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Standing Committee on Social Policy

Local Health System Integration Act review

Comité permanent de la politique sociale

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

Chair: Ernie Hardeman
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STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 24 March 2014

Lundi 24 mars 2014

The committee met at 1402 in committee room 1.

LOCAL HEALTH SYSTEM INTEGRATION ACT REVIEW

ONTARIO MEDICAL ASSOCIATION

The Vice-Chair (Mr. Ted Chudleigh): I call the meeting to order. We're here to resume the review of the Local Health System Integration Act and the regulations made under it, as provided for in section 39 of that act.

Today, we have the honour of having the Ontario Medical Association with us. If you would take the chair, you have 30 minutes for your presentation and then we get to ask questions for an hour and a half—goodness gracious; that has to be some kind of a record. We appreciate your attendance and we look forward to your expertise in this area. If you could each name yourselves for the purposes of Hansard, that would be very helpful to the people recording these proceedings.

Dr. Scott Wooder: Thank you, Mr. Chair. Scott Wooder.

Mr. Richard Rodrigue: Hello. Richard Rodrigue.

Mr. Peter Brown: Peter Brown.

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

Dr. Scott Wooder: Thank you, Chair, and members of the committee. We appreciate the opportunity to be here today. My name is Scott Wooder. I'm the president of the Ontario Medical Association and a family physician from Stoney Creek. With me today is Peter Brown, a senior policy analyst from our health policy department, and Richard Rodrigue, senior regional manager, northern region, from our engagement program delivery department.

The Ontario Medical Association represents the political, clinical and economic interests of the province's medical profession. We represent about 30,000 physicians. We also represent medical students, retired physicians and residents.

The OMA is committed to ensuring that physicians are at the forefront of building a stronger, higher-quality and sustainable health care system for patients. We believe that Ontario needs to focus its efforts on building a patient-centred health care system that enables integration between providers and creates a collaborative network of care centred on the patient. The OMA believes that these integrated relationships need to look different in each community, as they will reflect the unique mix of patients, physicians, resources, other health care providers, and geography. My comments today will focus on how the LHINs can better facilitate integration with physicians. I'll offer comments about improvements that the LHINs could make in executing their current responsibilities and highlight examples of successes as evidence of how the current LHIN authority is sufficient to achieve our shared goals.

In 2006, the government of Ontario passed the Local Health System Integration Act and divided the province into 14 LHINs. The government chose integration as the backbone of its regionalization strategy, and the OMA believes that focus serves us well. It creates a shared goal—integration of services—but allows for flexibility in how that is achieved to meet local needs.

A number of services, including hospitals, CCACs, community support services, long-term care, mental health and addiction services and community health centres, were placed under direct control for LHIN planning and funding. However, the government rightly retained responsibility for other things, including major capital projects, physicians, ambulance services, laboratories, provincial drug programs, provincial networks and programs, independent health facilities and public health. We understand from following the proceedings of this committee that some groups, including the LHINs themselves, are interested in expanding the LHINs' authority. The discussions about primary care are of particular interest to the Ontario Medical Association, and I'd like to talk about it for a moment.

As I'm sure you know, physicians differ from the list of providers that are under full LHIN control by the fact that our practices are not funded by the government. Medical practices are self-funded by the physicians who run them. We run small businesses. Although the government remunerates physicians for the services we provide, they don't fund any infrastructure costs or provide costs for staffing and supplies. In addition, physicians have no benefits, WSIB or pensions. It's difficult to imagine how LHINs could assume control of self-funded services without fundamental changes to the system.

It's not clear to me that the people who have proposed the idea of moving primary care under LHIN control have a full understanding of either the current system or how extensive and disruptive the suggested changes would be.

Although the OMA has serious concerns about the proposal for LHINs to control the delivery of primary care, we strongly support efforts to better integrate our system and believe that family physicians need to be at the table.

I'm going to change focus now and talk about system change and how to best engage physicians.

I'll start by saying that physicians want to improve patient care, but we've got limited infrastructure, time and capacity within our practices. That means we need to see that any proposed system will result in real improvements to patient care. Changes also need to be practical—talking with physicians early in the process will help LHINs make sure they pursue relevant and achievable aims.

Successful LHINs have found ways to engage physicians in timely and transparent ways to achieve meaningful results. I'm going to talk now about some of the things that the OMA is doing to support LHIN engagement with physicians.

In 2007, the OMA established a regional engagement service to facilitate physician relationships with the LHINs and other regional system partners. We have seven regional managers based across the province. Mr. Rodrigue is one of them. The regional managers serve as local OMA points of contact for physicians and work with local health care stakeholders to ensure physicians are informed, involved and engaged in influencing local health care.

The OMA has also invested in the development of primary care councils. In some LHINs, these are known as primary care networks. These formal networks of physicians, other health care providers and health care institutions within a given community meet regularly with LHINs and other system partners to discuss and seek solutions to local services. As a new initiative, these councils are active in some areas and in development in others. Over time, it's anticipated that these councils will be a key contributor to improved physician engagement, service integration and delivery at the community level.

The OMA knows that clinical expertise is even more powerful when coupled with system knowledge and leadership skills, so in 2010 we established the Physician Leadership Development Program in collaboration with the Canadian Medical Association. Physician leaders graduating from this program are applying their skills at all levels of the system, including the LHINs.

I'd like to talk a little bit about some of the elements of successful collaboration from the physician perspective. One recent example of effective and meaningful integration is the Ontario health links program. Health links are an example of how greater collaboration between existing local health care providers can occur without changing the existing responsibilities of the LHINs or any other system partner. The program is based on the notion that a fully integrated health and community care sector improves the ability to provide more appropriate and less costly patient care to Ontario's seniors and those with complex conditions. Through a partnership model, key providers are brought together within a health link. This is achieved by articulating a clear vision, demonstrating value to the participants and empowering their participation in the development of care pathways and practice-based resources. This ultimately enhances the capacity to provide high-quality, effective and efficient patient care.

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Evidence shows that physician commitment is critical for sustainable change. Local clinical leaders have an integral role to play in local planning and implementation because they support individual clinicians in fulfilling their accountabilities. They do this by enabling communication, creating awareness and facilitating the training and education that prepares their colleagues for change.

However, LHINs must be cautious about relying too heavily on a cadre of like-minded clinical leaders. Real partnership requires that front-line physicians feel they have a voice in the system, too. Physicians expect a partnership relationship with the LHINs and want to contribute to their success. Building a partnership necessitates engaging physicians and other health care providers from the outset. This helps to instill a sense of ownership over health care improvements and reduces the resistance to change.

I'd like to tell you a little bit about my personal experiences in physician engagement so that you will understand my background and interest in this matter. I've been an elected member of the OMA board, a director since 2003. Before that, I was the lead physician in primary care reform. I've been on three negotiations committees, twice as chair, and I've chaired the OMA committee responsible for implementing Ministry of Health and Long-Term Care and OMA agreements.

Whenever I've gone to a physician group and told them what we were planning to do, I have received serious pushback from our members. This occurs even when the suggested changes have merit. The process that has worked is asking physicians what challenges they face in providing good-quality care for their patients, asking them for suggested solutions and then bringing back a product that actually reflects their input. Physicians want to be engaged in a real, meaningful way. We need to learn from our experiences and build upon them to move the province forward.

In closing, the LHINs have a leadership role in integrating services and aligning priorities tailored to regional and community needs. They need to work with Ontario's doctors to make it work.

Thank you, Mr. Chair.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. You had 30 minutes; is there any other—that's it?

Dr. Scott Wooder: No, I didn't think we would use the entire 30 minutes.

The Vice-Chair (Mr. Ted Chudleigh): That's fine. Thank you. We will now move to the third party for questioning. Each party will have 30 minutes of

questions, and you can take it as a block or you can go into rotation; that's up to you. Yes, Ms. Gélinas.

M^me^ France Gélinas: Let's get started. Good afternoon and thank you so much for coming and participating in the review of the LHINs. My first question comes from page 3—I don't know if your pages are lined up the same as mine—where you make the comment: "However, LHINs must be cautious about relying too heavily on a small cadre of like-minded clinical leaders." What did you mean by that?

Dr. Scott Wooder: Well, there are 30,000 practising physicians in the province in the 14 LHINs, so there are several thousand physicians in each LHIN. Our concern is that if a LHIN engages with a very small group of physicians, hires them for their expertise—we're glad they're doing that; we think they should, but if they only get input from a couple of dozen physicians, then they may not get a clear picture of what's actually happening within the LHIN. We'd ask them to consult more broadly than just within a small group of people they've engaged.

M^me^ France Gélinas: Can you give me an example where a LHIN might have done this, where they consulted mainly with like-minded clinical leaders?

Dr. Scott Wooder: Sure. We did a survey of our members in January of this year. We asked them a series of questions about LHIN engagement and we kept responses from over 1,000 members. Eighty-five percent of the respondents did not feel that the LHIN had been effective in creating early and meaningful involvement of physicians in planning and priority-setting; 71% indicated that if they wished to provide input to the LHINs, they would not know how to do that; and two-thirds indicated a willingness and eagerness to provide that input into strategic planning. We have physicians who don't think that they have been engaged and don't know how to get engaged but wish that they could get engaged.

M^me^ France Gélinas: Rather interesting.

We've talked a bit about engagement and how it doesn't seem to work too good. If you could decide how it should be done, except from what you've shared with us, how do you see it rolling out to physicians in my riding that could be the solo physician in town or a very small group practice? Most of them bill OHIP and don't get paid to participate in engagement meetings or anything like that.

