service accountability agreement, and yet funds continue to flow, because there might be a difficulty in providing an alternate health service provider. What do you see? Is there some need for clarity or some change legislatively there?

Mr. Robert Morton: I'm thinking of the nice way to say this, but perhaps I'll just be bold. We all play games. There's gaming within the system about whether you sign or not. But clearly, the mechanisms within an SAA, a service accountability agreement, talk to it having an evergreen facility to it. And so it's the re-signing of the agreement that connects in any new funding.

So base funding will continue, because you can't just say to a hospital that has said, "We can't sign the HSAA because we don't know what our funding will be through the new funding model, HBAM, or we don't know what the prices on the quality-based procedures are"—it would be like cutting off your nose to spite your face if you said, "Okay. Since we don't have an HSAA signed for you as of the beginning of the period, we're cutting all of your money off." We will not add any additional funding, any changed funding, until the HSAA is added, but it would just create chaos within the system if we didn't continue to flow money. But I'm suggesting—my understanding of the HSAA is it allows us to keep funding at the previous year's rate until the new SAA is executed.

Ms. Helena Jaczek: We'll keep whatever we have—a minute or two—for the next round.

The Vice-Chair (Mr. Ted Chudleigh): Thank you.

You have two minutes and 40 seconds, I believe.

Mrs. Christine Elliott: Okay. I'll try to use it wisely.

Thank you very much, Mr. Morton, for your presentation. In speaking about some of the challenges to the LHINs, we've talked a lot about primary care. We have talked a little bit about children's treatment centres and the fact that they're not included. I was just wondering if you could comment on any concerns that you have around that and any ways that you see it could be dealt with. I recognize they're funded by different ministries, but we're seeing more collaboration amongst ministries on various different services and issues. I would just like your comments on children's services generally, if you would.

Mr. Robert Morton: Children's services generally—it's tough. If you're a parent of a kid with significant disabilities, it's really tough. You're looking to a whole range of segments, sectors and silos within the system, and when parents say to me, "I tell my story again and again and again. Don't you people talk to each other?" or "I carry a file box with me to meetings," it shows the need for us to find ways of serving kids' needs.

So there are many players in the kids' space. There's the Ministry of Children and Youth Services for children's mental health. There's the children's treatment centres for rehab services, for the preschool speech and language program, for the early identification program, so moving into the developmental services space. Then we start to connect to the Ministry of Community and Social Services for these kids, as well, as they become adults and certain programs are delivered by the local association for community living or however it's named within their community.

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Then we have health, and health is there for those kids from the moment they're born, through their primary care—through family physicians to specialty services, pediatricians and specialty hospitals. An emergency visit connects those kids to the system as well. We're all in it with these kids, be they kids who are just having an acute episode or kids who have a chronic disability or a condition that requires ongoing care.

Generally, there are real challenges, and some very good work has been done. In the complex care coordination work that was done by Dr. Charlotte Moore, she focused in three spaces. One is kids who are medically fragile and technologically dependent, and there are some good recommendations for systems integration. We're never going to put the whole—we're not going to mush everything together. We've got to find workarounds for these kids.

The Vice-Chair (Mr. Ted Chudleigh): Thank you, Dr. Morton. Our time is up. We'll move to the NDP.

Miss Monique Taylor: That will be me, Chair. How long do I have, Chair, like, total?

The Vice-Chair (Mr. Ted Chudleigh): Ten minutes.

Miss Monique Taylor: We have 10 minutes left? Great. Okay, thanks.

Hi. Thanks for being here.

Mr. Robert Morton: Hi.

Miss Monique Taylor: My question is around long-term-care facilities. You had stated earlier that baby boomers want to stay at home. I agree with you: That's probably the case, I'm sure, in most cases. But we're finding issues where there are wait times in so many different service areas that that's becoming an impossible task.

I have a resident right now—he has Parkinson's—who has been waiting to get a specialist appointment for a year. Now that he has got the appointment, he is told it's two years until the appointment. When the family called to complain, they kind of switched it back down to a year. But at this point, the Parkinson's is completely out of control, and they're going to have no choice but to put that person in a long-term-care facility. What's your thought on that?

