



ISSN 1180-4327

**Legislative Assembly
of Ontario**

First Session, 41st Parliament

**Assemblée législative
de l'Ontario**

Première session, 41^e législature

**Official Report
of Debates
(Hansard)**

Wednesday 11 May 2016

**Journal
des débats
(Hansard)**

Mercredi 11 mai 2016

**Standing Committee on
Public Accounts**

2015 Annual Report,
Auditor General:

Ministry of Health
and Long-Term Care

**Comité permanent des
comptes publics**

Rapport annuel 2015,
vérificatrice générale

Ministère de la Santé
et des Soins de longue durée

Hansard on the Internet

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

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

Index inquiries

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

Le Journal des débats sur Internet

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

Renseignements sur l'index

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

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



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

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 11 May 2016

Mercredi 11 mai 2016

The committee met at 1231 in room 151, following a closed session.

2015 ANNUAL REPORT,
AUDITOR GENERAL

MINISTRY OF HEALTH
AND LONG-TERM CARE

NORTH EAST COMMUNITY CARE
ACCESS CENTRE

CENTRAL COMMUNITY CARE
ACCESS CENTRE

CHAMPLAIN COMMUNITY CARE
ACCESS CENTRE

ONTARIO ASSOCIATION OF COMMUNITY
CARE ACCESS CENTRES

Consideration of section 3.01, community care access centres, home care program.

The Chair (Mr. Ernie Hardeman): There we go. We'll start the meeting. This is a meeting of the public accounts committee. We're here this afternoon to have delegations concerned with the CCAC—the community care access centres—home care program, section 3.01 of the 2015 Annual Report of the Office of the Auditor General of Ontario.

With us here, we have a representative, the deputy minister from the Ministry of Health. We have the Ontario Association of Community Care Access Centres, Central Community Care Access Centre, Champlain Community Care Access Centre and North East Community Care Access Centre. We have them all sitting here.

Before we start, there are not enough microphones for all the delegations we have today, so we want to make sure that when we change speakers, when we get to the question portion of the meeting, we just move the mic—or at least point it in the direction of the person who's going to speak, the one nearest to them.

With that, we welcome all of you here this afternoon. I'll just point out that you'll have 20 minutes to make your presentation as to what you would like to tell us to start to debate, and then we will have questions from each caucus. We will start with the third party in the first round. It will be 20 minutes for each party, and we will

then decide how much time is left. That time will be divided equally, and then we'll make one more circle with the rest of the questions.

Again, we thank you all for giving your time to be here today. We'll turn it over to you, Deputy.

Dr. Bob Bell: Thank you, Chair. I'd like to start off by thanking you for the opportunity to address the Standing Committee on Public Accounts with respect to the Auditor General of Ontario's report on community care access centres.

With me to my far left is Nancy Naylor, associate deputy minister of delivery and implementation since mid-2015, the person in the ministry with senior executive responsibility for CCACs. I'm also delighted to be joined by Catherine Brown, to Nancy's right, from the Ontario Association of Community Care Access Centres, OACCAC, as well as colleagues, chief executive officers of the Champlain, Central and North East CCACs: Marc Sougavinski, Megan Allen-Lamb and Richard Joly.

Finally, I'd like to thank the Auditor General of Ontario, Bonnie Lysyk, for both of her reports on CCACs. We, as the ministry, appreciate her advice on strengthening home and community care in Ontario.

As you know, the Auditor General has done a considerable amount of due diligence to investigate the efficiency and the effectiveness of our CCACs. Her reports have been divided into two distinct phases. Phase one examined CCAC compensation practices, operating expenses and the overall cost-effectiveness of the current home care model. Phase two examined and provided recommendations on CCAC program effectiveness and efficiency. This, of course, is the focus of our conversation today.

The Auditor General's second report on CCACs highlighted a few key themes that I would like to explore:

- the need to expand supports for caregivers in Ontario;

- the need for standardized guidelines for prioritizing clients to improve consistency of service;

- the need to better utilize health resources by diverting low-needs clients from CCACs to community support service agencies; and

- the need to review home care indicators to improve performance.

We accept and endorse all the recommendations of the Auditor General. Her work has been a catalyst to deepen our plan to improve home and community care.

I'm also pleased to say that since the second report was tabled in the Legislative Assembly in December 2015, significant progress has been made to address the Auditor General's recommendations. I'm going to highlight a few of our successes for you now, and let the true experts in home and community care sitting on either side of me provide you with their context on the CCACs and home and community care landscape in Ontario.

In addition to the recommendations from the Auditor General's report, the ministry received expert advice from the expert group on home and community care, led by Dr. Gail Donner. Their report, *Bringing Care Home*, highlighted ongoing service challenges including lack of consistency, lack of support for caregivers and difficult transitions from hospital to home.

We listened to their advice and in May 2015, we released *Patients First: A Roadmap to Strengthen Home and Community Care*. In this, we laid out 10 steps which we are taking to bring change to the home care system in response to Dr. Donner's recommendations. With the release of this publicly available road map, we focused first on improving the experience of patients and caregivers, we pursued regulatory changes and increased funding to provide 80,000 more home care nursing hours, and moved forward with bundled care models to coordinate service and help people in the transition from hospital to home. I am sure we'll discuss that further.

In the 2016 budget, we extended our commitment to increase funding by \$250 million to increase capacity to deliver high-quality home and community care. When considering options to allocate the funding, the ministry considers the Auditor General's recommendations carefully.

We are committed to continuing to improve services for patients across Ontario. As we move forward with changes, we are putting patients first. We cannot forget that thousands of people rely on CCACs every day for vital health care services such as nursing and personal support. We continue to provide the services that Ontarians rely on.

When we released the road map, we said that we believed that structural changes would follow as necessary. This was consistent with the advice we received from both the Auditor General as well as the expert panel. With the work on the road map well under way, it is time to start looking at structural changes within the system that provides home care services.

In December 2015, we released *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, a discussion paper that proposed changes to several areas in the health system, including home and community care. In this proposal, service delivery and management of home care would be transferred from CCACs to LHINs. As part of this transition, the employment of CCAC employees, including care coordinators, would also be transferred. Currently, CCAC care coordinators are responsible for assessing a client's requirements, including determining eligibility and developing a plan of service or care plan for home and community services.

The integration of home and community care in the proposed structure, we feel, would improve sector navigability and patient experience as clients transition through the various elements of the system. The shift would create an opportunity to integrate home and community care into other services.

Home care coordinators, although employed by the LHIN, could be deployed into community settings such as CHCs or family health teams, making access easier for Ontarians requiring home and community care. These coordinators could connect clients, caregivers and family physicians, for example, when developing a care plan, as is often done now by home care coordinators under the CCAC, but we anticipate, perhaps, more regularly under this revised model.

1240

Improved efficiency of management and delivery would increase funding available for patient care and would improve access to needed services. This will address some of the Auditor General's recommendations, including reducing duplication in delivery and assessment.

The development of clinical standards, decision-making supports and enhanced monitoring would improve the quality of care and strengthen public confidence in the system. In addition to strengthening the consistency of care across the province, the ministry intends to make reports publically available, focusing on transparency, as recommended in the report.

Combined with the work of the road map, changes to the structure and the function of home and community care will address some of the current variations in home and community services across the province by providing clearer definition of the type and extent of the care and support that home and community care clients—and caregivers, importantly—can expect.

The ministry spent early 2016 consulting on the discussion paper proposal. The response we received can only be described as inspiring. Between the ministry and the LHINs, we met with more than 6,000 Ontarians, led 253 consultations across the province, including those open to the public, and received 1,160 emails and 187 formal submissions, mainly from organizations. This feedback will inform draft legislation and implementation planning as the ministry moves forward with the *Patients First* transformation agenda.

I'd like to provide a bit more detail on the work accomplished to address the audit recommendations. Broadly, the ministry has:

- conducted an inventory of caregiver training and education programs across other jurisdictions to explore approaches that can be adapted in Ontario;

- convened a Patient and Caregiver Advisory Table on Home and Community Care to provide feedback and advice on the implementation of the road map;

- initiated the development, importantly, of a levels-of-care framework that will support clients with similar needs to receive similar levels of service regardless of where they live, and will be based on best practices consistent across the province.

We've also initiated work with Health Quality Ontario to review home care indicators and begin development of quality standards for home care.

The ministry looks forward to continuing this important work, and is committed to addressing the recommendations of the Auditor General. Once again, the ministry, the OACCAC and the three CCACs with me today would like to thank the Auditor General and her team. These recommendations will become an integral part of the evolving strategy in the coming months and years.

I'll now pass over to the CEO of the North East CCAC, Monsieur Richard Joly.

