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Lundi 17 mars 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

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**STANDING COMMITTEE ON
SOCIAL POLICY**

**COMITÉ PERMANENT DE
LA POLITIQUE SOCIALE**

Monday 17 March 2014

Lundi 17 mars 2014

The committee met at 1407 in committee room 1.

**LOCAL HEALTH SYSTEM
INTEGRATION ACT REVIEW
ONTARIO ASSOCIATION
OF COMMUNITY CARE
ACCESS CENTRES**

The Chair (Mr. Ernie Hardeman): I call the meeting of the Standing Committee on Social Policy to order. We're here to review the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act.

We're doing more public presentations, and the first presentation this afternoon is the Ontario Association of Community Care Access Centres. I believe they're here. As I read down the list: Sandra Coleman, chair and chief executive officer of the South West Community Care Access Centre; Barry Brownlow, treasurer and chair of the Hamilton Niagara Haldimand Brant Community Care Access Centre; Stacey Daub, chief executive officer, Toronto Central Community Care Access Centre; Frank Martino, medical doctor, Queen Square Family Health Team; and Laurel Stroz, care coordinator, Toronto Central Community Care Access Centre. I believe that's all the chairs we have at the end of the table, so we'll have to stop introducing people.

Thank you very much for taking the time to come and talk to us this afternoon. You will have a two-hour presentation. You will have half an hour in which to make your presentation, and then we'll have half an hour for each caucus for questions and comments on your presentation.

With that, thank you again for being here. The clock starts ticking now for your half-hour.

Ms. Sandra Coleman: Thank you very much, and thank you for the opportunity to be here today. As you've said, Mr. Chair, I'm Sandra Coleman. I'm here as CEO of the South West CCAC, but also in my capacity as chair of the board of the Ontario Association of Community Care Access Centres. I'm pleased to have the opportunity to speak with you again today and to introduce my colleagues. They will provide the core of our presentation today. Mr. Brownlow is the chair of the board of the Hamilton Niagara Haldimand Brant Community Care Access Centre and is also treasurer for the Ontario Association of CCACs; Stacey Daub, to my right, is CEO

of the Toronto Central Community Care Access Centre; to my left, Dr. Frank Martino is a family physician at the Queen Square Family Health Team and past president of the Ontario College of Family Physicians; and Laurel Stroz is a care coordinator at the Toronto Central Community Care Access Centre.

LHINs are leading a significant transformation of health care at the regional level, and home and community care is a critical component of that transformation. In our presentation today, we'd like to address some of the questions that have arisen throughout the hearing process about home care and about community care access centres. We also have some recommendations about how local health systems could be improved to better meet the needs of patients today and in the years to come. They're appended at the end of our remarks and we're pleased to go through those in more detail, if you wish.

At this time, I'd like to turn it over to Mr. Brownlow.

Mr. Barry Brownlow: Thank you, Sandra. As board members, we are responsible for ensuring that the organizations we govern deliver the highest quality of care possible to our patients while making the best possible use of taxpayers' dollars entrusted to them.

I'm an accountant by profession, and I look for economic benefits. A recent comparison showed that home care costs average about \$48 a day, compared to over \$800 a day in a hospital and \$126 a day in a long-term-care home. Now, I'm not suggesting that all the care that happens in hospitals or long-term care can happen in-home, but given changes in technology, medical innovation and patient choice, more care is taking place at home than ever before, and there are social and economic benefits to doing so. These benefits, along with other factors, will continue to drive growth in this sector.

As boards, we are responsible for hiring and retaining CEOs to provide effective leadership for our organizations. We have 14 CEOs managing \$2.2 billion of investment in home and community care, and we hold them accountable for managing the efficient and effective use of these resources.

There has been public debate about the compensation of our CEOs, and I'd like to provide some historical context. In 2006, 42 relatively small community care access centres were amalgamated into 14 larger organizations. The new organizations were more complex, they covered more geography and they served more patients. In 2009, boards undertook a third-party, evidence-based market review for CEO compensation. Based on this

review, which considered the substantial growth in budget, scope and complexity of operations, boards made decisions regarding adjustments. In 2010, our executive compensation was frozen as part of the broader public sector compensation freeze, and remained frozen until 2012. At that time, no further freeze was requested, nor required of us by the province.

As board chair, I take very seriously my responsibilities for ensuring that we have strong leadership in the CEO position. I'll illustrate with a personal example: In Hamilton Niagara Haldimand Brant—which has a population greater than Canada's fifth-largest province, Manitoba—we employ care coordinators who work with patients, their families and our system partners. Last year, they supported 75,000 patients with care plans and received more than 4.7 million patient visits.

To be able to recruit and retain capable, competent leaders who can oversee a complex service delivery organization in the health sector, we must be able to offer appropriate compensation. We understand that the province is considering additional measures on executive compensation; we welcome that, and hope that it will spur a larger debate on a broader human resources strategy for home and community care.

Thank you very much for your time, and I'll be happy to answer your questions. I'll now turn it over to Stacey Daub.

Ms. Stacey Daub: Thank you for the opportunity to be here today. I'm pleased to provide some perspectives on home care as you review the Local Health System Integration Act.

As you know, home care is garnering a lot of attention. This heightened interest is not surprising; it reflects its growing importance to Ontario. But home care itself is not new. Publicly funded home care has been around in Ontario for 50 years, but it's new to many more people. More people are aging and wanting to live fully, and as independently as possible, in their communities. More acute-care patients are getting treatments and recovering at home, rather than in hospital, and people with multiple complex health conditions, who just five years ago would have lived in an institution, are now living in the community. And many more individuals are choosing to live their final days, and die, at home.

All our patients have families, friends and neighbours who love them and who look out for them, so there is a rapidly expanding circle of Ontarians impacted by home care. It is becoming a major component of the health care system. When you consider the impact on families, millions are impacted, so we know there are strong opinions at times about our work. We understand the heightened scrutiny and accountability that comes with delivering a service that touches so many lives.

The CCACs are eager to participate in a public policy discussion aimed at improving services to patients. With home care set to take on an even more prominent role in the delivery of universal care, the province needs to examine what is working well in our home care system and to determine what we'd like to see more of in the

future. We need to focus on understanding and solving the right problems. So I'm pleased to offer some thoughts and ideas about some of the most important questions we need to think about to strengthen our home care system, informed by our experience as care providers and inspired by the needs and the hopes of our patients and their families.

Based on my experience, I'm going to talk a little bit about how we came to have the home care system we do today. Then I'd like to propose four questions we should be asking about the future of home care.

Three successive governments have shaped the way home and community care is structured, organized and operating in Ontario today. The CCACs did not choose their structures, their roles, or their operating model. I think it would be fair to say that if Ontarians were sitting down today to design a system of home care, they would likely not choose the exact model we have right now. That said, there are many strengths in the way home care is being delivered.

Because of CCACs, there is a single point of access and accountability for home care in every community across Ontario. We have care systems in place that enable over 650,000 people a year, of all ages, to be supported at home and in their communities. Each month, we help over 16,000 people go from hospital to home and receive home care, generally within one day of leaving hospital.

We serve the highest-acuity home care patients in the world. In fact, CCACs contribute to Ontario having fewer hospital beds and shorter stays in hospital compared to all other provinces.

In Ontario, there is one electronic health record for every home care patient. We have a single IT network. We are the only part of the health system to have this.

One of the reasons I believe there is an abundance of opinion on what CCACs should be doing is because we are the point where all the parts of the system meet. We oversee the quality of care at the patient level. When we hear a complaint or a concern from a patient, it's our job to follow up and address it.

We are present for some of the most difficult decisions that people ever have to make. We sit with seniors and families and explain what the public system can provide, and know that many families worry that it won't be enough. Sometimes families feel that it is time for their mother to move into long-term care. We are the ones to explain that her needs are not as great as those of many other seniors, and so she will need to wait.

We do our best to provide support and a caring touch as we watch caregivers deal with the anger and helplessness that comes with watching a loved one die.

We sit in meetings in hospitals and defend the decision not to place a patient in long-term care because the patient is capable of making that decision and does not want to go.

We need to make tough decisions about care levels that nurses or other providers disagree with, because we are the stewards of public resources that, like all public

spending, have limits. Our job is to distribute these resources equitably. We focus on the needs and the wishes of the patients, not the providers, with a focus on those most in need. Wherever demand exceeds supply, we ensure a fair and equitable access to long-term care, adult day programs, and other services.

These roles are not easy. We should be held accountable for carrying out these roles fairly and compassionately, but these are necessary roles that government has directed us to do.

Thousands of dedicated, knowledgeable, compassionate, creative and committed people are choosing home care as their place to make a difference to patients and to the province. Shortcomings in the system should not be attributed to the integrity of the people working in home care. Today, we invited Laurel, one of our care coordinators, to talk about her work. We thought this committee would benefit from hearing first-hand about the challenges that care coordinators overcome to help their patients. We need Ontario to begin thinking and talking about strengthening the home care system to make the most of the skilled and committed people who work throughout the sector. So let me pose the four questions that I believe we need to address in thinking about the future of home care.

First, how do we organize home care to deliver the best care at the best value?

Currently, there is one organization accountable for home care, with many organizations involved in its delivery. The CCACs employ care coordinators and some other health care professionals, like nurse practitioners and pharmacists. However, much of the care for our patients is delivered by people who are not our employees. We have contracts with 160 agencies to deliver nursing, therapies and personal support services. We estimate there are some 24,000 people delivering home care in Ontario. Some of these staff work for non-profit providers; some work for for-profit providers. These contracts and the contracting process, which has had many changes over time, have been controversial.

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On top of this, many patients receiving our care also receive services from other community organizations—services like home support, Meals on Wheels and transportation. Our patients also receive care from multiple parts of the health care system. Most of them have family doctors. Many get services and supports from acute-care, specialty hospitals and, increasingly, from non-traditional service providers.

Our patients tell us that the health system is “overwhelming” and “confusing” and that they “don’t understand.” They tell us they want better communication and more information. We see our role as integrating all of this care and finding ways to make it work for our patients.

There are likely better ways of organizing the system so that it is easier for patients and providers, but there are no straightforward, silver-bullet solutions. Several options have been suggested, like merging LHINs and

CCACs, or devolving CCACs into 11,000 primary care practices. There’s no evidence to suggest that these options will improve patient care. In fact, CCACs have been restructured many times. Most recently, we merged into 14 CCACs to align with LHIN boundaries, and I think that change was a good idea.

As a health care leader, I know how to lead mergers. I also know that they are painstaking, time-consuming, energy draining and can be costly. But the truth is, as public policy challenges go, it’s not that hard. It doesn’t take that much creativity or innovation. What is harder work, but offers far more value for patients and Ontarians, is addressing the unique needs of patients and working with our partners to deliver better home care. So I’m skeptical that one more merger is the right option, particularly when so much is already happening to improve integration of care across organizations.

Health system leaders, experts and policy-makers should be consulting with patients, working to answer the questions of how best to organize the system and the delivery of care around the needs of patients.

The second question I’d like to pose is: How do we ensure a strong and stable home care workforce? Let me share a little bit about the people who work in home care. They are a very special lot. They’ve chosen to work in one of the most unpredictable, uncontrollable environments: a person’s home.

One of the reasons home care costs less is that wages paid to many home care workers are often lower than the wages paid to workers in other parts of the health care system. This is especially true of personal support workers. They are deeply valued by patients. They spend the most time with our patients, and they are essential to keeping people at home. We should be asking ourselves if their pay reflects the importance of their work and what we ask of them.

As you know, CCACs have no direct control over salaries or administration within the organizations that we contract with. Many of us have found creative ways to improve the working conditions of personal support workers. We have organized team-based care and given personal support workers a stronger voice in how care is delivered. But the real needs and concerns of personal support workers warrant a fuller discussion of their own. In fact, if we are going to increasingly rely on home care, the province should have a broader discussion on a health human resources strategy for the sector. We need to consider how we support the paid and unpaid caregivers that the system so heavily relies on. We need to examine how the health system can improve compensation and support for those who do some of the toughest jobs in health care.

Third, how do we ensure a funding strategy that provides equitable access to care? The current government has made unprecedented investments in home and community care, but there is more to do to ensure equitable funding and access to home care across Ontario.

Our funding is a reflection of historical funding patterns and more recent decisions of individual LHINs.

The result of that funding is uneven across Ontario. This impacts access and service levels.

Another factor to consider is that the demand for home care is growing dramatically. We are supporting patients whose needs are greater and who need care for much longer. Many long-term care homes, CCACs and community services have wait-lists. We need a long-term funding and capacity planning strategy that builds the capacity to provide appropriate care in every community in Ontario.

I know that attempts are being made to address this question through new funding models, but these may not be sufficient to address the pressures that the health care system will feel in the coming years.

The fourth and final question is: How can Ontario's home care system increase transparency and choice for the citizens we serve? People want to know how to plan for their care needs. Families want to know what supports are available to their loved ones. In our current system, it is not always clear what services and supports people can expect. We can do a better job of this.

Places like Australia and Germany have standardized care packages. This allows people to know exactly what the publicly funded system is and is not able to provide. Other countries provide a dollar amount that lets patients and families choose the services that are right for them. Ontario's policies could allow clients more flexibility and choice about home care.

These are only four broad questions to start us thinking about the future of home care. As I said at the beginning of my remarks, the home care sector is gaining profile. But it needs to garner much more thoughtful public attention. There are no simple solutions, no easy paths. The debate will be difficult, with lots of opinions. I believe it is important that we use as much evidence as possible, and the most compelling evidence will come from the experience of home care patients themselves. But if we do decide to make changes to the system, we should take great care not to destabilize the home care sector. This isn't something that our patients or the health care system can afford.

You know, I began my career as a personal support worker. I've worked in a service provider agency, and today I lead a CCAC. My perspectives on home care have changed over time, but I do know that all of us who work in the CCACs believe that Ontarians deserve the best home care system that we can offer them. We know you share that goal, as do your fellow MPPs. So let's start having that discussion. I look forward to your questions, but first, I will turn it over to Dr. Martino.

Dr. Frank Martino: Good afternoon, and thank you for allowing me to contribute with my remarks. I am Dr. Frank Martino, a family physician at Queen Square Family Health Team in Brampton and past president of the Ontario College of Family Physicians. I'm pleased to be here today to offer my perspective.

A few years ago, primary care and home care worked very differently. Today, I'm grateful and pleased to report the picture has changed and, I must say, for the

better. As a primary care practitioner who works in my community daily, I can speak from experience to the positive and integral nature of the partnership between community care access centres and primary care and to the way we manage patients in the community together, especially our complex seniors with multiple conditions and patients that have been recently discharged from hospital who require services at home.

I'm pleased to say that I have a CCAC care coordinator who is dedicated to and works directly with my team. The system is working much better for me and my patients now, because she helps connect the dots for us. Sandra Hastings is crucial in helping me get to know what my patients' needs are and linking them to the entire basket of services available to them. Together we support patients on their journey through the health care system. I hope to reflect with you, if requested, on patient stories that I have experienced personally and that have been told to me by my colleagues that speak to this collaboration.

As the people who live in our community grow older, and more and more people are living at home longer with complex, long-term health needs, the role of care coordination at the patient level becomes fundamental to the care we provide. We also need to work together, and the partnership between community care access centres and primary care is crucial to the quality and success of the care delivered in the community. CCACs are an important collaborating partner for primary care, and as we move more towards team-based care, community care access centres offer an existing, organized team that can provide physicians and our patients with a multitude of services. Evidence tells us that team-based care is better for patients, improving their health and wellness significantly. Working together, we also reduce emergency department visits and offset costs in other parts of the health care system, preventing readmissions and reducing hospital length of stay.

When I assumed the role of primary care lead in the Central West LHIN, what my family physicians asked from me was to bring dedicated care coordinators into their practices and for them to better understand the available community-based services that they could access. More and more, there are dedicated CCAC care coordinators that are affiliated with groups of family doctors to create an efficient process where doctors are aware of the basket of services available to patients in their homes and communities through community care access centres. This way, doctors have that one-to-one contact with the dedicated care coordinator who can tell them how their patients are actually doing at home.

In the Central West LHIN, we are pleased to have a dedicated physician access telephone line for effective and efficient interaction. You know, family doctors are often a person's first and most common point of contact with the health care system. With community care access centres, we're developing virtual teams. In my LHIN, this leadership is crucial to providing coordinated care and seamless navigation for patients. Together, we can

make those very important connections. We piece together not only the big picture of the person's life and what they need, but also the whole picture. This virtual team approach adds up to quality care for the patient.

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Care coordinators act as our eyes and ears in the home environment. They help us keep people safely at home, remain independent in the midst of their loved ones for as long as possible and out of hospital and long-term-care homes. I would be concerned about the system making changes in a way that would disrupt my access and my patients' access to a centralized system for home care.

When we all work together, we make a meaningful difference because patients receive better care at home and across the entire health care system. Community care access centres facilitate this at the patient level in homes and in communities. We need to build on these successes. I am excited about the possibility and prospects that exist in this continued collaboration and partnership.

Thank you for your time, and I would be pleased to answer any questions you have of me later.

Ms. Laurel Stroz: Thank you for the opportunity to be here today. My name is Laurel Stroz, and I'm a care coordinator at Toronto Central CCAC. I work on a diverse, inter-professional team, consisting of nurses, occupational therapists, physiotherapists, social workers and speech pathologists. I am a social worker by profession.

Over the past several months, I've been disheartened at times to hear my work described as administration, bureaucracy and paper-pushing. That's why I wanted to be here today, because I assume that the individuals who make such comments have never had the opportunity to discuss care coordination with myself or with one of my colleagues.

