SP-26

ISSN 1710-9477

Legislative Assembly of Ontario

Second Session, 40th Parliament

Assemblée législative de l'Ontario

Deuxième session, 40e législature

Official Report of Debates (Hansard)

Monday 2 December 2013

Journal des débats (Hansard)

Lundi 2 décembre 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
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
Greffière : Valerie Quioc Lim

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

http://www.ontla.on.ca/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-3708.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7410 ou le 325-3708.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 2 December 2013

Lundi 2 décembre 2013

The committee met at 1420 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): Routine proceedings have finished and it's now orders of the day, so that means this committee will be called to order.

This is a meeting of the Standing Committee on Social Policy, and we're here for the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of this act.

LOCAL HEALTH INTEGRATION NETWORK CHIEF EXECUTIVE OFFICERS

The Chair (Mr. Ernie Hardeman): We're doing public delegations today, and the first one is the local health integration network chief executive officers, and Camille Orridge, lead chief executive officer. Welcome. Any one of the chairs at the front is fine.

Thank you very much for coming forward today. We will have up to half an hour for you to make a presentation to us this afternoon. Upon that, we will have up to half an hour for each caucus to have any questions or comments on your presentation. Hopefully, it will end up at the end that we will all benefit from your visit here this afternoon. So thank you very much for coming in, and the floor is yours.

Ms. Camille Orridge: Thank you. My name is Camille Orridge, and I'm the CEO of the Toronto Central Local Health Integration Network. I'm here today representing all 14 LHIN CEOs.

I want to start by thanking you for taking the opportunity for me to come here today. We welcome a review of the legislation that governs the LHINs, because this review allows us to strengthen the legislation and to enable the LHINs to meet our fullest potential.

I want to take the time to review the recommendations by the LHINs to this committee.

The first recommendation is to give the LHINs greater responsibility for managing the accountability for primary care and independent health facilities. While LHINs are proposing greater responsibility for planning and managing the accountability for primary care, this does not mean making changes to how physicians are paid. The negotiation of physicians' compensation should remain the purview of the Ministry of Health and Long-Term Care and the Ontario Medical Association. Billing would continue through OHIP.

In addition, as the LHINs work with local providers in their communities as a means to improve access and quality of care, it will be important that these organizations are appropriately connected to the rest of the local health system.

The second recommendation is to take advantage of provisions already in LHSIA, regulations that were drafted but never enacted, that would benefit the system today: regulations related to planning for aboriginal communities and regulations related to the flexibility of reallocating funds in order to influence performance of health service providers or shift funding between sectors or organizations as the system evolves.

Under LHSIA, LHINs are not able to hold surplus funds. Unspent operational and transfer payment funds are returned to the ministry at the end of each fiscal year. Allowing us to retain surplus into the following fiscal year and permitting health service providers to retain a portion of their surplus would give the LHINs a greater ability to fund larger and multi-year change initiatives.

The third recommendation is to define the responsibilities of the system for health service provider boards. As independent corporate entities, many boards see their responsibilities as primarily to their organizations, and don't always see themselves as part of a system or a network of providers caring for the same population, often for the same individuals.

LHSIA created new requirements for health service provider boards that obligate them to incorporate community engagement in their strategic planning and to align their priorities to LHIN priorities.

The act also includes a role for service providers to identify and participate in health system integration initiatives. While LHINs have had considerable success in collaborative governance in some areas, maintaining a collective commitment to system goals can be a challenge.

The final recommendation is to reduce the administrative barriers to integration. Collectively and as individual LHINs, we need to focus and accelerate our integration efforts in ways that support more person-centred care, improved access and quality, and greater sustainability. With eight years of experience behind us, LHINs have

identified several areas where integration can be administratively cumbersome for all parties involved. Through the review, the LHINs will be sharing with the standing committee our perspective on opportunities to improve the legislation.

I realize that, here today, I am speaking to a group of individuals who represent the public. As the CEO of the Toronto Central LHIN, I too am keenly aware of the responsibilities to the public to work towards improving their experience in their health care system and ultimately optimize their health care outcomes. Understanding and improving the patient experience has been the thread throughout my own career; it has continuously grounded the work that I do and has given it true meaning.

If I were to choose one single way to describe how LHINs are changing the system, I would say that it is to bring the patient perspective into planning. It is to ask how health care should be experienced before, during and after it is delivered for a patient in our communities.

LHINs are privileged to have community and patient engagement written within our mandate, for it shapes and drives everything that we do. The LHSIA legislation sets the architecture for a patient-centred system. The legislation sends a powerful message—that patients and communities should be front and centre in health care design and delivery, not individual providers—but it is the on-the-ground work of the LHIN that brings this to life.

Governments have a bird's-eye view of the system, and that's appropriate; they fly at 30,000 feet and establish in broad strokes what the public should be able to expect from our universal health care system across the province. Providers operate at the street level, with a strong understanding of the individuals who come through their doors.

No one else is tasked with looking at the system in the way that we are: to consider what health care looks like from the perspective of the patient. The LHIN is here to think about and plan for how our patients move across and through the system. It is our job not to help navigate patients through a tangled system, but instead to provide an invisible guide for patients by rebuilding and transforming the system into one where providers know who is doing what for patients, they communicate effectively during handoffs, and the patients themselves are empowered to own and direct their own personal health journey with the right supports in place.

The LHINs are regional planning entities. The regional planning model is pervasive across Canada and in most publicly funded health systems across the world. There is a broad recognition that a regional model is the only way to achieve provincial or national level goals in jurisdictions that have fundamentally different circumstances. No one can argue with the notion that the challenges of planning health services are different for the remote communities of the north or the agricultural communities around Leamington than they would be for downtown Toronto, where we have the highest density per square block in North America.

The regional model affords flexibility and allows for the transfer of accountability to a level that is much closer to the front lines of health care while still maintaining strong accountability and ties to the provincial mandate. It is critically important that all Ontarians can have the expectation of equal outcomes of health care, regardless of the circumstances or where they live.

The provincial direction is set based on the government's mandate for health care across Ontario. The role of the LHINs has evolved along with changes in the provincial focus. It is not a matter of shifting goal posts, but rather a story of an evolving context, new and emerging challenges and a drive for continuous quality improvement. Health care, for me, is really based on continuous quality improvement. To give you a sense of what this has looked like, I will discuss the major areas of focus during this time, what the LHINs' role was and what the impact has been.

1430

The first four years of the LHINs were driven by a provincial thrust to improve surgical wait times. This was a key area of focus for the LHINs' work. Our role was to set service accountability agreements with the hospitals, negotiate targets, monitor change and move patients or volumes around the system to leverage and reduce wait-lists. We delivered. Ontario moved from the bottom of the pile to scoring straight As in the national scorecards. Our results in wait times have outpaced other jurisdictions in Canada.

In 2008, a decision was made to improve emergency department wait times. This work continues today, and the role of the LHINs is again to create service accountability agreements to support this focus and to monitor change. Working through the ED wait times, however, brought some important system challenges to light with respect to the need to build a strong community sector. For example, it became clear that more resources and infrastructure had to be built into the community to address the large number of people waiting in hospital beds who could and should have been discharged home had these supports been in place.

The role of the LHINs in tackling these very complex challenges has been critical. There is no other entity tasked with making sure that behavioural and, in turn, workflow changes are happening across health care organizations and across and among clinicians.

Home First is an amazing example of the leadership role that LHINs play in holding providers accountable for better patient and system outcomes. Home First is a philosophy focused on keeping patients, especially high-needs seniors, safe in their homes for as long as possible with community supports. As soon as someone enters hospital, Home First helps to ensure that adequate resources are in place to support the person to get and stay safely at home while they and their families make decisions about long-term-care options.

One reason why emergency departments get backed up is that needed beds are occupied by patients whose acute care is completed and who are waiting to be transferred to a better place of care: home, supportive housing or a long-term-care home. Home First started in the

Mississauga Halton LHIN, and today all LHINS across Ontario are doing Home First. The Health Council of Canada's 2012 report states, "The Home First philosophy is quickly becoming an important layer in the health care system of the provinces where it is applied."

With a few minutes, just to give you the results: In Mississauga Halton, there was a 45% reduction in the number of ALC patients—those are patients in hospital who were ready to leave hospital—an 85% reduction in the total number of such patients being designated from 2008 to 2013. There has also been a 45.9% decrease in the number of referrals to long-term care directly from hospitals.

Imagine the trauma of being admitted to hospital, and then being discharged from hospital to long-term care. Home First suggests that you go home, get supports at home and then transition from there to long-term care, should that be required. The success of Mississauga Halton was repeated in the Central LHIN, Toronto Central LHIN and the North West LHIN, and now it has been scaled up entirely across the country.

The Home First initiative and other efforts to ensure that patients receive care in the most appropriate place have sparked a number of related innovations across the province. For example, in my LHIN, 134 long-stay ALCs were transitioned to the right place of care. These are people who were in hospital for longer than six months, sometimes longer than a year.

While this may seem small, the impact is enormous. Transferring one such long-stay ALC patient who has been in hospital for one year makes that bed available to 10 to 40 people using that same bed. North Simcoe Muskoka supported Home First seniors with an expansion of telemedicine to monitor blood pressure and vital signs.

The ER wait times strategy also shone a light on the need to deal with patients who were coming to emergency departments because of access issues with primary care in their community or a lack of basic support services in their community. This is particularly true for complex patients who have high needs. It is true across the province, but I will speak of a few examples. I'll use some from my own LHIN.

Before, an individual with mental health issues had to apply to 28 mental health supportive housing organizations, completing all the different forms to be placed on each wait-list for housing. Clients were on a number of different wait-lists. Now, there is one application and one list, streamlining access to over 4,500 supportive housing units in Toronto. Clients are now placed on a common wait-list for all suitable units, and caseworkers support clients through the intake process and to ensure that they have the support they need. This coordinated access initiative has expanded to now include streamlined access to case management and assertive community treatment teams. Efforts are now under way to include streamlined access to addiction services.

Before, for a family physician with a family in his office who had identified that their senior parent was in need of social and personal support services, the physician or the family had to contact up to 30 different agencies regarding 25 different support services for seniors. Now, through the Community Navigation and Access Program, in collaboration with the CCACs, they have one call to make, and they are assisted in getting the right provider. There is now one integrated access point for services ranging from adult day programs, Meals on Wheels and transportation to appointments.

One last example: There are many languages spoken in the province. In Toronto, there are 170 languages. The ability to effectively communicate with a provider is critical in getting an appropriate diagnosis, understanding your treatment and managing care supports like medication and self-care. Recognizing the importance of being able to communicate with your provider in your first language, we at the Toronto Central LHIN brought all providers together to initiate one competitive procurement process for translation services that everyone could access.

Before this initiative, some hospitals and very few community agencies had a means of speaking to their patients to ensure understanding of the diagnosis, treatment, medication etc. The cost per minute ranged from $1.80 to $8, with most providers not being able to access or afford telephone translation.

Having brought the group together and brought the continuum together, we have now reduced the cost to $1.50 per minute, and going down as others join. The result is improving client care, client experience, provider satisfaction and cost. In the first year, services have been translated into 89 languages, and almost 50,000 minutes of language translation have occurred. This was just the first year in this program.

These are changes that focus on removing the spaces or gaps that exist between providers, the links and the connectors that patients rely on when getting access to the providers and the care they need. Patients with multiple chronic diseases often present in the emergency department because they are challenged accessing the supports they need. We see similar patterns with patients returning to the emergency department post-discharge. Wraparound care for these patients and families, particularly the top users, has emerged as the new strategic focus for the health care system and the driving force behind system transformation.

1440

Across the province, there are approximately 1,400 health service providers, of which 154 are hospitals. The rest are community agencies or long-term-care providers.

Our system evolved in the 1950s, when we were younger, healthier communities. Now we have an aging population with a lot of chronic diseases and a lot of chronic illnesses. We need, then, to transform our system. The need for community care, given this, is on the rise, as we work to support healthy aging.

We will always need a strong hospital sector, and we are fortunate to have some of the best hospitals in the country.

Meeting the challenge of building and strengthening the community sector is one that holds many solutions for better quality, greater sustainability and a better patient experience—and, ironically, better hospital care.

The LHINs are local enough to know the context and the providers and regional enough to partner, as necessary, beyond artificial LHIN boundaries.

The LHINs are neutral; they are not entrenched with particular providers or attached to the current model.

The LHINs look at whole populations, covering broad geographies. We look not only at those who are actually accessing care, but those who should be accessing care and who will need to access care.

The LHINs integrate services. We span across the silos of providers to make sure that care is coordinated for our patients.

The LHINs have the mandate to listen to patients and communities. It is embedded in our DNA, and it is part of the reason we were established.

There is no single metric that captures the strategic objective of improving the management of complex patients. This work is critical to transform the system, and we are up to it. Managing complex patients, as I mentioned before, is the next system challenge. It involves coordinating care across all the environments. One of the ways in which we are now moving in that direction is with the advent of health links. Health links is population-based, it's local and it's getting us there.

We have worked with our partners in social services and housing to increase the value and impact of our investments, and have found that when we plan together, we do better in meeting the needs of our patients.

One thing I'd also like to bring forward is that the LHINs have in place over 1,400 service accountability agreements, and all of these have to be negotiated, brokered, mitigated and monitored. The management of these service accountability agreements is our tool that we use to improve the system.

In an environment where we have seen health care costs decrease from 6% to 2%, the LHINs have successfully been able to work with providers to maintain service. We no longer have a lot of hospitals in deficit budgets, as we go forward. Actually, the Fraser Institute, in their 2013 report, showed that Ontario is second in Canada in terms of overall value and value for money when it comes to health care spending.

Every day, LHINs work with providers to manage service pressures. As regional planners, we carry out this accountability for planning and performance management, and we do so better, I think, than any other iteration of regional entities that pre-existed.

We are transforming the system one day at a time. It's like fixing a bridge while people are still using it. You have to maintain it—while we are also looking at continuous quality improvement in other areas.

I want to thank you again for the opportunity to come and make this presentation on behalf of the LHINs, and now I would welcome your questions.

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

As the committee may have noticed, the bells are ringing, so we have about 20 minutes prior to having to go up to vote. So we'll start with the questioning and use as much time to our advantage as we can. We're starting with the official opposition.

Mrs. Jane McKenna: Thank you so much for coming in with this presentation. I think my first question is, at the very beginning of your introduction, you say you have orders to strengthen it and to enable the LHINs to meet their fullest potential. What do you mean by that? What fullest potential are you looking for, and in what way?

Ms. Camille Orridge: The first recommendation, that primary care is a lynchpin to providing care, particularly to frail seniors or people with complex conditions—currently, primary care is outside of the system and not integrated in our service delivery. By having the accountability agreement with primary care providers, where they work in teams and they can be integrated with other providers, we can then deliver wraparound care for those most in need.

Mrs. Jane McKenna: And how are you going to achieve that? What exactly, strategically, do you have in place to get the primary care where you need it to go?

Ms. Camille Orridge: We do that now by some primary care voluntarily working with us, and health links. For the health links, we have primary care at the table, acute care, CCACs, all of that at the table, and everybody is working together around how we coordinate care. When you can go to the table and hold everybody accountable for a particular outcome—we don't have that authority to hold primary care accountable, to participate and to achieve the common outcome.

Mrs. Jane McKenna: So how do you define "accountability"? It's mentioned so many times in here, the word "accountability," but I sometimes just wonder if that word is just a word that we use. Just for that example of what you just said, what do you specifically mean when you say you hold them accountable for what they're bringing? What does that mean?