Dr. Scott Wooder: First of all, you raised a great local issue in Sudbury and the north, where there's much more isolation. But in general, the process we see centres around the primary care councils that we've put in place. In those councils, which we've supported financially, there are physicians, other providers, institutions, hospitals and CCACs. The groups come together, try to solve problems and, most importantly, of course, come up with solutions that help our patients.

We would see the need to reach out to physicians. In some LHINs, physicians get an invitation to attend the meeting, which is great but doesn't always fit into physicians' work schedules. Physicians have a very difficult time meeting through the day. They're sometimes available very early in the morning or long after the workday has been completed. But we'd like a much more proactive engagement of those physicians—seeking their views. We think that other physicians are the key people to do that.

M^me^ France Gélinas: So if I understand, what you're saying is that the physician that is the primary care physician lead at the LHIN would reach out to his or her peers within the medical society at a time that is accessible to physicians billing OHIP? Is this the idea?

Dr. Scott Wooder: Yes. The primary care leads that you've talked about—I don't want to misrepresent it and say it has been a total failure. I know many of them. They're fantastic individuals. I think they need to be supported. We'd be happy to provide some infrastructure so they can talk to our members, their colleagues, and get these ideas to bring back to the LHIN. Rather than the LHIN provide the vision and goals, it should be asking the providers.

M^me^ France Gélinas: We know where sometimes the primary care physician leads did not work out so good. Can you give me an example where it did work out good, and what was the difference?

Dr. Scott Wooder: Sure. With the Chair's permission, I wonder if Mr. Rodrigue could speak to that.

Mr. Richard Rodrigue: Thank you. There have been some—I take the South West LHIN as an example—where they were set up early and certainly did a lot of key work in ensuring that the process was owned by the participants of the primary care network and that they had some good broad-base interactions with physicians and grassroots engagement, which they feel is very critical to their ongoing success.

I think about the North Simcoe Muskoka LHIN and their primary care network there. They've been effective in quickly getting the message out to the community in regard to rapid-response nursing initiatives, which has benefited the reduction of ER readmits.

Those are a couple of the examples that I'm aware of. Some of my colleagues are still working with the primary care networks to support them and to help them engage with the physicians in a broad-base fashion.

I personally work with the North East LHIN, with Dr. Al McLean and with the LHIN staff, to help support the primary care advisory council there and look at opportunities for engaging at a broader system level with physicians.

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Dr. Scott Wooder: Just if I might, Mr. Chair, I'm not trying to make the point that the LHINs have been failures in engaging the primary care sector at all. What I'm saying is, they have not yet been completely successful. If they are allowed to continue with their work, and if they come to us for expertise that we have engaging physicians, I think they can be successful. The real point we're trying to make here is that if the LHINs take over all the planning related to primary care, that initiative that's just in its formative stage will come to a screeching halt.

M^me^ France Gélinas: All right. Those are rather powerful words. Let me peel the onion on that. There are talks about the LHINs' mandate being—actually, primary care planning was always in the mandate of the LHINs. You're just saying that it's coming about now?

Dr. Scott Wooder: Our understanding, from following these proceedings, is that the LHINs are asking for an expanded role in planning primary care. Rather than that, we are suggesting a partnership between primary care providers, primary care physicians and the LHINs. We think that that partnership is the best way to help create an integrated system that will allow us to provide the best possible care for our patients.

M^me^ France Gélinas: When you say "us," do you mean the OMA, or do you mean the local membership?

Dr. Scott Wooder: I mean us as a province. I mean the providers, the payers, society at large.

M^me^ France Gélinas: So let's say the LHINs are given the go-ahead to start to plan for primary care in a more robust way than they have been doing in the past. You see this planning moving forward as a partnership with the physicians who practise within their catchment area. Is that it?

Dr. Scott Wooder: No; I see the current situation as one that should be a partnership between LHINs and providers, including physicians. I see it as a partnership that's an evolution that needs to improve, but if the relationship changes and the LHINs are given more power over primary care, I see that as an obstacle in that partnership.

M^me^ France Gélinas: I'm trying really hard to understand, and I don't. The LHINs are planning for hospital care, they are planning for home care, and they start to plan for primary care. What makes it derail? I don't understand. You're saying that it wouldn't work, but I don't understand what it is that wouldn't work.

Dr. Scott Wooder: Well, our experience in engagement with physicians is that when you tell them what to do, even if it's the right thing, they're very cautious. But when you ask them what can be done to make a system better, they're very engaged, very productive, very constructive, and they will work to make the system better.

M^me^ France Gélinas: All right. But you never see a point where there could be some reluctant little physicians out there who need to be told to change their practice—or big physicians?

Dr. Scott Wooder: Well, the physicians' accountability is to our patients, and I think it's difficult to have that primary accountability to our patients if we're not autonomous health professionals.

M^me^ France Gélinas: If you're not?

Dr. Scott Wooder: Autonomous professionals.

M^me^ France Gélinas: So are you saying that everybody else who works within the system, their primary accountability is not their patients?

Dr. Scott Wooder: I'm saying that for physicians, we would have a very difficult time with that dual accountability to a LHIN and to our patients.

M^me^ France Gélinas: All right. So what do you make of physicians who work within the community health centres? They are employees of the centre, so they have accountability to their employers to keep their jobs. Are they not able to provide good-quality care to the patients they serve?

Dr. Scott Wooder: No, I think that some of the CHC physicians I've met are some of the finest physicians in the province. They give very good care. They enter into that relationship, that contract, with the CHCs on a voluntary basis. What I'm suggesting is that obligating physicians to do it in a non-voluntary way would be an impediment to the relationship.

M^me^ France Gélinas: So if it is offered to them and they select in, then that leads to good-quality care, but if they don't select in and they prefer to continue to bill OHIP, then there's a problem with quality care? Am I on the right path, finally?

Dr. Scott Wooder: No, no, no.

M^me^ France Gélinas: No? Still not?

Dr. Scott Wooder: I'm sorry. I apologize if I'm not being clear.

M^me^ France Gélinas: I'll get it eventually.

Dr. Scott Wooder: I don't think the payment model inhibits a physician's ability to provide high-quality care. Most physicians, certainly those outside of CHCs, are independent contractors. We are small business people—small businessmen and small businesswomen. We pay our rent, we pay our staffs, we pay all the overhead costs. It's difficult to imagine how a semi-government agency like a LHIN would go in and control all those small businesses and have a productive relationship.

There are also some implications that we're concerned about in terms of being seen by CRA as being employees. That's something I think that the government should be concerned about as well. The more we look to CRA like employees, the more they'll treat us like employees. There are implications for lots of things in the system if we were treated by CRA that way; the government might be treated as an employer.

M^me^ France Gélinas: All right. The LHINs are always very careful in saying they want to plan for primary care, but that would exclude payments to physicians. It's something that you support?

Dr. Scott Wooder: I don't see how you can separate the two things, how you can plan for physicians, tell them what to do and stay independent of the way they're paid.

M^me^ France Gélinas: Okay. I think I'm going to let it go around.

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

Ms. Helena Jaczek: Thank you, Chair. Thank you for coming in today. As we examine the Local Health System Integration Act, known as LHSIA, of course what we're really doing is looking at what the current status is and how that's working. As you've said, we've received a number of suggestions for change.

First, I'd like to just concentrate a little bit on how the system is working right now, obviously with a focus on

physicians. In relation to the physicians who work in community health centres, they are members of the OMA, I presume?

Dr. Scott Wooder: Yes.

Ms. Helena Jaczek: Do you have any way of getting feedback from those individuals to your primary care councils that you've established across the province in order to sort of get a sense of what their integration and interaction with the LHIN is, how it's working and maybe some examples of best practice that they may have found across those CHCs? Could you tell us a little bit about how that works?

Dr. Scott Wooder: Physicians who work in CHCs absolutely are members of the OMA. They have their own section within the Ontario Medical Association. I've had a chance to interact with many of their members over the years as the chair of the negotiations committee. I've met with and was very proud of the fact that in 2008, for the very first time, the OMA managed to get representational rights for those physicians and negotiate changes to their compensation. So they're very much part of the Ontario Medical Association and very important to us. They have direct feedback to the OMA centrally through their section at an OMA council. Also, they do participate in our primary care councils.

Ms. Helena Jaczek: So then, if you could tell me a little bit more about the primary care councils. As you've mentioned yourself, there are thousands of practising primary care physicians within each LHIN, so how do you develop your primary care council? Are these, just as an example, elected members of the OMA? How do you form to ensure that you've challenged—I guess, in a way—the LHIN of not having like-minded clinical leaders consult with them? How do you ensure that you get good representation in your primary care councils?

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Dr. Scott Wooder: The primary care councils are not an organization of the Ontario Medical Association. They are actually an organization of the LHINs. We've supported the development. We've talked to the LHINs and had some co-operation in developing these primary care councils, and we've provided some funding so that they can get established, so—

Ms. Helena Jaczek: So how big are these councils? Obviously you're saying that the LHIN organizes them, but you know how they're constituted, so could you explain the membership and the size?

Dr. Scott Wooder: It's not only physicians. Physicians are included, but other providers are as well. Institutions are invited.

In terms of size, it's a fluctuating picture. Most LHINs bring on people as needed for specific initiatives. I've been to a couple of meetings of the primary care council in my own LHIN, and there were 12 or 15 people present, including five or six physicians.

Ms. Helena Jaczek: So if this group is constituted to study a particular project, presumably there's an outcome, there's a decision—"This is the best way to move forward"—and that, of course, is the intellectual property of the LHIN. Does that, then, get fed back, because presumably it's a good thing that has come out of all this consultation? Does it then get disseminated in any way by the OMA to other practising physicians within that LHIN area? Is there any feedback beyond the area of responsibility that the LHIN actually has, which is pretty limited when it comes to primary care?