Mr. Richard Joly: Thank you, Deputy Bell. Good afternoon, everyone. Bonjour, tout le monde. My name is Richard Joly and I am proud to lead the team of the North East Community Care Access Centre. I'd like to thank the members of the Standing Committee on Public Accounts for asking us here today to talk about the varied programs and services we provide to our patients, caregivers and families, and, of course, the challenges we all face in terms of limited health human resources, and the ever-growing demand for home and community care.

I'd also like to acknowledge the work of the Auditor General of Ontario and her office on behalf of the people of Ontario. In the North East, the AG staff got a small taste of what care coordinators and therapists experience on a daily basis: the challenge of travelling our vast geography during the cold wintry months. But I am happy to report today that they all survived their stay in northern Ontario.

It's no secret that home and community care is complex and changing very quickly. Ontario's 14 CCACs care for some 720,000 patients each year. That's more than double the number of people we served just over a decade ago, and their health needs are substantially more complex.

The ability to provide excellent, individualized care, both in the home and in the community, for so many Ontario residents is a great success story. Patients have clearly articulated their health care goals. They want to be home from hospital as soon as they can. They want to live independently, and with dignity, as long as possible in their own homes and home communities.

We help them achieve these goals through the hard work of our dedicated front-line health professionals, including CCAC care coordinators who liaise with physicians, hospitals, long-term-care homes, community support services and many other health care partners to provide this level of care on a daily basis.

There are 25 hospitals in my region where thousands of patients receive excellent care. The CCAC provides care to thousands of patients in literally thousands of different settings, posing challenges to consistent and standardized care. Across Ontario, there is a wide variation in volume and complexity of populations, system partners, human and financial resources and LHIN-driven priorities.

Consider this: The boundaries of the North East CCAC represent 42% of Ontario's total land mass. That's

roughly the size of Germany. And yet, we serve a population of only 554,000 people, who live in a mix of urban, rural and very remote communities scattered across 415,000 square kilometres. Yes, it is a daunting task, but on any given day, we provide individualized nursing, personal support and rehabilitation services to more than 15,000 patients in their homes and home communities across the northeast. How do we do it? Through collaboration and teamwork.

Our team of 240 care coordinators works closely with other health care professionals, with 40 contracted service provider organizations, at 25 hospitals, 43 long-term-care homes, 27 family health teams, six community health centres, 374 schools, 68 community support service agencies, six nurse-practitioner-led clinics and one group health centre. This is in the NorthEast alone. While we may be diverse in location and approach, all CCACs in Ontario share one common goal: to ensure patients get the care they need, when and where they need it.

It is now my pleasure to turn the floor over to my colleague, Megan Allen-Lamb.

Ms. Megan Allen-Lamb: Thank you, Richard. My name is Megan Allen-Lamb and I am the chief executive officer of the Central Community Care Access Centre. Like my colleagues in other CCACs, we welcome and acknowledge the recommendations made by the Auditor General to improve how we deliver care to our patients and their families.

Today, I am pleased to speak with you about care coordination as an increasingly valued and necessary role in Ontario's large and complex health care system.

Care coordinators are regulated health care professionals, such as nurses, who use their clinical skills each and every day to assess patients' medical needs and their support needs. They're working in partnership with our patients to co-create care plans with specific treatment goals. When patients are ill and at their most vulnerable, care coordinators get them the necessary services they need. They help caregivers and families navigate a very complicated health care system to keep them safe at home, in community, where they want to be.

Working on behalf of and in partnership with patients and their caregivers, care coordinators engage and consult with many members of the care team. That includes family physicians, nurse practitioners and other health care providers. Care coordination is at the heart of an integrated health care system, bringing together professionals and different services and supports, wrapping care around patients to keep them safe at home.

Knowledgeable and resourceful, care coordinators also focus on supporting caregivers in their role. We know more and more families are living with loved ones with complex needs and that we all need to reach out and support caregivers in the best way that we can. They are the heart of the home.

Each year, Central CCAC serves an increasing number of patients with complex, chronic health conditions. Just five years ago, approximately 56% of our patients had complex, chronic conditions. Today, that's well over

73%. In the past, these patients would have stayed in hospital for long periods of time. They would have transitioned to a long-term-care home. But today, now, we are pleased to share that we are bringing home many complex patients with chronic health conditions. We hear time and time again that home is where they want to be.

1250

Meeting the needs and expectations of our patients, their families and caregivers requires a focused and integrated approach to care. That's where care coordination is vital. Last year, our team—my team—at Central CCAC responded to almost over 300,000 calls from patients and families. That's 900 calls a day that the Central CCAC team is fielding, helping patients and caregivers get connected to services.

We delivered care to over 82,000 patients in community. I am delighted to share that our care coordinators completed over 70,000 visits face to face with patients and their families. In addition to this, we helped over 39,000 patients transition home safely and appropriately after an acute care episode in hospital.

In addition to that, we helped 3,800 patients make very difficult, life-changing decisions when moving into a long-term-care home. As you can imagine, those are very difficult conversations with patients and their families.

Lastly, we helped close to 2,500 patients die in their place of choice.

That is just a snapshot of the workload of one of 14 CCACs in this province. They are just a few of many examples of how care coordinators, working in partnership with others, positively impact the lives of patients, families and their caregivers, helping them get the care they need to stay safe, well and at home, where they want to be.

I am pleased now to turn to my colleague Marc Sougavinski to talk about the future of the health system, one that leverages the value of care coordination and delivers patient-centred care.

Thank you.

Mr. Marc Sougavinski: Thank you. Hello, everybody. Mr. Chairman, can I know how much time I have left, please?

The Chair (Mr. Ernie Hardeman): You have just under two minutes left.

Mr. Marc Sougavinski: Okay. I'm Marc Sougavinski. I'm the CEO of Champlain CCAC. I have been in this position in Ontario for about 11 months now. I was greeted on my first day by the Office of the Auditor General, which proved quite interesting. I recommend to my friends CEOs that they should always start with a report of the auditor. I mean it; it proved to be very useful.

Six months after the report, we have made some progress on a variety of issues—of course, not all of them, perhaps, but certainly many of those. We have taken steps to improve consistency of services. We have improved patient experience. We are reviewing and continue to refine performance and productivity measures

and caseloads for care coordinators and direct care nurses.

Home care is not an area where we can or should have long wait-lists. Wait-lists in home care are dramatic to the clients, to the community and to the system. We have continued to work actively with the ministry to monitor progress on wait times.

We have moved forward to further refine the definition of “missed care” and performance targets and are collecting that new data.

This, of course, will continue, but now in the context of a major reform and structural changes aiming at better integrating first-line services in the community.

In line with the auditor's recommendations, we are moving toward an organization where our care coordinators have caseloads that are manageable, so that care coordination is a more comprehensive and integrative venture than it is at the moment.

Our staff, and the service providers' staff, are building stronger expertise required to provide care to those patients who have tremendously high needs, as my colleague pointed out, that we care for now and that will be the trend for the future.

Patients and their families will be best served when different partners in first-line services are highly integrated. That means doctors, community organizations, community health centres, and even hospital specialists—why not?

We want more coherence and continuity from service providers, and staff better matched to the actual needs and characteristics of our patients.

We need a specific set of programs and support for caregivers, a recommendation of the Auditor General and the ministry's 10-point plan.

Finally, we must reach a point where budgets are better matched to the care for each patient. Patient needs and complexity grows. As the number of patients and length of stay in home care increase, funding needs to keep up.

At Champlain CCAC, adult complex clients have increased by 33%—and that's just in the last two years—hence, the tremendous importance of the work regarding the levels-of-care framework in which we are actively engaged with the ministry.

In conclusion, we support changes that will deliver higher-quality, more consistent, more equitable and better integrated home and community care across the province.

The Chair (Mr. Ernie Hardeman): I thank you very much for your presentation. I did have to look the other way. The Chair doesn't have to pay any attention to the clock unless somebody asks him to. With that, we will start the questioning with Ms. Gélinas.

M^{me} France Gélinas: I will start my first round of questions at what I call the 10,000-foot level and then drill down to some of the specific recommendations that the AG has done. As well, I want to thank you for the report that you have written, both the ministry and the CCAC, to address each of the recommendations.

But starting at the 10,000-foot level, we know from the report—I'm sure you're all familiar with wait times. I appreciated that in your presentation you mentioned that wait times are not acceptable in home care for many different reasons, yet we have tremendous discrepancies between what should be your association's guidelines on being assessed within three days, within seven days etc., and what's actually happening on the ground. So my first question is, how do we fix this? How do we make sure that the assessment and the home care treatment start within a length of time that makes sense, and that we don't have those long wait-lists?

Dr. Bob Bell: Maybe I'll start with the ministry's perspective and pass off to my colleagues, Ms. Gélinas. We recognize that there are inequities across the province from LHIN to LHIN and from CCAC to CCAC with respect to per capita funding depending on how it's measured—per capita funding based on age; per capita funding based on frailty scores. These are historic differences that need to be corrected.