Ms. Camille Orridge: I'll give you a concrete example. We have an accountability agreement with the hospitals and with the CCAC. We brought them together and said, "We need to reduce the number of people in hospitals inappropriately so by this number. Now, let's figure this out." Because we have an accountability agreement, we could write in the agreement, "For the funds you have received, these are the deliverables we expect for the population." So they sit together with the LHINs and they then go through—they change their processes. But because it says that you need to achieve this for the dollars you get, there's a different motivation to arrive at that.

Mrs. Jane McKenna: So each one of you—this is a direct question to you. So there are 14 LHINs.

Ms. Camille Orridge: Yes.

Mrs. Jane McKenna: Do you feel that they communicate to one another? Let's say one is stronger in one area than another: Do you feel that they communicate that information for their performance targets?

Ms. Camille Orridge: I think so. Now, all 14 have performance targets. We meet with the ministry at the beginning of the year. We negotiate the targets. The targets are different for different areas, because we're all starting at different places, and then we move towards achieving the target. What's interesting is that even when you achieve the target the next year, because it's continuous improvement, you still want to improve that target. So each LHIN is working with their providers from where they started and moving that agenda.

So I would say yes, each LHIN is moving their performance agenda. We may look different just because we start at different places and have different resources, but we're all involved in continually improving the system for people who live in our communities.

Mrs. Jane McKenna: Being not service providers but system managers, what do you think their best in the last—I'm going to say eight years, as you're saying here. What do you think they've done that is great for the taxpayer that has solidified the system in a better way so that we're moving forward with the patient-centred—

Ms. Camille Orridge: The heavy emphasis on patient engagement, patient experience, looking at the metrics such as the readmission rates, the ALC days: All of those are indicators that we use to bring providers together and to look at whether we are continually improving the system for our residents. I think the LHINs have systematically done that. If we look at wait times, we have seen a decrease there. We have seen a decrease in ALC.

1450

I can give you an example in my own LHIN where we got our stroke scorecard and it was not what we thought was the best. So we, as a LHIN, brought the acute, the rehab and the complex all together and said, "What are we going to do to improve this? Because we've got to do this for the patients." The emergency and the ambulance were there and we fostered that dialogue. It took us about six months. At the end of that process, we had two hospitals voluntarily no longer admitting strokes, because they didn't have the numbers to have an appropriate stroke unit. We saw an expansion in the other stroke unit so that they could then provide better stroke care. They enhanced rehab and we now see dollars moving to the rehab hospitals, because we all know that within seven days you should go, post-stroke, to rehab. That's the kind of work that I would say—across the province, each LHIN may have tackled something different, but step by step, that's the kind of work we're doing to improve patient care.

Mrs. Jane McKenna: To me, the measure of your success should be through the patient, right? Because it's patient-centred.

Ms. Camille Orridge: Yes.

Mrs. Jane McKenna: So where are those measured outcomes from? As an MPP, in my office—and I'll only speak for myself. The system is fragmented. The people are struggling like crazy to get the information that they have. How it's written in here makes it sound like it's a seamless system and that there aren't any problems at all, and I can tell you, from my office, day in and day out, that we have nothing but complaints about how it's a fragmented system.

So I guess my number one question is, if you're measuring your success through the patient, where is that so we can actually see that? Because it's not coming through my office in Burlington.

Ms. Camille Orridge: Two things I would say are: In a system that has over a million people going through it each day, I do agree and will embrace that, yes, there are areas for improvement—absolutely no question about it. We do not yet have one single measure that we can turn to for patient experience. We are now in the process of doing that. We have information like patient satisfaction surveys. We do not yet have a common set of questions across the entire system that everybody asks. We, as the LHIN, are now working with the providers to say, "We now need to work on that together so we can get at one measure that we can all report on consistently."

Mrs. Jane McKenna: Okay. It's eight years. Don't you think that would have come back eight years ago and that would have been your main target and your main goal? I'm kind of curious as to why it's taken eight years to come up with that conclusion.

Ms. Camille Orridge: I would say, yes, LHINs have been—the legislation was passed eight years ago. I would hold us more accountable in the last four years to get to this measure.

What we've done so far is looked at comparative data. We have started to have the data sources from which to gather the information, so we're looking at ICES data neighbourhood by neighbourhood. We're looking at the Picker, which is a common client satisfaction survey that everybody is using. What I would say to you is that the work has started, but it will take another year before we have that measure that everybody can rely on, because we've got to get everybody in the system asking the same question across the system.

If you were to ask each person about their individual hospital, you'd get one answer. But that's not the question we want answered about experience. We want to know about the experience across the entire system, so that's now being lined up across the system.

Mrs. Jane McKenna: I know you say there are 14 LHINs and some are urban and some are rural, but the reality is—I gather that there are different systems in each area. But if I'm a patient, I just want to know, going through the system, that the improvements you're saying you've made as system manager work or don't work. It's very simple. It's not a complicated end result.

Why is it that it's taken so long to get to that end goal? I'm just confused as to why you say that it's the last four years that you've noticed that you've been accountable, but what happened to the four years prior to that? And why is it going to take another year to figure that out? I guess if you're all supposed to be working for the best person, which is the patient, what is taking so long to actually get the proper formula? I just find it totally confusing, if you measure your success by the patient.

Ms. Camille Orridge: Yes, I'm not quite sure how I can answer that question by one simple answer, because health care is complex. The first four years, LHINs were a new organization starting up. As I said, the first was focused on wait times. Those were the priorities.

The patient experience is key. We are now trying to do the measures to do that. We have over 2,000 organizations. We're now trying to make sure that we standardize even the definitions that everybody is using about what you're asking about, about the patient experience. If we were to go today and ask everybody and every patient what does that mean, we would get a different interpretation.

So I totally agree with you—we agree with you—but the work is on the way to do that. I'm sorry, but it's not work that can be done overnight. The definitions are now being done.

I'll give you an example, again, in my LHIN. We have had all the sectors who have come together and have identified the patient experience as their number one priority. They have collectively identified what it is we're going to measure in order to do that. Each sector is beginning to gather that data.

Mrs. Jane McKenna: But you only have one measurement: the patient. This is why it seems very complex and convoluted when we talk about anything else. You only have one measurement, and that's the patient.

I guess my other thing is, for three months, most people in any employment, their probation is three months. You're in eight years. At what point do we realize that maybe it's not the best dollar for the taxpayer if we're still eight years later trying to figure out—and you're just saying that it's going to take another year to get where you need to go to measure the success of the patient. I'm confused.

Ms. Camille Orridge: Yes, and I'm sorry; I'm not sure of the question either. So let me just start. When you're talking about the patient and what the patient needs, the patient needs access—that's one of those measures that the patients have identified that's important. All across the province we have improved access. We have improved access to primary care. We have improved access to emergency departments. We have improved access to home care. So all of those are improvements in measures that the patients have received.

Mrs. Jane McKenna: But where do you get that—I'm just curious, because it's not in Burlington. So I'm trying to figure out where you are getting that data from that you're able to say those three things about access or accessibility. I don't know where you're getting that from. If you don't have surveys out there that are giving you this information, where are you getting that information from?

Ms. Camille Orridge: Where we have that information is the ICES data. ICES—and I can't remember exactly what ICES stands for—gathers data on every admission: the date they're admitted, how long they've waited, and they produce a lot of information, neighbourhood by neighbourhood, of the person's experience through the system.

CIHI, the Canadian information system, also produces information on patients' access to services. It tells you wait times—how long you'll wait for hip, how long you'll wait for knee, how long you'll wait for cataract. Those are all now official, established data points that provide information on access. Each LHIN produces a report card that gives this information.

I could go back, and certainly we'll have that discussion with the LHIN that Burlington sits in, but I am pretty sure that information is available, should be available, that can show how they've improved access, as one measure.

Mrs. Jane McKenna: Okay. So you can ask whoever else is asking—I know the other parties are here that are going to ask questions today. I find it hard to believe that I would be the only person that has this question that I'm asking you. We had Mrs. Cansfield here who brought this up herself, that you don't communicate with each other, that we're going to have a systemic problem anyway because the baby boomers are coming through. We clearly have issues and problems, and the thing that scares me is that if it's taken eight years to get where we are, and you're going to go another year before you can seem to iron things out—as the CEO of all 14 LHINs, I think the thing that worries me even more is that you're having a hard time, I guess, understanding what the question is.

Ms. Camille Orridge: Sorry, I'm the CEO of one LHIN.

Mrs. Jane McKenna: Oh, sorry. I apologize.

My last question will be, if you had legislation and you could change it to your wish list of what you would want to see changed, what would that be?

Ms. Camille Orridge: Going back, we would ask that the service agreements for primary care be included among the service agreements that are managed by the LHINs—for the independent health facilities, that their service agreements be managed by the LHINs, along with those of the hospitals and the community agencies etc.

We would ask that certain functions that were not enacted within the legislation happen. There's a function within the legislation for the French and the aboriginal communities; the French was enacted and the aboriginal wasn't. We're suggesting that that be done.

We're suggesting that the funds be able to be retained from one year to the next so that you can actually implement projects that cross over a year, to better improve client care.

We would be asking that all providers who get government-funded dollars not only be accountable to their individual boards, but have accountability for system planning and participating in improving the overall system.

Those are the major changes that we would ask for.

Mrs. Jane McKenna: Okay. That's it for me.

The Chair (Mr. Ernie Hardeman): Thank you. With that, we will stop there, before we start with the third party, and go to vote. We would ask if the delegation would be so kind as to wait for us to return after the vote,

and we ask the members of the committee to get back here as quickly as we can after the vote, to continue with this deputation.

The committee recessed from 1501 to 1517.

The Chair (Mr. Ernie Hardeman): Now that we have all parties represented, we'll call the committee back to order. We will start with the questions and comments from the third party. Ms. Forster.

Ms. Cindy Forster: Good afternoon.

Ms. Camille Orridge: Hi.

Ms. Cindy Forster: I just want to follow up—at the end, the last question, actually, from Jane McKenna, where you talked about the things you would like to see through your recommendations under the authority of the LHIN. What would health care look like if you had primary care and the other recommendations under the umbrella of the LHIN, in your opinion?

Ms. Camille Orridge: What health care would look like is, for the most complex patients or the patients who use the highest number of services, we would have a system where we could encircle those folks—wrap-around care—get providers working together with one common accountability agreement that they all have to participate in and deliver for that patient. I think we would see improved quality of care, improved access and improved safety. I think we would even end up reducing some of our costs, because some of the costs occur because of things that happen in transitions. That's a smaller number of our folks, but they're the larger users of health care of the highest cost. By having that ability, we would see significantly different—in being able to organize care for those folks.

Ms. Cindy Forster: Have you had any discussions with the OMA with respect to having primary care, under the LHINs?

Ms. Camille Orridge: Not in terms of their accountability under the LHINs, but we have been working closely all across the province with primary care. They're active participants in health links, where we're bringing folks together locally, community by community, to do the work around these populations. So they are at the table. We have incredible primary care engagement on some of these issues going forward. Their service agreements are not currently with the LHINs, but they are at the table.

Ms. Cindy Forster: There was a question asked about targets. Your response was that there aren't any standard targets; that every LHIN is operating based on where they start the year and where they're going. But, surely, there must be some standard targets across each LHIN. There may not be standards with respect to how you're going to reach that target or the amount of time you have to reach it, but there must be standard targets at each LHIN; otherwise, how would you have any equality in access to care?

Ms. Camille Orridge: Yes. For example, provincially, we would say that the number of individuals inappropriately located in a hospital bed is a target—I can't remember exactly what it is, but let's say it's 11%. It shouldn't be any higher than that provincially. That's what everybody is working towards. What I will say is, how you get there will vary because we're all starting at different places. In the north, I think they started at 21% of their beds occupied that way. Clearly, they're not going to reach the 10% at the same rate as Toronto, which was at 12% and is now down to 10%.

That's what I was getting at: that everybody is moving towards some of these common targets, but the rate at which you get there and the issues underlying it vary provincially. We have wait time targets for hips-knees, and I think almost everybody has reached them. We have cataract targets. But we all started at different places, so that's where you'll see the variation.

Ms. Cindy Forster: So there are standard targets, though, across each LHIN, and in addition to that, specific LHINs may have their own targets based on their geography or the people who live in their community.

Ms. Camille Orridge: Yes.

Ms. Cindy Forster: With respect to community care, is there any kind of movement or initiative in place with respect to the personal support workers and the people who are out providing primary care to the most vulnerable people in our communities, to ensure that seniors don't have a different person arriving at their door every day; to make sure that these people have full-time jobs, so that they can work full-time hours for agencies? Do you have any thoughts on how we can improve that sector? We hear about it in our offices every day. I've heard about it from my own mother, who had surgery and had six different people visit her over a period of a week or two. For the most part, what she would hear from the people coming to visit her was that they were part-time; they have to work for a number of agencies; they can't get full-time hours; they're working two or three jobs.

So I just wonder, how is the LHIN and the CCAC that respond to you dealing with that issue?

Ms. Camille Orridge: I think your question has raised two issues, and one is the continuity of care. There's also a table where the LHINs and the CCACs now work together to try to look at, "How do we work together? How do we get these benchmarks?", and continuity of care is one of the issues that's on the table.

Because my previous life was in the CCAC sector, I know that there's a lot of work under way in that sector and a lot of it is being driven by the LHINs about, how do you create teams? One of the things we have to do ourselves, as providers, and get our providers to do—but also work with the public—is that in almost every service we are providing, we should expect to get the care from a team. If you're a frail senior and you need care seven days a week, you're probably not going to get one person seven days a week, but neither should you get one person every day. I know there's work under way about creating teams of people so that the family of the patient would know who the members of their team are. I know—again, an example in downtown Toronto—because density is on our side, we have then also talked about, in certain neighbourhoods where you have a lot of high-rises,

creating a team of workers who then work for everybody in that area, so everybody gets to know who they are etc. That's the kind of work that's under way.

Job security: I think it's another issue. I don't know that I have an answer for that at this time, but I do think and would support that those are the people in the system who really need some focused attention in terms of job security, benefits and pensions.

Ms. Cindy Forster: Thank you.

M^me^ France Gélinas: My question also has to do with primary care. You open up your talk by saying, "The first recommendation is to give the LHINs greater responsibility for managing the accountability for primary care and independent health facilities." I will focus on primary care. You go on to say that "this doesn't mean making changes to how physicians are paid."

LHINs have supported making changes to how every other partner that has accountability agreements with you is paid. Hospitals used to have a global budget. They now pay for procedures; they're now on their HBAM. Why would you make a statement within the first five seconds of being here that says, "But we're not going to look at that"?

Ms. Camille Orridge: Yes, it is true that LHINs enforcing and working through the accountability agreements have gone to things like quality-based procedures. But in doing that, we have not engaged in the income or the cost paid for the nurse, the doctor—any of those individually. Those negotiations take place by different bargaining units, whether it be the OMA, the OHA, SEIU. The LHIN has not stepped into that river. We focus on the service outcome for patients.

The point I was trying to make here is that we would like the primary care physicians to be accountable to deliver care. Where the negotiations take place is not 14 times by each LHIN. It's done centrally, the way it's done now, through the OMA. That's what we were trying to articulate there. We want the accountability for the contracts, to include them in that planning, but not the actual negotiations.

M^me^ France Gélinas: But you realize that that's not what you said. Your opening comment doesn't say this. Your opening comment says that "this doesn't mean making changes to how physicians are paid." That doesn't mean we're going to stay out of union negotiations. You say "this doesn't mean making changes to how physicians are paid."