Mr. Robert Morton: We talked about primary care at length. A key piece, after we work through primary care, is specialized medical services.

You're absolutely right: We have incredible challenges. In some parts of the province there's a dearth of providers—

Miss Monique Taylor: I'm from Hamilton.

Mr. Robert Morton: Yes. In some parts of the province, there's a lack of providers. There are some subspecialties that are as scarce as hen's teeth. The geriatric specialists: In the whole of North Simcoe Muskoka, we have one, and numbers should show that we need many more.

What it speaks to is a different way of manpower planning. It goes back to the OHIP question; it goes back to the education question, that if we're really serious about a system, then we need to start managing health-care human resources in a more comprehensive way than just letting the alleged marketplace manage the supply side. We need to be much more thoughtful—and this is on a province-wide basis—about saying, "Where do we need certain physicians? Where do we need skills?" What's the plan? How do we work with the education system to say that in 2020, we'll need X number of additional gerontologists, rather than letting the current—

Miss Monique Taylor: But we're failing right now, and we're coming into this baby boomers crisis very quickly. I hope that you do change that scope, that people want to stay at home, because, yes, even though they do, our system as it sits right now is, unfortunately, not going to allow that, so we need to implement more beds.

I know that my city is so far behind. I have people on the wait-list who are never going to see that list because, unfortunately, they're going to die before they get there. Our CCAC is just on overload, trying to manage these. Our hospital beds are completely in wait-time crisis also. I know my colleagues still have many questions. But it's a major issue in Hamilton, where I'm coming from, and I think it's something that needs to be addressed.

Mr. Robert Morton: Yes, and in the ministry LHIN performance agreement that was signed for this year, there's a joint commitment between the LHINs and the ministry to look at this capacity question, to provide some direction so that we identify the significant gaps—the overages, if they exist anywhere—and we end up developing a plan that says, "How are we going to move forward?" We have to do it with the recognition that different communities have to have a different response because of the other mix of providers, the geography and the socio-economics of those communities.

Ms. Cindy Forster: We only have a very short time left, so if you could make your answer to my question as brief as possible: At a high level, how is the funding doled out amongst the LHINs? I come from an area, Niagara, where we had chronic underfunding of our hospital for many, many years. We have a huge lack of mental health services. So is it based on population? Is it based on geography? How often do you actually look at the funding and move that funding perhaps between LHINs?

Mr. Robert Morton: Great questions. It's going to be hard to answer briefly. Seventy per cent of our funding is to hospitals. The hospital funding is based upon a historical way in which hospitals were funded, and there were a variety of formulas that tried to recognize growth in communities and recognize demand. We're in the midst of implementing a new mechanism for funding hospitals that moves it away from global funding. Global funding: Any increase awarded the effective hospital the same as it rewarded the ineffective hospital. So over time, as we reduce the amount of global funding, we look more at the quality-based procedures. If it's costing your hospital $100 to do something and it's costing another hospital $50 to do something, if we pay everybody $60, we're going to reward the effective hospital and the ineffective hospital will have to improve. That's the quality-based procedures piece.

Then the balance of the funding is based upon the health-based allocation methodology, HBAM. That methodology looks at a population, taking it deeper than just the total number of people, but looking at it age-weighted: an older population will need more. But then it layers on that other considerations about health status. We know that lower socio-economics result in higher need for health services, so those poorer communities will end up having more through the HBAM formula. The LHINs work with the government on the implementation side, finding the corridors by which we can move forward.

On the community side—and then there's long-term care—that's where we've been trying to grow capacity in the system. The additional funding that LHINs have had available to them have gone to build community capacity, whether that's in community supports or mental health. Locally, we've done some very significant investments on the mental health side because our mental health planning work that the community is doing has pointed out a number of places where investments would really make a significant difference: some crisis intervention, some child and youth work, and some building of capacity within the organizations.

The 14% that is long-term-care facilities: That funding is tied to a funding formula that looks at the level of care

required by the individuals occupying the long-term-care facility beds. It's by—

Ms. Cindy Forster: Score.