Dr. Scott Wooder: I would hope that our involvement would not just be in propagating the final outcome of the decision, but in communicating with our members before the decision is made. We would provide communications infrastructure, to get input from our members before the decision is made. That, to us, is the ideal model. Then, once the decision is made, we would be co-operative in communication.

Ms. Helena Jaczek: Okay. So, then, I understand that you try and get the grassroots input, so that the physician members on the primary care councils can provide that input to the bigger group, and that once some sort of implementation of some future project is decided upon, you then get back to the field. Could you give us any example of where that has worked well?

Dr. Scott Wooder: Peter, I wonder if you could—

Mr. Peter Brown: Thank you. That's an excellent question. I think one of the things I wanted to just highlight, before I answer your question directly, is that, as Dr. Wooder said, each of the primary care councils—the primary care networks—function a little bit differently. They set, in many cases, their own direction in terms of relationships and process.

One particular primary care network in the South West, again, is acting as the leader in much of what you're asking. They've established what they call a network of networks, which is taking that relationship that they're creating between themselves and with the other providers that have built into their primary care network, working with the relationships that they have with the diabetic groups, the renal groups, the hospitals and with the LHIN.

What they're ultimately doing is bringing the network of providers that they have, gathering the information and sharing it with their colleagues; learning from their colleagues about the care gaps, care challenges and care opportunities that exist within their LHIN; bringing that to the table; having that in a very strong conversation with the LHIN about opportunities and partnerships; and then delivering some results.

You asked about one specific result. Well, in this case, in working with the diabetic community, the primary care network was able to partner with their network of physician services within the LHIN to create 100% orphan diabetic attachment, which was a goal a few years ago, one that not all realized, but one we know is very beneficial to realization. That would be, I think, one example for you.

Ms. Helena Jaczek: You mentioned that these primary care councils or networks are kind of at different stages of development throughout various LHINs. Can you give any reason why, in some places, there is such

success and in others there doesn't seem to be the same progress?

Dr. Scott Wooder: I think that part of it is timing. Some of them are early adopters and get out of the gate quickly and they're more mature in the development of those primary care councils. Others have just more recently started to do it. I think it really is a function of time. With the maturity of the councils, they become more and more useful. Even in the LHINs where they're currently working well, we think they can work much better.

Ms. Helena Jaczek: Yes. So in other words, the structure is something that you think has good potential. It has proven itself in some places, but it needs to be replicated, enhanced—more maturity, etc.—and we've got something that is positive for patients.

Dr. Scott Wooder: We think the model is sound. It needs to be given time, as you say, to produce the best possible outcomes for our patients.

Ms. Helena Jaczek: In terms of how you have organized yourselves, I was intrigued that you have seven regional managers. Does that mean that each regional manager has responsibility for two LHINs?

Dr. Scott Wooder: Yes.

Ms. Helena Jaczek: Your boundaries are coterminous, in other words?

Dr. Scott Wooder: Yes.

Ms. Helena Jaczek: Okay. Thank you.

Perhaps we'll just ask a little bit about the relationship between primary care and CCACs. As we know, CCACs have a service accountability agreement with LHINs, and we've spent quite a bit of time talking about CCACs in this committee. We have heard of some successful models between primary care and CCACs. Could you elaborate, from the perspective of the OMA, how you see where some of this would constitute a best practice? In other words, liaising primary care physicians to the ability to refer their patients to the CCAC in getting feedback and consultation: What sort of model would you say is working well in the province?

Dr. Scott Wooder: We haven't spent a lot of time internally looking at the policy around CCACs, so unfortunately I don't think I'm in a position to answer that question.

Ms. Helena Jaczek: The regional manager might not have any perspective?

Mr. Richard Rodrigue: Certainly we do look at opportunities. We are looking at having an enhanced strategy to work with CCACs and connect physicians with CCACs this year. We're still evolving that particular strategy.

Ms. Helena Jaczek: We heard from one family health team member—I think it was last week—

Mr. Mike Colle: Dr. Martino.

Ms. Helena Jaczek: —Dr. Martino of the Brampton family health team out there—that they had a very successful liaison. I think he mentioned that once a month or so, there would be a complete review with a CCAC care coordinator in terms of plans for their patients who were currently receiving services through the CCAC. Is that anything you've heard much about?

Dr. Scott Wooder: It's very interesting; I started to practise in 1986, and when I started to practise, that's exactly the model I had. I no longer have that. Certainly, in my practice back in the 1980s, it worked very well.

I know the physician to whom you're referring. He's the past president of the Ontario college. I think he's very highly respected. He has had a good experience with it; it certainly mirrors the previous experience that I've had.

Ms. Helena Jaczek: I had the same experience in the 1970s. It got lost somehow.

Dr. Scott Wooder: It's not a competition.

Ms. Helena Jaczek: It's fairly self-evident that this should be something that happens.

Anyway, we've heard of one example. That might be something of interest, I would think, perhaps, to the OMA, because he did allude to billing issues around that particular forum where a patient's status was discussed, so that might be worth exploring.

Moving to family health teams: Family health teams, obviously, include primary care; that's their raison d'être, in essence. Have you seen any models where family health teams, perhaps through health links or in some other way, are looking at integrated services which are somehow being led by the LHIN or encouraged by the LHIN? What's that process? We're hearing a lot about health links, but only a few models are really active, I think, to date. What do you see as the potential for family health teams and health links somehow trying to develop best practice around integrated health care?

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Dr. Scott Wooder: We're very strong supporters of health links, as you know, and we've taken a leadership position, partnering with the Ministry of Health and Long-Term Care in developing policy around health links and are very supportive.

I can tell you my own experience. I practise in the Hamilton Family Health Team, the largest family health team in the province. There's another family health team in Hamilton, associated with McMaster University. McMaster Family Health Team has taken the lead in our local health link. It's a very large one, and they're working very closely with all kinds of stakeholders in Hamilton, including the Hamilton Family Health Team.

Because of the size and nature of the health link, it has been divided into regions, and the majority of people, both physicians and patients, in Hamilton are part of that health link.

I know that in other communities, family health teams are leading health links as well, and it seems to be a model that we're hearing from our members they've had a very good experience with.

Ms. Helena Jaczek: What involvement does the LHIN have in that? Is a LHIN planner involved, or is it directly between the Ministry of Health and Long-Term Care and the family health team that this is all taking place?

Dr. Scott Wooder: No, I think the LHIN's priorities are taken into account, and the health link tries to work in coordination with the LHIN's plan—very much so.

Ms. Helena Jaczek: Okay, thank you. Now, as you've alluded to, we've heard some fairly radical suggestions as we've travelled around the province. One was to do away with boards of community agencies, hospitals—and boards of health, presumably, as well. Do you have any comment in relation to that suggestion? It was made, in fact, by the former CEO of a LHIN.

Dr. Scott Wooder: We don't have an opinion about doing away with boards of those kinds of institutions.

Ms. Helena Jaczek: At this point, the OMA is not hampered in its activities—caring for patients—by boards of institutions, then?

Dr. Scott Wooder: No, we don't find it is an obstacle. We have a limited capacity to look at issues, and we prioritize them every year. That has not been one that we've chosen to take a close look at.

Ms. Helena Jaczek: Another suggestion was to put not only primary care within the scope of the LHIN but also public health. Medical officers of health are members of your association. Have you received any input from them as to how they're feeling about that suggestion?

Dr. Scott Wooder: No. Sorry, maybe I'm incorrect.

Interjection.

Dr. Scott Wooder: No. That confirms the no. We don't see any need. We think the Chief Medical Officer of Health does a very good job with the other regional public health physicians in providing that care.

Ms. Helena Jaczek: Okay, thank you. I don't think we've used up all our time, but we'll keep the remaining.

The Vice-Chair (Mr. Ted Chudleigh): Okay. Thank you very much. We'll move to the official opposition: Mr. O'Toole.

Mr. John O'Toole: Just briefly, I look at the questions that have been asked; they're quite informative. I've been here a long time, but not all that much time recently in health. But I was, fortunately, a PA for a while—three or four years—in interesting times as well.

I've listened carefully to the points that I think are quite relevant to the discussion. One is the role of the CCACs, for sure, and that has been asked by France as well as Dr. Jaczek; also the whole idea of integration of services—it's broader—and who gets left out and how does that funding stream separate itself out of half the budget.

I'd just remind you that we have a document out there—I'm not trying to politicize—that I think is quite thoughtful. I'm sure there were physicians involved in drafting our Pathways document—this one here—Pathways to Prosperity. There were three points in there that are rather relevant to the discussion here today on the streamlining and efficiency. I think everyone wants to make sure that the publicly funded health care system remains dependable, and properly funded, I guess, is an important part of it, but all that in the context of the document authored by the Auditor General prior to the last election.

Where we are today—and I'm quoting from the document; this is worth looking at. This is the 2011 pre-election report on Ontario's finances. This was the Auditor General's comments, saying that they're going to cut health care spending to balance their budget from a 7.1% annual increase from 2003 to 2011—that's each year, 7.1%. They're changing it to 3.6%. That is half the budget. It's huge if they don't deal with it.

They call it streamlining: the right service in the right place at the right time; all these various fancy words, which most companies have gone through, and you're a private sector business. How is this affecting you, this change here, just at the nurse level? They've cut 14 in one of my hospitals and seven in another. Where is the efficiency? Where is it coming out of?

Dr. Scott Wooder: Thank you very much for that question. This was very much the focus of negotiations between the OMA and the Ministry of Health in 2012. I had the honour to be the co-chair of the Ontario Medical Association negotiating committee. We took the position at that time that we recognized the fiscal problem that the province had and we wanted to do our best to help out, but that we wanted any changes to be based on, or at least informed by, best available evidence. We didn't want to propose cost-saving measures that would have a negative impact on patient care.