Right now, you fund community health centres. Are you looking at also funding aboriginal health access centres, community-based family health teams, all family health teams, family health networks, nurse practitioner-led clinics—all of them?

Ms. Camille Orridge: Thank you for allowing me to clarify what was meant about payment for physicians. Yes, all primary care. Community health centres are now accountable within the LHINs.

M^me^ France Gélinas: The only primary care—

Ms. Camille Orridge: That's the only primary care that's currently within the LHINs. All of the other family health teams: They all have contractual agreements with the ministry. We're asking that those agreements be managed by the LHINs.

M^me^ France Gélinas: Why?

Ms. Camille Orridge: Because then, like all the other providers who deliver care, those accountability agreements can be streamlined and we can get common agreements to deliver common outcomes for patients and populations. Right now, we can do that with a large portion of the system, but not all. Yet, for most of the people we see—the aging population—primary care is key and needs to be part of that care plan.

M^me^ France Gélinas: Okay. Then, if it is important for you to be the one negotiating and harmonizing service agreements or accountability agreements with the primary care sector, how come you didn't ask for the same thing for the home care sector? You're not the one who negotiates the contract with the home care sector providers. How come you didn't ask for those?

1530

Ms. Camille Orridge: We fund several of the folks—when you say "home care," what do you mean? The CCAC we fund, we have agreements with, we hold them accountable for delivering of care. For some of the community agencies, we hold those accountability agreements, so those all come together in terms of delivery of the care to the patients.

M^me^ France Gélinas: Yes, but there are many, many contracts out there that you do not negotiate. All of the contracts that the CCACs negotiate are not with you. Why is it that you're asking to negotiate some of the contracts and be in charge of some of them in some parts of the health care system but not in others, and in other parts where you're already there?

Ms. Camille Orridge: So in all of the folks that we have contracts with—like, we have contracts with the hospitals. We do—

M^me^ France Gélinas: I'm talking about home care.

Ms. Camille Orridge: Right. But, as an example—and I'll use home care—we don't hold the contract they have with the oxygen and all of those. They manage all of those contracts to deliver the outcome we ask for. We do the same thing with the community agencies and with the CCACs. So if there's a different question as to whether or not those contracts should be held by the LHIN, we hold those contracts. We see that as holding the CCAC accountable for the delivery, and they, in turn, do that work. So that's why we did not specify that.

But for the primary care, we would like to see primary care being in the fold, just like we have the CCAC and the hospitals and long-term care.

M^me^ France Gélinas: Okay. Why not home care agencies? Why do the home care agencies have to go through an intermediary? Why do they have to go through the CCAC? You already have expertise in negotiating. You've already told us you do 1,400 of them. You want to do more, including all of the IHFs, as well as all of the primary care providers. Why not the home care providers?

Ms. Camille Orridge: At this point, the LHINs, through the legislation, the current legislation, do not do direct delivery of care. We have contracts with the CCAC. They deliver care, and the people they sub-contract with deliver care. So if the notion is that the LHINs should then also deliver those contracts, it's a role we'll gladly do, but it's not one that was in the original legislation, it's not one that we have done, and the model is that there is a separation of the planning and the management function at this time, and not the service delivery. It's been debated, discussed, but a final decision has not been made.

M^me^ France Gélinas: What is your preference?

Ms. Camille Orridge: I don't have a preference from the collective LHINs. My personal preference is that when I look across different jurisdictions, I see jurisdictions where the planning body also delivers services, and I'll see jurisdictions where the planning bodies do not deliver services. I've seen both work and I've seen both fail. My personal preference is more the one where the planning body does not deliver services.

M^me^ France Gélinas: Okay. My question was not to deliver the home care services. My question is: The money goes to the LHIN, the LHIN transfers it to the CCAC, and the CCAC holds the service agreements with a number of home care agencies. You hold service agreements with 1,400 service providers—

Ms. Camille Orridge: Yes.

M^me^ France Gélinas: —why can you not hold those contracts also?

Ms. Camille Orridge: It's possible.

M^me^ France Gélinas: And how come you didn't talk about this before?

Ms. Camille Orridge: Because it was not an agreed—we did not agree that that was a change in the model. The current legislation says to have that separation, and so we did not approach it that way.

M^me^ France Gélinas: Okay. Coming back to primary care, if your recommendation number 1, "The first recommendation is to give the LHINs greater responsibility for ... primary care," so aboriginal health access centres, nurse practitioner-led clinics, the FHNs, the FHGs, the FHOs, all this comes under the LHINs?

Ms. Camille Orridge: Yes.

M^me^ France Gélinas: What happened with the fee-for-service docs?

Ms. Camille Orridge: The fee-for-service physicians, currently—we have now seen about 80% of the physicians in Ontario moving into group practice. We now see all of the new grads moving into group practice. We see a significant decrease in fee-for-service. We do think that there are geographical areas where the fee-for-service docs still exist, mostly in downtown Toronto and some other areas.

I think there's an opportunity that those fee-for-service docs should also have contracts, and the contracts should be managed as part of primary care. There's a difference between us talking about fee-for-service docs and primary care teams. I think we are saying that we would like to see more and more movement, that primary care is all delivered in teams, and that the team has a contract within the LHIN.

M^me^ France Gélinas: I couldn't agree more. But then I come back to your opening statement, and you leave me puzzled as to how you can open up by saying something that, then, you say you don't support when I question you.

Ms. Camille Orridge: I guess I'll try and clarify again. What we are talking about is that we do want those contracts—so thank you for the opportunity to clarify. We do want those contracts. What we were saying we were not asking for was to have that right to negotiate the cost and the salaries. We think that should remain, like so many other negotiations, central, but we do want and are asking for the right to manage all of those agreements.

M^me^ France Gélinas: Okay. I want to talk about another topic that you didn't talk about at all in your report but that we've all raised: There are areas of the province where the LHINs are hated. People have organized together. They've bought the T-shirts. They are beating down the door to come and be heard. They have been wanting to be heard for months; that turns into years that those people have been wanting to be heard. They are not happy with the LHINs. How did we end up there?

Ms. Camille Orridge: I have not had that experience myself, but I have spoken to my colleagues and so I am aware and have some knowledge about the issue.

The LHINs have a unique mandate, and it is that we have to listen to our communities. This perspective from our communities is really invaluable to understand the system, how it's designed and how we provide care. We do listen carefully, and we have certainly learned from the Ombudsman's report and the auditor's report where that has not occurred in the past, and all LHINs have reviewed that and learned from that, and we are all listening. The information we gather from our community engagement helps us to solve problems.

But in addition to bringing the patient perspective to health care planning, we also have a responsibility as system managers to advance the mandate of the government. This often involves difficult choices. We also have to manage things such as safety and quality, and sometimes those also mean difficult choices.

M^me^ France Gélinas: Let me give you an example: You go into a community where the community gets together, you put in a ton of work, and the community decides that the best way to overcome those barriers to access to primary care for a community is to have a community health centre. The ministry has a position that there's not going to be funding for new community health centres. So you have a responsibility to advance the mandate of the government, which is no new community health centres, and you have a responsibility to listen to the people you are there to serve. The population has spoken and said that the only way to give access to this particular community is to look at putting together a community health centre. How do you handle your

responsibility to listen to the people who you are there to serve versus the government agenda?

Ms. Camille Orridge: I would say we do that every day, and each LHIN does that in a number of ways. One is that we would certainly listen to what the community says. We would take that to the powers that be and say, "There is an issue here. This community needs access to primary care. If it's not a community health centre"—I'm not sure why that decision was made—"what else are we going to do, because we still have to provide access"—and through that, would then hopefully work through and negotiate to get what is required in the community, which is access to primary care. I wouldn't commit that it would end up being a community health centre, but we should still be working to get what is required, which is access to primary care.

1540

So that's the role we play, as LHINs, all the time in trying to bridge those gaps and bring those sides together and find solutions.

M^me^ France Gélinas: Interesting. To those people who are very unhappy with some of your colleagues, what do you recommend we do? How do we bring those people back on board when people campaign to make sure that Ontario gets rid of the LHINs because they are not happy with the work that they have done? They have been wanting to be heard for a long time; nobody has listened to them. We're about to embark. I guarantee you, we will hear it loud and clear. How would you respond to those people?

Ms. Camille Orridge: I would say that health care is fraught with tough decisions, and the LHINs' work is to listen and to make that happen.

I would also say that I'm not sure, I don't have any information, that that feeling of dislike, anger—T-shirts—is across all the province.

M^me^ France Gélinas: No, it's not; it's in pockets.

Ms. Camille Orridge: It's in pockets. I would say, then, to go through a structural change where you then refocus resources, all of those things, to address that issue may not be the appropriate way to go. However, I think there needs to be, where those issues still exist, an all-out effort now to bring all the sides together, to say, "How do we work through this and pass this?" There will always be difficult issues that need to be worked through, and I'm not sure we can always change structure because of that each time.

M^me^ France Gélinas: Why do you figure this has not been done in the last three years?

Ms. Camille Orridge: I don't know, specifically, where it hasn't been done. I know, specifically—

M^me^ France Gélinas: Do you want me to give you an example? There are people in the Niagara Peninsula who are so angry that they have bought yellow T-shirts; they are waiting for us; they will be there by the hundreds. They've tried to go to their LHINs; their LHINs were closed. The meeting rooms were not adequate; they would not listen to them. By the time they finally got a hearing, the decision was already made. They're not happy.

The value you add is to give people a voice. If you don't give people a voice but you take your direction from above, from the ministry, and you implement what the ministry wanted—the ministry doesn't need you to have our wishes put on the ground. The minister is the minister, and it goes as she sees fit. What is the value of the LHINs in their eyes?

Ms. Camille Orridge: I would say that it's—"unfortunate" is too easy a word to say about what has happened in Niagara and how that continues to play out in Niagara. I think all parties involved in that need to try to address that. I would just be concerned that what has happened in Niagara then gets translated to all LHINs across the rest of Ontario. That would be the only concern that I would have. I do think that issue occurred; it needs to be addressed, but I'm not sure that that should then be the sole reason for other action, versus focusing on addressing what is still the outstanding concern.

M^me^ France Gélinas: Another area you didn't touch at all is the boundaries. Do you have any recommendations for us? Some groups will come forward with recommended boundary changes. Is there anything you want us to hear?

Ms. Camille Orridge: Yes. I would say that the question of boundary changes should be discussed if we're hearing that it's impacting patient care. If it's impacting patient care, then, yes, the ministry should bring folks together to come out of this committee and then we should look at it. But I think to change numbers, boundaries, because of some other perception of a number wouldn't be the way to go. But if there are clear areas of concern that have been raised, then yes, I think it should be advised, the ministry should hear it and we should all look at it, and make those decisions based on that.

M^me^ France Gélinas: Given that your primary mandate is to listen to the people you serve, have you heard of any groups that would like boundary changes?

Ms. Camille Orridge: Speaking provincially, there are areas in the province where the boundaries—I have not heard any questions about the boundaries. I have heard the boundary issue predominantly in the GTA and predominantly in two areas of Toronto.

M^me^ France Gélinas: Which are?

Ms. Camille Orridge: Donna Cansfield's geography, where that particular geography is in Etobicoke. I would say, yes, it has been raised. Patient care concerns have been raised and I would say, yes, they need to be raised and they need to be looked at. I don't have a concrete answer on that, but I do think it should be a decision based on patient care and patient flow.

M^me^ France Gélinas: Another area that you don't touch on at all is the French-language service entities that give recommendations to the LHINs. You talk about First Nations, but not about the French-language ones. There are a number of them that have made recommendations to their LHINs, to be completely ignored. There is another group that is not too happy with some of your

members. Any ideas as to how we ended up there, and any idea how we make it better?

Ms. Camille Orridge: Again, for clarification, what I mentioned about the aboriginal was that the legislation—and I don't remember the exact wording, but the legislation talked about enacting services for French and aboriginal. The entities came about through the enactment of the French, but the aboriginal was never enacted. So the point I'm making is that that, too, should be enacted. That's a different question from this one, but I just wanted to clarify why I've mentioned aboriginal but not French.

The French entities certainly have made recommendations. There has been a lot of work, as far as I'm aware, with the LHINs and the French entities in terms of delivering French services. I would like to know more about specifically where those concerns have been raised. It's not something that I'm familiar with or aware of. I know that Toronto Central managed with a French entity for three LHINs, and all the working relationships that I'm aware of are that we meet together all the time, we share things, and all of their recommendations we have been working on. But I think it would be good to hear that to be able to address it.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll now go to the government. Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Ms. Orridge, for coming before us. I know that you're representing all 14, and that's obviously quite a challenge, so thank you for giving us the presentation that you did, drawing from a number of different examples. Trying to transform health care and move to a more community-based way of operating is obviously a very challenging one.

Thank you for making some recommendations. The first one that has attracted some attention is a particularly bold one, I would say. As a physician myself, I know how difficult physicians find change. I'm wondering: In the fact that you are proposing greater responsibility for primary care, have you talked with any of the associations of family health teams? Have you initiated some of these discussions, either as the lead for the 14 or within Toronto?

Ms. Camille Orridge: Yes. Across all the LHINs, a lot of work has gone on in primary care. I can say that South East LHIN was the one that was out in front, doing a lot of work with primary care. The LHIN and family health teams work well together. I know in Guelph that the primary health care team there and the LHIN have worked well together, and they've included other providers like the city, the municipality, in working together.

1550

In downtown Toronto, I can say we have a number of family health teams. Two of our health links are actually led by family health teams: Taddle Creek and one in the east. So there's really good engagement. There are a number of solo docs that we are just now reaching out to engage, and that's a horrendous task.

Each LHIN now has primary care leads, and they go out and are working with primary care physicians.

So a lot of work has been happening between LHINs and primary care, even without this.

Ms. Helena Jaczek: So you do have some allies out there. In other words, there are family health teams that are embracing this opportunity. Is that correct?

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: Could you give us an example of where there has been a barrier? You have been talking a lot about patient care and how it matters if it is impacting the patient. Could you give us an example of where not having this responsibility has been a barrier to good patient care?

Ms. Camille Orridge: An example I would give is in downtown Toronto—and this may happen all across—where, on the books, you would say there are a number of primary care teams and a lot of primary care physicians, but 60% of who they see do not reside here. Therefore, we have pockets of people who do not have access to primary care. I know that's true in the north, and I know that's true elsewhere as well. But people often don't think of that in, say, the downtown.

In beginning to work with the primary health care teams, I can truly say family health teams like St. Mike's, Taddle Creek—when we have met and said, "This is the issue," they have stepped up, and they have started to change their practice to make sure that these people who live in their neighbourhood, and some of which are the most complex, are now being attached. So if we look at patient attachment to primary care, we have had a significant increase in the amount who have been attached to primary care in the last two years.

Ms. Helena Jaczek: As an example, say a person was to go to St. Mike's emergency department for a condition that they're going to be, obviously, discharged, not hospitalized, what you would envisage would be suggesting to that patient that they immediately attach to a family health team. Is that how you would see that—so people don't get lost, as you say?

Ms. Camille Orridge: Yes. What we have in place now is that out of that emergency department, they would call Community Care Connects, which is a program run by the CCAC. Their role is to attempt to make sure they get connected to primary care.

We also have, in the health links, a number of the primary care teams that have made a commitment to admitting these individuals. So we're seeing more and more of these individuals being admitted to primary care through the health links agreements that have been reached.

Ms. Helena Jaczek: That's good to know.

Your second recommendation is related to, essentially, multi-year planning, allowing the LHIN to hold surplus funds. Explain it to me so I'm really clear. You allocate funding from the LHIN to save—let's use the CCAC. At the end of the year, for some reason, the CCAC might not have utilized all of its funds, but they have an idea for some sort of new program the following year. They would reallocate that funding back to you, and you would hold it, pending a new agreement, I presume.