A couple of measures for correction: One is the use of the health-based allocation method, a way that has been used across the system to try and true up health care funding, giving appreciation for elements of increasing population within certain communities—the Central LHIN, for example—appreciation for elements related to acuity, age and populations. That's one method of realigning, using incremental funding to increase proportionately, according to needs determined by the health-based allocation methodology, how much incremental investment we provide to each CCAC.

The second method is to look at incremental funding models and look at the distribution of funding based on the needs of the most acute patients, so to look at the proportion of patients in communities, in addition to HBAM methodologies, that have higher acuity scores—MAPLe 4, MAPLe 5 patients—to use that as a way of truing up disparities in funding that occur, with, as you know, \$250 million of incremental funding this year for the home and community care sector. Looking at distributing that incremental funding in a way that addresses some of these inequities: That's a starting point from the ministry perspective.

Perhaps I could ask my colleagues to talk about their—

Mr. Marc Sougavinski: I'll speak to wait-lists. I put it in my presentation. It's something that I call a phobia of mine, because I think that from the wait-list there are a lot of other issues that appear. That's where your assessments are laid. That's where everything starts.

It really important to understand that everybody has wait-lists because usually there's not enough capacity to absorb everyone. But in home care, it's really essential that we have a system that doesn't allow for a lot of wait-lists to occur, because we're really the last line. We're at home. If there is a wait-list in long-term care, we might increase home care to help people waiting for home care.

If hospitals function at a higher capacity, we all meet together and we see how we can get clients out faster and

how can other hospitals troubleshoot. In home care, it's not possible. If we don't give the service, people are at home and they don't have it. It's a shame, because it's the least expensive service, if you compare it to many others.

1300

I think that right now, we have provisions and work towards improving the levels of care, and a budget that better matches the different levels of care that we have, as Dr. Bell mentioned. But for the time being, the important thing is really to monitor those wait-lists very, very closely and make sure that we develop partnerships with others when we realize that we can't handle it anymore. We basically have to reallocate and reprioritize our budget constantly, but that will, by definition, create a certain amount of inequalities and hurts for the people who don't have the service.

Mr. Richard Joly: If I could just add, the one thing we also want to do now and in the future—the demand will just increase, and we know that. We need to decrease the demand on home and community care, and one way of doing that is working with our partner, CSS, our family health teams and so on, and also bring innovation in home and community care.

There is a lot of innovation going on. I can tell you from experience that we've changed our model of care for managing congestive heart failure of COPD patients by using Telehomecare. It's a huge success using Telehomecare. They have their nurse. There's the satisfaction of our patients saying, "I know it's just a phone call away that I have my nurse, and I'm connected. I can send my blood pressure, I can send my weight and so on, and I get advice."

Looking at service delivery models like Telehomecare, we're now actually expanding it with physiotherapy. You can imagine that Telehomecare makes sense in a geography like ours, but it makes sense for everywhere in Ontario.

That's one piece of innovation that home care can do, and there are many other ones.

Ms. Megan Allen-Lamb: Perhaps I can add to that. First of all, with respect to the reassessment wait times, we recognize the findings from the Auditor General in that regard. Patient safety and timely delivery of care are of the utmost priority for our care coordinators. Our care coordinators work together as a team on any given day, looking at the patients' needs and balancing those with assessment timeframes. We took the results from the auditor very seriously, and I can share that within Central CCAC, we are close to 90% of the assessments being completed within the established guidelines, and that our sector is also coming together in the next several months to look at those guidelines again, based on the complexity of the patients that we're serving today.

M^{me} France Gélinas: I will come back and drill down on this. That was my first 10,000-foot question. My second one is that the auditor made it clear that a similar assessment of needs leads to different levels of service, depending on, first, where in Ontario you are; second,

where in the cycle of the fiscal year you are, as in, if you are assessed in February or March, there's a good chance you will get less services than if you were assessed for the same problem and same needs in June, because of the need to balance your budget.

Again, at the 10,000-foot level, how do we make sure that people with the same level of needs get the same level of services without a race to the bottom?

Dr. Bob Bell: Thank you. Perhaps I could ask Associate Deputy Minister Nancy Naylor, who's leading the ministry's approach to the Donner report, as well as the Auditor General's report, to talk about levels of care, the work that's developing.

Ms. Nancy Naylor: Thank you for that question. I know our colleagues will add to it, so I'll make sure to leave time for them.

But briefly, I think the Auditor General's commentary and her recommendations around consistency of care resonated with all of us, in part because we'd had the advice from the expert group on home care led by Gail Donner. Her report, *Bringing Care Home*, had also raised that issue, and it has been the subject of work led by the Ontario Association of Community Care Access Centres as well.

We know from our data that when we look at clients with similar priority levels or acuity levels, they do receive slightly different levels of PSW support, nursing support. It is a positive trend that that dispersion is narrowing over time, and it's partly because of the collegiality in the sector and people working together. But we are working provincially on a levels-of-care framework that would define priority levels and acuity levels in the sector. In part, we have a good foundation to build on, with the RAI assessment tools and the MAPLe priority levels that are used by the CCACs to assess their long-stay clients, so we have a typology to build on there. But we do expect to be validating that with an expert panel over the coming months.

We are also working with Health Quality Ontario on some common care standards. They have initiated one on wound care. That's a big patient population in home care. A number of experts from home care and clinical sciences are coming together to evaluate the existing wound care standards and agree on a common approach there.

That's a couple of initiatives that are underway. I do want to leave time for our colleagues to speak to this as well.

Ms. Megan Allen-Lamb: From a CCAC perspective, when our care coordinators are in the home assessing patients, as we know, they are regulated health care professionals, and they're looking at the type of care that the CCAC can provide, but they're also looking at the different community supports available within each community.

Consider Mrs. Jones, living in a small rural Ontario town. Mrs. Jones has early onset Alzheimer's. She's living alone. There aren't the services available that may be available to Mr. Smith, who lives in an urban area, and the CCAC coordinator can coordinate transportation,

get him to an adult day program; he's connected to a seniors' group. It's the same diagnosis with early onset Alzheimer's—and he also lives with his family. In that circumstance, a care coordinator may assess that Mr. Smith receive two hours of personal support because he has all of these other community support services available to him, versus Mrs. Jones living alone in a small rural area, who doesn't have that same access to different services. A care coordinator may allocate up to seven hours, for example, of personal support for that patient. Same disease, same trajectory in their disease progression, but very different services available to them within the community they live within.

Mr. Richard Joly: From personal experience with my mother recently with end of life—I have to tell you she had a lot of support, and she never received one day of service from home care because of all of her support. In the assessment that she had, she scored very high, but her preferences were, "I have my family, they can care for me," and so on.

But then you could have someone else, another family—and you may have experienced that yourselves—where the daughter lives six hours away, and they need more support. So the assessment is the same, but the hours delivered are not the same. I have to tell you, the care coordinators live that every single day.

M^{me} France Gélinas: Just coming back to the RAI assessment, when do you expect the wound care recommendations to be out and implemented?

Ms. Nancy Naylor: My understanding is they're aiming for this fall. It's just gotten under way. They've had their first meeting. They expect to take about six months to evaluate existing wound care standards. At that point, they'll be reporting out to the health care sector and to the ministry. We'll be working alongside them to say, "How do we deploy this once it's ready?"

The system is very ready to have this. It's a good exercise for us to be prepared for training care coordinators, training service providers who treat these kinds of patients and to make sure from the ministry's perspective that we're supporting that not only with deployment expertise, but potentially funding implications.

One of the things they are evaluating, at the request of RNAO, another key stakeholder, is the use of devices, such as special casts and offloading devices. The clinical standards group will be evaluating the extent to which those contribute to wound healing for patients with complex wounds. So this particular term of reference is focused on the types of wounds experienced by diabetic patients or patients with circulatory problems.

M^{me} France Gélinas: Coming back to you, Deputy: When you talked about going to HBAM and using the incremental funding, do you actually measure the gap as to, if we had all the money in the world, this is what is needed to fill the gap, but we don't, so therefore we will take what we have and spread it to cover as much as we can? What is that gap, and have you ever measured it?

1310

Dr. Bob Bell: One of the advantages that Ontario has—that Canada has, indeed—is a plethora of data

related to patient care assessment that describes in a fairly objective way what patient needs are. We've got RAI scores, as you know, done over the telephone, the so-called RAI contact assessment, as well as RAI home care. Not only that; we've got one of the world's leading academic experts in how RAI scores can be used to evaluate contextual differences between care needed by patients and different outcomes that patients might expect.

Dr. John Hirdes, who is on the research faculty of the University of Waterloo and is a key member of Nancy's team, is helping us to understand the needs that patients have. Translating those needs into care plans and care protocols, as you've heard from my colleagues, is so highly dependent on the contextual factors of whether there is a committed family with health care experience. Are there community support resources present in the neighbourhood? Is this patient living in a rural versus urban area?