We are health care professionals who play a critical role in the home and community care sector and in the lives of the people that we care for. My toughest days are the ones where I visit seniors who are isolated, unwilling to trust and refusing services. I've visited homes with unimaginable living conditions. I've stood in the midst of squalor, moving from foot to foot to avoid having cockroaches crawling up my leg and then seeing those cockroaches climb onto my client's wheelchair and person; with bedbugs hopping around the furniture; with mouse and dog feces spread across the floor. I've looked in cupboards that are devoid of sustenance.

Oftentimes, these are not the seniors who embrace your assistance. These are individuals who are fiercely independent, wanting to live in their homes for as long as possible, but afraid to ask for or accept help. As a care coordinator, you begin by looking for a way into their lives. You need to build trust before you can provide any sort of assistance. Then, you set about to create a circle of support.

Care coordination is not an easy job, but it helps provide a face to the health care system that many very sick individuals struggle with. We help individuals navigate that system and walk with our clients through their health care journey.

Ms. Sandra Coleman: That concludes our formal remarks—

Interjection.

Ms. Sandra Coleman: Oh, sorry. Go on. Go ahead. Sorry.

Ms. Laurel Stroz: While it is not always easy, it is a job that I love because it makes a difference to people. We sit at the bedside of palliative clients. We ensure that their final wish to die at home is respected. We ensure pain is managed and that the family is supported. We help kids who no one else thinks can go to school attend school with the other children from their neighbourhood. We do this all with the support of a care team, one that includes nurses, personal support workers, doctors, pharmacists and other community services. Sometimes I have to push harder to make sure things happen the way they need to. Sometimes the team has different ideas; we challenge each other. My job as a care coordinator is to mediate that discussion, to help the team rally together to meet the client's needs.

The best model is one of collaboration from acute-care settings to primary care to home care. By working together, we increase the capacity for seniors to stay at home, to successfully have their health care managed outside of acute-care settings, and to ensure that clients have what they need when they need it by acting as a voice and advocate for those who need our assistance most.

Care coordinators care for our clients. We have searched streets, parks and homeless shelters for an elderly person with dementia who is unsafe, who has health complications, such as hypoglycemia. We sort through boxes of medications in clients' homes, removing expired products and reducing the risk of overdose. We sit through hospital discharge planning meetings and we hear a list of reasons why an older person shouldn't go home, but then listen for when the client wants to be home, and then we help make it possible.

Like my colleagues, I am a CCAC care coordinator. It's a job that we're proud to do. Thank you very much for having me here today.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. Now you can make your closing comment.

Ms. Sandra Coleman: Yes. I apologize for intruding. That concludes our formal remarks. I appreciate that we haven't talked a lot about LHSIA, but as I said, you've heard from us about LHSIA in some of the individual sessions leading up to today. There is a consolidated set of recommendations that are appended to our remarks, but we wanted to take our time to address some of the things that you're hearing about: community care access centres. You have our written summary. We'll leave that with you. We're pleased to answer all your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. Thank you all for your presentation. That is almost exactly to the end of the 30 minutes, so we will now have 30 minutes for questioning from each party.

We will begin with the official opposition. You don't have to use all your 30 minutes at once. We'll just make

the rotation and keep going until everyone's time has been consumed.

With that, Mrs. Elliott.

Mrs. Christine Elliott: Thank you very much for coming this afternoon to make your presentation. I was just following you along in your presentation. I noticed on page 6 you were talking about shortcomings in the system and that they should not be attributed to the integrity or values of the people working in home care. I'm not sure who should answer this, perhaps Ms. Coleman. What do you see as the shortcomings of the system presently?

Ms. Sandra Coleman: Stacey and I can both address that. It was in Stacey's comments as well. We know from our patients' perspectives that we've made great strides; for example, with programs like Home First that have been now rolled out across the province, across all CCACs working with our hospital, LHIN and other community partners. With that, hundreds of people in each of our communities are able to be at home instead of hospital or long-term care. They have better health outcomes and it saves money for the health care system as well.

But that care is still available to fewer than potentially could benefit from that type of enhanced service level in the community. There are questions around improvements in terms of the service levels that we can provide, as well as, how do we continue, for example, on the collaborative partnership that Dr. Martino spoke to, and ensure that there is a dedicated care coordinator with every primary care physician across the province so that that type of teamwork is spread and replicated.

The CCACs have made a commitment to having a dedicated quick-care coordinator attached to every primary care practice. We're partway there now but we need to continue that journey. Stacey?

Ms. Stacey Daub: The only thing I will add—I mean, I think I made most of the commentary in my remarks. I think that the home care system, like other systems we have—the acute-care system, the long-term care system—were designed for a time and we have some catching up to do in terms of getting them ready for the next generation of patients and clients.

I think Ontario in some ways is not unique in that there's growing demand for home care. I think the public policy challenges that we face in terms of the levels of support we can provide at home, how we can become much more coordinated, as I talked about, how we can build a stronger health human resource force, how we can make sure that there's fair and equitable access and funding across the province so that every Ontarian has the opportunity to remain in their community—I think that remains a challenge. I don't think it's for lack of trying, whether it's at the individual level—but many of these issues, I think, are quite complex and need what I believe is a very thoughtful debate to try and understand from the patients' perspective, what are the most important things we can improve?

When I make reference to shortcomings, the difficulty we have in some circumstances where people need

services, whether it's long-term care, or other really good examples, I think, are young adults who have very complex medical conditions and parents who would like to see other community environments for them to live in—those are the types of shortcomings I'm talking about, which I think every system has. But I think the job that Laurel has is very difficult, not only because you're trying to navigate a complex environment, but there are also just some services that aren't available and you have to be creative and find other ways to actually do that.

Mrs. Christine Elliott: Would it be fair to say it's primarily a funding-related issue that's the shortcoming? Or are there other structural problems that you're encountering that impede your ability to deliver the best possible coordinated care?

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Ms. Stacey Daub: I could only speak in Toronto, where I feel, from a funding perspective locally, I have had a lot of support, both from my local LHIN but also from my hospital partners and others who are quite interested in investing in home care. Locally, I would say that it is a whole new generation of clients that we're serving. In the past, if we had a simple client who was coming home to get some post-hospital care, you didn't need the level of integration that you need today. Today, we need to spend more time building a team in the eyes of the client and it's harder work. I don't believe that we could ever employ everybody who interacts with that client, so you have to figure out a way to develop a relationship with primary care. It's not as easy as popping a care coordinator into someone's office. It's about relationship-building. It's about shared purpose and figuring out ways to do things together when physicians might have done them very independently and we might have done them independently. You have to learn to work differently with other people.

Mrs. Christine Elliott: Other than increasing funding, what do you think would be the most important thing that the government could do to strengthen the role that you play?

Ms. Stacey Daub: I came here today not with prescriptions, but with some ideas. I think the issue, from my perspective, is that I could tell you what I think, Ms. Elliott, but my fear would be that I would be speaking from my perspective, from the perspective of my organization. I think the true strength in understanding how to strengthen the system would come from engaging patients and the people who receive service to understand what's most important to them. I can tell you what they've said to me, I can tell you what personal support workers have said to me, but I think, in some ways, we would be better off to hear it from them.

I did mention in my address the issue of control and choice. I think that we have a different generation of home care consumers who want more control and choice over their services, and I do think that we have some policies in place that make that difficult. I think that that wouldn't be a difficult thing to do to start to figure out how, even if you spent the same amount of money—and

I'll give you a quick example. We serve a lot of children with medical complexity. These are kids who may have had a tragic accident or were born with a particular type of neuro-developmental issue, and at the very beginning of their lives, parents want a lot of support and they want a lot of people coming in because they're learning how to care for their child. But very quickly, they become the expert in their child's care and they want more choice over the people who are coming into their homes, the types of individuals, the types of services that would be unique and helpful for their families. Our system, I think, is still based on a different time when there was maybe less complexity in the clients that we served, as well as people not wanting as much control and choice. People want more control and choice now. I would like to be able to do that with families.

We've done some small tests where we've taken families and we've looked at how much we've spent with them on their care, and we've said to them, "If you were to design this differently and if it was really going to help you to do the best in caring for your child and your other kids, what would that look like?" We've been able to work with the rules and bend the rules a little bit to be able to design services that make a lot more sense for them, but aren't really in keeping, I think, with what the policies would kind of dictate.

Mrs. Christine Elliott: So a broader sort of consultation with the public would be something that you would think would be in order? I can certainly tell you that that's what I hear in my community office as well from people who are getting some level of home care services, but that might not be what they want or need. They'll tell me, "They're offering me X hours of a certain service, but what I really need is in another area." So a greater degree of flexibility, I think, would certainly be in order.

You also mentioned, on page 5 of your presentation, that there is one electronic health record for every home care patient.

Ms. Stacey Daub: Yes.

Mrs. Christine Elliott: That's certainly at odds with what I hear from some of the home care service providers in my area, who tell me that it's still very reliant on phone calls and faxes. So I was wondering if you could elaborate on what you mean by that, please.

Ms. Stacey Daub: Sure. Prior to the merger—and anybody can jump in—of the 14 CCACs, we had, I don't know, six, seven, eight different home care systems, and every one of those home care systems would have interacted with the providers, our partners in care, in a different way. We have had CHRIS, which is one record—we have one way to communicate with our providers. We have something called health gateway—

Ms. Sandra Coleman: Health Partner Gateway.

Ms. Stacey Daub: Sorry, Health Partner Gateway—and it provides a common way for us to communicate with our providers. I think you're probably referencing the fact that some of our provider agencies have records as well, but I would say, from my perspective, that they are much more integrated—light years ahead of what

they used to be—and there are many of us who are trying to work through the issues of reporting and thinking about how to do that differently.

For example, with our palliative team that works in my community, instead of the phone calls and faxes, they have a daily virtual huddle. The physician is on the line, the nurse is on the line, and the care coordinator. They do quick bullet rounds of every patient that they serve in our community. They talk about what's most important to that client and what they're working on, and it eliminates all of that paperwork.

We need to do more of that in every part of the province, and there are all kinds of reasons why agencies and others—you know, privacy has been a blessing and a curse, I think, in some ways, in the province, but we need to work through those. If you ask most of our patients, they would say that they would rather share information in a safe way amongst us than be overly careful about it so that we don't know what one another is doing. I think there's more work to do, but I think we've made enormous progress from the past.

Mrs. Christine Elliott: Okay. Thank you. I have a few more, but I'll wait till the next round.

Mrs. Jane McKenna: Thank you so much for being here today. I guess, first of all, you would measure your success at the CCAC by the patients and how they're feeling in the system. I can say for myself, as an MPP, that we're grateful for the caregivers, because they're exhausted. Without them picking up where they're totally struggling, because they don't seem to be getting the answers that they need—the frustration when they come into my office, as an MPP, is heartbreaking for us. I know for myself trying to get through the system, it's fragmented as it is, and I don't know how the average person would even be able to facilitate that.

Being here today, when we've been going through all of the processes of all this, I guess my one question to you is: We're trying to find recommendations to make it better, because it is for the patient, right? It's not about anything else except getting them the proper necessities that they need and deserve. So what would you say that we could do for ourselves, as MPPs, to be able to facilitate that information for the people that are coming in that are struggling?

Ms. Stacey Daub: One of my MPPs is here. Mike Colle may not recognize me, but I work closely with Michael Prue, and I just met Doug Holyday.

It's interesting, I don't get a lot of complaints through my MPP office. I get more of those who are trying to figure out a way to connect to people who are confused by the system. So from my perspective, I do think that the care coordinators' roles are really important in terms of connecting the dots.

It's not for all populations. As I mentioned before—I'm saying this is simple, but it's probably not simple for the people who have received it—you can take a knee replacement. They need simple coordination between the hospital and the rehab provider, but they don't need that level of coordination. Once you get to much more com-

plex situations, I think care coordinators would be very useful.

The other thing that I think we do as a system is that we have a tendency to focus on the client and the individual, not the caregiver. For example, we may have a daughter who really wants her mom to move to long-term care, into a nursing home. She lives an hour away from her mom. She's very worried about her. She thinks she's unsafe. She thinks she's going to fall down the stairs. The client themselves, the senior, does not want to move into long-term care. It is our role to support a client if they're capable of making that decision, and we support them to stay at home. What I think we haven't always done a good job at is then turning to the caregiver to say, "Okay, we're going to support the client. Now, how are we going to support the daughter, so that the daughter feels that she's supported as that caregiver?"

I know you're going to hear from Samir later. He did a big consultation with caregivers, and they talked a lot about what they need more of from the system. We have to spend a lot more time thinking about the caregivers. They're carrying an increasing burden. And I think back to my other point: I think that if we could give them more certainty about what they will get from the public system—it's not that transparent. It's not that we're trying to hide anything; it's just not that transparent in the way that it's—it's not something so easy to understand. There are countries that have had service packages and service levels that are much more transparent, so you can at least have more control to think, "At least I know about the public system; now I can think about what we need to do," whether it's a family, a neighbour or others.

Those are a couple of examples. I don't know if anybody else has any suggestions.

Ms. Sandra Coleman: May I add?

Mrs. Jane McKenna: Yes.

Ms. Sandra Coleman: I might turn to page 24, where we start our recommendations. I think that the first two are on-topic for your question, Ms. McKenna. One of the reasons for the frustration, absolutely—oh, I'll wait and make sure you have that in front of you.

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Mrs. Jane McKenna: We don't have 24.

Ms. Helena Jaczek: We stop at page 16 of your recommendations.

Ms. Sandra Coleman: Okay. Do you have a section at the end that says "Review" and then lists several recommendations?

Mrs. Jane McKenna: Yes, we do.

Ms. Sandra Coleman: Okay. So I had the wrong—

Mrs. Jane McKenna: Yes, 16.

Ms. Sandra Coleman: We have a different page reference, but at least we're on the same page, so to speak. Everybody's there?

Interjection.

Ms. Sandra Coleman: In addition to absolutely what Stacey said, I think one of the other reasons for the complexities is also because the services are different from community to community, and I don't just mean from

Toronto Central compared to South West. Even within South West, the services available in Oxford county can be different than those available in London-Middlesex compared to the Owen Sound area, for example, within our community.

There would be a tremendous impact from having a pan-Ontario, cross-system capacity plan that would take stock of how many community services, how many assisted living and supportive housing locations, and, yes, how many long-term-care beds and hospital beds, but the government and all of us have a pretty good handle on that. But it's in some of these other services that are absolutely critical to people, especially as we are shifting more care to community: assisted-living spots, adult day living places, mental health supports etc. Right now, there is no single place to go to understand what that capacity is, how variable it is and, therefore, how to support investments to make a difference.

In the LHIN areas where they have started to make some of those changes and do an assessment of the variability and capacity within their geographies—for example, in South West, they discovered that there was a four- or fivefold difference in the number of assisted-living places compared to where you were within the South West. That's just within the South West, never mind comparing to the north and other places in the province. That analysis is then guided—their investment strategy of how to, in turn, ensure that they're attempting to have more equitable access to some of those important services.

I think this fits with your question as well, that there is not an equitable distribution of capacity and services in the province, and I think the LHINs are in an ideal position to be able to undertake that kind of analysis.

Mrs. Jane McKenna: I guess my question is, whose job description is it, then, to be the single place to figure that out for everybody?

Ms. Sandra Coleman: Well, I think it's the LHINs' job to lead, but they would be working, then, with all of the health service providers to understand their part in that, and the CCACs would certainly have a tremendous amount of data to feed into that. Because of where we sit, looking at patient flow across the system from hospital to home to long-term care, being a single point of access to adult day programs, assisted living etc., we can be a single source of information that would be very important to that, but there would be other pieces that you would need to understand as well—so how to collate that in a way that isn't just informative within South West but actually can inform a pan-Ontario strategy to ensure more equitable access.

Mrs. Jane McKenna: So is that in the works to do that right now?

Ms. Sandra Coleman: Well, as I said, some of the LHINs are going forward with exactly that type of capacity planning. We think there would be real benefit to tackling that across all of Ontario.

Dr. Frank Martino: If I could just speak to that for a second, In the Central West and Mississauga Halton

LHINs—the two LHINs have actually gotten together and looked at capacity when it comes to senior services, and at the table is primary care, community care access centres, hospitals, long-term-care organizations and community providers.

It is really important to understand that there is some fat in the system. We're just not accessing it appropriately, and probably not having significant flow-through through those services.

Mrs. Jane McKenna: I have one more question. I think the number one thing that people fear is the unknown, right? When they don't have the information at hand, it's fearful for them as a caregiver, or whether it's the patient. I think it's great to have home care, but where I struggle with is that we're doing it because we don't have any long-term care and we don't have anywhere to put these people, so we kind of say, "Okay, here, we're going to put you in home care." And because it's so complex and there are so many variables that you're saying here today of trying to match everybody up with everything, how can we figure out, if we're going to do home care to the best of our ability for the people who deserve to be at home, how do we streamline for those people to have the best care that they can have at their fingertips? Because not everybody's the same, right? What you offer somebody, like what Ms. Elliott was saying—just because you offer that, they don't need that. How are we going to figure that out as MPPs—to give them these services so they're not coming in feeling frustrated and exhausted—that we're trying to figure out something for them? How do we streamline that for them if we're going to do home care?

Ms. Stacey Daub: I think I mentioned earlier that I do think more information about what the public system can provide and having a better sense of what that actually looks like, and including that in people's planning and making that very transparent and open to people, would be very useful.