During that negotiation, we made a number of suggestions that were implemented into the final agreement. I'll give you a couple of examples. We eliminated the annual health exam for people between the ages of 18 and 64. That was based on evidence—very well-known, documented evidence—that a personalized health review was a much more appropriate intervention.

We also looked at screening intervals for Pap smears. We didn't want to hurt anybody by neglecting to provide the best possible care, but there was very good evidence that we could delay the onset of initiating Pap smears and increasing the interval between Pap smears based on the evidence.

There are a large number of similar types of examples I could give you. We ended up saving, through unrealized utilization, over $700 million a year.

In our opinion, and I haven't brought the evidence with me, we've significantly bent the growth in the cost of care associated with physician spending.

Mr. John O'Toole: Has the OHIP annualized budget decreased?

Dr. Scott Wooder: No. The rate of growth—

Mr. John O'Toole: That's the answer I wanted.

Dr. Scott Wooder: The rate of growth has decreased significantly.

Mr. John O'Toole: Yes, the rate of growth is by eliminating access to service. Basically, that's it.

You did the whole thing on Pap smear. As well, breast screening has been reduced, or at least the scientific argument is being presented that suggests it's redundant.

The reason I mention that: There are certainly motives for the current government, and, I suppose, future governments who really actually might have a chance of governing for looking at the 7% changing to 3%. That's really the argument here.

I appreciate—because you look after the OHIP negotiations, so you're saying. That's important.

Community health centres in my riding of Durham are quite successful, and the family health teams. Those family health teams aren't new as well. They were started under our government; they were family health networks. There was a great deal of reluctance in the negotiations at that time about the role of the doctor and who paid the nurse practitioner. That basically was the problem. The model didn't pump enough money into the system to satisfy.

That's primary care in a nutshell, the family health team—whether you need a nutritionist, psychologist or some other to deal with your primary stress or whatever it is causing your health issues. How do you respond to that? That's collaborative health. The model of primary care is collaborative health. You buy into that, I gather, the collaborative model?

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Dr. Scott Wooder: I practise in a family health team.

Mr. John O'Toole: Yes, that's what you were saying—in Hamilton.

Dr. Scott Wooder: I was on the board of directors of the Ontario Family Health Network, which was trying to implement the family health networks to which you've referred, so I'm very familiar with what happened.

I'd just point out that a minority of people in Ontario are served either by a family health team or a community health centre, so there is an equity problem associated with the services.

Mr. John O'Toole: Do you feel that's where they're trying to move to? In the collaborative model, everybody is sort of rostered with someone to get care. Isn't that really what they're doing? They're squeezing you out of the equation in terms of this independent silo under OHIP. It's going to get mushed into the primary care model and really do a number on the whole primary care with the family doctor—and the role of the nurse practitioner, as a nurse-practitioner-led clinic.

Dr. Scott Wooder: We don't feel squeezed out of that at all. We feel it's a tremendous opportunity. Interprofessional care is something we believe in very strongly. We think that we can make use of each other's skills, talents, backgrounds and experiences to provide the best possible care for our patients.

Mr. John O'Toole: That's good. I'm not an expert by any means. I'm just really concerned about how they're going to—it really is that you are getting more—you're eliminating services to be able to maintain the fundamental bucket that you have now.

We see the comments on the CCACs as spending an inordinate amount on administration, so we're not really in that whole grouping everything under the LHIN. Two or three of our recommendations are pretty helpful. I think number 12 says "fundamental strengthening of our health system by making one-time improvements in efficiency ... such as eliminating administration in LHINs and CCACs...." How would you respond to that? I mean, it's the regional model right now.

Dr. Scott Wooder: We're not talking about eliminating services. We prefer to think about it in terms of not doing things that aren't supported by evidence, so that we can provide good care that is supported by the evidence. So it is not doing things that don't make a difference for people's health, and making sure that the things we are doing have a very firm evidentiary basis.

Mr. John O'Toole: It's certainly supported by what you said, but in the public's view, especially women's health, it becomes political, really. I'm not in a position to decide one way or another. You're the voice that we need to hear from. You're a trusted voice that is independent, and it supports your case of independence, really, of saying, "Who is a group that we can talk to?" Certainly, the OMA is that group, from clinically based decisions on reducing perhaps some routine stuff, I suppose you would call it.

Do you think there's any advantage in them looking at themselves, looking inward at the CCACs and the LHINs, to find efficiencies there, put them on the table, put a number and require them to have one system—the data systems, the payroll systems, the backroom stuff? Are you satisfied that the 14 LHINs are doing anything in that direction today?

Dr. Scott Wooder: I think we should all be obligated to look at the way we conduct ourselves and find efficiencies wherever possible.

Mr. John O'Toole: Those are really good answers. The thing is, I recall going—when eHealth came in, I was on the Smart Systems for Health board for about 10 years, and my background was systems; I was a COBOL programmer. I remember the OMA pulled out of it at the last moment. They were on board for the eHealth—the privacy issue became the issue, and it sort of got pulled off the table—that is, the legislation. Since you've been there so long, you would remember that discussion with Elizabeth Witmer, I'm sure.

I just remember that the issue there was about looking at over-doctoring, over-drugging—all the efficiencies of looking at your records to see whether a doctor is not appropriately prescribing or is over-prescribing or whatever else.

There are about three or four systems operating today under the other—it's eHealth today, but it was Smart Systems for Health. There were about nine modules. They looked at drugs, labs, long-term care, emergencies. These were all independent systems that you looked at the model to manage efficiencies. What's your view on having one system for every doctor, whether it's with the tablet that we had—the tablets were out there. It would almost diagnose for you. You would check off this symptom, symptom, symptom. The reason I'm asking that is, there is a lot of money, over $1 billion since 2005, I think, in eHealth—for part of that, there was another $1

billion spent—and we don't have a system. You're talking about this new system, the health links, I guess it is—there's the federal system; it's called Health Infoway. Is there one system, and do you think you should all—doctors' offices and everybody—have the same system?

Dr. Scott Wooder: There's been great success in digitalizing primary care records. Ten million Ontarians have an electronic version of their medical record in their family physician's office. The concern we have—and it's not unique to us; I think it concerns everybody—is the lack of connectivity between various parts of the health sector, not being able to view the information that's contained.

The other issue that you brought up that's really important is data extraction and analysis. We're firm believers that, on a practice basis, we should be providing information back to practitioners about how they're doing in drug prescribing or test ordering or other quality indicators. You know, what are your results in terms of your diabetic management? We'd like to feed that back to the physicians. There's a lot of evidence that when you do that, when physicians discover that, somehow, they're an outlier, that they prescribe a lot more antibiotics than their peers do, they will reflect on their own practice and change. We're not in favour of doing this in a punitive way, of saying to somebody, "You order too much of this test or this drug," but giving the information back so that they can change their practice. We're convinced based on evidence and experience that physicians will take that—

Mr. John O'Toole: Who should be doing that assessment and analysis? Should it be the OMA or should it be the LHINs?

Dr. Scott Wooder: We have a proposal, not that I can talk about it in detail, but we certainly have a proposal that we would be interested in helping extract that data and feeding it back to our members.

Mr. John O'Toole: I could probably go on for a while. I'll save some time for my colleagues. Thank you very much for being here and for your straightforward answers. I appreciate it.

Dr. Scott Wooder: Thank you.

The Vice-Chair (Mr. Ted Chudleigh): Do you want to do it now?

Mrs. Jane McKenna: Yes.

The Vice-Chair (Mr. Ted Chudleigh): Go ahead.

Mrs. Jane McKenna: Thanks so much. It was nice meeting before we started here today. I have a couple of questions. I guess my number one question is this: You have on page 2, "Successful LHINs have found ways to engage physicians in timely and transparent ways to achieve." After eight years, don't you think they should all be successful?

Dr. Scott Wooder: We would hope they'd be more successful, and we would certainly be happy to facilitate that.

Mrs. Jane McKenna: We've heard numerous times, over and over, in here that they're in silos and not one communicates with the other. So I think if I knew a successful LHIN was doing extremely well and doing clearly what you need to be engaged as physicians, that it would be imperative—since the success of how everybody streamlines is exactly what you're saying is the success of the patient, we're clearly missing the mark of the patient, then, if not everybody's successful after eight years, wouldn't you say?

Dr. Scott Wooder: I think we're on the right track, in that we do have some structures in place that will improve communication between providers and the LHINs and patients, everybody involved, all the stakeholders in the health care system.

Mrs. Jane McKenna: I'm curious as to what exactly that would be, because you're talking here, first of all, about partnerships for the planning for the primary care with the LHINs. We've had numerous times, over and over again, in here that they think they should be doing the primary care completely by themselves. I wonder why they think that, unless they see a flaw in the system of what's happening. Now, do you know why we've heard that numerous times, that all of a sudden now they want to do that? It's curious.

Dr. Scott Wooder: I think I'd be speculating about their motives.

Mrs. Jane McKenna: They're speculating?

Dr. Scott Wooder: No, I don't want to speculate—

Mrs. Jane McKenna: Oh, you don't want to speculate.

Dr. Scott Wooder: —as to their motives. Sorry.

Mrs. Jane McKenna: Okay. I'm just wondering, if we don't have the partnership, you said the survey that you spoke to Ms. Gélinas about—you did a survey of 1,000 doctors. I think you said two thirds—you can correct me if I'm wrong—felt that they couldn't even figure out how to talk to the LHINs to get the answers that they needed to be part of the process. So how's that partnership working right now?

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Dr. Scott Wooder: There's certainly room for improvement.