I think it's fair to say that the optimum care plan, the optimum level of care for each patient, is an analysis that we're currently undertaking based on many years of RAI data being collected, and the opportunity for us to now model that going forward. In terms of the gap, I think it's fair to say that we don't have a systematic answer for you at present. That's part of the modelling exercise that we're looking at.

What we do recognize, of course, based on demographic trends that the Ontario population is growing and Ontario's population is slowly aging, is that it's anticipated that more people will be frail, that more people will have cognitive decline, that more people will have need for care in home and community.

We also recognize that when we do surveys of patients' and Ontarians' desires, people tell us they want to be looked after in an independent setting in their home. I think it's fair to say that this answer is evolving, with the analysis of level-of-care data, and with the standardization of home care contracts used to employ personal support workers, nurses and therapists who actually provide care as we standardize those contracts.

I think it's fair to say that, as a ministry and as care providers across Ontario, we're learning a lot about opportunities for increasing efficiency of care and the introduction of technology that allows us to actually provide physiologic monitoring at home that previously could only be provided by a nurse driving to a home, measuring the patient's oxygen, measuring their blood pressure and their pulse. This can now be done over their iPhone.

M^{me} France Gélinas: Coming back to my questions, where I asked if you measured the gap between what is presently available and what should be available to meet the needs, the answer is no.

When you do set a new target, such as, "This year, we'll give out \$250 million more," where does this number come from? Is it based on money available or is it based on needs of the patients served by the CCAC?

Dr. Bob Bell: I think it's fair to say that in developing the budget for the Ministry of Health, there are a variety

of priorities that could use extra funding. There's no question.

I think what we're looking at in home and community care is an absolute priority. Certainly, increasing the budget by 5% is a meaningful stake in the ground that says, "This is an important and evolving area for investment in the health care system."

At the same time, I think it's responsible to Ontario taxpayers to simply say that it's an evolving area with rapidly evolving technology, with rapidly evolving standardization of levels-of-care measurement, with ways that we pay health service providers. It's responsible for us to be constantly re-measuring service wait times as we make these investments.

I think it's fair to say today that we don't know, with the variety of changes occurring, what would be the optimum amount of money to invest in home care. I think we're learning that as we make these investments and measure the impact. I think we'd say, in response to your excellent question, we're learning the answer to that question, and it's responsible for us to look at the variety of substantive changes that are being made in home care delivery and estimating what that further investment is.

M^{me} France Gélinas: How much time?

The Chair (Mr. Ernie Hardeman): One minute.

M^{me} France Gélinas: One minute. I'll save it for my next turn.

The Chair (Mr. Ernie Hardeman): Okay. Very good. Thank you. To the government: Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today. I want to start out by saying, when we were looking at this report and I spent a bit of time thinking about health care—I always like to remind people that it's care that's delivered to thousands of people in thousands of places by thousands of people every day, and people with unique needs. When I was listening to Mr. Joly, I hadn't really spent a lot of time thinking about all the relationships that exist inside that world with hospitals and service providers, contractors, public health agencies.

There's a lot of complexity that exists in the sector and that's a challenge that goes right across all sectors of health care; most people don't recognize that when they look at that from someone receiving service. I think the paradigm that people have is a nurse visiting in the home and checking on your mom or your dad. I know that it's more complex than that, but I think that their expectations are that we're there to serve them.

My first question is a 10,000-foot question and it's around variability and the variability of service. I had the opportunity in the last year to speak to a lot of people on another issue, palliative care, which intersects with your world very much. The experience of the Champlain LHIN where I reside is that variability is not an issue because we're served and well contained within our geographic area, but I did hear about variability of service across—and in particular, I know that Mr. Milczyn has an intersection; my colleague, Yvan Baker, I think has four corners. So he's got four different CCACs serving people. It highlights the challenges that are there.

So when you're talking about a level-of-care framework, can someone be more specific about how that's going to change what it is and meet the expectations of people in a consistent way?

Dr. Bob Bell: Perhaps I'll start and then pass to my colleagues. I want to deal with the issue of LHIN boundaries, as a starting point, because we recognize that this is an issue for our CCAC colleagues, for home care delivery, health service providers, and certainly within the Patients First framework that Minister Hoskins announced on December 18.

The opportunity to look at a revision of boundaries of LHINs is something that is of interest. We know that LHINs have been present for 18 years. CCAC boundaries are defined by LHIN boundaries, and certainly the opportunity to align these perhaps better with municipal boundaries, with board of health boundaries, is something that's under active consideration.

When we think about the standardization of care, perhaps one of the best places to think of it is in the area that I know is of intense interest to you, and that's palliative care. To provide the framework for where we're starting, we know that 70% of Ontarians say that when they're reaching the end of life, they want to remain in their home or in a non-hospital setting. We know that, currently, when we measure the outcome for patients who pass away from a cancer diagnosis, 70% of those people end their lives in hospitals. So we're not doing a good job of meeting the needs, as you well know from your conversations across the province.

If we look at the way that this will get better, one of the things we need to do is carefully measure these outcomes. As you know, in the Ontario Palliative Care Network strategy, one of the initial investments is in a registry that actually recognizes which patients have palliative care needs. That's perhaps more readily available for patients with cancer diagnoses, but we also know that patients with advanced congestive heart failure, advanced chronic obstructive pulmonary disease, folks with a variety of other conditions can be recognized by their providers as having palliative care needs—perhaps not as readily recognized as with cancer patients.

1320

Those patients, their families and their caregivers undergo distress if somebody who is in the last stages of unfortunately passing away from heart failure goes back and forth to the emergency department, constantly being admitted to hospital, as opposed to being recognized as a patient who has palliative care needs, managed at home or perhaps in a hospice with symptom support and an understanding of what choices are available, and the support to make those informed decisions.

We think that we could do a much better job of standardizing care, thanks to the great work that you've been doing, giving us feedback from across the province and helping us to introduce the concept of the Palliative Care Network, which defines who is in need of palliative care. We think that's a very important step of standardizing care for those patients who have end-of-life needs.

Other areas in terms of standardization I'm sure my colleagues would respond to.

Mr. Mark Sougavinksi: I can give a high-level response too, because I've been around the health system for 30 years—I'm not that old, but still—and this issue of harmonization is always omnipresent.

I understand it's a complicated question, but when you're at home, dealing with people at home, you are going to have a lot of variations. Don't forget that at the same time that we want to harmonize everything and we want everything to be the same, within limits, we also want people to have choice and to make decisions for themselves. To balance the two is not always easy.

I had situations where we do an RAI assessment, we do a score; the person is entitled to so many hours of care to help them—it was for a child—to give a bath and so on. The person doesn't want that. The person would rather use that money and do something else with it, which doesn't really correspond to our program. What do we do in a situation like that? Do we make an exception and go along with the wishes of the person? But then it's going to be very different from what we give to the neighbour.

These are the real questions we have when we are in people's homes. The people are not in our hospital or in our environment; we are in their environment. So there is that factor—

Interruption.

Mr. Mark Sougavinksi: Music when I speak.

So that's important. I think that we also don't want to take away from the judgment of our professionals. We hire people who are very skilled. We are care coordinators, mostly nurses. They go home. You don't want everybody managed via a test that we do. People have an expertise. They have a certain professional judgment. They need to exert it. So there again, you are going to have some differences, depending on each situation.

I think that we need to have a certain amount of broader categories. Certainly, we could have more harmonization between ourselves—the CCACs or whatever it's going to be called in the future—to make sure that if we have wait-lists, which we shouldn't have, they're managed in a way that's a little more even throughout the province.

But I would also caution against being too obsessive about it, because we're really in an environment that's moving constantly and we want to respect people's opinions, choices and wishes. I think that's a top priority in our kind of service—in every service, but particularly when you're in somebody's home.

Mr. John Fraser: Okay. I may come back to it again.

I have another question that's a bit more specific and not at the 10,000-foot level. It was under the section on how coordination of in-home services needs improvement, and there were issues around caseloads and how caseloads are variable as well, which is a concern.

But one thing that did concern me when we were discussing this and when we took a look at the report was the case of discharge follow-up. There was variability

across the three CCACs that were looked at. You all know who you are and you all know how you scored. One CCAC followed up with 83%, one did not follow up with 82% and one didn't measure. That's pretty wide variability. I want to understand why there is that variability. What is being done specifically to deal with that?

We used to have something called, "Take them to the peas." I came from the grocery business, so if somebody asked you where the peas are, you didn't point them over there; you took them and you made sure that they got there, and that you completed that question or inquiry, that transaction. That goes against what I think is a customer service model—but it's also the model of how do you ensure the outcome that you intend is actually happening, or that you're able to intervene if necessary?

I don't have the data in front of me in terms of re-admissions after a discharge. I know there's a broader question, but I have a concern for the one that hasn't followed up with 82%. What's being done to remediate that? I'm not sure—I think that's—

Mr. Marc Sougavinski: You're looking at me.