Ms. Camille Orridge: Yes. Right now, at the end of the year, all funds not spent within the year in the community sector go back. But very few initiatives of the kind of change and the change management we want to deliver in the system can really get done in a year, or can start in September and be finished by March. So what we're saying is, if we then are able—and it incents us to generate savings, because, "You know, if I do this and I save this, I can apply this to this project, or I can continue it after April to finish it." That's not feasible now, and that's what we're asking for.

Ms. Helena Jaczek: So your accountability agreements with, say, the CCAC are annual, just one year at a time? How long is the agreement with them?

Ms. Camille Orridge: I'm not 100% sure. I think they're longer than a year, but the funding is annual.

Ms. Helena Jaczek: I would have thought if the agreement was for three years or something, you would want to see a three-year plan. But the intention would be multi-year planning and budgeting accordingly that would fit that?

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: Okay. I would think one might want to tie the agreement to some sort of planning that would allow for that.

Ms. Camille Orridge: Probably, yes.

Ms. Helena Jaczek: Okay, I get the picture.

Your third recommendation—I found this rather cryptic, the way it's worded. Your last sentence was, "While LHINs have had considerable success in collaborative governance in some areas, maintaining collective commitment to system goals can be a challenge." Could you give an example so I can really understand what the issue is?

Ms. Camille Orridge: Most organizations are under the Corporations Act. Under the Corporations Act, if you're a board member, your obligation is to that corporation; so if the budget is short or if you're making a decision, you're making a decision for that corporation. We're saying that's not good enough. You need to be able to do both. You need to be able to say, "No, I also have an obligation to the system." Some of the time there will be tension in those decisions, but you can't just make your decision in that silo, because the impact may be on the rest of the system.

That's where the LHINs have been bringing everybody together to make sure that we understand decisions, and saying, "No, sorry, that will impact this other hospital or impact the community or impact patients, and you can't really do that." Our agreement allows us to say that from a funding point of view, but we would like that to be also part of the governance accountability as well.

Ms. Helena Jaczek: How would you make that work? Are you trying to say that the legislation that we currently have in the act should be changed in some way to require that those service provider boards have a clause in their bylaws or something?

Ms. Camille Orridge: Yes. We have included one that talks about patient engagement, community engagement—asked them to include certain things. We're suggesting that there be some wording that addresses the need to be system players as well.

Ms. Helena Jaczek: Would you have a concrete example where the fact that this isn't right there in writing has impacted on patient care?

Ms. Camille Orridge: I'll give you an example where I know it was the goodwill that made it happen—but goodwill is always about the people at the table at the time, so if that goodwill changes, it would not happen. It's easier to be concrete from a Toronto perspective, but this is happening all across the province.

If I look at the stroke example, when you've got all the hospitals coming together and you look at where the patient went in the ambulance and how many patients a hospital should have in order to have a functioning, well-equipped stroke unit, and you've got a major hospital saying, "We do not have enough of these patients, so we should move this service from this hospital to this one"—and they voluntarily did that—that's not always happening, but some of the time that's what is required. So it happened, but it made us very conscious that if it's not voluntary, even those kinds of good patient safety things don't happen.

Ms. Helena Jaczek: Okay. I understand where you're coming from.

The final recommendation is to reduce the administrative barriers to integration. Does that not connect with your previous—you're saying at the board level you want to have agreement on integration more readily.

1600

Ms. Camille Orridge: It's not all about integration; it's an obligation to be a system player, right?

Ms. Helena Jaczek: Okay.

Ms. Camille Orridge: And system players are not always all about obligation. Sometimes it's about sharing resources. It's about not being able to say, "I offer this program, but I only offer it to my patients versus all the people in the community who need this service."

Ms. Helena Jaczek: That's what you mean by administrative barriers: within the organization, sharing human resources or—

Ms. Camille Orridge: No. That first example is about being a system player. The example of integration is that it has some very set rules and timelines, but as you do this work, after a number of experiences, those don't always play out as efficiently as they could. So we will wait for 60 days because it says 60 days, even though all the parties have already agreed to do something; they've already done the community engagement; they have done everything, but there is a clause that says you must still wait another 60 days. Those are the barriers that we're saying that, after the experience, we should re-look.

Ms. Helena Jaczek: So there are unnecessary delays.

Ms. Camille Orridge: Delays, yes.

Ms. Helena Jaczek: Okay. You have been talking a lot about the patient perspective, and my colleague from Burlington talked a little bit about the whole issue of patient satisfaction and so on. Can you share with us a

little bit about what progress you've made in terms of looking at that aspect?

Ms. Camille Orridge: Yes. The difficulty with answering the question about patient experience as one metric and why it's taking so long is because patient experience is made up of a number of components, such as access—if you can't get access, you're not going to be satisfied. But if you get access and the quality isn't good, you're not going to be satisfied. If it's delivered, but it's not safely done, you're not going to be satisfied. Patient experience is made up of at least six or seven different aspects. We are now gathering the data on each of those, making improvements in each of those, but we have a long list of places that we go to for the information to show that we are making improvements.

For example, we know we have improved on access, and we can provide you with the information that shows access. We are improving attachment to primary care. We have more people now attached to primary care than before. We now have the NRC Picker that collects patient satisfaction from all the various providers. We have surgical efficiency data. Cancer Care Ontario is beginning to generate reports about wait times—wait times for hips, wait times for knees, wait times in the emergency department. All of those data elements have taken time to build and to be in place. So we are moving towards being able to report on patient satisfaction across all of those, but it isn't likely that there will just be one measure to say patients experience. We're saying these are all the things that need to be done for patients to have a good experience. We have made progress in some, some we're just starting, and the data collection also takes a while to happen.

Ms. Helena Jaczek: On page 9 of your presentation, you had a couple of graphs. I presume this is aggregate across the province. Is that correct?

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: So we would be able to get this kind of data from our own LHIN.

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: Okay. What kind of relationship do you have with Cancer Care Ontario? How do your jurisdictions match?

Ms. Camille Orridge: We work with Cancer Care Ontario on a number of fronts. There's one table that brings together the LHINs, Cancer Care Ontario, the OMA, the OHA, and together, we all, then, work at, what are the systems issues and how are we going to work together towards them? So we do work with Cancer Care that way.

We also work with Cancer Care on a number of other initiatives, like dialysis, kidney disease, and so in each of those, we work with them in terms of, what are the deliverables, what are the outcomes they expect, and we work with them on wait times.

Ms. Helena Jaczek: Okay, but there are no accountability agreements going between you and—

Ms. Camille Orridge: Not at this point. We have had conversations about how we do that work together, yes.

Ms. Helena Jaczek: So that's something that could be pending and over time would potentially be worked on.

Ms. Camille Orridge: Yes.

Ms. Helena Jaczek: Okay. My favourite topic, boundaries, as I represent people in the Central LHIN—I think it's very important that you made the point that every day there are hundreds of thousands of people having interaction across the health care system, and we, in our offices, probably just get those complaints. We do get complaints, obviously; we seldom get accolades in our constituency offices. So it may be a small number of issues, but we hear about them.

I would say, from the perspective of the Central LHIN, that there are definitely issues in terms of patient care and the seamlessness which we're all striving for from a patient perspective, when they're hospitalized at a downtown academic health sciences centre or whatever and then they return to Central. This is no secret. I've talked to the CEO of my LHIN and the chair of the board about this kind of issue, and we forward these issues. I was glad to hear you say that there might be some issues around boundaries, particularly in the GTA.

One of our colleagues, the member for Etobicoke Centre—her constituents belong to one of four LHINs, so the boundary issue is very, very important.

If there were a desire to look at something for the GTA, could we count on the LHINs in the GTA to perhaps start looking at what might make for a seamless patient experience?

Ms. Camille Orridge: What I can say is that the CEOs of the GTA LHINs are now meeting monthly, and we are identifying those issues that are cross-border, and we are trying to address them one at a time, because for us, it should be seamless.

An example of two things that have happened—Central LHIN initiated a program around long-stay children needing to leave Bloorview. The accommodations were in Central, but the children were in Bloorview in Toronto. Central initiated the project, led the project; we agreed on it; we cost-shared the funding, and that has occurred.

The MCIT, the mental health—not having mental health services, police, health care services across the city of Toronto. We are doing some work now, co-chaired by—the Toronto Central LHIN asked the police and Toronto East General to co-chair this. They have now designed the program to cover the entire city of Toronto. A portion of it is in North York. We work together as the five LHINs. Toronto Central has funded it; Central, in turn, will pick that up.

So issue by issue, we are starting to work to address those issues. We are very aware of them. I think the boundary issue should come about through—there should be two discussions. One, let's address the issue so that patient care isn't impacted; then, let's look at that and see if and where there should be those changes. But I would separate those two things.

Ms. Helena Jaczek: Certainly, as you get more into the social determinants of health—and I see that, ob-

viously, from your perspective in Toronto, you know how important those are—any of those services are organized at the municipal level, the upper-tier municipal level and York region. So if you're talking supportive housing, if you're talking public health, if you're talking police, the justice system, that is all at the municipal level, which has different boundaries. I'm very glad that that's recognized and you're talking about it.

Ms. Camille Orridge: The other thing I would just like to add is that there is also—because that is really key—a table where the city of Toronto and the five LHINs come together. We're identifying what the issues are for the city of Toronto and saying, "Let's now problem-solve them." So, yes, there's work under way because it's identified as an issue.

1610

Ms. Helena Jaczek: Okay, thank you. I just have one last point. You talked about the data that you use. Essentially, you get your data from CIHI or ICES, the Institute for Clinical Evaluative Sciences. You don't sort of replicate that in-house in each LHIN. Basically, each LHIN is provided with the data required for your geographic area, pretty much, by ICES and CIHI, so there's no duplication; that's what I'm getting at.

Ms. Camille Orridge: No, the LHINs have actually worked well together to reduce—for example, the Toronto Central LHIN manages the IT for all 14. Wherever possible, we do that. When it comes to things like data analysis, Hamilton Health Sciences centre created—I know the acronym; we call them "DI." Toronto Central LHIN goes there, so all of our provider data goes there. We try as much as possible to not duplicate, or to share wherever we can. So no, we don't all build out those things ourselves.

Ms. Helena Jaczek: Thank you.

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

Mr. John Fraser: What's left?

The Chair (Mr. Ernie Hardeman): You have about six minutes left.

Mr. John Fraser: I won't take the full six.

Thank you very much, Ms. Orridge, for coming today and presenting to us. Your presentation has been great; it's very informative.

Most of my experience has been, where I'm from—which is in Ottawa, which is the Champlain LHIN, which is in a bit of an ideal situation. Its geography is right and it kind of fits the model, so it has been a very positive experience, but there are some challenges. What I want to focus on is whether the experience that we have locally is replicating itself, to the best of your understanding, in the province. I know that from a public engagement point of view, our board meetings are held monthly. They're open board meetings. The public is invited. They're actually very well attended by the media. Is that something that happens across the board or is—

Ms. Camille Orridge: All LHIN board meetings are open to the public, all the committee meetings are open to the public, all our information is put up on our website and my quarterly report to the board is posted on the website, so yes. As I mentioned earlier, all LHINs certainly took the auditor's report and looked through it. All the governors and all the boards did, and they made significant changes to ensure that the recommendations were embraced and implemented.

Mr. John Fraser: Would you say it would be a regular practice that boards travel to have their meetings? I know that, within ours, they travel to have their monthly meetings, so they would have them in a different community, say Renfrew or Arnprior.

Ms. Camille Orridge: To my knowledge, they do. I think that Toronto Central would be the only one that doesn't.

Mr. John Fraser: Yes. It would probably be problematic to move around.

There was one thing that you said that struck me, and I wanted you to elaborate on it a bit more. When people are at the table, that's when goodwill happens and when things get done. Again, I know this is the experience that we've had in Ottawa over a number of things, whether it's maternal newborn or hips and knees, where people put aside their interests to make sure that we could succeed in terms of providing better care. I know you gave the example of strokes, which is an excellent example. Are there any other examples that you might be able to point to? I know there's a lot of that. We're talking, in the health care system, about serving 13 million people with hundreds of thousands of providers.

Ms. Camille Orridge: Yes. I know that all the LHINs have engaged in these kinds of initiatives. I know that several LHINs, for example, just did a lot of work around transportation where they brought all of the providers together and have issued common transportation for non-urgent transportation. I know that has occurred. I know that Simcoe has done a lot of work in bringing all the providers together, and they have standardized a lot of the community services. They have streamlined it. The list can go on; we can send that. But every LHIN has a number of those initiatives, both in hospitals as well as in communities.

Mr. John Fraser: Just going back to your first recommendation about primary care, does every LHIN have a primary care lead now?

Ms. Camille Orridge: Yes.

Mr. John Fraser: I know it's relatively new. I think it's in the last year or so that they've been—I know they're identified in Champlain.

Ms. Camille Orridge: Yes.

Mr. John Fraser: Currently, what would their immediate mandate be, just so I understand?

Ms. Camille Orridge: Most of the primary care lead's role is to go out and engage primary care in the LHIN and engage them in the planning and then participating in the move forward about, how do we work together? How do we serve complex clients? What services do you need? What we have heard is that a lot of the primary care physicians need help from the rest of the

system in order to take more complex patients. It's not that they don't want to; it's that they need support.

The primary care leads engage them and then bring them to the table. Then, through health links, we're beginning to provide them with the other supports that they need. But their role is to work with the LHIN and to engage primary care providers.

Mr. John Fraser: The challenge we hear about is GPs who aren't really integrated.

Ms. Camille Orridge: Right.

Mr. John Fraser: They're doing their job. They're doing a great job, but they're not connected to the system.

Ms. Camille Orridge: Right.

Mr. John Fraser: So how do you see gaining that accountability? I think that's the biggest challenge in there. How do you see that working?

Ms. Camille Orridge: I think it's a two-way street. It's not only that these primary care physicians are not engaged in the system; it is that the system itself isn't organized to support them. The example that I gave earlier of a physician in his office with a patient who needs community care but would have to call 30 agencies, that's not a good use of a primary care physician. Now we have one number to call, so he or his secretary only calls once. We need to provide primary care with information. "You have a diabetic who needs diabetic education? Here is where you go."

Mr. John Fraser: So it's an accountability that goes both ways.

Ms. Camille Orridge: It goes both ways. We have to provide primary care with supports as well.

Mr. John Fraser: It's not just simply saying, "Here's what you've got to do for us."

Ms. Camille Orridge: No. We have to get the discharge summary to the primary care physician before the patient arrives after hospitalization. Those are all the things that primary care needs to do a good job.

Mr. John Fraser: It's to come to an agreement on shared responsibility for the patient?

Ms. Camille Orridge: Yes. That's the shared responsibility piece.

Mr. John Fraser: Thank you very much, Ms. Orridge.

The Chair (Mr. Ernie Hardeman): I think that was a very good answer. We'll stop there, and we'll go to the official opposition. Ms. McKenna.

Mrs. Jane McKenna: Hi. I have a first question: As a system manager in a LHIN, can you tell me if one of those job descriptions you have is finding solutions?

Ms. Camille Orridge: I would assume that it is. I don't necessarily personally have to find the solution, but I have to ensure that the solution is created, yes.

Mrs. Jane McKenna: Okay. So that would be just something you would do, or is that part of your job description?

Ms. Camille Orridge: I assume it's part of my job description as the CEO.