Mrs. Jane McKenna: Yes. But I guess where I struggle is, as MPPs, we're all supposed to know our job description and know what that is. After sitting in this—I've been part of this process since the beginning. I'm just curious as to how we figure out what everybody's job description is so the person you're supposed to be taking care of, which is patient-centred, actually gets taken care of, without all of this minutiae. There just seems to be so much going on after eight years, except for the patient. I struggle, being in here, with that.

You talk about primary care. You talk about there being 1,000 people who are in the primary care council. So what happens with all that information? Is it just another layer of bureaucracy? I'm just wondering why we need someone else to do that for us. Were we not capable of doing it ourselves before we got this council going?

Dr. Scott Wooder: When I started a practice, I knew that if my patients would just do what I told them, they'd be so much better off. I had to unlearn that very quickly,

because it doesn't work that way. In fact, what I have to do is have a discussion with them, engage them. I kind of regard myself as an adviser, as a mentor, as an educator, helping them make the right decision.

It's taught me a lot about engagement within the system, that the top-down approach doesn't work. That's my concern. That's a concern of the doctors of Ontario in having primary care somehow under the control of LHINs. We think that's not the right approach. The right approach is to engage grassroots physicians, nurses, personal support workers, the people who are actually providing front-line care—institutions, hospitals. Have them give information to the LHIN. The LHIN has to plan and coordinate. Absolutely. I agree with all that. But we don't want to be put in the position where the LHINs are telling individual practices what to do, individual physicians what time they should have their offices open or whether or not they're allowed to retire, what model of care they should be in. I think that's the wrong way to go about it.

Mrs. Jane McKenna: Okay, then just one other thing. I guess, in the 21st century, when you're talking about not being able to communicate, some of the physicians—you know, everybody has different hours and times. I find that so hard to believe in this day and age, when there are so many places we can go to, that you can have people talking at any time of the day. If it's so important to fix what we're doing right now, and we're trying to get the recommendations to do that, why is it that we don't all just try to figure out what that is, so if it's 7:30 in the morning, we can all figure out how to do 7:30 in the morning? Because if you're not part of the solution, you're part of the problem.

Dr. Scott Wooder: I know that from a physician perspective, sometimes we're overwhelmed by the amount of change that we've gone through. If I reflect back on the last 10 or 15 years in my own practice, the number of changes that have gone on, I've gone from being a physician-only practice to an interprofessional team. I've gone from being a paper-based practice to being an electronic practice. Our payment models have been changed. The emphasis on evidence has dramatically changed, that we no longer rely so much on expert opinion and past experience, but we actually look at the evidence of what works. All these changes taken by themselves make a lot of sense, but when change all comes at a group together, it's overwhelming sometimes. Sometimes just one more thing for physicians is just too much for them to manage.

Mrs. Jane McKenna: Wow. That's concerning.

Dr. Scott Wooder: Well, I guess I'm an optimist. I look at all the great things that have come about because of all that change and all the great work that's been done by individuals and groups. A physician who was mentioned earlier—he's been a leader. Lots of physicians are doing great work, and lots of nurse practitioners, physician assistants. There's lots of really good things that are happening. So that's what I prefer to focus on.

Mrs. Jane McKenna: I'm going to pass this off to my colleague.

Mr. Bill Walker: Thank you. Could I just ask how much time's left, Mr. Chair, so I can understand?

The Vice-Chair (Mr. Ted Chudleigh): You've had 19 minutes so far. You've got another 10 minutes to go.

Mr. Bill Walker: Thank you.

Thank you very much—very informative. Your second paragraph on page 2 suggests: "It's not clear to me that the people who have proposed the idea of moving primary care under LHIN control have a full understanding of either the current system or how extensive and disruptive the change would be."

I guess I have a couple of concerns. One would be that I'm sensing, obviously—and I'm relatively new to the Legislature, so the learning curve is still pretty steep—that there was not a lot of prior consultation before this model was imposed upon the system. We've now had eight years, though. You're still concerned that there are not people in the process who truly understand the current system or how extensive and disruptive the change would be. Could you elaborate on that a little bit?

Dr. Scott Wooder: Yes. I think the passage you're referring to is the lack of understanding that has to do with proposed changes, not the current system, so a proposed change whereby LHINs took over control of primary care. That's the concern that we're expressing.

Mr. Bill Walker: I guess the concern I would have if I'm the general patient out there—who we should all be focusing everything we do on. They're not—the people in my riding of Bruce–Grey–Owen Sound—relatively comfortable that the LHINs are doing a great job and a bang-up job, currently, for their health care. So if the feeling from them is that they've truly implemented a system that's not working extremely well already and they've not consulted and understood what the ramifications are of adding yet more change, why would we be moving ahead with this? Why would we be adding more change to a system when the public does not feel comfortable now? I believe, again, that the two thirds number that you shared with us of your membership suggests that they don't feel comfortable that they can even have a dialogue and a lot of ability to have good impact and influence. It seems strange to me that we would be moving forward, then, until we actually satisfied the patient that we've got a good working system in place.

Dr. Scott Wooder: We're not proposing any changes to the current system. We think that the LHINs need more time. We welcome the input they have allowed us to give, but we don't support any significant changes with regard to our members.

Mr. Bill Walker: We've had eight years to implement this system and you're suggesting more time. What type of a timeline are you looking at to actually give the patient comfort that we have a well-functioning system that truly serves their best interest?

Dr. Scott Wooder: I'm not sure that I'm really the best person to ask.

Mr. Bill Walker: Can you give me broad strokes? Are we talking like a year? Are we talking five years? Or are we talking another eight years?

Dr. Scott Wooder: I think we've seen some changes, we've seen some improvements. The development of the primary care councils—it's still in its formative stages—I think has been a positive development. I think the excellent work that we're doing together on health links is another example of some things that, under the current structure of a partnership, are working well.

Mr. Bill Walker: You've referenced now—I'll move a little bit into the health links. It's interesting that these health links have come along at the end of the eight-year implementation period. I'll be a little bit aggressive and suggest that there was a health hub reference in the product that my colleague from Durham referenced, and not very long after, health links came out, which may be just circumstance; it may be ironic that they happen to be there. But where were they in the first eight years?

I'm getting most of this back to—what I'm finding here, being a member of Parliament in the last two and a half years, is that most of these initiatives are thrown onto the public. They're imposed on people like the medical community or other areas of our province without a lot of prior consultation to ensure that it's going to work, to ensure that it's actually going to be able to be implemented for the benefit of the person at the end of the row, whether that's health care or whatever industry we may be looking at.

So I find it interesting that, again, we're now eight years in and now we're looking at a link. Why wouldn't that link have been there in the first process? Where were you? I think you've been a little bit concerned that you weren't at the table as a true stakeholder from day one, being able to have input into the system.

Dr. Scott Wooder: I can't speak to why, in terms of priorities, it came up when it did. I can say that we've chosen to regard it as a forward-looking development, one which we support and want to make successful, because we think that in the end, it will help improve the quality of care that we're able to give to our patients.

Mr. Bill Walker: So you're comfortable that the health link is an enhancement. You're comfortable that you, as the OMA, are truly going to have a stake at that table and a true voice?

Dr. Scott Wooder: I think that's been our experience and we're very hopeful that it will help improve the quality of care in this province.

Mr. Bill Walker: You mentioned a little while ago that you had real concerns in regard to the payment model and how you were going to retain being an independent businessperson and yet be treated almost like an employee to some degree. Can you share with me—do you truly believe that there's a system currently in place that's going to work tomorrow to allow you to have that dual role, with the current LHIN structure that is in place?

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Dr. Scott Wooder: I think the key is the relationship between the LHIN and the physician. Our contention is that a voluntary relationship, one that's built on mutual goals of integrating service and doing what's best for our patients—now, that's the model that we support. We don't support the hierarchical model, where the LHIN is in charge and dictates to the physicians what they should be doing. We think we should be equal partners in this discussion, bearing in mind that we both have ultimately the same goal, which is to improve the care that we give to our patients.

Mr. Bill Walker: Okay. A final one for this go-around: It certainly seems, again, from a lot of the feedback that we're getting—and I think my colleague from Durham referenced earlier that approximately 40% of a CCAC budget goes to administration. We know that a fairly high percentage of the LHIN budget goes to administration, supposedly to coordinate services. You've been in the business since the 1980s, I believe. As a naive young guy—a little younger than that, at least—I would suggest that there's a Ministry of Health that has a fairly large contingent of people, and now we've added yet two more layers in there that seem to do a lot of time spinning paper as opposed to the front-line health care that my constituents are asking for.

Do you have an opinion, as the OMA, that there would be a potentially better model that would go directly between the provider and the Ministry of Health, which is charged with the responsibility for the successful operation of the health industry?

Dr. Scott Wooder: Well, we certainly want to make sure that resources are in place to provide direct patient care.

Mr. Bill Walker: You're not really suggesting if you feel that there's a better model than the two that are currently existing.

Dr. Scott Wooder: Well, for instance, the notion that CCACs spend 40% on administration—I'm not an expert on that. I believe that includes case management, which isn't done at the bedside but is absolutely necessary to coordinate the care for individual patients. Again, I'm not an expert in that. I'm really giving my own opinion on that, which probably isn't as helpful as an actually fact-based position from the OMA.

Mr. Bill Walker: Thank you. I'll turn it back to my colleague from Durham.

Mr. John O'Toole: Thank you. It's very helpful. I have great respect for the OMA. They have traditionally—this probably sounds like you. Physicians continually, as you said, want to be engaged in a real, meaningful way. Basically you've run the system for years, respectfully, as a profession. You have a college and a union of sorts—this professional association—that is able to find agreement with the government on the pay scale side and on the ethics and the procedures of the college and what's the scope of practice etc., and that's a commendable thing. I understand, and I would probably support

the view of the OMA when it comes to looking at the role of the LHIN.