Mr. John Fraser: I'm not sure which—well, you all know.

Mr. Marc Sougavinski: In terms of the data, I'll have to check. I don't have those data in front of me per se. I can tell you that we are absolutely doing those follow-up calls. At the time of the audits, it was the year prior, so I'm not certain about that. I can tell you now we're doing them and I can get the scores easily.

There's a process with discharge that goes there to—I mean, it's important also to point out we don't throw people in the street. There's a meeting with the family or the person. Certainly, everybody knows how to call us back if they need some help further down the line. We make sure that whatever the needs were of the people who were in are now complete, satisfied, and then we move on. We do make those calls, but I can't tell you today what the exact percentage is. It's high; we do all the calls as far as I'm concerned. We'll miss some because sometimes we call a few times, and after that we give up. So it's not 100%, but it's systematic.

So I'm not certain about the data you are presenting. For me, it's really in the past. But it's not the case right now; I can guarantee you that, if it's us that we're talking about.

Mr. Richard Joly: I think it's a great question and it's critical. You're right: In the private world service business, you go and service your car, you get a follow-up: "Were you completely satisfied?" I know that because my wife owns a car dealership. I looked at that model, saying, "How can we do that in health care?" Hospitals have figured that out. Hospitals are now following up on discharged patients. Home care needs to do the same.

Marc said correctly that every patient knows where to come back to if they need to come back, but to do that warm follow-up and prevent a person from going to the hospital and so on is a critical piece for our sector, and we've undertaken steps as a sector to standardize that process. That work is under way.

Mr. John Fraser: So in terms of the follow-up after that, if there's remediation that's—

Mr. Richard Joly: Correct.

Mr. John Fraser: —as a result of—

Mr. Richard Joly: You just nip it in the bud if there is an issue going on with the patients or families.

Dr. Bob Bell: Perhaps one of the things we should also mention are so-called bundle care pilots, demonstrations that are occurring now across six hospitals, I believe. Nancy, would you like to comment on the progress that we're seeing with bundle care as something that we think will represent the future of post-discharge home care in the province?

Ms. Nancy Naylor: Right. Those are a promising initiative under the home and community care road map that Minister Hoskins initiated last May. We have launched those in six sites, including hospitals like Trillium and Sunnybrook. It represents a partnership between the hospital and a community provider to define an episode of patient care. It could be a cardiac episode, it could be a CHF or COPD episode, as Dr. Bell was mentioning. The idea is to define a care pathway. So in a sense, even though a patient changes care settings, they really never experience discharge from one care provider to another care provider. What's been interesting to us is that all of those teams have taken a little longer than they had originally intended to define the care pathway and to define the resources it takes to provide that support.

1330

Our participation has been a little bit of project management money, but also an offer to create a customized budget for those types of patient episodes. We use what we call a carve-out from both the hospital budget and the home care budget to put that together, so it's not just bundled care, but bundled funding to accompany those patient episodes. That does seem to focus the team's solidarity around that particular patient population and the episodes of care.

Right now, we're aware that we have just under 400 patients in one of those trials, so we're expecting to learn a lot. We're expecting to take the care pathways that we have developed in those six and spread those, but also identify some new types of patient populations that might benefit from that type of initiative.

Dr. Bob Bell: I can say as a cancer surgeon who used to have a lot of patients discharged after major surgery that one of the biggest challenges for this patient population in Ontario leaving hospital is exactly what you've defined: the sense of a sharp transition, not a warm handshake. That's changing pretty dramatically now across the province, both in the hospitals you've identified—"Here's a number to call 24/7"—but also in, I think, our home care systems. There's much better communication occurring between the hospital providers and the home care providers.

Mr. John Fraser: Thanks. How much time?

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

Mr. John Fraser: Four minutes? Okay.

Mr. Sougavinski, I just want to let you know I wasn't singling you out. Our office has had good support in terms of response to any inquiries. But it is a concern, that variability when I look at that, because intuitively, I think that's an important way to keep people out of being readmitted to hospitals and into emergency wards.

I do have one more question. It's a bit more of a personal anecdote. It has to do with my mother saying this to me; I didn't initiate her saying this to me. This is before you were there as well, Mr. Sougavinski, but I think it's an experience that's across the province, which is: "You know, I can remember someone coming in to assess me, but I never heard anything else. Then, I saw somebody else." My mother has mentioned that to me on more than one occasion. My mother was a registered nurse, and she's in her eighties. It was around—my father, before he had cancer, was diagnosed with vascular dementia. That was an experience that we had.

I have a question. How are we addressing those duplications that exist in the system and preventing those? Because that's a waste of resources. Also, on a trust basis with a client, if you talk to somebody about meeting their needs or finding out what their needs are, and then you don't give a response, that creates a gap.

That's it, if anybody wants to take a stab at that.

Mr. Richard Joly: I can tell you about another innovative initiative, because we lived it in the North East CCAC. What we've heard from patients' families is that the communication between organizations and so on could be much better. Now, we share assessments. Our assessments are shared between hospital, community support and so on. We know what organization assessed what, and we can use that. It's a repository of all the assessments.

But one innovative way to put down the communication barriers is a program called e-notification. For us, we were early out of the gate with our 25 hospitals. It's all done in the background; it's all electronic. Essentially, an e-notification is—if a patient presents in emerg, instantly we get a notification that that person is now in emerg. So it doesn't take days or the chaos of, "Is the person receiving home care? Let's find the home care coordinator." It's done automatically.

I've seen it live and I can tell you that the ER doctors and nurses love that e-notification. They know what the plan of care is in the home; they can continue it in emerg. Then we even get an e-notification if the doctor decides, "Let's admit that patient." Now that we know the patient is admitted, we can call their service provider and say immediately, "Cancel that visit," so that there are no missed visits and so on.

Then we get an e-notification when the doctor says, "Now, this person can be discharged into the community." It's tremendous for the care coordinators. It reduced that kind of confusion. The patient didn't need to repeat their stories. Now, the physicians caught on to e-notification because we have that now in 25 hospitals. They want e-notification into their practice. So I'm a physician; I want to be notified immediately when my

patient presents in emergency and presents in being admitted. That's an innovative way of trying to break those barriers.

The Chair (Mr. Ernie Hardeman): Hold that thought. Official opposition, Ms. Munro.

Mrs. Julia Munro: Thank you for joining us today. I too have a 30,000-foot question to begin with. It stems from the references that the auditor made that others have referred to, and that is the question of, in her own words, "Home care funding to each CCAC is predominantly based on what each received in prior years rather than," within budget, "on actual client needs and priorities." As others have explained, this leads to making discretionary decisions on budgeting as the annual clock ticks away.

I want to go beyond recognizing that as an issue. I want to know: What are the obstacles to making it an easier thing to understand in terms of why one CCAC might have a different level of service than another? In my role as an MPP, somebody phones and says, "Well, my neighbour got this and I've got this. My cousin lives in North Bay and they have that." It seems to me that this is an issue. It's also an issue in terms of your own planning and it being subject then to these historical relationships as opposed to ones that then might, in fact, reduce questions around caseload management and things like that.

I'd like to start with that particular comment by the auditor: What are some of the obstacles and some of the reasons why we should be looking at it?

Dr. Bob Bell: Thank you for that question. I think it's fair to say that there's a lot of history in home care. As you know, home care used to be under the purview of public health. It then transferred to CCACs; I think it was 45—

Ms. Megan Allen-Lamb: Two.

Dr. Bob Bell: Forty-two CCACs prior to 10 years ago, and then, currently, the transition to 14. It's also fair to say that there has been a fair amount of history with the allocation of contracts for health service providers. Of course, the major expenditure that CCACs make, care coordination, is something that we've talked a lot about today, but the actual visits to the home, in addition to the assessment visits, are made by personal support workers, nurses and therapists who are employees of health service provider organizations, as you know: VON, Saint Elizabeth, etc. There's a lot of history related to the contracts that define the payment, the terms of work, for the various people who provided service through the health service providers. I think we're starting to move on a lot of that history and a lot of that inequity that existed.

For example, personal support workers: This has been a very precarious form of work. People going into your home to look after your mum or your dad didn't have solid employment to really define that work. Certainly, the increase in pay over the last three years, this being the final year of increasing pay for personal support workers, by \$4.50 to a minimum of \$16, has been essential to bringing a stable floor and to make this a less precarious

form of work. That has also highlighted to us, as we've implemented that investment in personal support workers, the differences and the lack of standardization in health service provider contracts as well.

1340

We understand how this happened over the years, but the issue is, can we now bring standardization to those contracts? One of the major tasks that results from Dr. Donner's recommendations is to consider how we might standardize those contracts, which would change the equity of distribution of resources across the province.