Mrs. Jane McKenna: Just picking up off of Ms. Gélinas when she was talking about Niagara: Just so I'm not putting words in your mouth, I just want to know when you said about the LHINs that you were hoping it wouldn't—and I might be wrong, so I just want to reiterate this—or that you didn't want the negativity to go to other LHINs, what did you mean by that?

Ms. Camille Orridge: Let me try to be clear. What I was getting at is, there are 14 LHINs in a large province and a large number of people who access the system. So yes, there's always room for improvement, and there are always going to be issues that aren't quite right. It may not be perfect in health care, and we're always working on continuous improvement.

So yes, there's an issue in Niagara. The issue that surfaced was in Niagara. I'm hoping that we have the opportunity to address that issue in Niagara. What I was trying to get at is that that issue, as significant as it is, not be the only issue that then determines what happens or the functioning or how LHINs performed generally across the province. That's the point I was trying to make. I was not taking away from the issue in Niagara, but I was also trying to say—because the question was, if you're hated there, should LHINs generally be supported? I was trying to make that point.

Mrs. Jane McKenna: A question is then—maybe you can't answer this; that's fine if you can't—if you're solution-driven, why can't we find a solution there in Niagara?

Ms. Camille Orridge: I don't know that we can't. I don't know it enough to be able to say whether we can or we can't. I cannot—I don't know.

Mrs. Jane McKenna: Okay. That's fine. That's all I have.

1620

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

Mrs. Christine Elliott: Thank you, Ms. Orridge, for coming today, and for your presentation. I'm sorry I missed the first part, but I have read the paper. My question relates to the wait times and getting the wait times down in certain areas: hips, knees and cataract surgeries.

I've heard something rather disturbing recently, and I'd really appreciate your comment on it. I've heard from several physicians in this area that they have been told that it has been mandated through the LHINs, and it has been communicated to them through the hospitals that they work out of, that they are to optimize their data and that this has resulted in some reporting of data that is inaccurate. For example, if someone has been waiting for six to eight months for cataract surgery but it actually gets booked two months out, the wait time is reported as being two months rather than six to eight months.

Can you tell me, first of all, if there has been any kind of mandate through the LHIN to optimize data, and secondly, what it means to the LHIN?

Ms. Camille Orridge: I have heard nothing in terms of LHINs instructing anyone to optimize data. What I have known is that as LHINs, as we have been using data

for decision-making, we have asked folks to go back and look at data integrity and ensure that their data is accurate. What we have found during that is that, in a number of areas, the coding was not accurate. I know in one of my LHINs in particular, the way they coded, they did not code palliative care, which meant that when it came to the funding formula, they had lots of patients that they were not capturing. That was not optimizing the data for negative reasons. It was trying to make sure that the data integrity was good. I have not heard or know of anything about optimizing data in any negative way.

Mrs. Christine Elliott: Have you heard from any physicians with respect to any of these issues? Have any concerns been raised to you with respect to wait times generally in these areas?

Ms. Camille Orridge: Not in those, not in the hip, knee, cataracts, no. I've heard about wait times in the super-specialities, like ankle. We took that back as LHINs, and the ministry has responded, and we got some increases in OR times for those services. But I haven't heard anything else about that.

Mrs. Christine Elliott: The other thing that has been said to me by some of the physicians is that they've been told by the hospitals that if they make any complaints, their volumes will be cut. Have you heard anything about that?

Ms. Camille Orridge: No. That would be a—no. And I will ask my colleagues. It has not come up at any of our tables that that is an issue, and we meet regularly and raise issues regularly. That has not been raised.

Mrs. Christine Elliott: So this is obviously a matter of concern because it affects the credibility of the data, if it's true.

Ms. Camille Orridge: Sure, so—

Mrs. Christine Elliott: What would you recommend the physicians do if they are concerned about this?

Ms. Camille Orridge: Normally and in the past when these kinds of issues emerged, what the physicians would do, and what I would expect them to continue to do is, they would have taken it to the OMA, they would have taken it to the LHINs, they would have taken it to the hospitals, and the issue would be addressed. They have multiple places in which to take those issues.

I would welcome physicians getting back to us to say, "These are the issues." I have not heard it. As I said, my colleagues have not raised it at our monthly meetings, but I will raise it.

Mrs. Christine Elliott: Well thank you, and I'll certainly let those people know who have been raising those concerns with me.

Ms. Camille Orridge: Yes, I would certainly welcome hearing that.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Ernie Hardeman): That's it? No further questions? If not, well, thank you very much for your presentation—very informative. We look forward to the committee digesting all that information.

Ms. Camille Orridge: Thank you.

SOUTH EAST LOCAL HEALTH INTEGRATION NETWORK

WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK

The Chair (Mr. Ernie Hardeman): Our next presentation is a dual presentation from the South East Local Health Integration Network and the Waterloo Wellington Local Health Integration Network, Paul Huras and Joan Fisk. Paul is the chief executive officer of the South East LHIN, and Joan Fisk is the chair of the Waterloo Wellington LHIN.

Paul, welcome. It's good to see you again. It was quite a while ago you were head of the—what was it, the health council?

Mr. Paul Huras: The Thames Valley District Health Council.

The Chair (Mr. Ernie Hardeman): Thames Valley. I knew it was something like that. It's good to see you again.

Mr. Paul Huras: I read a nice article about you in the paper, in the London Free Press, on Saturday.

The Chair (Mr. Ernie Hardeman): That's right. The only reason it only appeared once: I couldn't afford it a second time. But thank you very much.

As previously, we give you half an hour to make a presentation. You can use any or all of that. We will then divide the time that's left equally between the three caucuses for asking questions. Normally, they get a set time, but we're going to be short of time, so when you're finished with your presentation, I will then decide as to how we divide the remaining time. Thank you both very much for being here. The floor is yours.

Mr. Paul Huras: Great. Thank you very much. First of all, thanks very much for the opportunity to speak with you about LHSIA and the local health integration networks. You have an important and demanding job, but I know you take these responsibilities seriously, and I trust and truly respect each of you in your commitment to improve this important legislation. I hope you find my insights contribute to your task.

My experience includes working in health research centres, district health councils, hospitals and community care access centres prior to my role in building the LHIN model for over eight years now. I am speaking to you about my own experience in the South East LHIN, but also from a provincial perspective on the LHIN role and the success of the Ontario model, as one of the original LHIN CEOs who has been here since the beginning.

With a significant decrease in bureaucracy, local health integration networks have led improvements in health care performance across their regions and together across the province. Specifically, access to care has greatly improved. The Canadian Institute for Health Information reports Ontario is the only province to reduce wait times. In the South East, because of new programs, such as the short-stay unit that we implemented at Hotel Dieu Hospital, and our role in a better way to do allocation and in-year re-allocation of volumes, people in the

South East wait seven months less for hip and knee replacement surgery: 140 days now instead of 380 days in the past. Those are numbers, but what's important is that's seven months pain-free.

More people have a family doctor. Because of the introduction of Health Care Connect through the province, in the South East, 96% of the population report they have a family doctor compared to 80% before the LHINs. Health Care Connect, in fact, was an idea generated in the South East from engagement with local primary care physicians, which has now been rolled out provincially.

More seniors are able to delay hospital admissions, delay moving into long-term care and return home sooner from the ER. Because of programs like SMILE—that's Seniors Managing Independent Living Easily—designed by local seniors and developed by the South East Local Health Integration Network, and programs like Home First, first developed at the Mississauga Halton LHIN and now adopted by all LHINs, emergency visits by seniors decreased, alternate-level-of-care patients are more appropriately placed and wait times from the community to long-term-care homes have been reduced in the South East.

The cost curve is bending, and hospitals are balanced as a result of the management by LHINs of their accountability agreements. These agreements allow us to intervene if financial or program performance is not what is expected. Because of the service accountability agreements, the South East hospitals are balanced, even though there have been decreases to the funding to five of our seven hospitals as a result of the new health system funding reform.

In addition, in the South East, we have initiated the financial turnaround of several health services providers, including hospitals, requiring performance improvement plans, or PIPs. We don't believe it's acceptable for someone who is a health care leader today to say, "I have a problem. We need more money." We, in fact, have changed the culture.

The administration of health care has become more efficient. Because of the work of the South East LHIN, over 40 community care providers utilize a common system for payroll, financial reporting, maintenance of enabling technologies and human resource services. The seven hospitals in our LHIN have a single benefit plan. They have developed 3SO, which is a common supply chain management system. They have just committed to pursue a single computer platform and have contracted for a single non-urgent transportation system.

1630

For the first time in Ontario, as a result of the LHINs, we are measuring health care performance. We are setting targets based on these measurements, and we're actually achieving results.

LHINs are developing plans which are based on patient experience. In the South East LHIN, our addictions and mental health redesign is based on the client and the family experience. It is changing the way we think services should be delivered: shifting from episodic care to providing support where necessary during the client's life journey and linking more closely with providers outside of health care, like housing and social services.

These are just a few examples of how we have been able to make a difference in the South East. Similar stories could be told across the province of LHINs improving access, improving services and making health care more efficient.

The Ontario model of health care devolution: I want to talk about that for a moment. Devolution of health care decision-making to regional entities has occurred in every province in Canada, even Alberta. Alberta had it, and then they changed it dramatically, but it's still considered devolved decision-making. What is unique about the LHIN model is the alignment of priorities and accountabilities throughout the province. Devolution should not mean every region does what it wants. In Ontario, it means the Ministry of Health and Long-Term Care sets provincial priorities and holds the LHINs accountable for improvement through the ministry-LHIN performance agreement.

The LHIN takes those provincial priorities and adds local priorities based on the unique needs of its population. It holds the health service providers accountable through service accountability agreements, H-SAAs, M-SAAs and L-SAAs. Health service providers then use these priorities for their programs and staff and hold them accountable.

In Ontario, there is alignment from the minister right to the front line. In Alberta, I understand that was not the case when they had, last, nine regional health authorities. I've been told by the deputy minister in Alberta at the time that, because of the severe lack of alignment, that province made the drastic changes that it's struggling with today.

Another thing that makes Ontario different from most other systems is that we continue to have independent health service providers with their own boards of directors. I believe this makes our system stronger and more innovative. But it means that we need all of these providers working together and thinking like a system.

LHINs are committed to improving access to high-quality care through the development of regional systems of integrated care. In the South East, we provide $1.1 billion to 124 different health service providers and their programs. The service providers and their staff who deliver these programs are dedicated, hard-working and innovative people. But for the most part, these organizations have worked independent of other organizations.

LHINs are demanding regional thinking, and we are seeing system leaders emerging. These leaders are realizing that (1) working as a system has more to offer a patient than any one organization can offer itself, and (2) only when an organization works together with other organizations, pursuing a common vision and resolving variations in care protocols, can they truly be responsive to the needs of the patient.

Like all regionalized health care models, there will always be questions about the number and the size of

regions. Although some call for fewer LHINs, some call for more LHINs. On average, LHINs serve roughly 900,000 people per LHIN. That is more, on average, compared to any regional health authority except the Alberta model.

Although some say the borders are not perfect, the reality is that no border division can be perfect: When you have a near-perfect referral pattern for an area such as cardiovascular health, you probably have a very imperfect border for addictions and mental health and other services. What's perfect in one area may not be perfect in another area. The LHIN borders were developed based on the analysis by the Institute for Clinical Evaluative Sciences of the referral patterns in the province. For example, in the South East, 96% of the residents in the South East receive their care from providers in the South East, making it very self-sufficient. It may not be a perfect boundary, but it would be hard to beat.

I have been told by regional health authority CEOs that when they have revised their boundaries, they have seen significant disruption in their care delivery post-realignment. My point is that I believe boundary changes don't achieve much, and they take energy and commitment away from patient improvement.

Roles of LHINs: Local governance is central to the LHIN model. Our board members are part of our community, and they engage with health service provider boards to promote regional thinking and integration.

LHINs are governed by a nine-member board, as you know, appointed by orders in council and accountable for oversight of the LHIN's operations and for engaging health services provider boards. LHIN board members are appointed based on the skills they bring to the table.

LHINs are health system managers. As system managers, LHINs rarely need to dig into the day-to-day operations of a particular organization. Instead, LHINs are able to focus on the system to improve performance and access to high-quality care. This allows us to focus on our mandates, which include local health system planning, integration, funding, accountability and performance, and community engagement. I'll talk about each of those in a bit.

LHINs lead local health system planning. LHINs conduct local planning using detailed quantitative analysis and qualitative analysis. In the South East, for example, our quantitative analysis includes looking at seven to 15 sub-regions in the LHIN, breaking the data down by age, sex and other factors. We develop population projections, we apply health service utilization rates to these projections, where available, and we also apply prevalence and incidence rates to determine future demand. We then analyze current capacity and potential capacity which could be achieved through system integration or clinical innovation.

Our qualitative analysis brings in the community perspective through community engagement to put the data in context and to understand what is working well, what is not working well and what improvements are necessary. Some of the things we do in the South East to engage our communities include citizen panels, open houses, web-based workbooks, web-based surveys and community development planning processes, as well as health service provider engagement.

LHINs promote and lead integration. Integration is about health service providers developing partnerships and agreements to ensure their component parts work together to meet the needs of patients.

LHSIA defines integration, including facilitated and voluntary integration, as well as the LHINs' role in supporting and driving integration. This includes horizontal integrations, or partnerships between providers in the same sector; hospital to hospital, such as the seven hospitals in the South East working together as a regional system of integrated hospital care with clear roles to achieve coordinated on-call coverage, common transfer protocols and repatriation procedures, common medical human resource planning, recruitment and credentialing. All those are what we are striving for in the South East. Also vertical integration, or partnerships between providers in different sectors, within sub-LHIN geographies: These partnerships are linking hospitals with CCACs, addiction and mental health providers, long-term-care homes, primary care and community support services.

We also have the responsibility of funding. LHINs allocate over $24 billion in yearly operating funds, with nearly 2,000 service accountability agreements. The South East LHIN alone has the responsibility to allocate $1.1 billion, with over 100 service accountability agreements.

LHINs allocate new funds, such as the 4% community sector increase, which goes to selected health service providers to address provincial and local priorities. LHINs also reallocate community sector projected surpluses to ensure maximum value of the LHIN-specific envelope. The South East LHIN sends out close to 1,000 funding letters each year.

Accountability for performance: All LHINs negotiate service accountability agreements with each of their providers. This is one of many examples where we work together provincially. LHINs work together and with our sector partners provincially to achieve a common template and schedules, including common measurement indicators. There is one for each sector: hospitals, long-term care and the community sector. These agreements are then executed regionally, where we work locally to achieve specific details for the schedules, including health-service-provider-specific performance targets.

LHINs constantly monitor performance of our providers, and when a provider is failing to perform, we analyze the problems and work with them to address them. If performance continues to be an issue, the LHINs approve a performance improvement plan and conduct quarterly or monthly reviews.

LHINs engage our communities. Every year, across the province's LHINs, thousands of people are engaged in discussions about services in their communities, what is working and where we can improve. Each LHIN en-

gaged thousands of people from the general public annually. Each LHIN engaged hundreds of patients annually and hundreds of providers monthly.

1640

In the South East, we engaged around 1,000 residents to inform our hospitals' clinical services roadmap. Our most recent Integrated Health Service Plan included web surveys, where people would actually get on the web and spend 15 minutes to complete a workbook. Sometimes they would complete seven workbooks on different services at 15 minutes each. Sometimes they were completing these at 2 o'clock in the morning. People said, "That won't match your demographics." In fact, it did. When we looked at the demographics of the people who completed these workbooks, they matched the demographics of our region. During the development of our addictions and mental health design, we have engaged an additional 600 individuals, close to 250 of whom were clients and families.