It's a moving way to think about the system, because if we would have thought about what home care looked like even five years ago, we would have been constrained, I think, by not seeing the possibilities of what could be for many people. So we have to be very careful that we think about the future not in the rear-view mirror. I think the first thing is to think about: What are the types of people and individuals and how much care do we think is possible to be provided at home, at what level, and when should someone actually be considering long-term care, and having a better understanding of that?

If I think of five years ago, before Home First, I always tell the story that when people were very uptight about the ALC issue in the province, I got a call from my LHIN to say, "You need to help us to fix this." We went into the hospitals at the time—maybe it was longer than five years ago—and we did what we thought was the right thing, which was to speed up the process: "If only we could get the long-term-care homes to respond quicker." What we ended up doing many, many years ago was having more people go to long-term care than

needed to. Once they got to long-term care, they got their medications and they recovered from whatever illness they were in the hospital for. We saw that there were many possibilities to get people home. So we have to be very careful to think about the future and what capacity.

Right now, I think the one big gap is between home care and long-term care. Many of us are trying to think of that whole idea of one-on-one visiting in a client's home. When you talk, for some people it becomes overwhelming. You need a lot of support. What you might hear from some of your constituents is that they have different people coming in. If you have someone who's getting care seven days a week, you can't have the same person coming in every day of the week.

There are other models. In Toronto, we've developed something called neighbourhood care teams. We have teams of personal support workers in buildings who fan out to a neighbourhood. In Mississauga Halton, they have Supports for Daily Living; other places have assisted living. At some point, when the care needs become very significant, I think you need to think of—there's a gap. People don't want to go to long-term care, but the intensity of the service that they need—we need to think about redesigning that a little bit or it does become overwhelming for people.

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

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

M^{me} France Gélinas: Welcome to Queen's Park, everyone. I'll go in a little bit of a different direction. I realize that CCACs are able to offer good jobs to the people who work for you. The jobs have respectful pay; they have benefits; you offer a pension plan. This is the type of job that every health care worker should have access to. You also negotiate contracts with care providers, but then the people who work for those contractors—mainly PSWs—certainly do not enjoy respectful wages or benefits or pension plans, like the people who work for CCACs.

I know that you value good jobs, because you offer them to your own employees. Where is the disconnect? When you do negotiate with the care providers, how do you take this into the mix? Because the example you were just giving us, that you don't have the same providers—well, I would tell you that if more PSWs had full-time jobs, the number of people that came to give you your bath would decrease exponentially and you would see the same person coming in over and over a whole lot more if you have full-time jobs, respectful wages, meaningful benefits and pension plans, none of which exists. When you negotiate those contracts, how do you take that into account?

Ms. Stacey Daub: Maybe I'll start, and then I'm going to pass it over to Sandra about the negotiations and the contracts. Unfortunately, you weren't here at the very beginning; we did talk about personal support workers. I, myself, started as a personal support worker; my mother was a personal support worker for Red Cross. So I'm

very familiar with personal support workers, and have relationships with many.

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What they will tell me, number one, of all the things that are most important to them—because lots of people speak for them, and I would love to have them here today as well to speak for themselves—is guaranteed work. Lots of people talk about benefits and hourly wages and other things, but what I hear from them and I hear from my circle of colleagues is that they would like guaranteed work.

I made reference to the fact that there are different workers in the clients that we're serving who get substantial—you could never send the same worker in, and in fact, Sandra will talk about our continuity scores. We track continuity for our clients. We have very high continuity, over 90%, so my clients in Toronto are not getting different workers every day. Again, in a place like Toronto, I've been able to work locally to develop neighbourhood care teams where we've tried to—I can't directly impact the wages and the benefits of the personal support workers, but I've been able to do a lot locally to indirectly influence their working conditions.

M^{me} France Gélinas: Why can you not? You sign the contract. You give them the money.

Ms. Stacey Daub: Sandra, do you want to talk a little bit about contracts?

Ms. Sandra Coleman: Yes. As you know, we don't employ the personal support workers, so any of those levers, if I can call them that, that would be able to directly impact on wages, benefits and working conditions aren't open to us. But I agree with you: It's not that we don't have a sphere of influence. Part of that sphere of influence is, what is the model of care and how are we supporting our patients with personal support work?

I have also heard in South West that moving forward with something like Home First was not only of tremendous benefit to the people who were able to then remain at home instead of in hospital or long-term care, but the personal support workers love that model because it offers four- or eight-hour shifts for them that give them that greater stability of employment. Furthermore, they have the opportunity to engage even more intimately and develop even stronger relationships with their patients.

M^{me} France Gélinas: I get all of this. I also come from the field, so I know how PSWs work. Where I live, we say that Home First is finally enough home care. We don't call it Home First; we call it "Finally, enough home care." It only works 30 days, and after 30 days you're back, begging for more hours.

I'm interested in your negotiating contract and your sphere of influence. So there are no levers; you will dish out billions of dollars of contracts and none of this can be used to get what everybody who works for CCAC has: a respectful job.

Ms. Sandra Coleman: I was going there next, in terms of sphere of influence. Another sphere of influence is regarding our contracts. While we are not the employer, there is an opportunity to understand how we

describe that work and how we create the conditions for success, because personal support is such an important part of the care that we provide for our patients.

In 2006, for example, that was the last time that there was a whole strategy, working collaboratively with government, with our service providers and with CCACs to understand that there are inequities in this important area, and what are the opportunities to have a strategy that would make improvements of a very tangible nature, exactly as you're describing. That's when, for example, a personal support worker minimum wage was introduced that is higher than what was the general wage at the time.

We have advocated since last fall that it's time for us to address again that issue—it's been since 2006—and to have a renewed strategy that would not just look at the minimum wage, although I do think that's an important piece of it, but also to understand what other elements could be brought to bear that we could work on collaboratively with our service provider partners who are the employers.

M^{me} France Gélinas: Can you name me some?

Ms. Sandra Coleman: Well, the last time, there were specific conversations around travel time, in terms of mileage as well as the time spent in the car travelling. That's a really important piece, especially where I'm from, which has a lot of rural areas, and for you as well, where the distances are quite large. Pensions and those kinds of issues—I think the potential is there for that type of comprehensive strategy to exist. Our suggestion is that it's not just time to update the strategy, but that it's essential to do it fairly soon and to tackle it on that broad basis, but collaboratively, with our service providers. It won't be able to be just a quick change to the minimum wage, I don't believe. I believe that's a necessary piece of it, but we believe the other components are going to take the employers as well as the CCACs to come together and understand how we can make change.

M^{me} France Gélinas: In the last eight years, has any CCAC been successful in using some of those leverages to effect change?

Ms. Sandra Coleman: Certainly when new services are being rolled out, we have the opportunity to understand: What are the right contractual arrangements that would support that?

I'll go back to Home First, but for a different reason. When we rolled out Home First in the South West, instead of having that be volumes that would be open to all of our current personal support workers, we did a separate and distinct call for interest from our providers because we wanted them to commit to a specific training program, to enhanced continuity requirements, to the services in terms of shifts that would be available, and that would also—because this was entirely new volume, what was their recruitment and retention strategy?

M^{me} France Gélinas: And how did you put that into a contract?

Ms. Sandra Coleman: We were able to put that into a contract with the provider that was successful in that, and it means that our Home First volumes are with those

terms and conditions that enable us to continue to hold the provider accountable for that recruitment and retention and training that's really important to our patients.

M^{me} France Gélinas: Why is it that changing those terms and conditions in the existing contracts hasn't been contemplated, done or tried?

Ms. Sandra Coleman: We moved all of our contracted service providers to a similar contract in October 2012. It was for a two-year period; it is coming up this October. We are actively considering now: What are the necessary changes and issues that we need to be collaboratively discussing with our contracted providers?

M^{me} France Gélinas: So what happened in 2012?

Ms. Sandra Coleman: All of our providers were moved to a similar contract template with the same terms and conditions of employment across the CCAC.

M^{me} France Gélinas: So did you see an improvement in the PSW working conditions?

Ms. Sandra Coleman: In the South West, we track the issues around continuity. We track issues around missed visits, around referral acceptance. There has definitely been an improvement, I would say, over the last year in the case of the South West.

Ms. Stacey Daub: From my perspective, and again in our earlier remarks, this is a public policy discussion. I think it goes well beyond the CCACs in terms of thinking of a health human resource strategy for home and community workers. The environment has changed. It's a much broader discussion that needs to occur. I don't think the CCACs themselves—based on the very basic fact that we don't directly employ. We've recently had confirmation of that; that we are not the employers. We don't have the ability to directly impact their wages and benefits. There are many countries that have grappled with this.

Contracting services is not unique. It happens across Canada, but it should come in a way that makes the most sense to the patients and is fair to the workers who are in it. I think we, as a sector, would welcome that discussion. There are many things to think through. There are countries who have moved to standardized rates for services that are set at the provincial level that make sure that people are adequately being compensated for the work they do. There are other ways that others have done it in terms of pooled benefits. There are all kinds of opportunities, but from my perspective it is a public policy discussion that needs to happen with government, which we would be part of and which I think personal support workers themselves should be part of. In the interim, we have a responsibility, where possible, to try and improve the working conditions. I can tell you, I do that every day in my job.

M^{me} France Gélinas: Can you give me an example where you have been successful?

Ms. Stacey Daub: I can give you many examples. I gave the example of the development of neighbourhood care teams, so that an individual personal support worker—a team. They're not working one-on-one going to different houses; they're working as a team of workers.

They have a nurse with them and a care coordinator in a building in a neighbourhood, so that they can meet daily. They can share and exchange support, so that they don't have to travel as far, so that they can get more hours in a row.

We have also developed an ethical decision-making workshop and processes. We have a full-time ethicist. We do more work with personal support workers than any of the other professionals who work in the system because they want it. They're the ones who come out to the sessions—we pay for those sessions—where we work through the very difficult situations, the morally—the things that are most difficult for them.

We do quite a bit of work.

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It would also be my expectation that Laurel and care coordinators who are working are thinking about the personal support workers and the way that they do their care plans. I know that they don't send people out at night. I think that it is an organizational responsibility to care for the other care providers who are part of our team and to do what we can have a part to do, but there are other things that need to be discussed at a broader level in the province that are public policy decisions that we should contribute to. But the personal support workers should have a big voice.

I will add one more thing. I am working with my LHIN; we're doing a review of what the opportunities are to have pooled benefits and other things for personal support workers, and what the policies would look like. I often look at policy issues, so in many ways, am I thinking about it? Is it frustrating that I don't have direct control? I would love to make a difference in every personal support worker's life tomorrow. I can't, so I have to use the levers that we have available to us to try and do that.

M^{me} France Gélinas: Okay. We're still going to talk about compensation, but this time at the other end. Executive compensation has been a very concerning issue. It has hit the front page of the papers, for all the wrong reasons. Can you explain to me: What is the process by which CEOs receive their salary increases?

Mr. Barry Brownlow: I'll speak from the perspective as the board chair of Hamilton Niagara Haldimand Brant. There are a number of functions that the board is responsible for. One is to make sure that there's a good CEO in place, and that has a number of different components to it. The first component is to make sure that the job is done and that the job is done well. That's primarily a system of performance reporting that in our CCAC takes place as an interface between the CEO and the board on a quarterly basis. I can give you some sample objectives in performance management.

M^{me} France Gélinas: I'm familiar with those.

Mr. Barry Brownlow: But then the wage, the component that is a fair and equitable wage, is based on a comparison of what the wages are out there, and that takes into place what it would cost us to replace our CEO if some accident happened to her or lightning struck or

she just took another job. So we have to have a market-based comparison. We take our time doing that to make sure it's fair and accurate. That's the part where we have to live with the numbers, because the market is the market. I would love to get gas at 90 cents, but it's \$1.25.

M^{me} France Gélinas: How do you reconcile the fact that in 2008 we had the recession that didn't know when to end, that the government sent out directives that salaries were to be frozen—and certainly the people at the lower end saw their salary being frozen, but not the people at the top. How do we reconcile that?

Mr. Barry Brownlow: We don't. They were frozen until 2012—is that the right year?

Ms. Stacey Daub: Yes. I think France wasn't here when you made your original statement with that content from the beginning.

Mr. Barry Brownlow: That's okay. You asked the question; I'll answer it as best I can. They were frozen in 2012 and after that time they weren't, so the market forces started to prevail. We need a CEO. We need the CEO to be paid because we would have to replace the CEO at those wages.

M^{me} France Gélinas: So you're telling us that all the CCAC CEO salaries were frozen from 2008 to 2012?

Mr. Barry Brownlow: I'm just going to ask for confirmation, because some of those times were before my time.

Ms. Sandra Coleman: It was 2010.

Mr. Barry Brownlow: It was 2010 to 2012.

M^{me} France Gélinas: What was put out in the paper where what was published under the—not freedom of access, but the—

Mr. Barry Brownlow: Sunshine list?

M^{me} France Gélinas: —sunshine list, where we saw the salaries continue to go up through 2008, 2009, 2010, 2011, 2012. They continued to go up. What am I missing here?

Ms. Stacey Daub: Maybe I can give an example. I can give a personal example. What they did in my example: I was the first person to be put in the Toronto Star. They took my predecessor, Camille Orridge, who left the organization halfway through the year, and they compared her salary to my salary of four years later. So it gave a very distorted view of what actually happened.

M^{me} France Gélinas: So what actually happened?

Ms. Stacey Daub: I was hired in 2011 as a new CEO at a salary. The predecessor on the sunshine list only counted for a half or three quarters of the year for my prior—you were comparing apples to oranges, the point being that I don't believe everything I read in the paper. I think there was some accurate information in terms of how the salaries changed.

Barry, in his address earlier, indicated that our boards all observed the freeze that was in place for the two-year period, and that happened. But I can't speak for other—I can only speak for my own experience. So it's a very distorted view, what was in the paper.

The only thing I would add is that we have talked, as a sector—we are very interested in the public policy debate

that's happening around executive compensation writ large in terms of the public service, and I think we feel quite confident that if anything was put into effect, we would be happy to fall into that process.

M^{me} France Gélinas: Okay. A change of path before my time runs out: You've all seen the report by RNAO that suggests that the contracts for the service providers be with the LHINs rather than with CCACs. You've explained a little bit to me as to the limited leverage you have on those contracts—to effect change for PSWs, anyway. So what would be so wrong in having those contracts handled by the LHINs? They already handle thousands of them.

Ms. Sandra Coleman: I'm wondering if it's sort of a two-part answer, if you don't mind, on the RNAO, because I think Dr. Martino would have some perspective, since part of the RNAO model involves primary care as well.

I'll just start by saying that from the CCAC perspective, part of the RNAO's suggested model would be devolving. It isn't just that the contracts shift to the LHIN. It's that then the care coordinators attach instead to the individual primary care practices. In the case of South West, where I know the numbers best, that would be 700 to 800 disconnected and separate family practices.

On behalf of a patient, if you look at it through a patient's lens, I think some of the challenges that come from that are that if you don't have a family doctor, how do you then gain access into home care? That's not very clear.

Also, if I'm thinking about being discharged from hospital, there are literally hundreds of discharges a day. In a given month, there are over 3,000 discharges out of some of our larger hospitals, any one given hospital. So if you imagine LHSC, London Health Sciences Centre, with hundreds of discharges a day going to hundreds of different primary care practices, that hospital would then need to be interacting with dozens, if not hundreds, of disconnected primary care practices.

I think the advances that have happened since the new merged model took effect on January 1, 2007, that has gone a long way to improving the consistency of care—if you're getting discharged out of LHSC, whether you live in Huron county, whether you live in Oxford county or whether you live in London, you have access to the same level of equitable home care services, all through a single point of contact within the hospital. That would become impossible under the model.

But I think the primary care voice is very important on this, if I may.

Dr. Frank Martino: Are family doctors ready for another layer of governance and organization? I don't think so. I don't think that the single-shingle physician has the resources, the understanding of care coordination, to absorb a care coordinator within their practice. I think physicians work better if there is central care coordination and in developing a structure so they fall and drift out of their silos into a better integrated system.

There are care coordinators in practices. They work very well, especially in larger practices. Do you have the volume to support a single care coordinator in each practice? I don't believe so. Can you do it centrally and in a coordinated fashion through a community? Absolutely, and it's being done very well in my LHIN.

My care coordinator visits once a month. We go through our list. I actually look forward to that day, because it allows me to spend time and discuss my patients in a more comprehensive manner, in a more coordinated manner. It also allows me to discuss with that care coordinator other issues that I may have that involve other patients who probably would fall through the cracks if I didn't have that dedicated care coordinator.

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M^{me} France Gélinas: How do you get paid when you spend a day or half a day with the care coordinator?

Dr. Frank Martino: The actual fee schedule allows for that.

M^{me} France Gélinas: So you bill OHIP?

Dr. Frank Martino: Yes. You don't bill at the rate you do for managing a patient within your clinic or in the emergency department or in the hospital, but the remuneration is sufficient to—but it's not really the remuneration, France; it's actually the impact you have on your patient during that period of time.

M^{me} France Gélinas: I agree 100%.

Dr. Frank Martino: When I pick up my day sheet and I look at that patient, I go, "Oh, my God, they're back. I can't do anything more," and you feel that degree of—your heart drops. It's that heart-drop moment you feel, "I need some help here," and if you're not on a family health team and you're a physician in the community, that virtual team is really something important in your day. I can guarantee that physicians would go to those care conferences and not get paid, because it really does relieve a lot of the stress you have in your day.

I mean, you put out easy fires throughout your day. It's those five or six patients, the five or six complex cases, often seniors, that you struggle with, and it's that navigation, that care coordination, that makes a huge difference.

