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Lundi 14 avril 2014

Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

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

Chair: Ernie Hardeman
Clerk: Valerie Quioc Lim

Président : Ernie Hardeman
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 14 April 2014

Lundi 14 avril 2014

The committee met at 1402 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

The Chair (Mr. Ernie Hardeman): I call the committee on social policy to order.

Interjections.

The Chair (Mr. Ernie Hardeman): If we could have everyone in the room just pay attention a little bit, we can get started here.

It's the April 14 committee on social policy. 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 the act.

DATA AND TECHNOLOGY SOLUTIONS

The Chair (Mr. Ernie Hardeman): First this afternoon, we have a delegation to make a presentation: Data and Technology Solution, Mr. Jeremy Albisser, principal consultant and owner. If you would take a seat there. We thank you very much for coming in to make a presentation this afternoon. You'll have nine minutes to make your presentation. You can use any or all of that time. At the end of that, we'll have three minutes from each caucus to ask questions and to make comments. With that, the floor is yours, sir.

Mr. Jeremy Albisser: Thank you very much, Mr. Chairperson and Vice-Chair. Thank you for the opportunity to come here and speak with you about the Ontario Local Health System Integration Act and its impact on Ontario integrated health service providers.

To give you a little bit of background, for the last 10 years I've been on the front line between the local health integration networks and the integrated health service providers in the rollout of accountability. When the LHINs asked the integrated health service providers to sign accountability agreements, I'm one of a number of people in performance measurement management and accountability that will interpret that legislation, come up with benchmarks, work with communities, hospitals and the LHIN to come up with targets and benchmarks and negotiate funding.

For the last 10 years, Ontario's integrated health service providers have stepped up to the plate. There are over 1,100 community mental health and community support service agencies across this province that have individual boards of directors responsible to their local clients, patients and families. They have stepped up in the form of providing accountability reporting requirements. They have stepped up in the form of providing quality indicators, performance indicators. They have stepped up in the realm of patient and staff satisfaction surveys.

I know that over the last little while you have all been hearing from a number of those community support services and community mental health and addiction organizations here in the province of Ontario. I can tell you from the data point of view, from somebody who's been analyzing this data for a while, their work is spectacular. It is cost-effective. It is well done. These people are engaging their communities, and they are doing great work.

On the flip side, I am going to read the second page here. I will read the interpretation that most of the integrated health service providers have been using for accountability; I know that there have been a lot of questions in this committee about what accountability is.

For health service providers, for people who provide care to patients on a daily basis, accountability to them means "To have in place the tools, mechanisms, processes, checks and reports necessary to ensure that negotiated targets and benchmarks are met in an equitable, patient/family-centric, evidence-and-quality-driven way, which maximizes the cost effectiveness of the resources placed in our care." The resources placed in their care include the people, technology and funding, and these people have stepped up.

The health system transformation over the last 10 years has been a huge burden on these people—administration costs; cost-of-living adjustments—and the work that they have done has not been acknowledged to the extent that it should.

I remember that at the beginning of the health system transformation the promise was made that, in the rollout of accountability, if health service providers could meet this definition of accountability, the turnaround would be that the government of Ontario—the Ministry of Health—would address funding gaps, would provide equitable access to dollars to ensure that there are consistent levels of care across the province and to ensure that their staff members are taken care of.

For the last little while we've seen hiring freezes. We've seen wage freezes across all of these sectors that have had an impact on their ability to hire and retain

staff. It's had an impact on their ability to prepare for the oncoming seniors crisis. The aging workforce in the community sector and the hospital sector—across all of these sectors—is significantly higher than in the private sector, and there has not been—and is not—the preparedness for the oncoming retirement and increase in boomer health service needs.

I've included a bunch of recommendations that are broad, broadly speaking. You can read through them. Suffice it to say that I've worked and done analysis for the Auditor General for the last SE and accord fundings. I did analysis for the waiting-at-home program for the Mississauga Halton Community Care Access Centre. I've done analysis on program after program in the province of Ontario, and I can tell you that the Ontario health service providers have stepped up. It's time for the Ontario Legislature to step up with the funding that was promised at the beginning of accountability.

I welcome any questions that anybody has.

The Chair (Mr. Ernie Hardeman): Okay. Thank you very much for your presentation. With that, we will start with the official opposition with questions.