Community engagement is one of our core values. LHINs have worked together to develop a common community engagement guideline and a common decision-making and priority-setting framework that reinforces the importance of engagement to ensure transparency and improve satisfaction. I believe that engagement has resulted in better decision-making about adjustments, improvement, development and funding.

Now to talk about transformational change: Given the growing demands on our health care system, all LHINs are focused on transformational change. Transformation is required today because of two key environmental factors: (1) today's economic reality and (2) the patient of today.

Today's economic reality: Health care is fortunate to have 2% of the annual budget increase, but this is much different than the 6% to 12% that health care has been used to in the past. The 2% is actually 0% for hospitals (much less for the South East hospitals) and 4% for the community.

Today's patient is very different than the patient for whom the system was originally designed. Our health system was designed for the patient who had an acute episode. It was built around hospitals and an assumption that after their hospital stay, the patient returned to full independence at home. But the reality is that most care is provided in the community. When we think of today's patient, they may be suffering from multiple chronic conditions, which they will have for life and for which they require a care plan involving multiple care providers working in sync to wrap care around the patient.

These two realities are demanding completely new ways of working. I'd like to highlight a few examples of the transformational change under way in LHINs today. The first one I'll talk about is quality. The Excellent Care for All Act has been instrumental in focusing every part of the system on the quality care that we deliver. It requires health service providers to develop quality improvement plans, beginning with hospitals, the CCACs and now also primary care. LHINs review these plans. Additionally, we know from our engagement of patients and the public that, generally, people are pleased with the quality they receive from their health professional, such as their doctor or their nurse; generally, people are pleased with the quality of care they receive from their health care organization, such as the hospital, a CCAC, long-term care etc.; but, generally, people are not pleased with the quality they receive from the system. They reference a lack of information transferred from one provider to the next prior to their visit, lack of medication reconciliation, lack of timely test results and having to repeat their story. Integration of services is and will continue to have a huge impact on improving quality care, while producing greater value for the same level of funding.

The health services funding reform: Funding hospitals based on a single common economic adjustment was archaic and perpetuated inequities. The new funding formula will contribute to equity across the hospitals by funding hospitals based on a 30% allocation for global budget, 40% for the uniqueness of the catchment population using the health-based allocation methodology—typically called HBAM—and price points and volumes for selected quality-based procedures, such as hips, knees, cataracts and kidney procedures. This means some hospitals will have increases to their funding, and some hospitals will lose funding based on redefining fair share. We estimate that the South East hospitals will actually lose between $30 and $40 million post mitigation.

More importantly, however, the new approach to funding hospitals is complemented with a new approach to building capacity in the community sector. The 4% increase to the community sector is program- and priority-specific and not for cost-of-living adjustments. It is being allocated to organizations which can assist higher complexity patients to come home earlier and stay home.

I believe that funding reform will actually strengthen hospitals over time by allowing them to focus on acute care services and giving us better information that links together quality and costs.

Health links: The LHIN model does not currently include all of primary care, only Ontario's 108 community health centres. Health links, which I know Camille spoke about earlier, are giving us new ways to engage primary care providers. Health links are accountable to LHINs and are being implemented by LHINs across Ontario.

Health links were designed to link health service providers together in small geographic areas to share resources to better meet the needs of patients. In the first instance, they will focus on patients with complex conditions, but eventually, health links will serve all types of patients.

Health links include primary care: Now primary care is on the same level as other health service providers in the determination of how best the providers, together, can meet the needs of individual complex patients. By bringing primary care to the table and by making all providers

in the local geography accountable, I believe health links are truly transformational. The model will build on the model developed provincially by the LHINs.

Soon the entire province will be covered by health links. Since they were launched, there are now 35 health links approved, and the goal is to have between 70 and 90. The South East has seven approved health links covering its entire geography. These health links will ensure patients discharged from hospitals will have primary care appointments made within 24 hours, medication reconciliation, coordinated care plans etc. They will be evaluated on 11 different criteria.

Health links now allow LHINs to indirectly invest in primary care providers that are members. Since health links are accountable to LHINs, LHINs can identify community sector priorities, ask health links to submit proposals and allocate funds to those health links which show the ability to perform.

Opportunities to improve LHSIA: As someone who has been with the LHINs from the beginning, I can say that I believe LHSIA is an important piece of legislation and has contributed to improvements in health care delivery over the past eight years. As you consider your recommendations, I hope that you will see the importance of maintaining the LHINs' strong regional population perspective, our flexibility for locally driven solutions and our commitment to community engagement.

But LHINs also see some improvements that could improve value: primary care, specifically. Regardless of the gains we are seeing from health links, all primary care needs to be accountable to the LHINs. If full integration is to be achieved, primary care cannot be left out. They play an essential role for patients and clients to help navigate the system, and they need to be part of our planning and accountability structure.

This does not mean making changes to how physicians are paid. Physician compensation remains the purview of the Ministry of Health and Long-Term Care. Billings would continue to be through OHIP, and I believe that's the case in all regional health authorities.

Independent health facilities: Independent health facilities provide community clinics. These clinics can help lessen the demand on hospitals in a more cost-effective way and improve access to services locally and in the community. As part of the health system, they need to be accountable to the LHINs so that we can ensure these clinics are contributing to improved access and delivering value for money.

Defining health service provider responsibilities to the system: As I said earlier, many health service providers see their responsibilities as primarily to their organization. LHSIA requires providers to engage the public and participate in integrations, but boards need to see themselves as part of a true system of care. Provider boards need to have responsibilities to the system as well as their own organization.

More flexibility to allocate funds: There are some provisions in LHSIA today that haven't been acted on and that have the potential to benefit the system. One of these is greater flexibility to utilize projected surplus funds. Allowing LHINs to utilize and to retain surpluses into the next fiscal year would give us a better ability to fund larger and multi-year change initiatives that benefit the patients.

1650

In summary, LHSIA has taken the new model of health care devolution in Canada—Ontario's LHINs—off on a great start to improving health care in the province. In fact, I have been told by regional health authority CEOs that it is time for them to start paying more attention to LHINs as they are achieving results that have escaped their grasp. LHINs have proven the models work and work well.

This review of LHSIA is timely. Like all new systems, the model should be reviewed and improved as we evolve and grow. Ontario needs to continue its leadership in health care improvement. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. Ms. Fisk, do you have a presentation, too?

Ms. Joan Fisk: No; I'm here to support the governance model.

The Chair (Mr. Ernie Hardeman): Oh, very good. I was going to say he did a great job with his presentation, but he used up almost all the time—

Ms. Joan Fisk: Yes.

The Chair (Mr. Ernie Hardeman):—so I didn't know how I was going to share that.

With that, we will have about 20 minutes for each caucus. We will start with the third party. Ms. Fife.

Ms. Catherine Fife: Thank you for the presentation and the overview of the South East LHIN to the standing committee

One question: You've mentioned independent health facilities here on page 9. This is an area that I think we need to be careful and cautious about. One of the trends that has recently come to our attention, not only in Toronto but in southwestern Ontario, is the outsourcing of specialist procedures to community clinics. You reference here that this is a more cost-effective way to deliver services.

The research, from what I've read, and I've read both sides, is that the cost-effectiveness of outsourcing specialist procedures to community clinics is questionable. In particular in our region, gastroenterology is being referenced outside of the hospital setting, which is a concern for us because the farther you get from LHIN oversight, the farther away you get from true accountability, in my estimation. Do you think you can comment on that, please, Paul or Joan?

Mr. Paul Huras: Yes. Just to be clear, Joan and I agreed that I would handle most of the issues related to operations, and Joan would handle questions related to governance.

Ms. Catherine Fife: Sure.

Mr. Paul Huras: I think any system or program has the risk of being inefficient if there aren't certain rules and regulations put in place and accountability agree-

ments. Being part of the LHIN environment, having a service accountability agreement, allows us to ensure that there are performance targets, including volumes agreed to for the price that's allocated. Therefore, we would have the authority to be signing an agreement with an independent health facility to ensure that they achieve this performance and that they achieve it within this budget. If they didn't, then we would go in and review, ask for a performance improvement plan and have the right, in fact, to have the money removed if it continues to be inefficient. So I think bringing them into the LHIN model actually would prevent the problem that you're suggesting could happen.

Ms. Catherine Fife: So you have no concerns of an increased privatization of health care?

Mr. Paul Huras: Well, health care is pretty private in Ontario anyway. It's publicly funded, but the people who deliver it are funded. In long-term care, there certainly is a private sector, as well as the public sector. Again, I believe that the accountability agreements allow us to manage that and manage it appropriately.

The other thing is that I would not want these clinics to be set up without a relationship with the hospital to ensure quality. Because, in many cases, these services could be searchable services, then the quality relationship with the MAC of the local hospital would be important too, and that could be arranged in the same agreement.

Ms. Catherine Fife: Okay. So just to be clear, you're saying that the LHINs would have cost controls placed on these community clinics, as well as quality control and oversight?

Mr. Paul Huras: The quality would be part of the ECFA. Right now we don't have control over quality, but we're trying to improve quality by having system integration, and system integration, we believe, leads to quality. The quality governance, the oversight of the governance, would be achieved by the relationship with the Independent Health Facilities Act with the local hospital.

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

M^me^ France Gélinas: Thank you for coming to Queen's Park.

My first question is kind of—you open by saying, "To begin: With a significant decrease in bureaucracy...." Where does this statement come from?

Mr. Paul Huras: The fact that in the previous system, with district health councils and regional offices of the ministry, it was a true bureaucracy, because neither of those two organizations, which were two layers totalling 16 DHCs and seven regional offices—23 organizations, more staff than what the LHINs currently have, but also, more importantly, it was a reporting relationship. No one made a decision until it was in Toronto. So there were layers of bureaucracy. Decisions are made at the LHIN, so in fact, bureaucracy has decreased.

M^me^ France Gélinas: We are about to embark on a visit to different communities. Some of them have already reached out to us, and one of the things we hear often regarding bureaucracy—we'll take home care—is that the ministry transfers money to the LHINs, the LHINs transfer money to the community care access centre, the community care access centre transfers money to a home care provider, the home care provider often subcontracts to a number of different providers, and then those people pay the PSW barely above minimum wage. This could also be seen as a bureaucracy. How would you counter that?

Mr. Paul Huras: The CCAC we see as a provider. They do provide some direct services, and they do contract for their home care services. The hospital actually contracts with the physicians in a way—I'll put quotations around that, "with their physicians"—to provide surgery. They use that facility, but they also provide surgery, and the surgeons are not employees of the hospital. So there is a type of a contracting relationship. We see the hospital as a service provider. We see the CCAC as a provider.

"Bureaucracy" is sometimes used as a bad word, and sometimes it needs to be seen as a good word. Bureaucracy is similar to management in the private sector, and you do need some degree of management—the four roles of management: planning, organizing, controlling and monitoring. You need that in any type of system, including the health care system. So there will always be some degree of bureaucracy. We should constantly be looking at the size of bureaucracy and if we can run organizations and systems more effectively and efficiently with less bureaucracy. That should be a constant look that we always take.

What I'm saying is that the LHINs have decreased bureaucracy in Ontario's health care system.

M^me^ France Gélinas: And you base that on the number of staff on the payroll, you base that on—

Mr. Paul Huras: The number of staff, the number of levels and specifically the fact that DHCs could not make decisions, regional offices could not make decisions, and it had to go to Toronto to make decisions. That certainly was a bureaucratic process. LHINs make a huge number of decisions before we need to go to the ministry for specific decisions. So, yes, I would say it in fact has decreased bureaucracy.

M^me^ France Gélinas: I was a little bit surprised by the comments you made regarding changing boundaries. You basically saw it as a capital waste of time. How do you balance that with people who feel that they would be better served if the services that they reach out to are part of a single LHIN rather than five different LHINs?

Mr. Paul Huras: It depends, again, on which service it is, because you can draw what may be close to an ideal boundary for cardiovascular surgery, but it's not the ideal boundary for some other type of program. The search for the ideal, the perfect boundary, is elusive. You can fuss and fuss or you can make sure that you work around those problems.

Yes, they do create problems. I believe one of the members is from the Champlain area, and Champlain and the South East have a number of boundary issues that we are trying to work through; in fact, one of our health links covers providers in the Champlain area, and the two LHINs have worked on that.

1700

There should be ways that we can work through those boundaries. I appreciate that, for some people, that is a problem. We need to recognize that and see the best way to deal with it.

M^me^ France Gélinas: If I look on a continuum, you see fussing about boundary change as a capital waste of time, but there could be some little gains. You thought we got it right on the first time with the 14 LHINs, the way we have it now?

Mr. Paul Huras: No, I'm saying that no boundary is perfect. You can spend a lot of time trying to get perfection in boundaries and never achieve it. ICES is one of the most astute system research bodies in the country, and it was their conclusion. But once you settle on it, you need to focus on the things that will really drive improvement to patient care. I think that distracts the focus on improving patient care.

Again, what we've been told from the west, especially regional health authorities in Manitoba, Saskatchewan and British Columbia, is that when they spend time and they actually change boundaries, the words given to me have been, "We throw the system into chaos for a couple of years, and then it settles down again."

I don't think we need that. I think what we need are ways to improve the delivery of health care to our patients.

M^me^ France Gélinas: I'm on page 6 of the version that we have, and another thing that surprised me is that you talked about the 15-minute-long survey that people fill out at 2 o'clock in the morning and how it matched the demographics. What demographics were you looking at?

Mr. Paul Huras: We're looking at basically age structure, so we're looking at the age-sex structure, and it was similar. We did not go in and ask for details on economics, income etc. But on age and sex, it seemed to be a very close match.

M^me^ France Gélinas: Age and sex of the people in your LHIN area, or age and sex of the people who use the health care system?

Mr. Paul Huras: This was to the public, the general public, and this was specifically related to—we did this twice for our clinical services road map and once with our integrated health services plan.

M^me^ France Gélinas: All right. So you have to share your secret with us. The biggest users of health services are usually not the most computer-savvy, so how did you overcome that barrier?

Mr. Paul Huras: We advertised, advertised and advertised about the survey, and we made sure people were aware. We also told them that they could go to libraries and use computers there, and they could come into our office too. They could come into the office and pick up a hard copy if they wanted, or come into our office and use our computer.

M^me^ France Gélinas: How many hard copies did you get, would you say?

Mr. Paul Huras: I'm guessing 7%.

M^me^ France Gélinas: All right. Let's go into the reform that you are looking at, the first one being with primary care. Same question as I asked your colleague before you: What would you see included into primary care for which the LHINs would have responsibility, aside from the community health centres that are already there?

Mr. Paul Huras: There are thousands of primary care entities in this province, and they don't work in a system, and they have difficulty, and they have had difficulty, working with other providers.

Many of these entities—whether they're family health teams, family health organizations, nurse-practitioner-led clinics—in addition to physician compensation, they have additional money. They have money for nurse practitioners, diabetes educators, youth counsellors, but they don't all have the same distribution of that. So some patients may be able to access a primary care provider that has a nurse practitioner, and some patients may not.

If we had primary care accountable for that portion of the money, then we could ensure that they were accountable for being part of the system, for being part of improving access to care, for ensuring that we had 24-hour—maybe not 24-hour, but 18-hour—practice open so that we could have same-day appointments.

When we were building the health links, I had doctors come up to me and say, "Paul, how soon is this going to happen?"

I said, "Well, we need to wait a bit because it's becoming a provincial approach."

They said, "Well, we think we can offer Saturday and Sunday access."

I said, "Go on, no one is talking about that."