M^{me} France Gélinas: So for physicians who work within an interdisciplinary team practice already, the model works is what you're saying—

Dr. Frank Martino: Not necessarily—

M^{me} France Gélinas: —and for a fee-for-service solo physician, then it doesn't?

Dr. Frank Martino: I think in a fee-for-service solo physician model, if you have central care coordination and you have that care coordinator visiting that single physician office, that works well too.

M^{me} France Gélinas: That works good?

Dr. Frank Martino: You just need to have a roster of physicians that you're dedicated to. So Sandra Hastings comes to my clinic that has 17 physicians, but she goes to a few other groups. It's easy when she comes to the 17 physicians, because it's on one site and she can devote a day or two—you know, we have rosters of up to 40,000

patients—to deal with those patients who require home care. But she'll go over to the physician across the street who has a roster of 2,000 patients and deal with their patients. It is, you know, on preplanned and appointed times that they review that case.

M^{me} France Gélinas: But you still didn't answer the first part of my question. If you're already in an interdisciplinary team setting, so you already have a care coordinator, you already know the patients from cradle to death, you already have the family history, you already know where they live, who supports them, who brings them to their appointments, is the son or daughter abusive or helping? You're a primary care provider; you know all of that already. The CCAC knows none of that.

Dr. Frank Martino: In fact, we don't. So if I visit that home, I would know a lot of those things; if I don't visit that home, I wouldn't. The care coordinator does know that. They actually visit. They get those reports and they feed them back. They'll say, you know, "Mrs. X is having struggles in just navigating her home. She will no longer be able to make it up the stairs to the second floor. Maybe we should look at moving a bed downstairs for her." I wouldn't have known that.

My family health team does have interdisciplinary care providers. We have dietitians, we have NPs, we have social workers, but we don't have that connection to the home and to the community, and we don't have access to the number of other baskets of services that the community care access centres do have. We have more than non-family health teams do, but definitely we do not have access to that basket of services, and we don't have the knowledge to navigate them.

If you look at the physician who is not part of an interdisciplinary team, their knowledge of those community-based services is much lower. I thought I was someone who could navigate: "Oh, God, I know what's out there. Hell, I'm a family physician and chief of the department at my hospital." But when the care coordinator came, I was in awe at the number of services she could get my patients into, the day programs I wasn't aware of, and that was just to name one of many.

M^{me} France Gélinas: You still haven't convinced me that having this person with this knowledge—I come from a community health centre. I can guarantee you that the nurses in my community health centre knew every day program and who drove who where, and will the dealership pick you up if you live in Chelmsford and bring you to your appointment? They knew all of this, so I know that this exists successfully within the primary care system. It doesn't work so much for solo, but this knowledge and skill that you've described—why does it have to be attached to a CCAC? Why is it not attached to the people who have followed these patients all along? That's called primary care.

Dr. Frank Martino: I think we have a collaborative relationship, and I think that that collaborative relationship works extremely well. I can speak from my own experience: Members of my medical community would feel uncomfortable having another layer of bureaucracy

within their office to manage, another level of governance—

M^{me} France Gélinas: So if somebody visits, it's not called bureaucracy? When does it become bureaucracy?

Dr. Frank Martino: When I have to worry about its function within my own office, in my own clinic.

I tend to disagree with you in the sense that community health centres know all of this. There are patient navigators and care coordinators in a lot of community health centres. There are not very many in family health teams, and definitely not in family health groups and in three- or four-physician offices.

Do you have the capacity in those smaller groups and physician offices to support a care coordinator? Probably not. Would it be done efficiently that way? Absolutely not. If you had someone centrally, with the skills and the organization behind them, it would be much more efficient and effective.

M^{me} France Gélinas: Okay. Because my time is running short—

Interjection: You've got about a minute.

M^{me} France Gélinas: Oh, damn. I wanted to talk to you about placement into long-term-care homes. We still get a ton of complaints on people in hospitals being pressured to be put on the lists of long-term-care homes that they don't want to go to. This pressure is often applied by your care coordinators who work in those hospitals, to get them out of there. It's a huge issue. I just wanted your view on it, and where the CCACs fall when it comes to having the long-term-care home of your choice rather than vacating the bed as soon as you can.

Ms. Stacey Daub: I can only speak for Toronto. I have something at the board level all the way through the organization that's called "supporting people in their choices." It's a board-level policy. My expectation would be that every care coordinator supports the client in their choice. If they choose not to have five names on their list for long-term care, they do not need to have five. If they choose not to go to long-term care, they would not need to go to long-term care.

Can I say that our hospital coordinators don't get immense pressure from everybody involved related to the fact that they would like to see clients pick homes with shorter wait-lists? But it is our job, and it is a critical job and a job that should be supported, for the care coordinators to have an independent voice that supports the client in their choice. So I feel confident in Toronto that we do not force people to add lists. We do provide counselling and support, but it is our job to support them in their choices.

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

We'll now go to the government side. Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Chair.

Thank you so much for coming and bringing the team to give us a different perspective from each of the speakers. I think this was very useful.

It took me back to the late 1970s, when I was in practice here at Women's College Hospital. I visited 423

Yonge Street one day a week with a home care nurse, and we used to see the cockroaches in the apartments and so on.

Mr. Mike Colle: Any bedbugs?

Ms. Helena Jaczek: There were probably bedbugs. We didn't see them. I don't remember them hopping.

Having said that, it makes me feel that some things are very similar. What is different now, and why we are talking so much about CCACs even though this is a LHSIA review, is that, because of the transformation occurring in health in Ontario, we are obviously putting this huge emphasis on home care, much more than we used to, and there's an additional layer of complexity in terms of the type of care that is provided to patients.

I'm going to start off by talking about patients. Stacey, on page 8, you talk about how health system leaders, experts and policy-makers should be consulting with patients, and you've given us a few suggestions of things that you have heard. Do you formally—each of the 14 CCACs—do patient surveys? How do you do them? Is there a common template across Ontario, and do you have those results in some sort of tabulated form?

Ms. Sandra Coleman: Is it okay if I answer?

Ms. Stacey Daub: Sure.

Ms. Sandra Coleman: Yes, the CCACs work together. We use the same patient-engagement tool. The tool is by the phone, as opposed to a paper-based survey. That enables issues around translation and speaking with, potentially, a caregiver instead of the patient, if there's a substitute decision-maker involved. We have learned from practice that doing a phone-based survey seems to be able to get the most helpful information.

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Province-wide, our patient satisfaction scores of those who rate our care as good and excellent are well over 90%. In South West, our scores are in excess of 94%. We report on those publicly. Starting on April 1, our patient satisfaction scores will be part of the quality improvement plans that all CCACs will be posting through Health Quality Ontario, and so all of that information will be public.

There's a breakdown, as well, on some of the scores with those same patients' evaluation and rating of the service providers with whom they are connecting in their homes. So it will have multiple dimensions around their home care experience.

If I may add, it's also important, we all believe, to not just have that quarterly process happen, but to have true patient engagement, and so, many of us have patient councils or advisory councils. Many of us are delving much deeper into understanding the patient experience. That can be by having focus groups, but it can also be much more meaningful than that by involving them in the recruitment and the retention process and being part of interview panels, as well as participating in discussions around—if we are going to consider a new pump, for example, to be used with some of our children with complex medical health needs, we should call together a group of the parents of children who are using that pump

and understand and get their input into what's working and what's not.

Ms. Helena Jaczek: In terms of collating this information, again, one of the examples that you gave was that parents of children with very complex needs have suggested, is there some potential of some—I don't want to put words in your mouth, but it sounded like some sort of group opportunity where there would be some provision of service where, perhaps, whether it be for respite care or permanent—that that was a concrete example where you've heard things like that. You've heard about flexibility around funding; this is the dollar amount potentially that could be used in terms of your needs, but it doesn't quite fit.

Have you collated these types of recommendations in some sort of document that we could access? This is what I'm trying to get. You've given us a couple of examples, but what we would really find very useful, I think, and if it's possible to have that kind of patient input—the raw scores of 84% satisfaction, I'm not too interested in that. I'm talking much more about concrete ways that we can gear the system more towards patient need. Do you have that, and could we get it?

Ms. Sandra Coleman: Part of the work that we have done across 14 CCACs has been, similar to some of the some of the questions that Stacey framed in her presentation today, to understand what are those big questions that we need to address in order to meet the growing demand for home and community care and how to do that as effectively and efficiently as possible.

So we have released a series of four discussion papers, called *Health Comes Home*, that try to frame what some of those big issues are, and we are in the process now of reaching out to a whole plethora of stakeholder groups, including patients, to engage them in this debate. We have the four papers that we can share that frame the discussion, but we're in the midst of gathering the information and collating it. We don't have that ready yet; we're in the midst of that engagement process. One of the papers is specifically geared around aging and the seniors' population, as well as palliative care. One of the papers is around children's care and mental health issues, because those are both really important.

We hear from our patients that they want to have a say in some changes that would make their care experience better, so we're engaged and embarked on that work, and would be pleased to share that with you. It should be available within the next three to four months.

Ms. Stacey Daub: I was just going to add to that. I have a particular interest in children with medical complexity, and so I work with the Provincial Council for Maternal and Child Health, and we have done a large-scale engagement with parents about their thoughts and needs. Again, it's a whole different generation of parents, so we're collating that.

I think there are multiple ways. The one around the flexibility and choice, I think, is one that we really need to be thoughtful to. I know that Dr. Sinha put it in his report. I think there are some real opportunities in other

jurisdictions that we could learn from in terms of that flexibility and choice, and would very much—again, I think the CCACs would like to be a part of that.

We're just finishing another policy paper locally in Toronto about flexibility and choice and what some of the policy options might be, and we'd be happy to give that to government.

Ms. Helena Jaczek: I guess, then, that leads to the question of process. You're busy working on all this. Do you share this with the LHIN? Did the LHIN ask you to do it? Where does the ministry come in? Explain the process to me.

Ms. Stacey Daub: My perspective is that every health system leader and health system organization has to contribute to thought leadership and change. I have a role, as an individual CCAC, to listen to my patients and to try and bring those issues to the fore and advance them, sometimes directly with my LHIN, sometimes with the ministry, sometimes with my association. I use all of those channels actively.

My LHIN—I work with the Toronto Central LHIN—is very responsive. We partner on many common issues. Not only do we partner, but we partner with our hospital partners, our community health centres and our primary care practices on particular issues. At other times, we work directly with government on issues that come in a different form. There are a variety of ways, but all of those channels are particularly important.

I guess the question is, how do we talk about the most important policy issues in home care so that we are really on the front road of strengthening it for the future? I think it's a good time now. I think people are talking about it, but I would prefer to have those conversations—

Ms. Helena Jaczek: What I'm really getting at here is, thank you for acknowledging—you have it somewhere in your statement—that if we were to design the system now for home care in Ontario, we wouldn't necessarily do it the way it is. We're interested in positive recommendations coming from the field. I would say I think it was our impression around this table on all sides—the three parties here—that there was very much of a defensive attitude that was coming to us as we started this process, that everything was perfect. So I'm glad to see that there are some concrete recommendations coming from you, because that's what we need to hear.

We're putting a lot of money into the whole community health piece, and we want to get it right. I mean, this is an opportunity, as we build the community side of things, to get it right. I think it's really important to acknowledge that every tax dollar needs to be put to its very best use. Certainly, from our perspective, there's no need for any sort of feeling of defensiveness. It's simply that we need to get at the right answers.

Now, I want to get fairly specific on contracts and contract management. You mentioned a contract template with your service providers. Where did that template come from?

Ms. Sandra Coleman: The CCACs work collaboratively with our service provider partners to understand

the current contracts that were in place and then to understand what changes are necessary to—in 2012, when we moved to the existing contract that we're on, the world was very different then. The nature of the expectations and volumes and everything were very different from what they were when the prior template had been agreed to.

That is a fully collaborative process with our contracted providers. Tables are struck for the purpose of hearing everyone out and reaching consensus on what those contracts need to look like and what the changes need to be.

Ms. Helena Jaczek: Again, it came from within the CCAC world. It wasn't the LHINs getting together and saying, "Henceforth, you, CCAC, will use this type of a template"? That wasn't how it worked at all?

Ms. Sandra Coleman: No. The LHINs had a voice and were part of the engagement process to make sure that—for example, there needs to be a cascading impact so that the expectations that LHINs are held to by the ministry, in terms of what their performance indicators are and which ones of those really come to life in the home care and CCAC world with our contractor providers—to make sure that then there's a cascading in terms of our accountability agreements with the LHIN and also our contracts with our contracted service providers.

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Ms. Helena Jaczek: In terms of your contracts going forward, you saw that we were puzzled about the single electronic health record, because obviously in our offices we hear that things are pretty much all over the map and people are falling through cracks and so on. Have you not included that every service provider will start using the single electronic health record? Wouldn't it be very easy to insist upon that as part of the contract?

Ms. Sandra Coleman: I wonder if it's a difference between the IT platform that we have in place with our contracted service providers and the experience in the home of the constituents, which is where you're hearing the experience. As Stacey said, we have a pretty complete and robust not just CHRIS system but eHealth connectivity with our contracted providers in which, as the RAI assessment is done by our care coordinators—you may know about that assessment that's done in the home—that is electronically transmitted to our contracted providers, along with the information that describes when services need to begin, the nature of those services and the outcome and goals that would be expected. That's all transmitted electronically.

Where the reality is different for the constituent is that, in their home, there is no electronic health record. There can't be one.

Ms. Helena Jaczek: But surely your care coordinator has an electronic—

Ms. Sandra Coleman: She has a BlackBerry or some type of electronic handheld, but that is different. The client can't get in and see that. So many of us—for example, in South West, we have a chart in the home, a binder. It's a simple binder. We actually ask our service

providers to chart as they are in the home, to use it as a communication tool with not just our clients and patients but their family members, who may not always be in the home. I know when my dad was receiving care, the first thing I did when I came home on the weekend to visit was to look in the binder and see what had happened. Sometimes they were leaving questions for me to answer as the daughter and substitute decision-maker, and sometimes I was able to write notes back.

We are moving forward very quickly with an electronic reality that is better than almost any other part of the health care system. Where we encounter the reality of coming to a ground halt right now is in the home itself. How do we create a connectivity that would enable our clients to be part of the circle of care in an electronic way? That's where we really need to get to.

Ms. Helena Jaczek: I think that would be ideal. Certainly, as has been said, there is no question—in our community offices, we hear about people being discharged from downtown Toronto hospitals. They move up to Markham, wherever, and people somehow don't get the care they were told they would get etc. So something is just not being coordinated.

Ms. Stacey Daub: Maybe I'm in the best position to respond to that. My organization transitions 68,000 people every year. I'm the person responsible for part of those transitions. I have over 100 CCAC staff who work in the hospitals. I would say to you—and I watch the adverse events and what happened—that we have very few situations where a client doesn't actually get service. What is more likely is that it is a reflection, I think, of system issues, either that the services that might be available in that community are hard to get to, that there's not a nurse available or a physio available, that the service levels are different in that community, or, quite honestly—I think of the most recent one that was in the paper. They had never been referred to us. So it was hard for me to lose them in the cracks when no one had ever actually asked me to do the transition for that patient.

So I think some of the things that you're speaking about are broader issues of how we communicate from hospital to home, whether it's hospital to primary care—and Frank can probably speak to the complexity of that—or how we communicate between CCAC and hospitals.

I feel like we are doing a much better job. For example, in Sunnybrook, which would likely discharge to many of your areas, we have moved to an integrated discharge planner for complicated clients. We no longer have a social worker, discharger planner and multiple people coming, because it's confusing for people. We have an integrated discharge planner who starts to meet with them from the time that they arrive—so much earlier—and develop a relationship, because it's partially relationship-building, so that at the end of the day they have a much better sense of what's happening and it doesn't come as a surprise.

I think there are a lot of other things that we could do, particularly around hospital discharges. They're scary. It happens very quickly, and there is quite a bit of work

happening between primary care, I think, hospitals and CCACs. We need to do more, quite honestly, in terms of those transitions because they're really important.

Ms. Helena Jaczek: And there are a very large number, and, of course, what we hear about are those few. The capacity issue leads to your point and your recommendation in terms of looking at capacity across the province and having some sort of a plan. So I certainly understand—

Dr. Frank Martino: Just to add to that about transitions: Transitions are something that—25 years ago, when I managed my own in-patients, there was no issue about transitions. I had spoken to home care; I knew exactly what the plan was. I didn't have to do a med reconciliation because I ordered those drugs and I knew very well what they were going to be. As we've moved into an electronic age—because I didn't have an electronic medical record back in 1990 but I do have one now—I think it is a systems issue and it is an issue with regard to eHealth and where we're moving.

I think we're making big strides. If I look at my own community, we had a 17% uptake of an electronic medical record just three and a half years ago. We have an 84% uptake now. I think we all have a hunger to get this kind of activity and for it to happen quickly. We are moving forward with very innovative ways of communicating discharges: births, deaths and discharges for patients in the community care access system.

In our area, we have an enterprise fax system. Physicians are faxed that discharge summary, actually, before the patient is discharged. We have an understanding with our hospitalists and our physicians who provide in-patient care that they need to dictate that within 24 hours. Most of them dictate it, knowing that a planned discharge is going to happen, before the patient leaves. It's actually in my inbox before the patient makes that appointment.