Mrs. Jane McKenna: Thank you so much for coming in here today. You've said numerous times in your presentation there that they have stepped up to the accountability. Can you be specific in what they've done to step up?

Mr. Jeremy Albisser: To take one example, when I was working at the Mississauga Halton Community Care Access Centre, the CCAC had been in a deficit position the previous year. The CCAC was placed into what's called a performance improvement plan, and I, as the manager of decision support and research, was responsible for providing our local health integration network with all of the data necessary to ensure that we were meeting the targets of that performance improvement plan.

About 700 indicators were reported over the course of a year. To put that in perspective, the World Bank recently recommended that 600 indicators for managing an entire country's health system is too many, so a CCAC that steps up with 700 data points on a yearly basis, meeting all of their targets and meeting their performance, for example, is them stepping up.

In addition, I don't know how many people have actually read a multi-sector accountability agreement, but there are requirements for patient satisfaction surveys and staff surveys. A large chunk of those surveys are not only done; they're available on each one of the individual health service provider's websites, along with all of their accountability agreements. I would remind you that they've done all of this, in large part, without any increases to administration funding or even increases to base funding.

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Mrs. Jane McKenna: So do you think more money means better service?

Mr. Jeremy Albisser: No. What I think is that for the last 10 years no money has meant decreases in funding with not significant decreases in service. So a service provider that has a zero budget increase over five or 10 years and is still servicing the same number of patients has in fact improved their efficiency significantly.

Mrs. Jane McKenna: You talked numerous times here about evidence-based outcomes. Then you've said here you've got performance improvement plans that are measured. Can we see those measurements?

Mr. Jeremy Albisser: If you go to each one of the integrated health service providers, almost all of them are required to and do post them on their own websites. It is a bit of a hassle to go to each one of the service providers, but there are a lot of service providers out there, so they tend to handle it on an individual basis. Remember, each one of these agencies has an individual board of directors that's responsible to their members, or in large part responsible to their members, and they are very responsive to their members. So the documents are really available to their own members, as opposed to people all the way up in the ministry or in the government. But they are available.

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

Ms. Cindy Forster: Just a couple of questions. I kind of flipped through the first few pages, and if I look at page 3 of 14, it says that in 2012, 65-plus is at 15%, and that it will be at 17% by 2020.

Mr. Jeremy Albisser: Yes, and 20% by 2027.

Ms. Cindy Forster: But when I actually go to the next page, 2013, it says that 65-plus is at 22% already.

Mr. Jeremy Albisser: I'm sorry. This should be 2031.

Ms. Cindy Forster: Oh, 2031. Okay.

Mr. Jeremy Albisser: Yes, 2031. Thank you for bringing that to my attention. I apologize for the mistake.

The other important thing to remember is the X axis there, with the adults, the 15 to 65. There's a significant drop in the available workforce, both for regular health service providers but also in the volunteer community. So if we look at the huge number of volunteer hours that are put in by health service providers, by Meals on Wheels, by delivery people, as the population ages we either need to significantly engage the retired community so they are supporting each other as the senior population becomes older and older or we're going to have significant increases in health care costs.

Ms. Cindy Forster: So you actually are a private company?

Mr. Jeremy Albisser: I'm an individual.

Ms. Cindy Forster: And you actually have done work for the Auditor General in addition to doing work for, I'm assuming, a number of CCACs and LHINs. How many of the 1,100 agencies that you mentioned have you actually done work for, say, in the last five years?

Mr. Jeremy Albisser: I had a two-year contract with the community care eHealth in the rollout of the MIS/OHRS reporting system for community mental health and addictions.

Ms. Cindy Forster: Yes.

Mr. Jeremy Albisser: And during that time was the audit by the Auditor General on the SE and accord funding rollouts that had happened previously. So I've actually analyzed all 400 of the community organizations for the government of Ontario.

Over the last five years, it would be the CCAC, 11 adult day programs, and Baycrest, which I was at for about—

Ms. Cindy Forster: And Baycrest? And what about the LHINs?

Mr. Jeremy Albisser: I've never worked for a LHIN, though I was the last information management analyst in three of the regional offices before they closed down and became the LHINs.

Ms. Cindy Forster: When they were the district health councils?

Mr. Jeremy Albisser: Well, there you had the regional offices and the district health councils. I was in one of the regional offices. The regional office had a staff of about 150 people at its peak, and they would have been replaced by one LHIN.