And he said, "Well, we can do it. With that many physicians together, we can make an agreement that we will provide that coverage. That would mean being on call maybe once every two months with that many physicians. The thing is, we can build that into an accountability agreement and thereby get more out of primary care."

So it's not physician remuneration; it's about this other amount of money that's available, and we need to hold primary care accountable for that money.

M^me^ France Gélinas: What do you do with fee-for-service physicians?

Mr. Paul Huras: There are fewer and fewer solo practice fee-for-service physicians, and what we did with all our family health teams—as you know, family health teams are not accountable. In the South East, I can tell you what we did with the family health teams. We went to them and said, "Look, we have accountability agreements with community health centres, but we don't have accountability agreements with you. Accountability agreements certainly are about looking at how well you are achieving targets, but it's also about alignment. It's about alignment with priorities etc. That should be of value to you. If we don't have an accountability agreement, how interested would you be in signing a memorandum of understanding?"

And they were; 10 of the 15 signed a memorandum of understanding because they wanted that aligned. We could work with them, even the solo practitioners, and sign memorandums of understanding until such time that we're able to see funding go into these providers.

The other advantage of accountability agreements with primary care—and I apologize for going on—is that we can invest, then, in their organization. We can't invest in any health service provider that doesn't have an accountability agreement. If primary care had an accountability agreement with us, we would be able to invest in it.

M^me^ France Gélinas: What I'm hearing you say—let's say we take the typical FHT. The accountability agreement is for the part—the ministry does not include the part that pays physicians. Are you telling me that what you're looking at is for the accountability agreement only for the part of the FHT that is anything but physicians, that is the other part of the interdisciplinary care, or do you see yourself receiving money from OHIP and then transferring it to the FHT?

Mr. Paul Huras: No, we don't see that. In community health centres, that does happen indirectly because the physician is on salary, but you wouldn't need to do that for the fee-for-service solo practitioner.

M^me^ France Gélinas: No, I mean within a family health team.

Mr. Paul Huras: Within a FHT, you wouldn't need to do that. That money could still be the OHIP money, but the other is a fair amount of money that does allow you to hold the provider accountable for that money and for ensuring that they're focusing on the goals of the LHIN and their priorities.

M^me^ France Gélinas: So the biggest human resource in primary care is physicians, but you would continue to not fund the physician part of the family health teams, family health organizations—FHT, FHO, FHG and all the rest of them, the alphabet soup?

Mr. Paul Huras: Whether it actually would be extremely valuable to do that—I don't believe there's any regional health authority that actually has that responsibility, that actually allocates the physician reimbursement. There are many difficulties with that, in working with the OMA and sorting that out. That could be a long discussion and could be a valuable discussion, but we could act quickly with the other part. You could actually achieve accountability for primary care with the other part and have significant results.

M^me^ France Gélinas: I agree, but you're missing the biggest part.

I want to go before I run out of time because this happened to me last time. The French-language services entities, some of them, are not too happy with their relationship with the LHINs, where they feel, "Why have we got a system where a majority gets to have a veto about what a minority wants and has brought forward?" So at the system level, the LHINs are majority English and they get to veto what the French-language services entity brings forward. Any comments as to the structure of that?

1710

Mr. Paul Huras: In the South East area, we were the last LHIN to have a designated community. When the LHIN started, we did not have a designated community. I think all other LHINs did.

We've been developing that relationship and I think we're developing it in a positive way. It probably isn't as fast as the French-language community would like it, but it is positive and we have a joint action plan. We're progressing and we report on success with that.

I think it's a challenge for all LHINs to make sure that we're meeting the needs of every group. There is a French language act and we often hear people say, "Well, there are greater populations of other groups than the French," and I say, "That doesn't matter. This is an act. We have to respect the act and we have to help the French language. This is part of our heritage." So we do work on that and I think most LHINs do that. It is a challenge because the requirements can be perceived as beyond what is really the expectation.

I don't think the French community in our area expects there to be a French hospital. I don't think the French community in our LHIN expects there to be totally French services. What they expect is that when they come in, they have the opportunity to go back to their mother tongue immediately and that there is a capability to do that, and we're working towards that.

I'm not answering your question, but I'm telling you that in the South East, I believe that we're trying very hard to meet the needs of the French-language community.

M^me^ France Gélinas: I'll agree that you didn't answer my question.

The Chair (Mr. Ernie Hardeman): Thank you very much for the question and for the answer you did give, even though they don't match; we can't do anything about that.

We will go to the government side. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair. I think maybe my colleagues will have some questions as well.

Mr. Huras, you were for many years with the Thames Valley District Health Council, I believe. If you were to say what was the most important thing, in your opinion, that the shift to LHINs has meant for patient care, could you sort of in one sentence convince us that moving from regional offices and district health councils to LHINs—what is the key difference that that's made for patient care?

Mr. Paul Huras: We are much, much more nimble. We are able to move very quickly on making decisions. The DHCs did wonderful work in every part of this province, some in some clinical areas, others in other clinical areas, but every DHC could tell you great stories. But all that great work often led to two years of waiting for a decision, and people's lives and health care were affected by that.

In the LHIN, we were looking at long wait times in the South East, for example, for orthopaedic surgery—very long wait times. We were the third worst in the province,

if not second worst in the province. We looked at ways that we could improve that, including developing a short-stay unit at Hotel Dieu. We were able to turn that around within half a year, and you saw immediate response. We are much more nimble. LHINs are a true devolution. We are achieving results and it's quite gratifying.

I enjoyed my time with the DHC. I learned a lot, worked with some great providers. This is more satisfying.

Ms. Helena Jaczek: So when you say more nimble and quicker decision-making, that's because it's done at the local level, as opposed to waiting for Queen's Park to weigh in?

Mr. Paul Huras: We're not seeking recommendation. We're very aligned. We're not off on our own, doing whatever we want to do. We're aligned with the ministry. We understand the ministry's vision, we understand the ministry's priorities and we work in our area to identify the local uniqueness of our providers and, more importantly, of our patients. That does allow us to really understand the issue and move quickly on decisions.

Ms. Helena Jaczek: In relation to your presentation, you detailed a particular successful program. I guess that's the other piece that we want to hear: What is being done because the LHIN was there that might not have been done before?

You made reference to the SMILE program. Could you maybe tell us a little bit more about that, what it's doing for patient care and why the LHIN was required to make that happen?

Mr. Paul Huras: The ministry identified aging at home funding available, and it was, how do we allocate this money? The purpose is to keep people safe and comfortable at home and to give their families and themselves confidence that they could stay at home.

We could have asked all providers that currently existed to give us a proposal. Instead, we went to seniors and said to them, "What would keep comfortable? What would keep you confident to stay at home? What would your families need to reassure them that you are safe at home?" They gave us this idea, so we built it. It was unique, it was different. We weren't too sure—and we ended up with them calling it SMILE, Seniors Managing Independent Living Easily. It's the use of money for the purpose of keeping them at home.

I'll give an example: a woman living out in the country who can't afford or is struggling with heating bills and uses wood to heat her home. The children say, "Mum's got to go to an emergency department, has got to get into a long-term-care home. We're not having her slip on the sidewalk or the country path to get to the wood. We're not having this. We've got to get her in a home." She's relatively healthy. She's receiving care from the CCAC, so things are pretty good for her, but that service isn't available. We can make money available to someone down the concession road who would come in and bring wood into her home. It's what aging at home money was about, and that's how we're using it.

There are people who get Meals on Wheels, but Meals on Wheels comes at a certain time. There are some ethnic groups who don't eat at 12 noon; they eat at 2 o'clock. This allows a neighbour who has a similar type of ethnic background to provide that.

We did an evaluation, and we actually found that it was improving the life for the patient at home and actually preventing them from visiting the ER and ending up in acute care. Also, it delayed their admission to a long-term-care home.

Interruption.

Ms. Helena Jaczek: Don't worry about the bells you'll get used to it.

Mr. Paul Huras: Thanks.

Ms. Helena Jaczek: Keep going; we're at 24 minutes.

In terms of that program, was that administered through the CCAC?

Mr. Paul Huras: No. The CCAC had an opportunity to take that on. We explained the program. We asked providers to submit on it and actually have the VON delivering that care directly.

Ms. Helena Jaczek: I see. So it was sort of a separate accountability agreement, then, with—

Mr. Paul Huras: We already had an accountability agreement with VON. It had to be one of the providers that we had an accountability agreement with, but it was a different role for them.

Ms. Helena Jaczek: Approximately how many seniors have been part of this SMILE program? I sort of want to get a sense of the size of it.

Mr. Paul Huras: I think it's close to 500.

Ms. Helena Jaczek: I see. Okay.

We've seen some of your recommendations, and obviously they're very similar to Ms. Orridge's, which is not surprising. My colleagues have gone into the primary care issue, which I called bold before; I now call it ambitious, as I think about it. You're not aware of any other province that has expanded the role of the regional health authority like this, correct?

Mr. Paul Huras: No, sorry, a misunderstanding: I was saying that the LHIN didn't need the accountability for the physician compensation, the direct fee or the money that would go for the fee payment. But in regional health authorities, I don't know of any regional health authority that has the fee for physicians actually in it too—

1720

Ms. Helena Jaczek: But they have brought physicians in terms of accountability?

Mr. Paul Huras: Yes.

Ms. Helena Jaczek: Which provinces are those?

Mr. Paul Huras: I think all provinces have the full scope of primary care in their regional health authorities—I'm not sure about all of them, but I know a number of them do. Alberta, for example, does; British Columbia does, is my understanding.

Ms. Helena Jaczek: Do you know how they operationalize that? Do they have accountability agreements?

Mr. Paul Huras: I think primary care is part of the authority, but the actual physician reimbursement—I'm getting out of my knowledge now, so I'm speculating.

Ms. Helena Jaczek: Well, it's always interesting to look at the other models, obviously. I mean, no one wants to necessarily reinvent the wheel, so that will be interesting to hear a little bit more about as we go forward.

However, we do know that some regional health authorities have disbanded hospital boards, as an example.

Mr. Paul Huras: Right.

Ms. Helena Jaczek: Now, you're not making any proposal like that. You are essentially saying that the boards of the service providers that you have accountability agreements with—or at least Ms. Orridge was very specific—need to recognize sort of the authority of the LHIN as it relates to system integration. How do you see this working?

Mr. Paul Huras: I'll defer to Joan.

Ms. Helena Jaczek: Is this one for Ms. Fisk? Okay.

Ms. Joan Fisk: It's an interesting question that you have about governance, because hospitals and all our service providers often have a volunteer board, and it is one that has—

The Chair (Mr. Ernie Hardeman): Could we just move your microphone down a little?

Ms. Joan Fisk: Sorry. Can you hear me better now? I'll come a little closer.

Hospitals and other service providers all have volunteer boards. One of the things that we have done in the Waterloo Wellington LHIN over the last two years since I've become the chair is, we've worked with those boards to have them understand what their accountability agreements actually are. Previous to that, I don't believe that they really understood how they fit in the system; so community engagement is very much part of what we do on the governance side of our communities. And it is getting local perspective when we do hear, on the ground, what their issues are and how they feel about what health service providers are required to do.

Ms. Helena Jaczek: In terms of what you need—so you've had a good dialogue and things are working because they now understand your role better, but is there something in the legislation that you would like to see to ensure that that occurs?

Ms. Joan Fisk: I believe it is in the legislation. They do have this written in the guidelines. It was really more about awareness of what really is their role and what is their responsibility in that particular sense—and also getting them to understand that they're part of a system. It's really an important piece of the communication.

Ms. Helena Jaczek: Mr. Huras, do you have something to add?

Mr. Paul Huras: I was just going to say that when LHINs were first developed, I remember someone speaking to the LHINs—the CEOs and the board chairs from a regional health authority, actually—and they said, "You know, with all these boards in place, I don't know how you're ever going to get anything done." I said at the time, "Well, it may take us a bit longer, but by bringing the boards on"—when you think of it, we've got over 100 organizations, at least 10 board members. We've got all this extra social capital available to us. If we get them on board in making a decision, that's a pretty darn strong decision. It's probably stronger than what regional health authorities can get because anybody can sabotage a decision; but if you get the boards agreeing to this, "Yes, this is the way to go forward," it's very, very strong.

Ms. Helena Jaczek: Okay. Thank you. Now, my board chair for the Central LHIN was kind enough to forward a number of recommendations. One that I was interested in in particular was the role of the health professionals advisory committee, because I believe that is in legislation, that there is a mandatory requirement that a LHIN have such an advisory committee, in essence. In your experience in the South East LHIN, have you found this to be a useful structure, or do you have any recommendations related to it?

Mr. Paul Huras: The structure is useful. We meet every third month, and we do have turnover on it because people are moving to other parts of the province.

But it's advice. Their responsibility is to give the CEO advice that influences decisions. We will speak to them about priorities, about developments, about plans, and get their feedback about how we should look at this from an interdisciplinary perspective, a health professions interdisciplinary approach, and also any advice they would have for us about how to work with the health professions on this particular issue.

I still think we're all sorting out the role of HPAC. The role probably varies in each LHIN, and some LHINs have it meet more often than not. It is an area to be reviewed, I think, and to really look into the value. We have seen value, but I'm not sure if there's not more value that we could obtain from this group.

Ms. Helena Jaczek: How are the members recruited, or how are they chosen, to be on that particular advisory committee?

Mr. Paul Huras: We advertise, but we also shake the bushes, from people who we know in the industry or in those professions, to identify others who might interested in serving in this role. We interview them and explain to them. We'll invite those who are interested to come and observe a meeting, and then they'll help decide whether or not this would be valuable for them.

Ms. Helena Jaczek: As an example, the physicians aren't necessarily the district representatives of the OMA—or someone who, perhaps, has been elected by a body?

Mr. Paul Huras: We heard that interest originally. Our LHIN did not go that way. Yes, we do not have elected representatives.

Now, we do work with some of the elected representatives from the OMA. They have these regional coordinators—I think there are seven of them; so each one has two LHINs that they work with—and we do have discussions with them twice a year, anyway, and those are very valuable discussions. It's not part of HPAC.

Ms. Helena Jaczek: Okay, those are all my questions. Anybody else?

The Chair (Mr. Ernie Hardeman): Mr. Fraser?

Mr. John Fraser: Thank you, Mr. Huras and Ms. Fisk, for coming in today. I do want to comment on your SMILE program. It sounds like something that's the kind of community-based solution that you want to find, that adapts to what local needs are.

I wanted to ask you, just to follow up on the previous presenter, you do have open board meetings?

Mr. Paul Huras: Yes, we do.

Mr. John Fraser: You do. And do you travel as well, too, across your catchment area or do you do it just—

Mr. Paul Huras: We've done that every year except this year, and we're evaluating whether to continue to do that. In some of our communities, we were able to set up the meetings nicely, with contact with a radio station—we might have a pre-interview with our board chair before the meeting—but we still never got a large turnout.

Some of these areas are pretty small. I mean, we're one of the smaller populations. We have 500,000 people and a large geography; we're one of the most rural of any of the southern LHINs. But we never had a huge turnout, so we're looking at that. We probably will state it, but I think it's more related to our communications effort. But people are interested in their hospital very much.

Mr. John Fraser: I've seen the difference in hospitals in an urban area and in a rural area. There's a great affinity there, so people are very connected to it.

How do you manage, from a community perspective, having such a large geography and having such a rural population?

Mr. Paul Huras: We make sure we visit those places. We are there; we're talking to people. We've done a lot of meeting with chambers of commerce and Rotary clubs. We think it's very important.