I think we're struggling, but we will get there—Hospital Report Manager, GTA connect; a lot of innovative projects are just on the horizon. OLIS is a reality for most physicians. We can get lab tests. Getting an integrated radiology information system so that I don't have to repeat ultrasounds and X-rays when a patient shows up in an emergency room and I'm working a shift and I get really frustrated with the fact that I'm now having to duplicate a service—I think that those are things that are going to improve the way we connect.

I can say that when a patient of mine is discharged from CCAC service, I get an indication that they are. If I'm not happy with it, I pick up the phone and I get a warm body at the other end where I can complain. I think we're getting there. We're just at the horizon of things now, starting to accelerate. That snowball is going to get much larger.

Ms. Helena Jaczek: That's very reassuring. Our bedbug specialist has a question.

Mr. Mike Colle: I think bedbugs are like the symbol of a lot of the complex challenges we have in providing good health care, especially at home. It's because it's all the determinants of health and poverty and mental health

issues. I think the bedbugs and cockroaches and all those very resilient animals basically manifest how difficult everybody's job is. But I will ask a bedbug question in a second.

I just want to commend Dr. Martino for bringing to light the numbers here: 40,000 patients for 17 doctors.

Dr. Frank Martino: We have 18 now.

Mr. Mike Colle: Eighteen doctors.

Dr. Frank Martino: Yes. We unfortunately had one of our partners who passed away rather quickly after his last day at work. I still remember, back in late September, I said, "Mike, you're looking a little"—

Mr. Mike Colle: Who was that?

Dr. Frank Martino: Mike Dennis. He had been in practice for 49 and half years. He looked a little pale; he had a bit of jaundice. The next week he got it investigated. We found out that he had some liver failure, and about two months later he passed away of liver cancer. That physician had 2,200 patients. We have been very successful because we have a residency program to draw on a former graduate from our program who has now taken over his patients. Otherwise, we would have had 2,200 orphan patients. The group was very good in absorbing that patient roster.

So 18, yeah—18 and about 40,000.

Mr. Mike Colle: I think it just makes me be reminded of how many pressures front-line health care providers have in this day and age. It's just daunting. I was in my doctor's office last week, and just the phone ringing—he works in the basement of his house, but he works out of North York General too. He had just delivered a baby and then he came back. I said, "I wouldn't want your stress, Doc. I wouldn't want your stress." I don't know how you guys do it.

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In this committee, we're looking at improvements and different directions, and I think sometimes we don't think outside the box enough and we're not allowed to think outside the box. We just beat up old boxes all the time. But anyway, the one thing I had is—I'm dealing with a case right now where there's someone suffering from terminal cancer. The person is getting chemo, comes down here to Princess Margaret, goes home, is not able to really drive anywhere or go grocery shopping etc.; has some home care; but luckily, his sister is there taking care of him. She has basically moved in. Therefore, she is providing the transportation, the shopping, the cooking, the cleaning, the basic little supports that you need when a person is suffering through cancer in the late stages. I'm just thinking: Since you provide home care through contracted services, why not look at perhaps a system whereby, if there are caregivers who are outside the contracted services—that could be a family member, a friend, a relative—who are willing to basically provide some of those support services that you need—because it's not just what the nurse does; you have to clean the bathroom and you have to cook for the person and you've got to give the person company.

I know that they have this system in Italy where basically, if there is someone who decides that they're going to be a caregiver, there is compensation that goes to that person who provides that care at home for someone who is ill. So why couldn't the CCACs be able to, also, in order to expand the service provided—because if there's someone willing to do that, it would take pressure off of the demands you have, as doctors, as PSWs, as care coordinators. Why not enhance the system, because I think in some ways there might be a savings down the road, or else that person will end up in a long-term-care home; they'll end up in a hospital; they'll end up sicker, so you'd need more hours of care from the contracted service. Could that possibly be administered or examined as something that might work?

Ms. Stacey Daub: Absolutely. I think it's one of the public policy decisions you could make in terms of flexibility and choice. There are, in fact, many jurisdictions across the world that do that very thing in terms of supporting caregivers, sometimes even paying caregivers to provide the care and support to the individuals. So I think it is that kind of out-of-the-box thinking that we need to think about.

The one thing I want to correct: Home care is more than our contracted service providers. When we go in to a client, our job is to bring all of the resources to bear. So sometimes, it is actually helping—we can't pay family caregivers right now, but it is counselling about their role, and helping them to be better caregivers. We have a relationship with the Reitman Centre at Mount Sinai, and we train all of our caregivers on how to actually engage with caregivers and train caregivers. They have a role of helping caregivers be better caregivers or more supportive caregivers. They have a role to bring community support services. Sometimes they have a role to help someone get a wig because they want to go back to church and that's the most important thing. This whole focus, to me—I've always wanted to put this on public record. Years ago, my husband wanted to get me a t-shirt that said: "Home Care: It's More Than a Bath." It's far more than that. It is creating a village of care around individuals, and that is our responsibility and that is what I think we should be held to account for, and we need the flexibility to do that.

Mr. Mike Colle: But couldn't the village of care include—

Ms. Stacey Daub: Absolutely. It should include professionals, non-professionals and family caregivers.

Mr. Mike Colle: Is it possible to manage, or am I dreaming in Technicolor?

Ms. Stacey Daub: No. It would in fact be easier because, in my opinion, you need to bring—many family members want a part to play. If there were ways that they wouldn't lose income and could be remunerated to play that part, they would happily do it. Some simply can't because they have jobs and they are the primary breadwinner. So there are many ways to build that village, including unpaid caregivers and finding a way to potentially compensate them. Right now we do have policies

and things in place around family caregiver leaves and so on; they're just pretty limited.

Mr. Mike Colle: Not enough.

Ms. Stacey Daub: If you think about the people whom we're caring for, years ago it was for a short period of time. The interesting thing to me is, our length of stay is going longer and longer and longer because people are managing at home and they want to stay at home. So it's not going to be this short period of time where you're—I think of my own father, who is 88. People are living longer and staying at home longer, and we are going to have to be more creative.

You're going to hear from Dr. Sinha later, I think. He's done all kinds of research and has talked to people across the province. He might be able to give you some other good insight on how to think outside that box, because that's what we have to do.

Dr. Frank Martino: In Italy—you make a very good point—I have two aunts who have been taken care of through that particular system, where a younger senior, who is retired, is paid to care for a much older frail senior, and it worked very well for almost 10 years.

Mr. Mike Colle: Yes. I don't know if there are Ministry of Health people here, but I've been trying to push this idea, but I always say—and it's, "We've got to deal with this."

Anyway, thank you for that. Maybe I'll get back to you for a letter of support for my idea—but just to consider it anyway, because I know these things are not easy to deliver on the ground because it always needs coordination and oversight and so forth.

There's a cost to being a caregiver. Whether it's the PSW or whether it's the family member, it's gas, transportation, clothing, time off work, whatever it is—there is a definite cost. Sometimes we don't incorporate that cost, and we don't appreciate the time and effort and compassion that people can give to a person who's ill, and I think it might enhance that.

Just getting back to the bedbug thing, I was going to ask the care coordinator if she could—Laurel, I think it is. Right?

Ms. Laurel Stroz: Yes.

Mr. Mike Colle: So if you go into a home and you see the situation where obviously that person cannot take care of themselves—there's obviously hoarding or there may be bedbugs, cockroaches or all kinds of things—what can you do, outside the medical situation, to help them deal with those not directly health-related issues but obviously manifestations of other health-related problems? What would you do or how can you help those people in those conditions?

Ms. Laurel Stroz: Sure. I can just speak generally to that because every client has a very unique situation and would require a unique service plan.

I worked specifically in the Regent Park-St. James Town community, and there was a great deal of bedbugs and a great deal of cockroaches, and social/environmental issues in conjunction with other very poor social determinants of health.

It takes a lot of thinking outside the box in order to be able to provide health care in those circumstances. So my role as the CCAC care coordinator really was to partner with all of the other agencies that are able to provide supports, so volunteer agencies, cultural-religious agencies, Toronto Public Health and their bedbug team, and the local St. James Town Health Centre. We worked as a team and developed individualized service plans for each of those clients who would have very high health care needs: very frail, lack of social support, and in need of more intensive case management.

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

The official opposition: Mrs. Elliott.

Mrs. Christine Elliott: I just have a couple of questions on completely different issues. One is a concern that has been expressed to me by primarily nursing care providers that the practice that's been adopted by CCACs of doing direct hires is a conflict of interest that is negatively affecting them. I was wondering if you could tell me where you have decided to do direct hires and explain the rationale for that, please.

Ms. Stacey Daub: I was hoping this question would come because I've heard the issue of conflict of interest, and I'm not quite sure what they mean by "conflict of interest." It would be helpful to have a direct conversation with the providers, which I have tomorrow and will ask what they think that actually means.

CCACs have hired, directly, care providers for as long as I know, and I've been in the business—we hire occupational therapists, physiotherapists, social workers, nurses, in-care coordinator roles. Many of us, for many years, have been hiring pharmacists, nurse practitioners. Where it has been a local CCAC choice, it has been about the needs of a population or a client and our partnership. So, for example, with palliative, it made more sense to have a nurse practitioner associated with our physicians and our care coordinators working with the community nurses rather than having nurse practitioners hired by 10 or 15 different organizations. It made more sense to have a centralized team. It was in the best interests of the clients and it was in the best interests of the team. In fact, Russell Goldman, who is our medical adviser from Mount Sinai, helped us to think through that, and so did patients.

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I think what's interesting is that on the ground, when I talk to nurse practitioners and front-line nurses, they don't seem to have an issue with it. They work it out. They have respective roles. Laurel made reference to the fact that they have unique yet complementary roles, and their roles are to work together. So I generally don't hear the issue at the front-line level; I hear it up at the organizational level. Again, without having a direct conversation, I couldn't guess why.

More recently, in the last year, we were actually directed by government to take on a new role. We were given a new role. I'll give you a couple of examples. One was nurse practitioners for palliative, and many of us had

already been employing them for years. South West had them, I had them, and Central West had them. So that was nothing new, and it actually came as a blessing, because for our palliative clients, it was very helpful to bridge the gap sometimes when there wasn't primary care.

Mental health nursing was the second one. I myself wondered whether that might be a good role for the organization, so I consulted—even though government asked me to do it, I consulted with local partners. I phoned Mary Jo Haddad at the Hospital for Sick Children, I talked to CAMH and I talked to Dellcrest, and I talked to them about whether this was the right role. What they told me at the time is, "You're already in the schools, you already have a way in there, and you're going to be the first people to get care to kids who need mental health support, and we'll support you in terms of our supports and mental health training." In fact, in that particular situation, all 14 of us worked with the RAO to get standardized training.

Where programs make sense—and those roles, too, never existed before. I can't imagine why there's a conflict, because they don't exist anywhere else; they're not competing with anybody else. In that particular circumstance, I know in my community it made local sense as a way to get the care as quickly as possible to the kids in the school.

So those are two examples, and I don't know whether Sandra wants to—

Ms. Sandra Coleman: Again, I think the important part is that we didn't submit a business case and ask for it to happen; we were asked to deliver on this new program. I think part of the thinking, in addition to that patient focus that Stacey mentioned, is just also that they are scarce resources. In all of South West, there are 11 mental health and addiction nurses. If you can imagine a little bit about our geography, we deal with 474 schools, so I think part of it was also from a practical reality in terms of that critical mass. If you attach them to individual school boards, they're then dispersed, and you don't have that consistent approach across either any individual LHIN area or potentially across the province, and so I think that is something about the CCAC infrastructure that makes it attractive for government to ask us to roll out new programs, because we can ensure consistency across our geography, but also we work quite closely as a team of 14 CCACs.

Mrs. Christine Elliott: The concern that I heard expressed to me was that when you are the organization that is responsible for awarding contracts based on best value and best service and then doing direct hires yourself—what I've heard from some providers is that the overall costs are higher because what you pay directly is greater than what is paid through the contracted providers. Have you noticed any difference in your bottom line by proceeding with direct hires in this way?

Ms. Sandra Coleman: I can only speak for South West. We have not done that economic evaluation. The programs are still pretty new, but it would be timely, at

some point over the next year or so, to do that—once the program development and partnership development and the outcomes in tracking measures start to come in—to be able to ask that question. I'm not aware that we pay more than anyone else. I'm not aware that that's the case. We set our compensation according to the collective agreements that we have in place.

Mrs. Christine Elliott: I think that probably would be a good exercise and analysis to go through, because we want to get the best value for taxpayers' dollars, of course.

Ms. Sandra Coleman: Absolutely. And I think, again, to look at the roles: The roles are very different from any of the roles being done by our contracted providers. The mental health and addiction nurses are focused on that consult with the children in the school who need immediate triaging and access to resources in order to ensure that there's either a transition—they've been in hospital, potentially, and are now wanting to return to school, or, in the case of mental health issues, there's a worry around crises that may be happening. So we may be the front face of the interaction with the teacher or the school, the principal for that child, but then the role is to involve all of the other partners. There has been significant partnership development with the other mental health providers to make sure that they are still being brought in in all of the appropriate cases. It is being thought of as an enhanced catcher's mitt to make sure that the people and providers are being involved the way—and that no one's falling through the cracks.

Mrs. Christine Elliott: Do I have time for one more?

The Chair (Mr. Ernie Hardeman): About two minutes left.

Mrs. Christine Elliott: Okay. My other question has to do with administration costs, and you've heard a lot about that. I think there's a difference of agreement about where care coordinators fall—whether they're considered to be part of the admin budget or a front-line service provider. I guess my question would be to Ms. Stroz in terms of the percentage of the time that you spend in the community meeting with people versus the other administrative responsibilities that you have.

Ms. Laurel Stroz: Actually, the team I worked on was looking at that and looking at how we maximize the time that we're spending doing client care versus the necessary administrative tasks that we do. As I indicated before, I worked with a very needy population, and I did my best to be on the ground at least three days a week. I was working in a small, tight-knit community, so I could see probably about 10 clients within that time. The other two days would be spent—I'd do a lot of educational work, and in conjunction with that I would be doing some administrative work. I don't know the exact percentage for you, but I could say that the majority of my work, due to the nature of my population, was hands-on work with clients.

The Chair (Mr. Ernie Hardeman): Thank you all for your presentations this afternoon. I know it may not seem that way to you, but two hours does seem to fly,

doesn't it? Thank you very much for taking the time to come in and talk to us this afternoon.

DR. SAMIR SINHA

The Chair (Mr. Ernie Hardeman): Our next presentation is Mount Sinai Hospital's Samir Sinha, executive director—no, director of geriatrics. I'm in the wrong column here.

Good afternoon, and thank you very much for your attendance this afternoon. You will have 15 minutes in which to make your presentation. You can use any or all of that in your presentation. If there's any time left over, we will split it between the parties for questions or comments to your presentation. Your 15 minutes start right now.

Dr. Samir Sinha: Okay. Thank you very much, Chair, and thank you very much to the committee for giving me your time. I have a presentation here and I'm just going to try and get through it in about seven or eight minutes so that we do have time for questions as well.

On the first slide inside, I want to disclose the many hats that I do wear as a geriatrician. I'm here wearing many hats: one is that I'm the director of geriatrics at Mount Sinai, but when I was recruited back three and a half years ago from the United States, I was one of only 250 geriatricians in Ontario. I've taken a number of system leadership roles as well just so that I could help ensure the coordination of the care of my patients, given that I care for very frail, complex older patients across hospital, outpatient and home-based settings as well. In May 2012, I was appointed by the Minister of Health to lead the development of a provincial strategy around seniors.

Slides 3 and 4, in particular, speak to the reason why seniors have become a particular focus for the province: They number 14.6% of our population, they will double in numbers over the next 20 years, and they already are responsible for half of our current health and social care spending. Slide 4 just gives you an example that, again, they number 14.6% of our population yet they are responsible for 60% of our in-patient hospital days in Ontario.

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I've had the privilege of meeting with well over 10,000 Ontarians now to talk about the issues of seniors in particular, and slide 5 talks about some of the things that I heard through those consultations. For example, I think that we still are living within a system where we do little to empower older adults and caregivers with the information they need to navigate the system. We heard about that earlier in the conversations. We also don't require that any of our current or future health and social care professionals require training in the care of the elderly.

Another big issue that we have to address, if we're going to take our future challenges seriously: We still have very strong issues with silos between those who provide care—between hospitals, between primary care

and between our community care providers. That's a problem. We also talked earlier around the need for better capacity planning so we know what services we need to provide.

Slide 6 really just talks about the issue that—again, when you talk about the patients that I care for, those represent the 10%—the most complex individuals within our health care system. When you just look over the health care spending amongst those who are 65 and older, that 10% accounts for 60% of the health care spending, or \$12 billion for 190,000 older adults on an annual basis.

The goal of the strategy was really thinking about how we address our dilemma—which is on page 7—really focusing on that we actually have a mismatch. I often am quoted as saying, “The patients have changed and our system hasn't.” When we founded medicare in Ontario 50 years ago, the average age of a Canadian was 27 years of age. The average of an Ontarian today is 47 years of age, yet we have a system that was organized, as we heard before, for a younger population in particular. Our system is not currently matching the needs of its current and future users. Therefore, we need to address this. The majority of Ontarians told me that they plan to age in place.

I don't know if I'm allowed to ask the committee, but I asked this of over 10,000 Ontarians: How many of you in this room aspire to age in place and not end up in a long-term-care home? How many of you aspire to end up in a long-term-care home? One person; exactly. But the point is, the majority of you do not raise your hands because you would like to age in place, with your things—

Mr. Ernie Hardeman: I already live in a long-term-care home and I hope to live there forever.