As well, I find in my area they have improved. Because they have—I forget what the acronym stands for—an integrated service model, where they are picking winners and losers, whether it's thoracic stuff. They pick these priority areas, which I think are dictated by some medical models of, "What does the chronic health care model look like and where could we get the best bang for the buck?" That, to me, implies collaborative delivery of service. In all cases, you don't need a thoracic surgeon talking to someone who's got a bad cough. Do you understand? So who provides the service is where the changes are occurring now, independent of you, I think.

Increasing the scope of practice for nurses has been phenomenal for the last, I'd say, 10 years. We started it by changing the scope of practice. I think that's the future. I do believe that there needs to be highly paid and highly motivated professionals, whether it's at the cardiac, neurology or all these different levels. I think the persons getting squeezed here are the GPs, who basically, in your 30,000-member votes, are the majority of the votes. I think the professionals—the cardiologists, the neurologists, the orthopedists and all those—want OR time. It's about where the money is. I don't disrespect.

Amongst yourselves, are there subgroups within the OMA that might have a different position than yours? Because we can't afford the system, unfortunately. Lots of people in my riding, even today, are waiting, with an aging population, for the right drug—Esbriet, for IPF. That's being denied, despite clinic evidence that it should be prescribed. Doctors are writing me, because if they're a respirologist, they think Esbriet is the proper drug. Now, the ministry is just locking in. Deb Matthews, in all due respect, is saying—

The Vice-Chair (Mr. Ted Chudleigh): Could you wrap up, Mr. O'Toole, please?

Mr. John O'Toole: —no to most of those drugs. I guess I'm saying to you, because we don't get to talk to you professionals too often, your views will be accepted more readily by the public than almost every other view. The really high degree of receptivity for nursing—nursing has got a lot of public leverage on this discussion, and they're your natural partner at the bedside and in the OR.

The Vice-Chair (Mr. Ted Chudleigh): Mr. O'Toole, your time is gone.

Mr. John O'Toole: I just need one minute to finish my argument.

The Vice-Chair (Mr. Ted Chudleigh): No, your time is gone, Mr. O'Toole. I'm sorry.

We'll move to the third party. Thank you very much.

M^me^ France Gélinas: How much time do I have, so I use it wisely?

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

M^me^ France Gélinas: Okay. My first question is just a cleanup question again. You use "we"—I think sometimes it means "we" as in Ontarians; sometimes I think it means physicians. This time, you said, "Primary care councils belong to the LHINs, but we provided some resources." Who is "we"?

Dr. Scott Wooder: The Ontario Medical Association provided resources, funding, to the LHINs to set up primary care councils—not a lot of money.

M^me^ France Gélinas: Where does this money come from?

Dr. Scott Wooder: From our members' dues.

M^me^ France Gélinas: All right. So you provided it directly to the LHINs or to your members on the LHINs?

Dr. Scott Wooder: Richard, could you help me out?

Mr. Richard Rodrigue: Mostly in supporting the meetings, so directly to the primary care networks or councils. Usually it's to help fund meetings so that they can happen.

M^me^ France Gélinas: Can you give me an idea of how much money we're talking about?

Dr. Scott Wooder: I heard today in the neighbourhood of $5,000 per LHIN. As I said, not a lot of money, but enough to help facilitate meetings, bring people together, have discussions.

M^me^ France Gélinas: Per LHIN or per council?

Dr. Scott Wooder: Per LHIN. There's one council per LHIN.

M^me^ France Gélinas: Okay. There's seven regional engagement managers—

Dr. Scott Wooder: For 14 LHINs.

M^me^ France Gélinas: —for 14 LHINs and 14 councils.

Dr. Scott Wooder: Yes.

M^me^ France Gélinas: Got you. All right. That was just a little cleanup.

My other little cleanup: If I understand well, you see the future of primary care integration as in the providers coming together—and you said physicians, nurses, long-term-care homes, hospitals, PSWs—everybody comes together and feeds their advice, we'll say, to the LHINs, and then the LHINs plan and coordinate. Am I starting to better understand what you're saying?

Dr. Scott Wooder: Yes.

M^me^ France Gélinas: All right. I admit, I'm surprised that I'm following on—he and I don't usually follow in the same line of talk, but it seems like we are. Why are you feeding that to the LHINs and not to the ministry directly?

Dr. Scott Wooder: We're not shy about sharing our opinion with everybody. So we tell the ministry. We tell everybody who will listen.

M^me^ France Gélinas: But the structures that you have used some of your membership dues on and that you have been supporting is really a structure where you allow people to meaningfully give their advice to the LHINs.

Dr. Scott Wooder: That's absolutely right. You know, we think that it's important for us to not only give advice to other people about how they could spend money, but we want to make an investment in making things better. We will spend members' dues to do that.

We do that now in supporting our members to develop their leadership skills. There's a number of other initiatives that wouldn't seemingly be a usual way that a professional association would spend its resources, but we're willing to do that to make the system better.

M^me^ France Gélinas: Is there any brainpower being spent right now within the OMA that looks at what the future of primary care integration is? What could it look like? Where is this work being done and what does it look like?

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Dr. Scott Wooder: Yes, there's a tremendous amount of effort and brainpower; I'm looking at Mr. Brown because he's the big brain. I gave a lecture at McMaster University last week, and I talked to a group of students—not all medical students; there were nursing students, pharmacy students, PA students there. We were talking about interprofessional care. I told them a story about my own practice. When I started, I went in with two other physicians—actually, I took my practice and joined them. They had registered nurses working for them, but the registered nurses were answering the phone, they were filing, they were booking appointments, and they were giving advice to patients. That's not working to full scope of practice. We changed things. We hired administrative staff to do administrative work, and we changed it so that our registered nurses were doing things that registered nurses should do.

I also want to work to the full scope of my practice. I don't feel squeezed out at all. The ability to work with a team has changed my function to much more of an executive level. I make big decisions with patients. I'm not necessarily giving vaccinations, checking blood pressures and jotting down medication lists in the chart. I have other people who do that, and that is within their scope of practice.

An integrated interprofessional team allows me to do that and function at a much, much higher level than I was doing 25 years ago. That's our view of the future.

M^me^ France Gélinas: Okay, so could you expand a little bit as to what this team would look like? Who would be part? How many people would take part? How would it work?

Dr. Scott Wooder: Sure. It really depends on local circumstances. In the region of the province you're from, there are communities that have few or no physicians, so they would have a very different structure from where I live in Hamilton, where there are 350 family physicians, and we have 150 physicians as part of the Hamilton Family Health Team, and another 40 are part of the McMaster Family Health Team. So I don't think there's one formula that works across the province. I think it's up to individual communities to make decisions about who should be part of the team. That depends to some extent on what other resources are available.

Recruitment is a big issue, too. I would love to work with a physician assistant; I have trouble recruiting one. I know other people would like to work with a nurse practitioner, and they're just not able to compete with the hospital sector in terms of salary.

I don't think there's one model. I think the key is interprofessional teams working together for the benefit of the patients, everybody working to their full scope of practice, and having regular communication to check back with each other to make sure that these teams are functioning at a very high level. That's how we see the future.

M^me^ France Gélinas: Okay. I like the future. Talk to me a little about how, in this view of the future of integrated primary care, payment for all this fits in. You and I have already talked. I see fee-for-service as an impediment to working as a team, because you have the rest of the team that is on salary and has time to do this important dialogue between team members, and then you have one member of the team who is paid a fee for service, and if he or she takes the time to review a patient with you when the patient is not there, they lose out. They're the only loser in the room.

Dr. Scott Wooder: Well, I can assure you, physicians are rarely the loser. We do very well.

I haven't personally been in fee-for-service for 25 years. I've been in a capitated model during that whole time. The majority of comprehensive care family physicians now are being paid largely through capitation. The rest are being paid on a blended model which includes a portion of capitation. I believe, with bonuses and the capitation components, 25% of their income comes from capitation.

You're right: Even for those people, there is a barrier to working within teams because it has a negative impact on the physician's revenues. It doesn't on mine; I'm capitated, so I don't suffer that. But someone for whom the majority of their income comes from fee-for-service—it's not just the time taken in consultation, but it's the alteration in case mix.

We all see people with incredibly complicated medical problems who need to have a lot of time spent with them and their families. Then we see people with very brief, self-limited illnesses—a 30-year-old man with a cold. It's a very brief interaction. The payment for those two encounters is likely the same. So if there's a nurse practitioner who is part of the team and who sees the 30-year-old with a cold, then it alters the case mix, and the physician—it will have a negative impact on their revenue. But in family health teams, none of the physicians are fee-for-service; they're all paid through capitation. The majority of comprehensive care family physicians are. The model is being encouraged by the Ministry of Health, and the numbers are increasing, month over month.

M^me^ France Gélinas: So this is kind of your view of the future, where most physicians would be in an interdisciplinary team practice setting and being paid through capitation?

Dr. Scott Wooder: Being in an interdisciplinary team setting where the payment model didn't interfere with that, whatever the payment model was, yes. So it could

be salary, for instance, in a CHC. That's how they're remunerated and it works quite well.

M^me^ France Gélinas: Okay. You did mention a little bit about incentive payments. Those can also have interesting—I would say unintentional—consequences. You want to do something good and then you realize that, because this is incented and this is not, they end up doing this rather than that. What is the OMA future of primary care integration thinking about that?

Dr. Scott Wooder: You're absolutely right: Some of the incentives we've put in place have unintended consequences. Some of the incentives we've put in place are overtaken by new evidence. An example of that would be an incentive that was put in place to do Pap smears every two years, whereas current guidelines would suggest that every three years would be a more appropriate time frame. There were incentives put in place for certain childhood immunizations. Well, since we put those incentives in place, the list of childhood immunizations has grown.