Health care is very emotional to the general public. Laparoscopic surgery is a great example. If you were a health planner, you would take how long it took to take out your gall bladder—the length of stay was usually seven to 10 days—you multiply that by the age/sex need for gall bladders, you adjust for occupancy, and you come up with a number of beds. All of a sudden, someone comes along and develops a laparoscopic surgery—much better care for the patient, but it also takes that factor of 10 down to one or two. You do the same calculation, and it comes up that you need less beds. You close the beds, and the public gets very upset about that.

1730

We talked to business people. We've explained the pressures of the economy and the pressures of the fact that there's a new patient. We say to the business people, "You need to help us and your local health care providers in explaining this need to the general public," and they get it. They understand that there needs to be transformation and change. Change is scary to the general public. We go out and we talk to everyone who will listen. We get out there. It's a lot of driving, but it's very important, and you learn so much.

We had an engagement session in a rural area, a very rural area—so rural, six people came out, and they said to us, "If we had known a little earlier, the other six people wouldn't have gone to choir practice tonight." It was that type—but we met in this group a homeless person. I know of homelessness in cities; I didn't know of homelessness in rural communities. It was shocking.

We learn so much from those experiences. Sometimes, they're tough on us, but that's okay. Sometimes they give us great insight.

Mr. John Fraser: That's great. I want to ask you a bit about boundaries, because we were talking about that a bit earlier. Again, my experience is that we have very few boundary issues in Champlain LHIN. We obviously have a connection with you. Who else do you have a connection with?

Mr. Paul Huras: Central East—it's actually North East; a little part of us is linked to North East. The biggest issue that we have with Champlain, that we worked very well with, was the leftover from the Health Services Restructuring Commission, the divestment of the Royal Ottawa services that were in Brockville to the South East LHIN.

Mr. John Fraser: I know that was a particularly difficult one, because it was a major transformation.

Mr. Paul Huras: But by working together, the LHIN and the two hospitals solved it. We solved it in a great way, a way that met the needs of the patient. I think we're all proud of that.

Mr. John Fraser: I guess just to the remarks, I understand what you're saying: Boundary changes aren't going to solve things. But just as a piece of advice, if you're in a LHIN where more than 50% of your business is in a boundary, that presents a certain kind of challenge. What advice can you give to somebody who's in that particular situation?

Mr. Paul Huras: I think it's fine to look at them and just be very, very careful of being cavalier in thinking that you're creating the perfect boundary. If your goal is to create the perfect boundary, my argument is that you won't. But if there is a mistake there, if there are some opportunities to change them for the better, then we should be looking at that. I just say we do it with caution and be very respectful of the implications.

Mr. John Fraser: Thank you very much.

Mr. Paul Huras: Thank you.

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

Mrs. Jane McKenna: Thank you so much for coming in with your presentation. My first question is, when you say that you're out driving around all these places, what do you do with the information that you get?

Mr. Paul Huras: As I said, I think we have a very sophisticated quantitative analysis. We always put the quantitative analysis into context with the information that we receive from engagement. It grounds the data. I'm an epidemiologist by training. I believe it's important, once you've done the analysis, to step back and say, "Does this make sense?" By communicating and engaging communities, you're able to do that.

I could give you an example; I'd love to tell this story. We'll have a family member who will phone us and say, "I've got a problem. This has happened; this has happened. My mother has this problem," etc. It's a single patient, and we're not at that level. It would be so easy to say, "We're a system planner and a system manager; we don't really deal with an individual patient," but that's bureaucratic ho-hum that doesn't do any good. So we ask them, "Can you help us understand how the system has failed?" By them explaining it, then we can work with the provider to change the system.

We have examples where this has happened. What we did was, we brought in all the players that potentially could touch this patient, and we had them solve the problem. It was really interesting: All these visible leaders around the room watched as some of the non-visible leaders actually solved the problem. The thing was, they did solve the problem by speaking with each other.

So what the LHIN provided was this opportunity to listen to the problem and turn it into a system issue, which actually improved the life of this patient, the life of this family, but it also ended up with us changing the system so that future patients would have benefitted from the solution.

Mrs. Jane McKenna: Okay. I'm going to ask you again, because I didn't get an answer from you.

Mr. Paul Huras: Sorry.

Mrs. Jane McKenna: Again, what do you do with the data that you go out and drive around all these miles? What do you do—

Mr. Paul Huras: We use that to help make our decisions, but listening to data or listening to input doesn't mean we do everything we're told. If we did that, we would be changing things constantly. As many people tell us one thing, we have people telling us another thing. Listening and engaging does not negate our responsibility to make a decision. We use that information to help put the data in context, and it helps us understand the system and it often helps us make the changes that are good for the system.

Mrs. Jane McKenna: You just said a statement back a bit, a couple of minutes ago, about patients and it's not all about the patients. But as a system manager, don't you measure your success by how your patients are doing?

Mr. Paul Huras: Absolutely.

Mrs. Jane McKenna: Wouldn't that be your number one focal point?

Mr. Paul Huras: Absolutely. But what I'm saying is that some patients will tell us one thing and some patients will tell us the exact opposite.

Mrs. Jane McKenna: I think they're all going to tell you the same thing: how the system was that they went through. Regardless if it was rural or urban, everybody is going through a system that is set up by not a service provider; that you facilitate that as a system manager and if they're not getting through the system properly, there's an issue.

Mr. Paul Huras: Yes. Where that's a common issue, we act on it.

Mrs. Jane McKenna: I agree with Ms. Jaczek when she's saying you only have so many people coming to your office and clearly you're not having all the people come, but I can pretty much say that all of the—the MPPs I've spoken to all have the same similar problem with what we're saying, that the system's fragmented. You're not speaking from one LHIN to the next. The people who have great information are not passing that along and for the eight years, seven years, however long you want to say, there's a lot to be fixed. So—

Mr. Paul Huras: And there's been a lot that has been fixed, yes. You're absolutely right.

Mrs. Jane McKenna: I guess I'd like to see what those things are that you have fixed somewhere, because it just seems that one thing doesn't add up to the next.

My next question to you is, this SMILE program that you have, where do you get the money for that because in Burlington—

Mr. Paul Huras: Aging at Home funding.

Mrs. Jane McKenna: Excuse me?

Mr. Paul Huras: Aging at Home. It was a provincial allocation of money identified as Aging at Home funding.

Mrs. Jane McKenna: Okay. Because in Burlington, and I know other places say the same thing, it's hard enough just to get the basic nursing services for our people who are coming to us. I'm not sure, when you have other things, like Meals on Wheels and all these other things that you have, where that money's coming from in the sense that we're struggling in Burlington with just the basic services for nursing.

I guess my question again is, if you have that money allocated for there, why isn't it allocated for just basic nursing services and other—

Mr. Paul Huras: We've been investing in basic nursing services also.

The Chair (Mr. Ernie Hardeman): If I could just stop there, we have a vote. I have to adjourn the committee for the vote. Hopefully, if the delegates would just wait till we get back, and we ask all the committee members to come back as quickly after the vote as possible so we can conclude.

The committee recessed from 1739 to 1748.

The Chair (Mr. Ernie Hardeman): The committee will come back to order. Thank you all for your indulgence.

With that, we'll turn it back over to the official opposition. Ms. McKenna.

Mrs. Jane McKenna: As I was walking down to vote, I was thinking: You talked about how you were shocked, after eight years of having this position, about rural homelessness. Did you not ever think at any time that there was homelessness everywhere? It's a systemic problem, whether it's urban or rural.

Mr. Paul Huras: This wasn't after eight years. This was the second year into the LHIN development that I saw this. I had not seen homelessness, and I don't think

I'm that unusual; maybe I am. Homelessness is what you see—you don't see homelessness in rural communities unless you're living there.

This individual lived in a shack on the property of somebody else who just ignored it. But the point that he was making was that he didn't have an address; therefore, he didn't have OHIP, and therefore he couldn't get health services. We tried to figure out ways that we could address that.

Mrs. Jane McKenna: Okay, my next point here is that on page 10 here in the summary, you say, "In fact, I have been told by regional health authority CEOs that it is time for them to start paying more attention to LHINs as they are achieving results that have escaped their grasp." Don't you think they know that without having to be told?

Mr. Paul Huras: I think there probably are a lot of CEOs who look at their own environment and aren't scanning the wider jurisdiction all the time. What they were learning was what we were doing with health links, and they thought that was marvelous. They thought the integration that that was bringing at the sub-region level, the vertical integration that that was achieving—they were very, very impressed with it. They said, "We're not achieving this in our areas. We're not achieving that linkage of primary care with others."

Mrs. Jane McKenna: Then on page 7, health services funding formula, who came up with that funding formula?

Mr. Paul Huras: That's a provincial funding formula.

Mrs. Jane McKenna: You have on page 6, then, "I believe that engagement has resulted in better decision-making about service adjustments, improvement, development and funding." How is that? How have they resulted in better decision-making about that?

Mr. Paul Huras: SMILE is a good example. We engaged a lot with primary care physicians from day one, and that has helped us develop this relationship with primary care in the South East. That has had a tremendous input with the actual success we've had with health links. With patients and the general public, with our clinical services roadmap, we've been able to influence our clinicians, who are developing these plans regarding seven clinical areas, and the input of the patient and the patient experience is actually changing the way they're thinking.

Mrs. Christine Elliott: I'd like to thank you both for coming here today and sharing your thoughts with us. I have three questions, which hopefully I'll be able to get in in the time allowed, because we're rapidly running out of time.

My first question deals with the quality issues that you noted on page 7 of your report. You indicated that "generally, people are not pleased with the quality they receive from the system," and they referenced the "lack of medication reconciliation, lack of timely test results, having to repeat their 'story.'"

To me, a lot of that looks like it might be attributable to a lack of electronic medical records, but perhaps you could share with us what your perspective is on that.

Mr. Paul Huras: That's an enabler. Certainly, electronic medical records are a big enabler in health links. We are addressing that. The seven health links have all agreed to a common approach to electronic medical records and the exchange of information. That should enable them, but you still have to get the providers committed to working equally together, not a hierarchy of providers but providers actually working together equally to say, "This is a complex patient. This patient needs this, this and this. How do we do this?"

I don't want a hospital CEO to say, "We've got ALC patients. This is your problem. Get them out of our hospital." We need them working together and finding the way to do this. That's what we're achieving from this. These organizations now are recognizing that together they have an equal role in solving the problems of complex patients, these patients who need all these different components of care. When the system lets them down, it can go bad for the patient very quickly. We're trying to really address that, focus that and turn that around. I think we're starting to make some success.

Mrs. Christine Elliott: But certainly, the lack of progress on this file continues to be a problem in the system.

Mr. Paul Huras: The e-health file specifically, you mean?

Mrs. Christine Elliott: Yes.

Mr. Paul Huras: Yes, but again, there are successes across the province. In the South East, the fact that seven hospitals have agreed to a common platform is big. That's very expensive. One hospital had already made a decision to start going down the road of replacing their system, but as soon as we got to the point where there was agreement about one system, they pulled back and are going to go in a different direction. We will have one platform for the hospitals. Again, the seven health links that we have—it's tremendous that we are going to have a single approach to e-health or enabling technologies for that group too.

Regardless of any problems in the past—Canada has been slow with e-health, but speed is picking up now and we're starting to see it really take off, certainly in the South East and I know in other LHINs too.

Mrs. Christine Elliott: Thank you. My next question relates to the independent health facilities and your comments on page 9 that they need to be accountable to the LHINs. I'm just wondering what you would recommend in that respect. How do they need to be accountable and what are you recommending?

Mr. Paul Huras: I mean that they should be signing service accountability agreements with us, and in those agreements we would put performance indicators and targets. Then, for the funding they would receive, they would achieve those targets.

Every time we send out a funding letter, we put in what is expected for that funding. That didn't use to happen in health care. We've spent billions and billions of dollars in health care in the past, and you could tell you had this many doctors or this many nurses, but you couldn't tell much more than that.

Right now, every time that we send out a dollar, we say, "This is what we expect for it." We'd be able to do that with the independent health facilities and then that really creates them being a part of the system. It would help ensure that we're not just creating—and they exist today, but they wouldn't be outside the system. They'd be in the system in many, many more ways, and we would have this ability to say, "You're not meeting your targets" or "You are meeting your targets." If they're meeting their targets, then we could invest further in them in the future.

Mrs. Christine Elliott: So that would be primarily just by virtue of the contractual arrangement, rather than anything else. Is that correct?

Mr. Paul Huras: The contractual arrangement also identifies very clearly this alignment that I talked about, where they're connected to provincial and regional priorities and they understand those and what is their contribution.

Mrs. Christine Elliott: My final question relates to the wait times issue. You may have been here when I was speaking with Ms. Orridge about the optimization of data issue. Can you tell me if that has been something that you have been dealing with in either one of your LHINs? Has any kind of directive gone out with respect to optimization of data?

Mr. Paul Huras: I heard you ask Camille that. I'm surprised; we are not aware of any of that in Ontario. There are two different pieces of the wait time. There is wait time 1 and wait time 2. One relates from when the referral is made to the specialist and then the procedure is completed, but there's that other wait time in the front end. To really make movements on targets you have to be able to measure, and the first one is more difficult to measure. The second one is the one that was measured. That's where there was a lot of focus and that's where there have been a lot of gains made.

I have not heard, in our LHIN—and we work with the surgeons as well as the chiefs of staff and the CEOS, and we have not heard them coming to us that there has been pressure to change the reporting. I believe that it's done above board and appropriately, so I was surprised to hear you. I don't know what else I can add to that.

Mrs. Christine Elliott: Thank you very much. Did you want to add something?

Ms. Joan Fisk: Thank you very much, Ms. Elliott. I have never heard that optimization issue, but I do thank you for bringing that forward, because I would look, from a governance point of view, to make sure that the data we do get and the ones we make decisions on are the ones that are legitimate and are measuring the wait times we have in Ontario. Thank you for that.

Mrs. Christine Elliott: Thank you very much.

The Acting Chair (Mrs. Jane McKenna): Thank you so much.

For committee business, we'll do it tomorrow if we have time. For December 9, we're going to have the Association of Ontario Health Centres and also the Ontario Federation of Community Mental Health and Addiction Programs.

We're adjourned.

The committee adjourned at 1759.

CONTENTS

Monday 2 December 2013

STANDING COMMITTEE ON SOCIAL POLICY

Chair / Président
Mr. Ernie Hardeman (Oxford PC)

Vice-Chair / Vice-Président
Mr. Ted Chudleigh (Halton PC)

Mr. Bas Balkissoon (Scarborough–Rouge River L)
Mr. Ted Chudleigh (Halton PC)
Mr. Mike Colle (Eglinton–Lawrence L)
Mr. Vic Dhillon (Brampton West / Brampton-Ouest L)
Ms. Cheri DiNovo (Parkdale–High Park ND)
Mr. Ernie Hardeman (Oxford PC)
Mr. Rod Jackson (Barrie PC)
Ms. Helena Jaczek (Oak Ridges–Markham L)
Mr. Paul Miller (Hamilton East–Stoney Creek / Hamilton-Est–Stoney Creek ND)

Substitutions / Membres remplaçants
Mrs. Christine Elliott (Whitby–Oshawa PC)
Ms. Cindy Forster (Welland ND)
Mr. John Fraser (Ottawa South L)
M^{me} France Gélinas (Nickel Belt ND)
Mrs. Jane McKenna (Burlington PC)

Also taking part / Autres participants et participantes
Ms. Catherine Fife (Kitchener–Waterloo ND)

Clerk / Greffière
Ms. Valerie Quioc Lim

Staff / Personnel
Ms. Carrie Hull, research officer,
Research Services