The other thing is, of course, the province is different than it has been in the past in terms of aging areas and in terms of growing areas. I think it has been in the last three or four years that we've actually started to bring the distribution of home care services into the more "modern" approach, I guess is the term I'd use, to the distribution of health care resources that we use in other areas, as we've used in hospitals for the last six years with health system funding reform, looking at the attributes of populations and deciding how we service those needs.

This has been going on now in the home and community system for the last three years: the distribution of funding based on features related to the health-based allocation method we talked about earlier, and the distribution of incremental funding through that means. I think this year, that's going to progress even further. Looking at the relative distribution of resources to complex patients, using MAPLe scores, and understanding perhaps inequities that exist there, is one of the ways that we're looking at dealing with this issue. So we absolutely recognize this issue.

Again, making investments in an incremental fashion, I think, is responsible in that we know the ability to care for patients is evolving rapidly too, with things like technology, and we want to ensure that we're making judicious investments. One of the key issues in terms of the methodology for making investments is to look at inequities that exist in funding across the CCACs and regions.

That's the ministry's perspective on this, Ms. Munro.

Mrs. Julia Munro: One of the things that I would assume—and I'll ask you that question—as a fallout from this is that with that kind of rationalizing, you would be better able to provide measures of assessment. That whole issue about how care coordinators' caseloads vary, and some don't keep up to date, and all of those things: Would those kinds of issues be part and parcel of this other kind of financial lens put on the organization?

Dr. Bob Bell: Perhaps I could ask my colleagues to comment on the issue of standardization of workload amongst care coordinators' caseloads.

Interjections.

Ms. Megan Allen-Lamb: What I would say with regard to that is that our care coordinators in Ontario are delighted that the government has put a priority on standard levels of care. That is their biggest challenge when we have patients coming in from different regions

into our CCAC region. We hear about the different levels of service that are available in one LHIN area compared to the next. So we're absolutely delighted and pleased to see that within the 10-point plan.

In addition to that, in the 10-point plan, is looking at community capacity, because that is also part of the equation: not only standardizing the funding across the CCACs' levels of care, but understanding what are in those communities with respect to the different services and supports.

Mrs. Julia Munro: That leads into my next question. Will what you see happening in the near future also provide a flexibility? The flexibility I'm asking about is where a certain set of health issues seems to be more prevalent in a particular area. That area, that local CCAC, has been able, with this kind of flexible funding, to provide additional service on that particular health issue that somebody else doesn't have. So it would seem to me that we'd also be looking for that kind of flexibility, such that if it's an issue that is more predominantly in a particular area, they're going to be recognized for that.

Dr. Bob Bell: I think you're defining one of the key elements of the discussion document that Minister Hoskins released in December, and that is a new focus on what we call "population health" and defining particular health challenges within populations.

If you look at the distribution of health care resources across Ontario, you might think that the greater the population health needs of a community, the more health system resources might be invested in that community. And, of course, that really hasn't happened. It's been a historical, traditional allocation of resources or the selection of areas the practitioners want to practise in as one of the major determinants.

What we're looking at with the initiative to bring population health planning to the LHIN table through the integration of public health expertise, through the medical officers of health sitting at the LHIN table, through information coming from Public Health Ontario to inform population health descriptions and planning is to really look at this purposeful, thoughtful investment of health care resources. So if we have an area which has a higher prevalence of chronic disease like diabetes, we might think there would be more dietitians in that community, we might think there would be a greater focus on wound care in that community.

To be absolutely straightforward, that plan-full approach to health system resource distribution has not happened in a very purposeful way. We think it can happen in a much better way with this increased attention to population health that will inform all aspects of health system investment, especially home and community.

Mrs. Julia Munro: From what you describe, I can also see it having an influence even on choices for medical practitioners that would see an opportunity, that here's an area that recognizes the supporting role that is necessary.

Dr. Bob Bell: When you look at the past, it's hard to determine who has been responsible for the distribution

of primary care resources across the province. Surgeons may be recruited to hospitals that have needs for total hip replacements, but when you look at the distribution in primary care providers, advanced practice nurses and primary care physicians, there hasn't been a very plan-full approach to that. We think that's one of the opportunities we have.

The discussion document that was released in December says that LHINs should be responsible for that and LHINs should have an understanding of the regions within their LHINs, or so-called "sub-LHIN regions," sort of similar to the health links geographies that have proven successful in treating high-complexity patients, and that LHINs should have the responsibility to say, "Gee whiz, this area needs more primary care providers," and perhaps, because of the population health challenges present in this region, it needs a community health centre or it needs a family health team. Those are the kinds of planning changes that are anticipated under this discussion document that has been out there that we referred to earlier.

The wonderful thing about bringing together CCACs and LHINs is we also think the integration of primary care with home care is an enormous opportunity. When we think of the care coordinators, which you've heard a lot about, for complex-care community patients actually being embedded within primary care environments, we think that's a huge opportunity for increasing integration, as I know many of our CCACs are currently doing. We think to further evolve that will be a big piece of better distribution of resources.

Mrs. Julia Munro: Thank you.

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

Ms. Lisa MacLeod: I have a number of areas I'd like to address with you. I think I'll start out where John Fraser left off, with respect to the Champlain LHIN. I was disappointed to learn that 82% of your clients that were discharged didn't receive follow-up. Given that we know through the auditor's work that 25% of discharges are often premature, I'm wondering how you reconcile that with effective care. In my community—I live in Ottawa—at the same time today, the Ottawa Hospital said that they follow up with every one of their discharged patients. That was a public announcement that they made on social media.

My question to you, sir, as well as to the association and to the deputy, is, how could that happen, and what concrete steps have you taken since this auditor's report has been tabled in order to ensure that that number is closer to 82% being followed up, rather than 82% not being followed up?

1350

Mr. Marc Sougavinski: Like I was saying to Mr. Fraser before—and I will give you the same or a similar answer—as we speak today, I can certainly tell you that those phone calls and those follow-ups are being made. I cannot tell you if—

Ms. Lisa MacLeod: So what did you do that's different between—I mean, I do understand that you

weren't there, but what processes have been put in place? It's all very well and good for people to come to these committees, as they often do, and tell us that they're doing it, but they don't show us the proof.

So I guess my question to you is one step beyond where Mr. Fraser went. What processes have you put in place in order to ensure that you can tell me, as the local member of provincial Parliament, that in two or three years, if the auditor goes back, she will actually find that that statement is accurate?

Mr. Marc Sougavinski: Essentially, our team reviewed the recommendations of the auditor, and many of those related to very specific issues like this one, and others—caseload size or number of assessments reached within a certain time. When we reach the number of calls made afterwards, after a client is discharged—our teams have basically reinstated that. I know it was stopped for some time. I'm not exactly sure of the reason why at that time.

It's kind of an on-and-off switch, so basically we made sure that the switch was turned back on and that it's been done. Data is available; I just don't have it with me today but I will be pleased to get it for you, absolutely. There's no problem with that.

Ms. Lisa MacLeod: Okay. That's really good. Just to continue on, because I do have you here: With respect to the Champlain LHIN, we get complaints from time to time—or the CCAC. We do get complaints from time to time. In fact, last Thursday, I had an opportunity to speak with one of my constituents who had just utilized your services, and what I was told was something quite interesting.

The materials, bandages and other health care aids that he required at the time: There was a necessity for him or his caregiver to order far more—I don't know what the appropriate word would be, but far more supplies than were necessary. Once he was complete and he was fine, they had basically bandages and gauze—a lifetime supply of it, effectively. Then another individual heard this story and recounted a similar experience.

I just worry, when you're looking at the high growth in costs of health care and home care and the fact that we are a growing population, particularly where I live in Nepean-Carleton. I look at that level of waste and diverting from what needs to actually be put in place, and I wonder how you can better manage that system, so that people are getting the appropriate level of care but that there aren't leftover supplies with those who have been discharged. I've heard that consistently throughout the years, but this particular week it had arisen again.

Mr. Marc Sougavinski: I can tell you that I'm aware of that issue, because I've heard it too, several times. It's an issue that's very high on our radar in terms of trying to deal with it, and it has been brought up by several of our patient committees that have experienced that same thing.

There is certainly improvement that we can do in the distribution and so on, but as it turns out, it's a more complex issue to address than we anticipated. Last year,

we went through an RFP. We visited the distribution companies that we have. We now have one for the entirety of Champlain. We're going to work with them to review the distribution of materials. There are issues related to the fact that when some material is given to a home, to get it back, to save it—because of infection, it's not necessarily the right thing to do and so on. Sometimes other issues are related to the fact that it's easier to order than to go several times to augment the material as needed and so on.

Right now, it's high on the radar. It's one of the main issues we have to deal with, and we're looking at it seriously to try to reduce that amount of waste—because we're talking about waste, really. That's what we're talking about.

Ms. Lisa MacLeod: Well, it is.

Mr. Marc Sougavinski: So we're very aware of that issue and we're going to take steps this year to go to the bottom of it.