Dr. Samir Sinha: There you go. Okay.

On page 8, you'll see my patient today, Mr. W, who is 104 years old as of a few days ago. He's supported through a house calls program, a home-based primary care provider. I provide his geriatric care in the home. He actually went to Mount Sinai Hospital. I've been out of the hospital all day today, but I can tell you that he was in the hospital at 9 o'clock this morning when he was having chest pains that weren't relieved at home. He was sent in by EMS, he was evaluated by our GEM nurse and he was actually just sent home two hours ago. How do I know that? Because we have everything integrated on our iPhones; we actually have things connected for those frail patients—again, another eHealth strategy that our hospital has implemented, connected with some of our community providers, including the CCAC. Anyway, it's how we've kept this 104-year-old back at home and not in the hospital, where he would have otherwise ended up today if we didn't have a good conversation occurring over email.

Page 9 really talks about the reason why the Ontario government decided to launch the development of the Seniors Strategy in particular. Ontarians told me that there were five key principles that were important to

them: those of equity, quality, access, value and choice. Those are things that you have been talking about today.

Slide 10 really just shows you that, during the consultation process—I had six months to travel to every single LHIN in Ontario, work with the LHINs and consult with Ontarians. You can see that I communicated with over 5,000 older Ontarians, 2,500 front-line health and social care providers, and 1,000 caregivers. My report, which the next few slides talk about, is a 233-page report. I knew that many of you were wanting to focus on the issue of home and community care, so you do have the summary of the report but you also have the chapter on home and community care that raised the issues that I heard, but also some solid recommendations to move the system forward, which the Ontario Association of CCACs fully endorse, as well as many other providers. The report, by the way, has been downloaded by 25,000 people to date, and I'm glad to see that many of the political dialogues are no longer focusing on building more long-term-care beds but actually about strengthening home and community care.

Page 11 really focuses on the chapters that show how these recommendations shouldn't just focus around the health care system, but also, “How do we strengthen our communities to really help people age in place?”

Page 12 focuses on the fact that we had 33 non-health recommendations really focusing on those broader issues, and 133 health care recommendations, 90 of which I'm told are now being actively implemented by the Ministry of Health as they're implementing the work on the Seniors Strategy.

Page 13 really focuses on why we made the argument that more investments in home and community care are the way to go. It's not only more cost-effective, but it's actually what's in line with what Ontarians want.

Page 14 helps dispel some of the myths around what our investments in home and community care getting. The fact of the matter is, while there are people who are still waiting for long-term care in Ontario, you will see with the last point that the actual rate of placement of older adults—75 and better—into long-term care has actually decreased by 26% over the last three years, principally because we've invested almost half a billion more in home and community care over the last number of years.

Page 15 really focuses on what the government and myself in my role that continues are continuing to advance forward in looking at the role of home and community care, but also the other areas to support Ontarians to age in place: everything from strengthening primary care to focusing on health promotion and prevention, thinking about how we improve scopes of practice, and also looking at areas like community paramedicine, which was one of the latest announcements to move forward.

In terms of a moment or two on the LHINs, in terms of the next slide, page 16 and 17—really, are LHINs useful? Well, what I learned from my conversations and from the work that I've done in the UK and the United

States as well is that, again, no matter what jurisdiction I'm in or what area of health policy I study, health care is a local issue. The fact of the matter is, when you try and organize things centrally—I think that's important, that the government sets the tone and sets the agenda, but at the end of the day, the issues of the North East are very unique and different than the issues of Toronto Central. So I think LHSIA provided a better vehicle in 2006 to plan, integrate and fund local health care.

I think I'm one of the only people who can proudly say, in this room or in this province, that I've actually travelled to all 14 LHINs and I've dialogued with thousands of Ontarians about what was absolutely important to them. Again, despite their working limitations, I think the key—and what I realized—is that the LHINs have come of age over the last few years, in terms of they understand their local needs and influence and manage local change as best as possible, despite their limitations. I think we now have an opportunity, through this review, to say either we end the experiment or we actually remove their overall limitations, in my view, that can potentially support the necessary health care transformation that is needed over the next two years.

You will see two examples on slides 18 and 19 of things that I have been involved in. The Toronto Central LHIN is my local LHIN. One of the examples was that with almost half a million people in the GTA having limited English ability and requiring medical translation, you can see what the average cost for hospital translation services was: \$1.70 to almost \$8 a minute. Working through the Toronto Central LHIN, we were able to consolidate through one contract, not just with the hospitals but also now free of charge for local community providers. Access to these services at \$1.44 per minute has not only saved dollars for all these providers, but it meant that people can actually get translation in their language of choice, which is absolutely important when making those decisions.

Another service that has been very personal to my heart was when the James Bay coastal chiefs and their elders invited me to go dialogue with the elders in those communities starting in February 2013. Those elders—where they don't have CCACs available in those areas to provide care, just the Red Cross—were saying to me, “We're not actually getting home care services because home care is not available in our community; therefore, our only choice when our care needs intrude is going to a long-term-care home in a community that we do not know, that's hundreds of miles away.” Therefore, the North East LHIN has used the money that was coming back to them for unused home care services and actually has created a grow-your-own personal support worker program funded through the Red Cross, where we've actually had dozens of local people now signing up for these courses. The first folks were going to graduate in July. This has been an issue of economic productivity, creating jobs in these communities, but also providing care.

Slides 20 and 21 are my concluding slides, showing that when LHINs were formed in 2006, at that point the

ministry chose to not enable greater control and integration opportunities for them, as we've seen in other areas where they've created regional health authorities in particular. The challenge is that their primary care services remain provincially administered. You've talked about how while CCACs in 2006 were merged to become co-terminous with LHIN boundaries, their functions were not integrated with them. I think there were good reasons behind all of these decisions, but I think there are opportunities with a LHSIA review to focus on where things can go.

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Currently, the LHINs work with 2,000 service providers. I think that should be fewer. Right now, health care is becoming focused on the provision of services closer to the patient's home. We need to have greater integration of the services and service providers. We heard great stories today about how that's actually happening, but that's not always the reality, and we need to move forward in those areas.

I'm not sure who decided the LHIN boundaries, but the fact of the matter is, they also don't relate to public health and EMS services, which remained out of the tent and within the realm of municipalities.

In terms of where we should go, I think we need to give LHINs greater responsibilities, personally, for managing accountability for local primary, home and community care services in ways that enable better access, efficiency and quality.

I think we need to better define those responsibilities of health care service provider boards to support and enable ministry and LHIN priorities to make sure that they are actually working within the plan of what the ministry and the LHINs need them to do, not necessarily what they want to do.

I think we need to give LHINs greater flexibility to allocate funds and reduce administrative barriers to develop more integrated models of care that make sense locally.

My contact information is on the last slide.

I think I have left about five or six minutes for questions.

The Chair (Mr. Ernie Hardeman): All right. Thank you very much. We just have time for one caucus, so we will go to the official opposition. Do you have any questions?

Mrs. Jane McKenna: Thank you so much. Wonderful presentation. You zipped right through that. It was very well put together.

On page 17, you're saying here that, “I can say that despite their working limitations”—the LHINs, there. So what exactly are their limitations?

Dr. Samir Sinha: I think the challenge is that we've given LHINs the opportunity to start organizing and planning health care, but they have very little control. In my view, they're the magical flow-throughs of which funding decisions have been made by the Ministry of Health, but not necessarily saying if LHINs actually have a better way of doing something.

For example, on the James Bay coast, the fact of the matter is, home care services are just not available. In some of our rural communities, CCACs don't have reach into those areas. So the opportunity to actually give LHINs the opportunity to say, "How do we organize services in that context?" or if we need to actually get hospitals starting to say, "We need to actually get you putting that discharge summary"—Dr. Martino's comment; or at Mount Sinai Hospital, where we give discharge summaries—is great. That's great practice, but that's not the reality for most hospitals. Sometimes LHINs don't have the power to say, "Thou shalt do this," for example.

So I think the opportunity is to also say that CCACs have actually been saving hospitals lots of money, because they're getting our patients out of those hospitals sooner. But the key is that the hospital then doesn't give that money that they've saved over to the CCAC, for example, or to the LHINs, to say, "How do we shift that money to provide more home and community care?"

I think when you give LHINs more power, in my view—just like regional health authorities have had in other jurisdictions—sometimes that means you get rid of all the boards of all those local organizations. These are very political decisions to make. But sometimes we have to look at—in a thoughtful way, of course: How do we actually enable those local providers to really be accountable for their local health populations and how to provide that care?

Mrs. Jane McKenna: As MPPs who are sitting around this table, we have job descriptions of what they are, and we can't say to people, "Well, we've got limitations," or, "We can't do this. We can't do that." So sitting through this process for—I don't know how long we've been doing it now. But I guess I'm curious that I always think, if you're not part of the solution, you're part of the problem.

Dr. Samir Sinha: Absolutely.

Mrs. Jane McKenna: At what point, after eight years—I think it's eight years they've been around—do we finally get a job description, understand what everybody's doing instead of—there's just so much clouded area all the time. Even here today with the CCAC is, "This isn't my responsibility," and this and this and this. I guess where I struggled with all of this is: When can we make a case of who's doing what, what the job description is, so we can stop saying, "There are the limitations. They can't do this"? I'm curious when that happens, because eight years is a long time to be still saying—

The Chair (Mr. Ernie Hardeman): Okay. Your time is up. If you just want to give a quick answer.

Dr. Samir Sinha: Absolutely. So my patient who is 104 years old says, "I was waiting for this to actually occur a lot longer." This is a reason why this is a 233-page report. This is not fluff. This was taking all the answers we heard from different people within primary care, home, and community care, and starting to sketch out what our system needs to actually look like to move that forward.

That's why I presented 166 recommendations to the government. It built on Drummond. It built on Walker. But the key is that I haven't seen, sometimes, as much action as we needed.

I thank the government for recognizing this report and actually moving on it, but I'd like to see every single recommendation acted on, because I think it will address exactly what you're talking about.

Mrs. Jane McKenna: Thank you for your recommendations.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That which we haven't fully absorbed we will read at our leisure.

Dr. Samir Sinha: I appreciate it.

CENTRAL TORONTO COMMUNITY HEALTH CENTRES

The Chair (Mr. Ernie Hardeman): Our next presentation is the Central Toronto Community Health Centres: Angela Robertson. Thank you very much for coming in and sharing 15 minutes with us this afternoon. As with the previous delegation, you will have 15 minutes in which to make your presentation. You can use any or all of that time for your presentation. If there's any time left over, we'll have questions and comments from our caucus.

Ms. Angela Robertson: Thank you very much. As you've heard, my name is Angela Robertson. I'm the executive director of the Central Toronto Community Health Centres here in this city. I'm here today to speak on behalf of my centre and to inform, hopefully, your reflections and recommendations as you undertake this review process.

As you would have heard from other provincial presentations, community health centres are a community-based model of care that provide comprehensive primary care services in combination with health promotion and illness prevention services to people who typically face a range of barriers in accessing health care services. There are currently 75 CHCs in Ontario, 17 of which are in the Toronto Central LHIN. Our centre is located in the heart of the city, Queen and Bathurst, and provides services to four priority populations: folks who are homeless, folks who are living with mental health and substance use issues, youths at risk, and immigrants and refugees. I think it's significant to underscore that the majority of our clients are living with household incomes of under \$20,000.

The goal of the LHINs, when they were envisioned in 2005, was to plan, coordinate, integrate, manage and fund care at the local level within defined geographic boundaries. This then was, and I think remains, a transformational agenda to create a patient-focused system and to move planning from the centre, as you've heard from Samir and others, of the ministry to the local; and from what was then the district health councils, which really lacked the resources and accountability levers to advance health system changes.

This was, and I think remains, a worthwhile vision. I'm here to comment on the strengths of the Toronto

Central LHIN and to offer some reflections on ways in which the LHINs can be improved for the next wave of transformation in the health care system. Specifically, I will speak to three areas:

- the LHINs' advancement of a health equity agenda;
- the LHINs' role in local planning and collaboration across sectors with broad determinants of health framework and objectives; and
- the role and scope of the LHINs with respect to primary care.

I think I will echo some comments that you've also just heard earlier.

On the advancement of a health equity agenda, significantly, in 2005, when the province launched a series of consultations to inform the creation of the LHINs, I was a participant then as the executive director of a small community mental health support organization. At that time, as key stakeholders, we were asked to identify 10 priority health system opportunities. Many of the identified priorities dealt with a range of issues related to targeted populations, whether it be mental health, seniors, addictions. Others were broader and targeted opportunities talking about the system as a whole. But within the Toronto Central LHIN, one of the priorities defined by the community was the TC LHIN advancing action, planning and investments in a health equity agenda with a goal of improving access and health outcomes for marginalized populations.

This we felt was a significant focus in Toronto because health equity was identified as a priority, because as you know, Toronto is home to large immigrant, racialized and multilingual communities. We have high levels of low-income households concentrated in what are termed "priority neighbourhoods" across this city. As well, we have high levels of homelessness and individuals who are precariously housed, and the evidence clearly tells us that there's a gradient in health whereby people with lower income, education and who are faced with other social determinant challenges around exclusion have poorer health and poorer health outcomes.

I think with that it was important, from my work and from the work of others in the organization, that the TC LHIN's leadership in adopting health equity as a key enabler, embedded in its strategic plan and with defined priorities, was also a major strength. The LHINs' leadership on this has resulted in four priority actions to address health equity which I think are instructive for this review process and for LHINs system-wide.

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They engaged in a process around the importance of equity data collection at the point of care. One of the things that we know, from the work that you're doing here and work that's happening next door, is that what you count matters and that what matters should be counted. The LHIN has worked on the data process around equity in terms of capturing equity data.

The other piece that the LHIN identified as a concrete action around equity was equity indicators. You heard from Samir around the advancement of a language inter-

pretation service. One of the key indicators there was ensuring that, to improve quality of care, patients and their families could understand the provider and the provider could understand the patient as one of the core principles about delivering quality care.

We have seen also that the LHIN has adopted a health equity assessment tool, which is really asking providers, before they undertake large system and/or program change, to look at: How will that program or system change impact those who are most marginalized in accessing care?

As well, we have seen the LHIN undertake work to advance the French Language Services Act by putting accountability measures in place for us as health service providers to have in terms of plans to enable language access for francophone patients and their families.

We have also seen the LHIN address barriers to known health care services. We have seen the LHIN take a leadership role in seeking to respond to gaps created in access for refugee care that were left by some of the cuts that were made recently to the Interim Federal Health Program, and I think that has been a significant LHIN leadership.

We have also seen the LHIN take a role in identifying and prioritizing work to support aboriginal youth, particularly aboriginal youth mental health programs, and we've also seen them undertake work around developing cultural competency for us as health service providers to provide more competent and responsive care and having done that in partnership with local organizations, specifically the Ontario Federation of Indian Friendship Centres.

Lastly, on the health equity agenda, we have also seen the LHINs adopt and really incorporate and advance an accountability lever by asking all health service providers, particularly hospitals and CHCs, to provide annual health equity plans whereby the LHINs can hold us accountable as providers for really responding to those who are most marginalized with access challenges.

I would say that the LHINs' leadership on equity speaks to the value, and its embedding of equity principles speak to the value, of building support structures that can be responsive to those who are most marginalized in accessing care, and here's an opportunity that can be leveraged across the system and across the province.

In terms of speaking to the role of the LHIN in local planning, I believe this is an area where the Toronto Central LHIN has excelled. It has used its strategic priority of addressing the needs of the 1% to 5% of highly complex patients with the greatest needs, requiring the most resources, and preventing and delaying serious illness and injury among those who are at greatest risk of declining health as a catalyst to convene local planning opportunities and collaboration with institutions and community-based providers. I am proud, as a CHC, which might be seen as a lowly community-based organization, that as a result of that effort, we now sit at planning tables with area hospitals, CCACs, family health teams, solo-practitioner physicians and social service

organizations seeking to support and improve navigation of the system for vulnerable and marginalized populations.

The LHINs' population health planning approach is responsive, appropriate and effective. The TC LHIN's strength in planning and collaboration has been keen in its awareness that health care support and intervention is only one strategy to create good health outcomes. Hence, as part of this broader collaborative planning strategy, the LHIN has sought to include in its planning other sectors like the city, United Way, Toronto Community Housing Corp. and the Toronto Transit Commission, just to name a few, with other community partners. This, I believe, ensures that the transformational system it seeks to build is linked and integrated into the broader social fabric and conditions which—we know that other parts of the system have significant contributing value to health outcomes, and the LHIN has seen those other places as key partners to bring to the table.

The LHIN has also created sector tables for hospitals and CHCs as a way to convene and ensure that proactively we can come to the table not just with the problems but also to talk through in terms of solutions.

Lastly, in terms of the role and scope of the LHINs with respect to primary care—and Samir indicated this in his presentation earlier—while as a CHC we are in favour of keeping the regional structure of the LHIN, we believe they should be given greater authority and responsibility for the planning and service delivery of the entire primary health care system. This includes family health teams. Currently, CHCs are the only type of primary care providers included in the LHINs' mandate. It is a challenge, I would suggest, for system planning and collaboration to have the family health teams being outside of this planning system when we know that the majority of individuals who access care are accessing care through these other venues and through these other opportunities. I respect that providers in the family health teams have negotiated contracts with the OMA; however, there is no reason why management of those contracts should not be under the LHINs' mandate.