The way we do that is that there's a joint OMA-Ministry of Health committee called the physician services committee that would review those on a regular basis. They would have a subcommittee that looks specifically at primary care and would review those incentives to make sure that there were no unintended consequences, or if there were, to make changes, and to make sure that the incentives were based on current evidence, not the evidence that was in place at the time the contract was negotiated.

M^me^ France Gélinas: Okay. So I have a different point of view. Why do you have to pay incentives for physicians to do the right thing? Every other health professional does the right thing because it's the right thing to do and doesn't need an incentive to get paid. But you don't have to answer that if you don't want to.

Dr. Scott Wooder: No, I don't disagree with you. Those incentives were not add-on payments. Those incentives were made in lieu of increases to the schedule of benefits. Our members would have much preferred to have not had the incentives put in place and just have had the increase.

M^me^ France Gélinas: Good answer.

Dr. Scott Wooder: I've been practising that one.

M^me^ France Gélinas: So in all of this conversation, I don't see a role for the LHINs in there. We're here talking about the LHINs; all of this future of what primary care could look like sort of makes sense to me. I would say that I would be ready to support a lot of what you've said, but I fail to see why we need the LHINs to get there.

Dr. Scott Wooder: Well, I can give you a theoretical example. A LHIN identifies a certain area of practice as a priority: diabetic management, improving end-of-life care, improving child-maternal health—something like that. They then go to the primary care community and say, "This is our concern; this is what we want to do. What's your experience? What changes should we put in place? How do we solve the problems we have in common?" Then they would act as partners in coming up with solutions, developing programs to improve care in those specific areas. That's the role I see of the LHIN.

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M^me^ France Gélinas: All right. So this comes back to the conversations you were having where the LHINs would get an informed opinion as to what other programs and services are needed and identify those areas of practice as a priority. How do they become a player in making sure that those areas of practice get picked up?

Dr. Scott Wooder: Physicians want to do the right thing. It's our training. It's a professional obligation that we have. That professionalism stretches back generations. We don't need a LHIN to tell us to do the right thing. We may need their help in deciding what the right thing is, and they may need our help deciding how to do that. But we don't need the LHIN to somehow sit as an enforcer of our professionalism.

M^me^ France Gélinas: Okay.

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. Your time has expired.

Ms. Jaczek.

Ms. Helena Jaczek: How much time do I have left, Chair?

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

Ms. Helena Jaczek: Thank you. Dr. Wooder, I'll pick up on something you said to the official opposition. You did say that with the LHIN structure, we're on the right track. You apparently started practice in the 1980s. You will no doubt recall, as do I, all the discussion around regionalization of health care. The concept—and this was happening across Canada in the 1980s and the 1990s—was that health care decisions should somehow be made more at a local level as opposed to in the ivory tower in the provincial Ministry of Health. That was, I think, a consensus view that developed over time. I'd like to point out to the official opposition that it was our government that actually took some action here in Ontario with the structure that we have in front of us, and further to that, given the complexity of the health care system, if we can call it a system—in other words, the number of players here in Ontario, a province with 13 million—this has been a complex, difficult task.

Perhaps there's a lack of understanding by some that changing from what we had before to even where we are now has, not at all surprisingly, taken a considerable length of time, as you've alluded to yourself. The change that has happened in medicine and the change that we have brought about through the Local Health System Integration Act is considerable, and it engages so many different players and so many different organizations.

I guess I'll ask you the question, then: You were practising in Ontario. We had district health councils. We had the Ministry of Health. Would you say that what we have now is an improvement?

Dr. Scott Wooder: Yes. I think the improvement is the whole change of philosophy, that we need a system. You question whether we have a system. Certainly, we

have more of a system than we did when either one of us started practice. Do we need to go further? Do we need to improve that? Sure, but we're on the right track.

Ms. Helena Jaczek: Let's turn it over to you a little bit to give us your ideas. Officially, this committee is looking at the act itself, the legislation. Has the Ontario Medical Association determined that there's any need for change to the legislation?

Dr. Scott Wooder: No, we don't have any specific recommendations about a change.

Ms. Helena Jaczek: In other words, what we're talking about is that within this framework, how can we make things better for the patient in Ontario?

Dr. Scott Wooder: Absolutely.

Ms. Helena Jaczek: One of the things you've said on behalf of the medical profession is clearly a partnership between the profession and the LHINs in terms of moving forward. Is that fair, that that would be the kind of relationship you would like to see?

Dr. Scott Wooder: Sure. We'd like to see a partnership with the LHINs, with the Ministry of Health, with the government, with the people of Ontario, with our patients, with the hospitals. It's the type of relationship—the partnership relationship—that actually works in making things better.

Ms. Helena Jaczek: If you were suddenly to be made the CEO of a LHIN, what would you do? What would be your types of actions? How would you reach out? Describe to me what you would do in that first three months on the job.

Dr. Scott Wooder: Well, in terms of better understanding the position—I'll stick to that, because that's what I know best—I would engage some lead physicians, people I trusted, people I paid, to go out and speak to as many physicians as possible. I wouldn't invite them in. I think there's a huge difference between inviting a physician to your place and going to meet them.

When I was elected to the board of the OMA, our approval rating amongst members was about 30%. It now stands in excess of 70%, and a large part of that, I believe, is that in 2004 we instituted a program where we would go out and meet members where they lived. Prior to that, we had meetings in council—usually here in Toronto; sometimes in Hamilton, London or Ottawa—but it was a fairly new thing. During my term as president, I've been to Timmins, Sudbury, Thunder Bay, North Bay, Windsor—I've been all across the province, and my predecessors and successors will do that as well.

The key there is going out to see the members, not inviting them in. And I'd ask them what changes they would like to see made. Some of the ideas won't make a lot of sense, but some of them will make a lot of sense, and understanding the motives behind even the ones that perhaps won't work will help inform.

The first thing I would do would be to go out, talk to people and ask them what changes need to be made.

Ms. Helena Jaczek: How would you better utilize the primary care councils? Do you think there's a way of beefing that structure up?

Dr. Scott Wooder: I think the primary care lead, who is a physician engaged by the LHIN, should be the person who goes out and does the engagement. They're usually, I believe, the chairs of the primary care councils, so I would use the people on the council—people who are volunteering to come forward—to engage in that. I would use them, their expertise and their contacts to go out and speak to front-line workers—physicians, nurses—and everybody who actually provides care to patients.

Ms. Helena Jaczek: And how would you perhaps—we've heard some criticisms about LHIN board meetings being very poorly attended. People don't know that they're happening. Usually, at least in my LHIN, they occur at night. Is there any way to engage more physicians in just hearing about the general business of the LHINs, or somehow engaging them better?

Dr. Scott Wooder: I'm not sure that attending a board meeting is the way to engage physicians. I think that some of the things that happen at boards—probably most of the people in this room have been on a board. There are a lot of fiduciary things that go on. I think that going out and talking to people where they live, talking about clinical and patient-related matters, would probably be more important than attending a board meeting.

Ms. Helena Jaczek: So, in essence, you feel that there's a lot of communication that is necessary, improved communication, treating physicians more as partners. You've talked about the top-down approach not working. In essence, you see stay the course; just simply improve the quality of the interactions. And—this is something that we've heard—ensure that, wherever there is a best practice, and there was a reference to South West, that this somehow be disseminated in a more effective manner across all 14 LHINs. Would you say that that's pretty much your position?

Dr. Scott Wooder: I think that everybody in the health care sector wants to do the right thing. They want to learn from their colleagues and peers who are maybe more successful in a particular area. So yes, I think that disseminating those best practices is important.

The key word used was "communication." We need to improve, too. The Ontario Medical Association needs to improve the way it communicates in this regard.

Ms. Helena Jaczek: I have no further questions.

The Vice-Chair (Mr. Ted Chudleigh): That concludes our session. Thank you very much for your patience, your understanding, and your knowledge that you've imparted to the committee. We appreciate it very much. Thank you.

Dr. Scott Wooder: Thank you, Chair.

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TORONTO CENTRAL LOCAL HEALTH INTEGRATION NETWORK

The Vice-Chair (Mr. Ted Chudleigh): Next, we have the Toronto Central Local Health Integration Network. Thank you very much for coming in. You have up to 15 minutes for your presentation. Any time remain-

ing will be used for questions from one, two, or three of the parties. Thank you very much. Could you identify yourself for the purpose of Hansard, please.

Interjection.

The Vice-Chair (Mr. Ted Chudleigh): Has there been a presentation circulated? No, I'm sorry, there has not been a presentation circulated. There's a background paper that has been circulated. The presentation has not been.

Ms. Camille Orridge: No. We're just getting it.

Good afternoon, and thank you for welcoming me back as you continue your review. My name is Camille Orridge, and I'm the CEO of the Toronto Central LHIN. You may recall the presentation I made to this committee in December, speaking as a representative of all 14 CEOs across Ontario.

In the past three months, you have travelled to different communities, from Windsor to Thunder Bay, collecting local expertise and hearing from communities all across this province. I commend you all for the time you have taken—that's a lot of listening—as we review the legislation.

While this committee took part in these local hearings, I've had my own encounter with the health system right here in the Toronto Central LHIN. I would like to take this opportunity to speak to you not only from the system perspective that the LHINs give me, but also to convey my recent experience as a patient, and another experience as a caregiver. I have learned a lot from my health care experience as I went through the system. I was able to highlight and identify what worked for me and what didn't. I hope my remarks today will underscore the integral role the LHIN plays as a local voice, a planner, and a partner who carries the patient's perspective.

I'd like to share the positive changes that are happening today in our health care system, but equally as important, I want to get out in front of what didn't work, because I believe that the LHINs have an opportunity to play a role in the continuous improvement of our system and finding patient-centred solutions.