We just had a new provider for our equipment, services, supplies. From now on, we're going to start the process of really looking at where it is that we have opportunities to improve that process. So you're right. It's on the radar and it's on the to-do list for this year.

Ms. Lisa MacLeod: I'm glad to hear that.

Ms. Catherine Brown: May I add to that?

Ms. Lisa MacLeod: Yes. Actually, who are you with?

Ms. Catherine Brown: I'm with the association.

Ms. Lisa MacLeod: Okay. I'm going to tack on one more question because I know we don't have—

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

Ms. Lisa MacLeod: I didn't have enough time.

The Chair (Mr. Ernie Hardeman): Okay. We'll do that in the next round. We thank you very much, but that time has expired.

We'll now go to the third party, again. In this rotation, it will be 17 minutes for each caucus.

M^{me} France Gélinas: Plus my one minute I saved from the first round?

The Chair (Mr. Ernie Hardeman): I appreciated it much. It will get me home earlier.

M^{me} France Gélinas: We're going to drill down a little bit. The Auditor General says that a client with a RAI home care score of seven would not receive any services in one of the CCACs, but would qualify for services in the other two. So there were three of you; we know which one is which.

I'm going to start with you, but I will ask all three CCAC executive directors as to how that could be. Why is it that, in your LHIN, a score of seven qualifies for services, but in another it doesn't?

Mr. Marc Sougavinski: In ours, it wouldn't, first of all. Essentially, we work with partners. We're in the community, and we work with partners. I think that there's a trend to—and it's also a recommendation of the auditor, actually—I think the word that was used even was “expedite.” But at some point we move clients who have lower RAI scores in the community sector to be served by community services.

If it's at the lower end, we say to people, “Well, you're not quite eligible for our services because we really”—if you wanted some kind of a threshold for public home care services—“but there are many community organizations that are there that can help you, depending on the need.” So we don't leave people cold, but we certainly orient them towards an appropriate association.

M^{me} France Gélinas: Thank you.

Ms. Allen-Lamb: how would a number seven score fare in your CCAC?

Ms. Megan Allen-Lamb: I would like to just go back and recognize the comments by the deputy with respect to the inconsistency that has existed for years, in terms of funding. That is then directly attributed to the amounts of care that we can provide in any given region.

With respect to any patients who come through our door at the CCAC, our care coordinators understand their challenges more than anybody else. When we don't have the funds to support patients, we certainly look to our community partners. Last year, I can share that we connected over 8,300 patients to community support services within the central region. So if we are unable to meet the demand, we certainly look to connect our patients—our care coordinators do that each and every day—to different community support services.

M^{me} France Gélinas: Mr. Joly?

Mr. Richard Joly: In our CCAC, certainly, they would qualify for services. But there is a huge difference and it's the geographical differences that exist. I can tell you from experience—I've lived in the northeast all my life. In many, many communities—our score of seven—those types of patients have no place to go. We're the only game in town, and we cannot depend on other community support services. We certainly spread our funding and so on in that way because it actually responds to local patient needs. We've been very successful at it.

We continue to refine how we do things in developing additional programs, different programs for a different population. I think of the self-directed funding, patient-managed care program. It's putting the patient and the family in the driver's seat.

We developed, in Ontario, all 14 of us, something called health lines. So in the northeast, it's called North East Health Line. We have 25,000 hits on the health line a month. That means patients, families, are engaged, in the driver's seat and trying to find the other resources that exist with the help of their care coordinators.

M^{me} France Gélinas: Coming back to you, Mr. Sougavinski, I'm at the other end of the RAI-HC score. So we now have a score of 15 in one of the CCACs that triggers a maximum of five hours of PSW care. In the other, that triggers a maximum of 10. Starting with your CCAC, how can you explain the difference?

1400

Mr. Marc Sougavinski: At 15, somebody will get a certain amount of care, and that also would depend on the other factors that we've mentioned before. You have to assess the family situation, their wishes in the situation, and you will get variations at this point.

It's not like—you have a score. That leads you to a grade where there is a range, if you want, of hours of care possible and a decision-making tree. But within that decision-making tree, there is also variation in terms of the global situation of the person, the resources they have and the possibilities.

M^{me} France Gélinas: So you're saying that at your LHIN, there are no maximums assigned to a level 15? So if your score is 15—

Mr. Marc Sougavinski: There would be a range. There would be a minimum and a maximum, yes.

M^{me} France Gélinas: There would be a minimum and a maximum. Okay. I'll go next to Central.

Ms. Megan Allen-Lamb: In every patient situation, our care coordinators are assessing their individual needs and co-creating, in partnership with the patients and families, a care plan to meet those individual needs. To Marc's point, they don't just look at a RAI score. They look at all of the supports and services available for that patient.

In response to your question, that is a very complex patient when you're talking about a RAI score of 15. Our care coordinators are guided by the regulations around personal support services and would take that into consideration with respect to the other services.

M^{me} France Gélinas: Do you have a maximum that you can give?

Ms. Megan Allen-Lamb: Our care coordinators follow the regulations with regard to personal support. We have very complex patients coming out of hospital, and typically, those very complex patients could get up to the maximum.

M^{me} France Gélinas: The maximum being 90 hours per month?

Ms. Megan Allen-Lamb: That's correct.

M^{me} France Gélinas: Okay. Mr. Joly?

Mr. Richard Joly: I guess there's an advantage of answering the third one, because they've answered the entire question.

I just want to emphasize that it is individual. These are human beings. It's no longer a number for a care coordinator. So they look through that lens and, yes, a score comes out—standardized assessment, which is a wonderful thing. It helps standardization in the province of Ontario. But then it all comes to individual circumstances in the communities.

So I would echo the comments of my colleagues, but just add that there's the human factor that comes into play. That's why these care coordinators are mostly nurses, but they're regulated health care professionals that report to their college, and they take that very seriously.

M^{me} France Gélinas: I have no doubt.

The next part that I'm going to go around is that the regulations state that up to 90 hours of personal support services can be provided to clients per month, but an actual maximum was typically between 56 and 60 hours at all three that she had visited. She goes on to say that

the CCACs claim budgetary constraints as a reason for never reaching the 90-hour maximum.

Did the auditor get it wrong?

Ms. Catherine Brown: I'm Catherine Brown. I'm from the association.

In reviewing the Auditor General's report, and in working with our colleagues across the CCACs—those are regulated maximums that are provided by the province. They're not care guidelines; they are cost guidelines. It's how the government helps to regulate the amount of service that we provide. They recently changed those guidelines for nursing service hours—

The Chair (Mr. Ernie Hardeman): Could we speak a little more into the microphone?

Ms. Catherine Brown: Sorry. They recently changed those guidelines for nursing service hours, recognizing the need for a greater level of service that may be needed for some patients in regard to nursing hours.

Our goal, and the goal of CCACs, is not to target the maximum but to provide the right level of care. We're not looking to hit that number but, rather, our goal is always to stay below it, because that's a requirement under the law, and to make sure that patients get the assessed level of care that they need, which may or may not be 90 hours.

As my colleagues at the CCACs have indicated, those levels of service are typically for very, very high-needs patients, often palliative or extremely complex.

I'll turn it back over to Marc.

Ms. Megan Allen-Lamb: Just with respect to palliative care patients, we can go beyond the 90 hours. We can put in up to 120 hours in exceptional circumstances. Our care coordinators do that without any hesitation.

I want to be very clear, with respect to the findings within the auditor's report, that those are averages. But absolutely, when we have complex patients, especially patients who are choosing to die at home, we support them with the necessary services in those circumstances.

Mr. Richard Joly: It's also using a multidisciplinary team, so the resources that you have are not only looking at personal support, but if we have Telehomecare going in and doing certain things, if we have therapists going in, we looked at that to develop a plan of care. We're not automatically just saying, "Yes, the person scores a 15 and actually gets 90 hours."

The other exercise that we do at our CCAC, going back to your score of seven—that's how we manage to actually provide service to the lower-needs patient so that they don't creep up to a 15 and really keep them stable for the longest time. If we were to simply do the math and say, "A 15? You get 90 hours," I would have to reduce services to the lower-needs patients. We want to make sure that everybody has some care, but customize the care around the patient.

M^{me} France Gélinas: I thank you for your answers and I thank you for your in-depth knowledge of how this system works.

I have a hard time balancing this with the fact that every week or every second week in my office, a family

member will come and just cry their eyes out because they are so burnt out, because they can't take it anymore and because they are not able to get an extra 15 minutes of care that would make the difference. I had never seen grown men cry before I got this job, and now every second week, I have grown men crying in my office. I buy the box of Kleenex at Costco. It's always the same story.

I'm the health critic for my party. They are not only from the northeast; I get it from all over the province. They cry on the phone; they cry when they see me. They want to keep their loved ones at home. They want to do the best for their mom, for their dad. They can't have the support they need in order to do this and they will say, "I'm supposed to be allowed 90 hours a week, but because it is February and the CCAC has no money, I now have one hour a day. I cannot cope with this." It goes on and on and on.