Ms. Cindy Forster: And what about community health centres and family health teams? Have you done work for them as well?

Mr. Jeremy Albisser: Not directly, no.

Ms. Cindy Forster: Okay. Thank you.

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

Ms. Helena Jaczek: Thank you for coming in.

I'm looking at your recommendations on page 12 of 14. I wonder if you could just tell us a little bit more. You say, "If scarcity breeds innovation, then it's time to commercialize and take advantage of those innovations by providing funding for the adoption, use and sharing of technology and innovation using decisions made at the local level, i.e. BSO." Is that Behavioural Supports Ontario?

Mr. Jeremy Albisser: Yes, when I was at Baycrest, I was on the Behavioural Supports Ontario project, and it's a great idea. We have a significant existing problem and an oncoming problem with dementia and brain degenerative disorders. The problem is, these are really high-resource people that, truthfully, nobody in the world knows what to do with. Behavioural Supports Ontario was a great way of pulling together people from across the province, letting them try entirely different things, and then putting the mechanism in place for them to share it amongst themselves and build on best practices.

This is the kind of program that should be repeated over and over in Ontario for assertive community treatment teams, for addiction programs, for just about anything. If you don't have a solution to a problem, it's a great way to get a lot of people at the table to come up with solutions to the problem.

Ms. Helena Jaczek: In other words, you see the BSO as sort of a model that could be used in other program delivery areas?

Mr. Jeremy Albisser: And internationally. I think that it's one of the many things that—and this goes back to what I was speaking about when it comes to innovation. Ontario is actually leaps and bounds ahead of most other jurisdictions when it comes to assessing, managing and looking at the data for our health system. There is more data available here than there is anywhere else. We don't necessarily use it downstream as much as we do—the accountability all rolls up. Very little of the data comes back down, which is a big problem for community organizations and LHINs, who have limited resources to do detailed analysis, which they need to do. But still, there's more data available here, and the model that we've rolled out where—theoretically, at the board of directors level in the community, funding decisions could be made on things like purchasing iPads, purchasing technology, implementing technology.

For the last 10 years, there has been no innovation in this. The charities will raise their own money. Because it's their own money, they'll make their own decisions. Doing that at a local level really has allowed them to come up with the best practices. What we need to do is figure out how to take those best practices, roll them out to much of Ontario, and then the rest of the world, because they don't know what they're doing either—no better than we do.

The Chair (Mr. Ernie Hardeman): That does conclude the time. We thank you very much for being with us this afternoon to give us insight into your business.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): That's the only delegation we had this afternoon, so with the committee's permission, we'll go in camera to discuss some further report writing issues and other policies.

Ms. Gélinas.

M^me^ France Gélinas: Before we do that, I don't know if we have to do—remember, I had put a motion forward so that we include a review of community care access centres. We had talked about this in camera. Is it time for me to bring it out in non-camera?

The Chair (Mr. Ernie Hardeman): Yes, that's fine. We could do that first, if you'd like. There are some challenges since that one has come forward as to—not that the motion is out of order, but to the people higher up, shall we say, the people in the know, there's a challenge of adding it to that which the House asked the committee to study. The committee has all the rights and privileges to study whatever they wish, but it would be inappropriate to make it part of this report. So we can do this motion and then do it subsequent to the review of the LHINs, or you can, at this point, do as you did before and just leave it in abeyance until—we could still look at some of the parameters of the CCACs that reflect how the LHIN works, but not as part of the total LHIN study. With that, the floor is yours.

M^me^ France Gélinas: I would say I'm quite comfortable with where we have landed, as in, we all agree that through the hearings we heard—many people came forward to us talking not specifically about the LHINs

but talking about CCACs in their jurisdiction. We've all agreed that we will pay attention to what those Ontarians have said to us in order to try to make the system better and that the mandate of this committee is wide enough that we all feel that there would be some recommendations that will be specifically targeted at CCACs—or they could be; we haven't come to recommendations. There could be recommendations.

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As long as the door stays open so that the people who have come to us are respected in the fact that we've heard them, that we will deal with the challenges they have presented to us and that the door is open to this committee to make recommendations that target the community care access centres, then I am quite willing and comfortable just letting this motion sit. I'm not going to pursue it at this point.