Health links, I believe, are an example of bringing family health teams to the planning and care coordination table with the LHINs. However, they are not accountable to the LHINs. The risk here is the creation of fragmented primary care system and delivery models with sometimes possibly no alignment on strategic priorities, both from the government's perspective and from the LHINs' perspective. This, I believe, can only serve to undermine the building of an integrated health care system focused on keeping people well, not just treating people when they're ill.

As the evidence shows, early detection, treatment and intervention upstream create conditions for better health outcomes for patients and, in the long term, are more cost-effective for the health care system as a whole. Hence, an integration of the full scope of primary care under a single planning entity can make the LHIN a more responsive body, and I think the evidence proves that this would be worthwhile to pursue.

In conclusion, at Central Toronto we strongly believe that the TC LHIN and the LHINs in general have played a key role in building a more responsive health care system with tangible accountabilities, and we support their continued work as regionalized bodies in leading the planning, coordination, integration, management and funding of care at the local level across the province. Thank you.

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

We'll have questions and comments from the third party: Ms. Forster.

Ms. Cindy Forster: Thank you for being here today. This sounds like a pretty positive report about the Toronto Central LHIN from your perspective, but you haven't used any of your time to share with us perhaps some of the challenges that you face as a community health centre here in the centre of Toronto.

Ms. Angela Robertson: I think the challenge that I would begin with is on the third point, around the integration in terms of family health teams within the primary care structure. I think one of the things that we know as community health centres is that we will not be able to serve all of the most marginalized community members who need care—and that is part of our mandate, to focus on those who face significant barriers and challenges. With family health teams not being under the accountability structure of the LHIN, then some of that shared responsibility is hard to lever in some of the broader structure of primary health care for family health teams. The fact that that isn't present is a significant area for system improvement. The impact for us is that it means sometimes limited ability to plan across the primary health care stream, and that includes with family health teams as well.

Ms. Cindy Forster: Another area that you touched on but you didn't go into any detail on is around the issue of housing. We've heard about Home First for keeping seniors in their homes, but we haven't touched today on housing as being one of those determinants of health for people living on the street, for people living in shelters. Can you make any comments or have you been at any tables where those discussions have occurred, and is there any move to try and funnel some funding from a number of areas to make sure that there is more housing available for our constituents?

Ms. Angela Robertson: Yes, the housing conundrum is a challenge. It's a challenge for us given that one of our priority populations is individuals who are homeless and/or people who are precariously housed. What we have seen in this LHIN is some effort to do collaboration with local housing providers, both within the supportive housing sector in terms of mental health, particularly, the mental supportive housing sector, but then we've also seen the LHINs seeking opportunity to engage a Toronto housing company. Most recently, in the St. James Town, there was some work done around how to bring better coordination around all of the care for folks who are living in low-income support housing.

I would say that there needs to be a much more concerted effort on the part of LHINs across the board to drive advancing of a housing agenda, because I think without secure housing, without stable support and a stable base—we can invest a significant amount in the health care treatment end, but folks are not stabilized around their housing, so therefore it makes sustainability of that health where that intervention has occurred virtually, sometimes, impossible.

1640

The Chair (Mr. Ernie Hardeman): That does conclude the time. We thank you very much for your presentation, and I'm sure that the direction you were giving to somebody furthering the cause, they were listening and getting it done.

Ms. Angela Robertson: Thank you.

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

That concludes the public presentations this afternoon.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): We're now onto the next item of business, which was the motion that was tabled. The person tabling it is not here.

Ms. Cindy Forster: Correct.

Interjection.

The Chair (Mr. Ernie Hardeman): That's what I said: It's her motion. The committee can do anything they like with the motion if it's called, but if the person that's not here doesn't call it, it doesn't get called. She has moved it.

Ms. Cindy Forster: She has to be here to—it's already tabled. It's already moved, right? Can we not debate it?

Interjection.

The Chair (Mr. Ernie Hardeman): Okay. I'm told by the Clerk that we can have the debate on it if the committee wishes, because she moved it at the last meeting. With that, the committee's got the motion. Direction from the committee? Yes, Ms. Forster.

Ms. Cindy Forster: Thank you very much. Ms. Gélinas apologizes for not being able to be here to actually debate her motion, but when we talked about this—I think it was two weeks ago—at that point, there was another motion, actually, from the PC caucus, which I think ended up getting defeated. In any event, the reason that France Gélinas tabled this motion was that the Auditor General, who's going to be asked, I believe, by the PC caucus at another committee to review the CCACs, has told Ms. Gélinas that, although they're prepared and interested in doing that work, we would never see a report before June 2015 because of the backlog of work that is before the Auditor General's office already. So that is the reason that France moved this recommendation.

In addition to that, the information that the Auditor General would provide in June 2015 or later would really be a value-for-money audit after the fact, whereas this

particular motion is asking for more than just a value-for-money audit. It's asking for expert witnesses, including the CCAC leadership and staff and organizations that fall under the CCAC, to come and make presentations to us—health policy experts as well as patients and their families—in addition to reviewing administrative practices and compensation packages for this organization. Now, she did say that, if the committee members here wanted to defer her motion until after the Auditor General motion is dealt with at the other committee, she'd be happy to do that as well.

The Chair (Mr. Ernie Hardeman): First of all, in clarification, at the last meeting, there was no other motion. There was an amendment proposed to this motion that was ruled out of order—

Ms. Cindy Forster: Correct.

The Chair (Mr. Ernie Hardeman):—so it's non-existent. I would point out that what we're dealing with today is not whether a member that's not here would consider it appropriate to delay it or to deal with it. If the committee wants to do that, then they have every right to do that, whatever you—

Ms. Cindy Forster: I understand that.

The Chair (Mr. Ernie Hardeman):—want to do with the committee. I'd just point that out. So somebody could make a motion to defer it until another date. A motion like that would be in order, if the committee wishes that, or the committee can also carry on the debate and then actually vote on the motion, if you so wish.

So, with that, further discussion?

Mrs. Christine Elliott: Thank you, Chair.

The Chair (Mr. Ernie Hardeman): Yes, Mrs. Elliott.

Mrs. Christine Elliott: Ms. Forster is quite correct: There is a substantive motion right now before public accounts asking for the Auditor General to conduct quite a comprehensive audit. I'm pleased to hear that Ms. Gélinas would be amenable to delaying the vote on this particular issue until it has been clarified with the Auditor General as to exactly what she intends to do. I would certainly be happy to move a motion that a vote on Ms. Gélinas's motion be delayed pending clarification of the Auditor General's intentions in public accounts.

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

Ms. Helena Jaczek: Yes, thank you, Chair. I would go along with a deferral motion. From our point of view, I think we're very interested in the contents and what Ms. Gélinas wants to achieve. I think the Auditor General's review will be hopefully very comprehensive and include some of these items, but we have actually, during our committee hearings to date as part of LHSIA, requested some of these components already. I think we will be able to at least make some commentary in relation to some of these pieces that form this motion as part of the LHIN review in any event. We will be concluding that within this calendar year, so we might be able to point in a certain direction. But in terms of this motion to defer, we will support that.

The Chair (Mr. Ernie Hardeman): Okay. I would just clarify for the committee: A motion to defer—as

soon as you make it, there is no further debate, and you cannot include reasons as to why the deferral or when you are deferring it to. It's strictly a matter of deferring, and it will be up to the mover of the motion or anyone else to bring it back at a subsequent meeting. We can't relate it to anything else that's happening elsewhere.

Further debate on the motion?

Interjection.

The Chair (Mr. Ernie Hardeman): Well, we haven't heard it. Did you make a motion to defer?

Mrs. Christine Elliott: Yes.

Ms. Helena Jaczek: Yes.

The Chair (Mr. Ernie Hardeman): Okay, we have a motion to defer. We have a seconder. No further debate. All those in favour of the deferral? The motion is deferred.

Ms. Cindy Forster: Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Ms. Cindy Forster: One more issue, actually, flowing out of our committee hearings today: I'd like to have the committee approve a request for a copy of the market review study on compensation for the CCAC CEOs that we heard about today from the treasurer of the Ontario CCACs.

The Chair (Mr. Ernie Hardeman): Okay. Noted, and it will be asked for.

Yes, Ms. Jaczek?

Ms. Helena Jaczek: Yes, Chair. I'm wondering, in terms of our timetable going forward, when we will have an opportunity to look at the review of the Local Health System Integration Act, 2006, interim report, draft number 1. We have been provided with that table of contents and so on. Are we going to have specific time set aside for that discussion?

The Chair (Mr. Ernie Hardeman): Yes. As it relates to the next meetings on this, on March 24, we will have the Ontario Medical Association and the Toronto Central LHIN for 15 minutes, and report writing, so we will start then to review the information that we presently have.

Ms. Helena Jaczek: Thank you. That's good news.

One of the things I noticed in reviewing the interim report, draft number 1, is that Carrie has included the 15 recommendations from the LHINs themselves. I found it quite difficult to actually understand the rationale for some of their recommendations, and I'm just wondering if we might not want to have further testimony from them as to why and what exactly they mean.

The Chair (Mr. Ernie Hardeman): Well, if I could just finish—

Ms. Helena Jaczek: Yes.

The Chair (Mr. Ernie Hardeman): The next Monday, March 31, we meet with the Ontario Hospital Association, so even though we will be doing report writing at the end of the next meeting, that will be the appropriate time for you to suggest what more could be done, and if there are more people who you would want to hear from because of what has been done so far.

Ms. Helena Jaczek: Thank you, Chair.

The Chair (Mr. Ernie Hardeman): The first meeting of the report writing is not to exclude further public hearings. Anything else? Yes, Ms. Forster.

Ms. Cindy Forster: Just a question: Do we have social policy again tomorrow from 4 to 6, or not?

The Chair (Mr. Ernie Hardeman): We don't have anything to talk about tomorrow. Those of you who wish to come—if it's the majority of the committee, I'll come and sit here, but if there isn't a majority here then there's no sense in the Chair coming either. Ms. Elliott?

Mrs. Christine Elliott: Chair, with your indulgence, I'd like to introduce another motion, if I might.

The Chair (Mr. Ernie Hardeman): Yes. We have another motion.

Mrs. Christine Elliott: I move that the Standing Committee on Social Policy commit one day a week to consider Bill 135, Ryan's Law (Ensuring Asthma Friendly Schools), 2013. This review will commence on Tuesday, March 18, with one session of public hearings on Tuesday, March 25, followed by two sessions of clause-by-clause on April 1 and April 8.

The Chair (Mr. Ernie Hardeman): The motion is in order, except that the timing of the first meeting is difficult because, to have committee hearings on a bill, you have to have more than 18 hours to tell the public, "We're going to have the meeting." In fact, normally for the committee hearing to be tomorrow, the notice would have had to be given to committee members last Thursday. I just caution on the motion that it's going to be difficult to implement it in that time frame.

Far be it from me to suggest that hearing it is inappropriate, but the motion would work without actually setting that date. If the member would move the day to an acceptable date, it would make it a more acceptable motion.

Mrs. Christine Elliott: Yes. Perhaps, Chair, if I could amend it to include that the review will commence on Tuesday, March 25, followed by two sessions of clause-by-clause on April 1 and April 8.

The Chair (Mr. Ernie Hardeman): Very good. Thank you. Further discussion? The motion will be to commence the hearings on the 25th, which is a week tomorrow.

Ms. Helena Jaczek: Could we have a copy of the motion so we can review it in some detail?

The Chair (Mr. Ernie Hardeman): The copy is presently being made.

Ms. Cindy Forster: Can we take a brief recess while we're waiting for the copies?

The Chair (Mr. Ernie Hardeman): Recess requested. We'll have a 10-minute recess to get the motion printed.

The committee recessed from 1652 to 1701.

The Chair (Mr. Ernie Hardeman): I call the meeting back to order. The Clerk has passed out the printed motion. I just want to point out that there is a bit of a challenge with the motion. We have too many Tuesdays and not enough dates, and so if you would just cross out the first Tuesday, which says "Tuesday, March 18," and

then go on with the rest of it: “One session of public hearings on Tuesday, March 25, followed by two sessions of clause-by-clause on April 1 and April 8.” So it’s just that, out of the original resolution, they left the first Tuesday in and added the second Tuesday, when it’s actually going to start.

Ms. Cindy Forster: So how will it read, Chair?

The Chair (Mr. Ernie Hardeman): It will read, “I move that the Standing Committee on Social Policy commit one day a week to consider Bill 135, Ryan’s Law (Ensuring Asthma Friendly Schools), 2013. This review will commence on Tuesday, March 25, for one session of public hearings, followed by two sessions of clause-by-clause on April 1 and April 8.” You have to take the Tuesday, the 25th, and put it where Tuesday, the 18th, was.

Is everybody clear on what it says? Okay. You’ve heard the motion; it’s moved by Ms. Elliott. Any discussion? Yes, Ms. Forster.

Ms. Cindy Forster: First off, I would say that I don’t think we’d probably need two sessions of clause-by-clause on this particular issue. I think it’s a pretty narrow issue.

I’d also like to know what else is on our agenda, because we’re still dealing with the chemo dilution report. It’s not finished, and we’ve spent hours and hours and hours trying to get that done, so that needs to be completed.

We’re dealing with the LHINs review, and we still have people who we need to hear from, and we haven’t even started to get up and running with that report. So I’m hesitant to commit to three full days over the next three weeks on this issue until I know where we’re going to actually be going, and how quickly the LHINs report is going to be ready for us to start working on.

The Chair (Mr. Ernie Hardeman): I think I can somewhat, as Chair, answer some of the questions. First of all, we have finished the chemotherapy report. It is presently at the printer, so that’s finished.

The second item is the two days. If clause-by-clause is finished the first day, then we would have time to move something on that same day to put something in the next week. It doesn’t mean that two days have to be used; it just means that there are two days available. In fairness, if there’s a lot of discussion in clause-by-clause and in the two hours available you couldn’t get it finished, then you would be stuck with not being able to finish it at all. So I think—

Ms. Cindy Forster: Then you could actually book another day.

The Chair (Mr. Ernie Hardeman): —in the process, this is just making sure that there’s sufficient time.

Ms. Cindy Forster: So I would propose an amendment to this, Mr. Chair, that it be: “This review would commence on Tuesday, March 25, with one session of public hearings, followed by one session of clause-by-clause on April 1.”

The Chair (Mr. Ernie Hardeman): If I could, just for clarification, to make sure it works, if it meets the

needs of the committee: If you just said “with clause-by-clause on April 1,” you wouldn’t necessarily have to limit that it wouldn’t be two days. It would just say it was one day. But if you say only one day, then you could get stuck with the fact that you couldn’t get it finished at all, because you couldn’t go and finish it the following week.

So I agree with the committee that it likely won’t take more than—it would seem really strange if you could talk long enough on that size of a bill to need two days for clause-by-clause.

Ms. Cindy Forster: Well, I would say, then, “followed by clause-by-clause on April 1,” and just leave it.

The Chair (Mr. Ernie Hardeman): Okay. Yes.

Yes?

Ms. Helena Jaczek: Thank you, Chair. I suppose my concern is more around the process of introducing motions like this. We do have a subcommittee that could consider these items. There is a process through the House leaders. So I think we’re fine with going ahead on this one, but we seem to be going down a path of sort of ad hocery here. I would much prefer to have a clear path of what we want to consider over the course of the session—

The Chair (Mr. Ernie Hardeman): Again, as Chair, I agree with you. We should have a process, but as you know, we have nothing on for tomorrow, and if we don’t do something now, we won’t have anything on the following Tuesday.

I do have a list of the bills that are before the committee. Bill 104 is the Protection of Minors in Amateur Sports Act. Number 2 is Bill 135, the one that’s being referred to now. Three is the Paved Shoulder Construction and Bicycling Act, Bill 137. Bill number 4 is Bill 142, Major William Halton Day Act. And Bill 166 is the Toronto Ranked Ballot Elections Act. These were all the committee—the only one of the list that’s out of order based on the timing I have on my list is the protection of minors act.

Ms. Helena Jaczek: So further to that, Mr. Chair, could I suggest that we can vote and go ahead perhaps on this one, but could we have a subcommittee meeting or some sort of process where we can look at that list—

The Chair (Mr. Ernie Hardeman): I would point out to the committee and the subcommittee—and I’ve already spoken to the Clerk—that there’s a bit of a challenge with what we’re doing, based on the committee that’s going to deal with this bill starting on the 25th—there’s not necessarily the same members of the committee that’s dealing with this one, because this next one is not necessarily a health bill that would bring the health people in. So—

Ms. Cindy Forster: No, it is a health bill.

Ms. Helena Jaczek: Well, this one is.

The Chair (Mr. Ernie Hardeman): Well, it is, but it could very well be that the education people would have a greater interest in it than on the health bill, because it’s what they do at school and not how health is administered. So we should call a subcommittee to set up how we’re going to do the hearings. The notification for that

subcommittee will go to the sitting members of the committee, and they can then refer it to the critics that are required.

Mr. Mike Colle: Mr. Chairman?

The Chair (Mr. Ernie Hardeman): Yes?

Mr. Mike Colle: Just in terms of this motion, it's sort of difficult to decide what we should be dealing with—I mean, all of a sudden. There could have been some indication that this was going to come—that would have been helpful—that there would have been a subcommittee meeting. I know there are people here for the ranked ballot bill who are anxious to see it go forward. So who decides what goes—can I move a motion that we consider the ranked ballot initiative in this time slot? That's where we get to. Everybody cherry-picks a bill, and we don't like to deny any bill going forward, but on the other hand, who decides what cherries get picked if you don't have a process?

If this committee's going to deal with things fairly, you need some kind of subcommittee that sits and looks at a calendar and doesn't do this last-minute thing—“Well, we've got a date. Let's throw in this bill”—because there are other bills that could easily go in the same slot. You know, who plays God here, or who plays cherry-picker? I'm not sure.