Mr. Robert Morton: —score, methodology, and then divides up the provincial pot based upon your score relative to the provincial average. That's the big part of long-term-care facilities. That's personal care. The next part is for raw food; the next part is for—

Ms. Cindy Forster: I'm familiar with that.

Mr. Robert Morton: So all of those go together, but that—

Ms. Cindy Forster: But what about between LHINs?

Mr. Robert Morton: Between LHINs? The HBAM is driving funding out of inefficient hospitals into efficient hospitals, and that's not done on a LHIN-boundary basis because it looks at all hospitals and their performance. If we're a LHIN with hospitals that have been very effective, the hospital pot will grow, rewarding them for their efficiency and catching up on the underfunding. In other LHINs where hospitals have been relatively inefficient, that funding doesn't remain in the LHIN; it goes on a horizontal basis across the hospital silo.

Ms. Cindy Forster: Thank you.

M^me^ France Gélinas: We also have a francophone entity and a planning entity for First Nations. There are a number of francophone entities that are also not happy with their relationship with the LHINs—and I see you've put it in what you've put there: You ask the boards to align their priorities with the LHIN priorities. So what happens when the francophone entities listen to the francophone community and say, "This is the direction we want to take"? We'll take, for example, "We would like a new francophone community health centre in our community." They bring that to the LHIN board and the LHIN says, "This is not part of the LHIN priorities. Thank you for coming. Come again."

The Vice-Chair (Mr. Ted Chudleigh): In 30 seconds or less.

Mr. Robert Morton: In 30 seconds or less. I'll speak to the local experience on that very question—

M^me^ France Gélinas: I'm more interested in, do you have suggestions for improvement?

Mr. Robert Morton: Yes. I think every entity needs to have strong relationships with the LHIN. The entity needs to make deputations, delegations, part of the education program at the LHIN, so that the LHIN board members understand the role of entities and the importance of French-language services. We need to inform each other about our work. It is a partnership. We're interested in the same thing. All of the LHINs have a French-language services coordinator who should be providing advice to the board and to the providers as we, within the mix of providers, move to improving services for people—

M^me^ France Gélinas: But this is how it should work, and it is not working. I was asking for your recommendations.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much, Mr. Morton.

Ms. Gélinas has a very busy day, and I wonder if we could ask you, on behalf of the committee, to convey "Happy birthday" to your husband when you see him next.

Laughter.

The Vice-Chair (Mr. Ted Chudleigh): The government has two minutes left.

Ms. Helena Jaczek: Mr. Morton, just to pick up a little bit on funding: Obviously, as I represent an area within the Central LHIN, we're very interested in implementation of HBAM to address our very rapidly growing population. As part of this leadership council, do you discuss implementation of HBAM? Obviously, there are going to be winners and losers between the various LHINs. What kinds of discussions have you had?

Mr. Robert Morton: It's on the table. I wouldn't say we've had robust discussions to date, but as we see the implications of HBAM, as the so-called winners and losers become clear, we need to be very strategic. The government has done a good job with the mitigation, with the corridors, to try to ease that, but hospitals need to be working for where they're going to be over time. We've given time for hospitals to get their house in order. Hopefully, they'll be able to do that.

Ms. Helena Jaczek: What time frame are you looking at for implementation?

Mr. Robert Morton: I haven't got that technical piece. We'll make sure we get the right answer. It's either three years yet to go or—

Ms. Helena Jaczek: Well, I think it was four years originally, so—

Mr. Robert Morton: It was four years initially. Whether it's three years left or two years left—I'd have to check a calendar on that.

Ms. Helena Jaczek: Okay. I think we'll just leave it at that.

The Vice-Chair (Mr. Ted Chudleigh): Good. Thank you very much.

I believe this committee now stands adjourned until tomorrow—

M^me^ France Gélinas: No, no. We have to talk about our travelling days.

The Vice-Chair (Mr. Ted Chudleigh): I'm sorry, that's not on the agenda, and I'm not willing to entertain it. You'll have to have a subcommittee meeting to talk about it.

We stand adjourned until tomorrow after routine proceedings.

The committee adjourned at 1604.

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