We will continue to do our work with the LHIN review as long as it has been confirmed to me that our mandate is broad enough that if we want to address some of the issues that were brought forward, we'll be at liberty to do this, if we all agree.

The Chair (Mr. Ernie Hardeman): Yes, and I guess I'll just put it to the committee. I think that it's appropriate to do as we've been doing. I don't think that the committee, so far, in what we've heard and discussed about the CCACs, would in any way be an impediment to meeting the challenges that were presented to us when the House told us what to do.

Also, to deal with it when we get to that point, I think the question would then be, when we've heard all that we need to hear as it reflects the LHINs, whether a report on that would require a different report and a different process beyond that. You might want to make more recommendations than what you've heard, than what this report would enable. The committee does have a right at any time to call what it is they wish to review and report on to the House, so I think your suggestion would be quite appropriate.

M^me^ France Gélinas: Okay. I'm quite comfortable continuing on the work that we have done.

The Chair (Mr. Ernie Hardeman): Okay. Are there any further comments on that?

Mr. Mike Colle: Yes. I guess we've just got to be clear on that, in that—will we have an addendum or a complementary report that goes as an adjunct to the LHIN report?

M^me^ France Gélinas: No.

Mr. Mike Colle: No? So it all goes—

The Chair (Mr. Ernie Hardeman): No. If, at the end of the process, the committee feels that they wish to address the issues about the CCACs apart from the LHINs, it will require a study and a complete report on the CCACs. That does not mean you cannot look at some of the issues, as we've been doing, about the CCACs—

Mr. Mike Colle: Within our report.

The Chair (Mr. Ernie Hardeman): —within the report. But in order to really deal with them, you would require a totally independent report.

Ms. Helena Jaczek: Exactly. I was just going to say, further to that, that I don't see that there's anything to stop us from making comments on what we heard and the fact that, obviously, CCACs are agencies with which the LHINs have service accountability agreements. Clearly, we can make comment on that. But they are governed under a different act, and I think that's really important. Amendments, if there were to be any to the CCAC act, would have to be in a separate report, but we can always get to that point at some future date.

The Chair (Mr. Ernie Hardeman): Personally, I had a little concern about what we heard at the hearings, the amalgamation of the two boards. I don't know which report that would fit in, because there is no study presently available to us to study either the LHINs or the CCACs for that recommendation, and yet I do believe that at some point the committee should be able to make such a recommendation or recommend against it. That's why I think it's helpful to leave the discussion of how we deal with that second report until we finish this one.

Yes, Ms. Forster?

Ms. Cindy Forster: Yes. My question is to you, Chair. You said at the beginning that some other issues have come to light that may impact our motion. Could you provide a little more detail, or is the detail only that the CCACs fall under different legislation?

The Chair (Mr. Ernie Hardeman): We checked with the Clerks' department, and in fact they believed that the motion to suggest that this could be part of—the motion that we got from the House to review the LHINs, which is a statutory review, does not enable us to add to that. That's why we can study the impacts of what the LHINs are doing, but not study the different things.

The largest consumer of LHIN dollars is the hospitals, so this argument really would become, could we also do a complete review of the hospitals under that direction? And the answer would be no. It's just that we have to keep that in mind, that we're reporting on what the LHINs are doing, and we can look at some of the impacts of what they're doing on the different organizations they're working with.

Ms. Cindy Forster: Well, in some ways, I find that to be very strange. This is the governing body that actually plans health care in this province. It plans health care for hospitals, for long-term care, for community health centres and for all kinds of agencies. To say that we can't delve into that and make recommendations to me seems like, then why bother doing this review? Because those are the agencies that get impacted, and at the end of the day the patients who actually seek care from those agencies are the ones who are ultimately impacted. I think that to draw a line in the sand is not doing Ontarians any justice.

The Chair (Mr. Ernie Hardeman): No, and I would just point out that we're not intending to draw a line in the sand; we're just saying that if we have to go beyond what the motion from the Legislature says, we have a right as a committee to decide to do a full review of the CCACs, but it wouldn't be part of what they asked us to do, so it would be a separate entity.

M^me^ France Gélinas: Okay. I don't like word-smithing, but I want to be clear, and that will be to the Clerk. For the Clerk, is the mandate of the committee written in such a way that if our recommendations fell outside of this particular bill, then we could not make such a recommendation?