1710

The Chair (Mr. Ernie Hardeman): No, it's not about playing God, and where we are right now is that we have two Tuesdays open, and anyone had the ability to put forward a motion of what we should hear. This one, in fairness, is fairly close, because I think traditionally we go to the order that they came in, and in the order that they came in, this one would be number 2.

Mr. Mike Colle: What's number 1?

The Chair (Mr. Ernie Hardeman): Number 1 is the Protection of Minors in Amateur Sports Act.

Mr. Mike Colle: That's Jerry Ouellette's bill?

The Chair (Mr. Ernie Hardeman): Jerry Ouellette's. It's been—

Mr. Mike Colle: He's tried that for five years, so let's bring that forward. I'll move that.

Miss Monique Taylor: Chair? I had my hand up, Chair.

The Chair (Mr. Ernie Hardeman): No, that's not the motion we have on the floor. The motion—

Mr. Mike Colle: Well, notice of motion: I'm putting forward a motion—

The Chair (Mr. Ernie Hardeman): No, Mr. Colle. You can't move a motion when there's a motion on the floor.

Mr. Mike Colle: Yes, but my motion will pertain to this motion, because if you vote on this, then you omit my opportunity to put forward Jerry Ouellette's bill.

The Chair (Mr. Ernie Hardeman): No. You can amend a motion in any way you want, except you can't change—

Mr. Mike Colle: Okay. I want to—

The Chair (Mr. Ernie Hardeman): No, no. You can't change the intent of the original motion, and your

amendment would be out of order because it would be a direct contradiction to this motion, and you can't have a motion like that on the floor.

Yes?

Miss Monique Taylor: Thank you, Chair. You know, today we've seen a lot of things happen out of process, and it's really not the way things are supposed to be done. Things are supposed to be done in a process. This has been happening for many years, as I'm told, historically in this House, and I just feel that this should go to subcommittee to be discussed at that point of when these bills are going to come forward, instead of it being brought out at the last minute where everybody is running and scrambling to find an answer.

I know that you're in support of this coming forward, Chair, but you're sitting in the chair right now, so your position is to rule, not to have a discussion or an opinion on this, in my belief—with all due respect, of course. I just really think that this should be going to subcommittee and letting them deal with it there, because now we're seeing, as you saw what happened this morning, everybody jumping up with their own ideas.

Mr. Mike Colle: Yes, I've got two. I want to move Jerry's, and the ranked ballot people are here, anxiously—

The Chair (Mr. Ernie Hardeman): Order. I would just point out that the process is quite clear. This is discussion, in fairness, that could have been held at a subcommittee, with the recommendation, with exactly the same thing. That didn't happen. But remember, every subcommittee meeting is held with one member of each party at the committee, and then its recommendation comes forward exactly like this. You would have had no further notice of this coming forward if it had gone through a subcommittee and the subcommittee had said it was going to come here.

Mr. Mike Colle: No, but generally speaking, you get notice of a subcommittee meeting so you have time, and then you find out what's the subcommittee agenda. We are not given any agenda here, so that is not normal. I'm sorry, Mr. Chairman.

The Chair (Mr. Ernie Hardeman): It may or may not be. Right now, there is a motion on the floor to move forward with this bill that goes for a vote.

Mr. Bas Balkissoon: Take the vote.

The Chair (Mr. Ernie Hardeman): Okay.

Interjection.

The Chair (Mr. Ernie Hardeman): First we have an amendment to the motion. Ms. Forster moved that the motion be amended by striking out “and April 8.”

Miss Monique Taylor: But I would like an amendment, Mr. Chair, that we move this to subcommittee.

The Chair (Mr. Ernie Hardeman): No. That's not an amendment.

Mr. Mike Colle: Sure. It's in order.

Mr. Bas Balkissoon: Sure, it is.

The Chair (Mr. Ernie Hardeman): You have to deal with the amendment on the floor. Ms. Forster made an amendment to move that the motion be amended by

striking out “and April 8,” and that’s the amendment that’s on the floor right now—not the motion; the amendment to the motion.

Ms. Cindy Forster: I’ll withdraw my amendment.

The Chair (Mr. Ernie Hardeman): Okay, so now it’s withdrawn. Now what’s on the floor is: “The Standing Committee on Social Policy commit one day a week to consider Bill 135, Ryan’s Law (Ensuring Asthma Friendly Schools), 2013. This review will commence on Tuesday, March 25, with one session of public hearings, followed by two sessions of clause-by-clause on April 1 and April 8.”

That’s the motion that’s now on the floor. Further discussion on the motion?

Mr. Mike Colle: I have an amendment.

The Chair (Mr. Ernie Hardeman): An amendment to the motion?

Mr. Mike Colle: Yes. I move that the Standing Committee on Social Policy’s subcommittee meet to consider—

The Chair (Mr. Ernie Hardeman): That’s not an amendment. That’s not an amendment to the motion. You can take this motion and you can table it, refer it, anything you like, but if you’re going to amend the motion, you can’t change the motion itself. You can move it to a committee. You can table it. You can defer a decision on it and send it to the subcommittee, but you can’t change the motion.

Mr. Mike Colle: Okay. Then I move that it go to subcommittee.

The Chair (Mr. Ernie Hardeman): Further debate on that?

Interjection.

The Chair (Mr. Ernie Hardeman): I think the only proper way to do it is to vote on the motion. You either vote and agree with this or you agree for the subcommittee to look at what should be heard.

Ms. Cindy Forster: Then I’ll call for a 20-minute recess.

The Chair (Mr. Ernie Hardeman): A 20-minute recess.

The committee recessed from 1716 to 1736.

The Chair (Mr. Ernie Hardeman): Committee, come back to order. The motion on the floor is, “I move that the Standing Committee on Social Policy commit one day a week to consider Bill 135, Ryan’s Law (Ensuring Asthma Friendly Schools), 2013. This review will commence on Tuesday, March 25, with one session of public hearings, followed by two sessions of clause-by-clause on April 1 and April 8.”

You’ve heard the motion. All those in favour?

Mrs. Christine Elliott: Recorded vote, please, Chair.

Ayes

Elliott, McKenna.

Nays

Balkissoon, Colle, Dhillon, Forster, Jaczek, Taylor.

The Chair (Mr. Ernie Hardeman): The motion’s lost.

Miss Monique Taylor: Chair?

The Chair (Mr. Ernie Hardeman): Yes?

Miss Monique Taylor: I move a motion that the Chair of the subcommittee on social policy call a subcommittee meeting to discuss how to proceed with Bill 135. And if I may speak to that?

The Chair (Mr. Ernie Hardeman): It’s a motion, and you’re allowed to speak to it—

Miss Monique Taylor: Thank you, Chair.

The Chair (Mr. Ernie Hardeman): —ad nauseam.

Miss Monique Taylor: The reason for us wanting it to go back to subcommittee is because we believe it’s a very important issue, something that needs to be dealt with. We think that stakeholders need to have the proper, appropriate time to be notified, to have time to prepare to come to the committee to present their case. We want to support this, but we think that it needs to follow through the process to make sure that stakeholders do have enough time to be able to attend.

The Chair (Mr. Ernie Hardeman): Thank you. Any further debate? Ms. Jaczek and then Mr. Colle.

Ms. Helena Jaczek: Thank you, Chair. Certainly, I’m going to be supporting the NDP motion. Not only is this particular issue very important, but all the bills that are before this committee are important. To start picking and choosing, putting one ahead of the other, whether it’s chronologically, when it was referred to us, or by any other type of criteria that you might judge—the order of this, I think, is something that should be very much fleshed out. But certainly, in terms of this motion, I’m going to be supporting it.

Mr. Ernie Hardeman: Mr. Colle.

Mr. Mike Colle: It is hard to, as I said before, decide which bill all of a sudden is on the agenda—and this is a very worthwhile bill that most of us would probably support and go ahead. It’s not that. The point is that you can’t throw these bills before us at the last minute without due process, without any kind of discussion, and then say to people, “Well, listen, we’re doing this bill.”

I think what we need to do is consider this bill at subcommittee, where it should have gone in the first place, and also consider the other bills that are before us so that we can decide and map out the calendar to see where we’re going. If this is first, I’m okay with that, and it could go with that. But I just want to make sure that we have some kind of order and plan that gives due process to this bill, Jerry Ouellette’s bill—what number is Jerry Ouellette’s bill?

The Chair (Mr. Ernie Hardeman): Bill 104.

Mr. Mike Colle: —Bill 104, for instance, and Bill 166. I would like to ensure that, at subcommittee, we put some kind of plan together over the next number of weeks to see what we want to deal with in an orderly

fashion. This bill, along with the other ones, could be given some kind of calendar. It's basically a calendar motion, really, that will enable us to look at this in a reasonable way.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion? We've just finished writing the motion? Yes, further discussion, Ms. Forster?

Ms. Cindy Forster: Yes, I just want to get on the record. I think Bill 135 is a very important bill—I mean, there's probably nothing as important as children's health. But there is a process, and I've been in other committees where this has happened. It doesn't give the people who are on the committee the opportunity to even go back and talk to your caucus about, "Well, what bills does my caucus have sitting in the loop here, and how long have they been there?" I think when they come up at the last minute like this, it really puts all of us at a disadvantage, including the people who we may be representing around the bill.

I think it will give more time and more thought to when hearings will be scheduled, and more opportunity for parents who may want to come and present to have some advance notice as well. But we are supportive of dealing with this bill as expeditiously as possible.

The Chair (Mr. Ernie Hardeman): Okay. Further discussion?

Ms. Helena Jaczek: Yes. I'm wondering if Miss Taylor would consider a friendly amendment, that the subcommittee meet to discuss all the bills that are before the committee, have that discussion and try to look at some orderly fashion of hearing them.

Miss Monique Taylor: I believe that the subcommittee has the right to speak to all bills that are before them, does it not?

Mr. Mike Colle: But that's why you have to amend it. If not, you can only speak to this.

Ms. Helena Jaczek: You've made it very specific, I think, in your motion—

Mr. Bas Balkissoon: So we're asking you to broaden it.

The Chair (Mr. Ernie Hardeman): You can do it either way, but the subcommittee always has the power to deal with all the bills. We don't need a resolution to do that. If the resolution is to move this bill forward, then the appropriate one is the resolution as it's written. But your amendment is in order, if you wish to make it.

Ms. Helena Jaczek: Would you have any objection to making it, that we consider all of them?

Mr. Bas Balkissoon: Put the amendment forward.

Ms. Helena Jaczek: I'll move that amendment, then.

The Chair (Mr. Ernie Hardeman): Okay. The amendment is to add—

Ms. Helena Jaczek: All the bills that—

Mr. Bas Balkissoon: Consider all the bills that are in front of us and come back with a time schedule.

Mrs. Jane McKenna: Isn't that what the subcommittee does anyway?

Mr. Mike Colle: But it hasn't done it.

Interjection.

Mr. Mike Colle: I know, but it hasn't been called because this motion's on the table, so you usurped the subcommittee. You should've called a subcommittee. We could've dealt with it in the subcommittee and brought the bill forward. That's all I'm saying.

The Chair (Mr. Ernie Hardeman): Who should've called a subcommittee?

Mr. Mike Colle: The Chairman should've called a subcommittee meeting.

The Chair (Mr. Ernie Hardeman): Yes, except the Chairman was doing something else in this committee. There was no reason for anything to come forward. Any member of the committee has a right to put forward a resolution to deal with the future business of the committee.

I want to point out that, when you go to subcommittee, they can make all kinds of decisions to bring back to the committee for the committee to decide. This is the ultimate place where it's decided, at full committee, so there is nothing inappropriate about someone putting forward a motion to deal with future business for meetings that we don't have anything scheduled for. If we go a long time with this one, all the time that's going to be spent with this one is going to be gone, because we have nothing in front of the committee. I'd just point that out.

Mr. Mike Colle: No, but we have the other bills before the committee.

The Chair (Mr. Ernie Hardeman): No, none of them are before the committee until somebody is willing to accept that.

Mr. Mike Colle: That's what I said. So the question is, who decides what bill should come before the committee?

The Chair (Mr. Ernie Hardeman): This committee, and that's what we're doing right now.

Mr. Mike Colle: But you wouldn't let me move the motion to say that we should be considering another bill.

The Chair (Mr. Ernie Hardeman): No, because the motion was before the committee—what you wanted to hear. That's the Chair's ruling, Mr. Colle, and you can't change it.

Okay. Now, you can change this motion. Is there an amendment to this motion?

Ms. Cindy Forster: I just want to ask a question of the Clerk. Does subcommittee not have the right as a subcommittee to make recommendations to bring forward to the committee about the bills that are sitting before them?

The Chair (Mr. Ernie Hardeman): Yes.

The Clerk of the Committee (Ms. Valerie Quioc Lim): Yes.

Ms. Cindy Forster: Okay.

Mr. Mike Colle: That's what it usually does.

The Clerk of the Committee (Ms. Valerie Quioc Lim): That's what it usually does.

Mr. Mike Colle: But not in this committee. It's the—

Mr. Bas Balkissoon: But their motion is to a specific bill, and we would like it to be—

The Chair (Mr. Ernie Hardeman): Is there any amendment to the motion on the floor?

Interjections.

The Chair (Mr. Ernie Hardeman): Order. You have a motion on the floor. Is there any further discussion or amendment?

Ms. Helena Jaczek: Yes. I'd like to amend the motion of Miss Taylor to say that the subcommittee will consider all bills before the committee, not simply Bill 135.

The Chair (Mr. Ernie Hardeman): Okay. If you could provide the right wording—

Interjection.

The Chair (Mr. Ernie Hardeman): Mr. Colle, order. If you could word it in a way the Clerk can record it so we can vote on the amendment.

Ms. Helena Jaczek: Could I have a copy of Miss Taylor's motion, then, please?

Ms. Cindy Forster: So when's the meeting? When's the subcommittee meeting, Chair?

The Chair (Mr. Ernie Hardeman): As soon as we can call it.

I would just point out that, even with the original motion, it had to have a subcommittee meeting to set the process in place to make it happen. So it wasn't eliminating a subcommittee meeting, it was just to get things moving. And I commend one of the parties for putting something forward. No one else did.

Mr. Mike Colle: No, but this motion neutered the subcommittee by basically instructing the subcommittee to do specifics.

Miss Monique Taylor: No.

Ms. Cindy Forster: No.

The Chair (Mr. Ernie Hardeman): No, it doesn't.

Mr. Mike Colle: Yes, it does.

The Chair (Mr. Ernie Hardeman): No, it doesn't.

Mr. Mike Colle: It does neuter the subcommittee.

The Chair (Mr. Ernie Hardeman): The subcommittee could come back with a recommendation that says that Bill 135 should be dealt with after everything else on the list has been done. That's what the motion does.

Mr. Mike Colle: No, but then you gave the subcommittee a pretty specific directive. That's what I'm saying. You're putting the subcommittee in a very awkward situation. That's all I'm saying.

So when would the subcommittee meet? Then we could deal with this next week or—

Interjection.

Mr. Mike Colle: When would the subcommittee meet, and when would we deal with the bill, then?

The Chair (Mr. Ernie Hardeman): The resolution says that the Chair should call a subcommittee meeting, and that will be done as quickly as we can get a subcommittee together.

Mr. Mike Colle: As long as we respect the subcommittee, Mr. Chair. That's all I'm asking for: respect.

The Chair (Mr. Ernie Hardeman): Oh, there's nothing but respect for the subcommittee.

I just want to point out that the difference between the subcommittee and the whole thing is that the subcommittee is split evenly between the parties and the whole committee gives the advantage to the governing side.

Mr. Mike Colle: But not in this case.

The Chair (Mr. Ernie Hardeman): Yes, it is.

Mr. Mike Colle: We're outnumbered, though.

The Chair (Mr. Ernie Hardeman): No, you're not.

Ms. Helena Jaczek: No, it's equal. And the Chair votes with the—

The Chair (Mr. Ernie Hardeman): I vote with the status quo.

Mr. Mike Colle: There's four to—

The Chair (Mr. Ernie Hardeman): On the subcommittee?

Mr. Mike Colle: No, no, on this committee. Who are the sitting members?

The Chair (Mr. Ernie Hardeman): Four and four.

Mr. Mike Colle: Okay.

The Chair (Mr. Ernie Hardeman): We'll return in a couple of minutes. Committee is recessed.

The committee recessed from 1749 to 1752.

The Chair (Mr. Ernie Hardeman): Okay, we'll come back to order. Everyone has a copy of the motion on the floor, and we have someone who wants to make an amendment to it.

Ms. Helena Jaczek: Yes, Chair. If I could amend the motion to say: "I move that the Chair of the subcommittee of social policy call a subcommittee meeting to discuss how to proceed with Bill 135 and all the other bills before the committee."

The Chair (Mr. Ernie Hardeman): You've heard the amendment. Any objection or any discussion on the amendment? If not, all those in favour of the amendment? All opposed? The amendment's carried.

Now the motion will be: "I move that the Chair of the subcommittee of social policy call a subcommittee meeting to discuss how to proceed with Bill 135 and all the other bills before the committee."

Any discussion on the motion, as amended? No further discussion? All those in favour? All those opposed? The motion is carried, as amended.

Mrs. Jane McKenna: Hit that gavel, will you? Come on.

Interjection.

The Chair (Mr. Ernie Hardeman): I guess we didn't get a chance.

The committee's adjourned.

The committee adjourned at 1753.

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