Let me begin with my experience as a patient. Even though my job allows me to see the health system through a different lens than other Ontarians, I experienced the same feeling going into my surgery as many patients would. I had anxieties.

The first standout moment for me was during the pre-admission phase. I was extremely happy that all the tests required in advance were scheduled in one place and over one day. This experience was not unique to me. All the patients in pre-admit were treated the same, but that wasn't always the case. Previously, patients would have gone back and forth several times for tests, possibly to different locations, inconveniencing them and costing them in transportation and parking.

At the LHIN, we hear a lot about the gaps in patient care. They are the spaces between providers; for example, the time between the hospital visit and the visit to the family doctor after discharge. Best evidence suggests that those gaps in relationships make a difference to patient care.

I'll spare you the details, but the great news is that my surgery was a success. My discharge from hospital was another pivotal point for me. I just want to go back and say that the whole pre-admit was a major issue that the LHIN identified and had been working with hospitals on, because patients had said they were unhappy and it was in their patient satisfaction surveys. So there was a real push on from the LHIN for the hospitals to address this area of dissatisfaction.

My discharge from hospital was another pivotal moment for me as a patient. Prior to leaving, my medications were reviewed and I was told what not to take any longer and what the new medication requirements were. A home care assessment was also done so that I could leave the hospital feeling confident that I would be well supported in the community. Finally, I was given a paper copy of my discharge summary. The summary was a record of the reason for my admission, what happened in the hospital, all my medications, follow-up appointments, and instructions for my family doctor.

Up until a year ago, this summary would have taken months to reach family doctors. This gap meant that my family doctor would not know I had been hospitalized, what had happened to me, what changes had occurred and what was expected of her. Moreover, none of the community partners who were involved in my care would have had access to this information. I am happy to report to this committee that the summary I received is now a standard discharge plan.

The standardized discharge summary was a direct project of the Toronto Central LHIN. Our goal was to develop a consistent summary provided by hospitals to primary care providers and community support services. This emerged from a year's work we did with primary care. One of the issues primary care identified was not having this information, so we initiated that as a project.

This summary was developed with providers and clinicians at the table, and was designed to be easy to understand yet comprehensive. The summary provides all the information that clinicians say is critical for a safe hand-off from acute to primary care to community care.

Toronto Central LHIN brought our partners together throughout this collaborative process, and we were able to ensure buy-in and uptake, and increase implementation. Today, all 17 hospitals in the Toronto Central LHIN have begun implementing this summary in an effort to coordinate and improve medication reconciliation and follow-up instruction. This may seem like a minor change, but it gave me, the patient, the tool I needed to manage my own care. Each hospital in the Toronto Central LHIN is participating and spreading this practice across all divisions over the next two years.

I was absolutely thrilled to receive my summary. To be quite honest, the first email I sent to the office during my recovery was to let staff know that our hard work had paid off and the summary was a success.

This experience highlighted for me another change that should be on the radar of LHINs as we now talk about system change.

The LHIN is constantly scanning the environment to identify ways to improve the health outcomes of people at different stages of their journey throughout the health care system. We look for things that may not be on the radar of our health service providers because they don't fit easily into any one provider's area of responsibility.

In my experience, the only gap I felt when I left the hospital with my discharge summary in hand was something that would prepare me, on a very practical level, for the setting at home. For example, it would have been good if I'd had a resource that informed me of practical tips, such as preparing meals in advance, to help smooth out my transition to home. That would have been great. So I think there are still a lot of other things that we could do.

Let's move to my experience in my role as a caregiver and what I took away from that. So I'll introduce you to Barbara.

Barbara, like many seniors living in Toronto, is in need of care and wants to live independently in her own home. She is 83 years young, of Jamaican descent, and is a complex patient with visual impairment who suffers from dementia. But more importantly, Barbara was my mom's best friend, and she has no kids.

In 2008, I was asked to be her power of attorney for care, and I agreed to do that. Barbara took sick, was admitted to hospital and was discharged at just about the same time I was. We were both in the hospital at the same time and both discharged at about the same time. So we made quite a pair, with me as her power of attorney, me with a neck brace and immobile.

But she wasn't unusual. She's similar to a number of complex patients. She had visited her family physician, was admitted to acute care, and was then seen by the psychogeriatric team.

We were connected to the care coordinator in the hospital from the CCAC upon admission. We worked throughout that admission for a discharge plan. Upon discharge, we had one integrated plan that included occupational therapy, a home assessment, the family physician appointment, specialist referrals and appointments, community programming, transportation and medical equipment.

We started with a schedule for Barbara of getting seven days of in-home CCAC services and us providing the overnight. Since then, she has gone down to five days of in-home services and two days at an adult day program. We have started to plan what will happen as her dementia increases.

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As I went through Barbara's integrated care plan, I also recognized a number of the initiatives that were LHIN-driven and LHIN-funded initiatives.

The psychogeriatric outreach team out of Baycrest is a LHIN-funded program where Baycrest has responsibility for dementia and seniors with behavioural problems, and they now support long-term care and community care, using their expertise.

Integrated care plans are a big agenda for the Toronto Central LHIN, and we have funded that program specifically to improve the patient experience as they go across the hospital, to reduce the length of stay, and to reduce ALCs in hospital.

The enhanced adult day program: We did research and funded five enhanced programs across the LHIN for seniors such as Barbara to go to.

We also recognized that foot care was something that seniors needed, and those programs are now also offered out of the enhanced adult day program.

We have taken tremendous steps towards integrating care plans for our patients, but there are still gaps. One of the ones I found and observed is that we do not have in the system a streamlined assessment process. Every single provider was doing their own, different assessment, and they are not integrated. That is one of the failings I found, going through this myself, and that will be one of our next big tasks with the ministry.

The shift for me with the LHINs, and the questions that have come up, is that as a funder, not a direct provider, we bring together the various sectors. We don't have a vested interest beyond the improvement of assistance and outcomes for patients, and we can set goals and get everybody to work towards delivery of those common outcomes. That, for me, has been a key role of the LHIN, and certainly one that I have experienced.

There is a culture shift that needs to happen in our system, and I think the LHIN leadership is pivotal to making that happen. If nothing else, my personal experience has taught me to be grateful for what we have—Ontario's health care—and that it was there to serve me and Barbara.

These hearings—and even as we work on continuous quality improvement—sometimes have a way of diminishing the work that is actually being done well. It is easy to get bogged down in all the negativity, but in reality, if we get hung up, then we won't be able to create a better system for the future.

I think there is a lot of room for continuous improvement, and there is a lot of work to be done in that area. I think the LHINs can play a key role in making that agenda move forward by bringing the providers together, having common outcomes, and getting everybody to work together to deliver high-quality, cost-effective patient care.

I'm very comfortable and I'm here and I'm committed, as a LHIN CEO, to working for that delivery on behalf of patients as we go forward.

I wanted to thank you again for the opportunity to come before you, to make this presentation of my experience. I hope that I've given you a slightly different perspective of the role of the LHIN, because I've been able to see the impact of some of the programs directly on patient care. With that, I will stop.

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

Mr. John O'Toole: There's the bell, Chair.

The Vice-Chair (Mr. Ted Chudleigh): There is a bell, and it's a 10-minute bell, I believe. We've got about two and a half minutes of questioning left, of which the government will take part. Then we will rise and recess and go to the vote.

Ms. Jaczek?

Ms. Helena Jaczek: Thank you, Ms. Orridge, especially for putting the patient front and centre and for sharing your experience.

We had the association of CCACs in last week, and they talked a little bit about patient satisfaction surveys, not only in terms of the percentage who thought the care was excellent or good or whatever, which is not particularly interesting, but they also said that they are gathering ideas about things like gaps—as you described—in the patient experience.

Have you been receiving this type of information from the Toronto CCAC? How do you deal with this sort of information when it comes forward?

Ms. Camille Orridge: The OMA was here before. In this LHIN, we did an extensive bit of work with a lot of primary care physicians to find out what their needs were, what the gaps were for them to provide care. We have also worked extensively with the CCAC as to what is their experience in the gaps.

We've also gone out and done consultations with populations and with people and then pulled those pieces together. That has identified the priorities. It's out of that, for example, that the discharge summary became a priority because patients identified it; primary care doctors identified it. The hospitals didn't identify it, but they were the ones who produced it. The community agencies identified it.

We work with all of those providers together, but we start with, what are patients telling us that's not working? In most of the things that they identified, we were able to see that it's the hand-offs that were the problem. We have targeted that as some of our major initiatives.

Ms. Helena Jaczek: The discharge summary issue is big in the Central LHIN. So then my question is, how do you share your best practice or what you've heard in your LHIN with other LHINs? Do you share with the Ministry of Health? Where does it go from your desk?

Ms. Camille Orridge: Across all 14 LHINs, we do share. Again, just for information, we have one back office across all 14 LHINs: that one payroll, that one thing that's run by the Toronto Central. We have set up a system of one-out-the-door, perfected and spread. A lot of times, people say, "You're not consistent." A lot of it is deliberately not consistent. South West and Toronto Central first did the work on primary care, and spread.

We have done the work around the discharge planning. We've shared it with the ministry and we are now sharing it with the other LHINs. That's how we test-spread.

Ms. Helena Jaczek: Anything else—

The Vice-Chair (Mr. Ted Chudleigh): Thank you very much. We appreciate it, and thank you very much for coming back to the committee.

Ms. Camille Orridge: Thank you.

The Vice-Chair (Mr. Ted Chudleigh): The committee will now recess until the vote. When we come back, we will be in closed session, with MPPs and legislative staff only. Thank you very much.

The committee recessed at 1557 and continued in closed session at 1614.

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