The Clerk of the Committee (Ms. Valerie Quioc Lim): Because the House is specific in that we're looking at the Local Health System Integration Act—and in the motion, it does say, "including its recommendations with respect to amendments to the act and the regulations", so we do have to caution that the committee stay within that mandate. It is a statutory requirement, review of that legislation.

M^me^ France Gélinas: But there's also a sentence in the motion that we got from the House that says that other work as—I forgot the—

The Clerk of the Committee (Ms. Valerie Quioc Lim): "Shall consider, but not be limited to." The motion has set out that the committee is to look at the legislation, and under that, to consider different things, but we have to really stay within the legislation.

M^me^ France Gélinas: Because we've been requesting documents right now from CCACs that have nothing to do with the LHINs. They have to do with elements of what we've heard that we wanted to check for ourselves, so we've been requesting documents. Are we inside or outside of our mandate when we do that work with CCACs?

The Chair (Mr. Ernie Hardeman): We're right on the line.

M^me^ France Gélinas: Okay.

The Chair (Mr. Ernie Hardeman): I say that in a serious way. We're right on the line, because if we pass a motion like this, we're on the other side of the line, we are now doing a complete review of the CCACs. But what we've actually done so far with the CCACs is not how they operate; it's strictly on the pay scale for certain people. We haven't done anything at this point on looking to see whether, in fact, they're putting enough into the front line, how much and things like that. That would be a different report. Again, this committee has the power and the ability to set its own agenda as to what it does want to review, but that would not be part of what they've asked us to review from the House.

M^me^ France Gélinas: So, back to the Clerk, I would like you to check, because some of the recommendations that may come forward may have nothing to do with the act—they have to do with the findings that we have—are we wasting our time here as to everything else that we've heard about that won't necessitate a change to LHSIA, but per se is out of our responsibility? Is this what you're saying?

The Clerk of the Committee (Ms. Valerie Quioc Lim): I will check on that, because I know you were talking about things that we've heard and observed from presenters. I believe that we do have to stay within the legislation, but I will get back to you about how far, because of what we've heard from presenters and the information that we've checked because of what the committee has heard.

M^me^ France Gélinas: Okay. We may make changes to the law, but we may also—or propose changes to regulations or propose changes to the way they do things that will have nothing with the way the law is written. It will have to do with the way it is interpreted, the way it should be carried out, the impact that it has had on the health care system. That was my understanding of what we were doing, and now you're kind of narrowing it to the point where I'm wondering what we're doing.

Ms. Helena Jaczek: I think everything that we've requested so far falls under the mandate that we've been given, because the LHIN is officially, through legislation, the transfer payment mechanism to the CCACs. We have been asking about how those dollars transferred by the LHIN to the CCAC are accounted for. As far as I'm concerned, everything we've done is in the spirit of what the powers of the LHIN are and how they are exercising those powers.

M^me^ France Gélinas: I feel the same way.

Ms. Cindy Forster: Yes, I do too.

The Chair (Mr. Ernie Hardeman): I would just clarify again: Our mandate is that all the legislation and regulations made under it is what we're reviewing. So as long as the regulations that you refer to are not regulatory changes that need to be changed because of the CCAC act, as opposed to the LHIN act—then we would be over the edge, and that's why a full report would be inappropriate to be able to implement. But I think the committee has all the power to make recommendations on the information we were able to gather on the transfer—that the transfer, that which is being transferred to the CCAC, is questionable if you look at that, compared to what's being transferred to someone else. We can't maybe go all the way in to find out where they're spending it, but we can find out which organizations are getting the money, because that's part of the LHIN mandate.

M^me^ France Gélinas: Then I would ask the Clerk to check, if we make recommendations that go outside of this law, are we outside of our mandate? It's quite obvious that we've heard a lot of things that did not have to do with the act; it had to do with the carrying out of the function that came from that act, including following the dollars.

The Chair (Mr. Ernie Hardeman): Lastly, what we heard is not in question. The mandate is not for what people are telling us. The mandate is what we report back to the House. So as long as we don't come forward with—and that's why I say you can decide at that point whether you want to do a total review of the CCAC and put that in a report, because if it's CCAC matters, you would not be able to put it as part of the LHIN review.

M^me^ France Gélinas: That's what the Clerk will check. Thank you.

The Chair (Mr. Ernie Hardeman): Anything further on that? If not, we're ready to move in camera.

The committee continued in closed session at 1433.

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