How do you reconcile what I lived through with what you've just shared? We'll start with you.

Mr. Marc Souganvinski: Those are very tough situations, and I don't have a magical wand to solve these situations. I wish I had. But they're real; I understand what you say. We get that, too. We get a lot of people who need more service.

Like any other health organization that exists, we have our own limitations and capacity. We have a maximum capacity. I think if anything, today, we've made it very clear that the complexity and the needs of the clients are exploding, perhaps much faster than we are able to provide that kind of level.

We're not talking about home care like we used to 20 years ago, where somebody needs a bath here or there and a little bit of help. Now, it's a complex business that requires a lot of skills and a lot of hours of care. So we get those complaints.

We also get, in all fairness, a lot of people who tell us they're very happy with the service. You don't see them, I'm sure, because—

M^{me} France Gélinas: No, I do. I do. I'll move on to Ms. Allen-Lamb, please.

Ms. Megan Allen-Lamb: As I hear you speak, your comments are reflective of what our care coordinators feel every day, having very difficult conversations with patients and family members about the services that they have available to support patients in their home.

As we discussed earlier, the demand on home care is increasing exponentially. As we've seen over the past three to five years, the patient that we're serving today is very complex.

What we are quite delighted to see is the supports that are being targeted towards our community support services. Most recently, we know that there has been an enabling reg. so community support services can help our low/moderate-needs patients. Perhaps the deputy or the associate deputy would like to speak about that, because that is helping the CCAC handle the most complex, when we have community support service members in the community who can look at those low- to moderate-needs patients.

1410

M^{me} France Gélinas: Mr. Joly?

Mr. Richard Joly: I have to tell you that it's heart-breaking, those stories. I hear them, too. Hearing those things—they stick with you and you say, "What can we do more?" It is just those 15 minutes.

I can tell you that we've been at this program of patient-managed care or self-directed funding and essentially putting the patient in the driver's seat. A very concrete example: I have a wife who cares for her husband, a quadriplegic—very complex services. She came to my office on several occasions and said, "I have a solution for you," and it was patient-managed care, which is in the 10-point plan to actually put that patient in the driver's seat.

I saw her not too long ago after she was on our pilot project on self-directed funding, or patient-managed care as we call it. It was night and day. It changed their lives. She says, "Now I can do the things I want, but I actually employ those personal support workers and I let the things that I don't like so much—but you know what? Caring for him at 11 o'clock at night when he wants to go to bed, I don't need a personal support worker who shows up a bit later and so on—I'll do that—but I need help during the day because I work."

That's a solution, that program. I think we need to innovate and continue putting that patient first and putting patients in the driver's seat.

Dr. Bob Bell: Could I just comment on the recognition the ministry has really emphasized by Gail Donner, that when we're talking about home and community care, we're talking about at least two clients. We're talking about the home care patient, and we're also talking about the caregiver, and we recognize the stress of providing care to complex patients. The fact is that colleagues have talked about how patients are more complex today, recognizing, as Health Quality Ontario has talked about recently, one of the important measures that we should have and which we do have is caregiver distress. That's one of the elements of the 10-point plan as a focus on the educational needs.

Nancy, would you like to just comment—if you don't mind?

M^{me} France Gélinas: I don't mind, but I don't want to hear, "We'll review what's going on elsewhere. We will give them a website." I'm not interested in this. I'm interested in the caregiver who will have somebody who gives them respite so they can go to bed or they can get out of the house, so they don't come crying in my office.

Ms. Nancy Naylor: Understandably. I think there are two obvious responses. The CEOs see this every day and, as Megan and others mentioned, care coordinators manage this every day. Part of it is how they assign care relative to the types of patients coming in and the work that we've been describing here around identifying the levels of care, the standardized assessments so that we can inform the types of funding that we want to put in the hands of the CCACs, the home care programs and their care coordinators, so that people and their families know

that when they come in and they're being assessed, they don't have to direct their limited energies to advocacy on behalf of their family, that the care they're being offered, which they may or may not choose to accept—and I think we've heard some good examples about why caregivers might make different choices about accepting care. But they know that they are being offered what their family member is entitled to and what's appropriate under their circumstances.

That work which is at the bedside and is going to be informed by good clinical advice is going to inform our funding models going forward, but it does at some point boil down to resources. I think we do have a good track record of investing. We've seen over a billion dollars go into home care since 2003-04. There has been \$600 million since last year, and I think we're expecting that Minister Hoskins will be directing a substantial part of our community funding this year to home care and the kind of supports that the CEOs are referring to that make the care plans that their coordinator set—

The Chair (Mr. Ernie Hardeman): Excuse me. I think we'll have to stop there. That does include your extra minute. Mr. Milczyn.

Mr. Peter Z. Milczyn: Thank you. I just want to continue on the line of questioning Mr. Fraser and Ms. MacLeod started. This is an Auditor General's report, which is about looking at some systemic issues that are in place that need to be addressed. I love the line from the deputy about the purposeful distribution of resources. That's very important because once the resources are distributed to the local CCACs, there's an expectation of them being used as effectively as possible.

When I read about the great variation in the level of follow-ups, when I read that one CCAC didn't really track whether they follow up, when I read about issues with managing the contracts and measuring the performance of the contracts with the service providers that were in place, it leads me to question how much management oversight there was, how much data you were collecting and tracking and, when you got that data, what you were doing with it to boost productivity and efficiency. I think there's an aspect to it which is a ministry aspect but it's a local management issue and I'd be interested in hearing from the three CCACs on this.

Dr. Bob Bell: Could we start off on the data issue as the starting point? Would that be okay?

Mr. Peter Z. Milczyn: Sure.

Dr. Bob Bell: Because certainly the data issue is important and Catherine can perhaps explain that best and then go into the—

Ms. Catherine Brown: As an association, we support the 14 CCACs in a number of ways. One of the differences from a typical association is that we have a shared service data system that we support the CCACs with. It's an electronic patient record that all CCACs use to follow their patients. Their patients' care plans are developed in that electronic system. It's connected across the province. It's the only electronic health record that's consistent across the province.

What that offers us in addition to being able to follow patients and, as Richard described earlier, having e-notification and having others in the health system look at those records and understand where a patient's care plan is when they come into an emergency room or when they go back to primary care or the hospital, is that it also offers us the ability to track a great deal of data.

Many of the functions are consistently applied across CCACs. We measure, obviously, wait times and various other things. We track those and report on those publicly. A lot of the functions are functions that CCACs can select to use and can follow certain data elements depending on their local needs.

More and more, we're using the data system to drive change. We work with our CCAC partners to look at those data changes where there is variation, as you've just described, or where one may not be tracking it in the same way or using a different system to track it. We look at ways to bring a greater consistency to that and, most importantly, to use that data and that information to really apply a consistent approach to patient care.

I want to go back to—

Mr. Peter Z. Milczyn: Excuse me. You're telling me how things should be.

Ms. Catherine Brown: That's how things are.

Mr. Peter Z. Milczyn: I'm not necessarily—in the Auditor General's report, it raises flags as to how that's being done and the variations between different CCACs.

Ms. Catherine Brown: That's correct, and there is greater and greater consistency. The comment from Ms. Gélinas and from others—there has been a great deal of light shone upon home care in the last couple of years and that opens up a number of issues about what is and isn't happening. But the positive of that is that it pushes a change forward.

Home care: As Deputy Bell has described, the funding has not kept up. It has grown exponentially. Our population of clients and patients has more than doubled in 10 years. That's an extraordinary growth and we have kept up and continue to evolve, but we use our system more and more to help CCACs drive those efficiencies and drive those changes. Yes, some of the changes that the auditor highlighted are changes that were brought to our attention at the time and we are working on correcting and/or, as Marc, Megan and Richard have described, we have corrected. We continue to use the data system to evolve how we provide home care. It's critical, absolutely critical.

Mr. Richard Joly: I can tell you from what happens in the northeast. I've been at this for the last 10 years. We work very closely with our service providers to drive that change. We meet with them on a regular basis and we track specific indicators that will drive great outcomes; for example, five-day wait times for nursing—having your nurse within five days—and we target at 95%. It's the same thing for personal support. I can tell by tracking that information with the service provider, showing them the data on a monthly basis and saying, "You're not meeting here. What's happening?" and so on, and then

there's corrective action and continuously working with our folks on the ground, with our service provider. That's what's happening in the northeast.

1420

Ms. Megan Allen-Lamb: I would just further add to that that the Auditor General noted an area for improvement around audits with our service provider organizations. I can tell you that over the last year at Central CCAC we have conducted 21 scheduled and random audits with our service provider organizations. We work collaboratively with them to ensure that we're all meeting the needs of our patients, but we certainly have a contractual relationship with them. So when we go out and do our audits, we're asking them, "Are you doing what you say you are doing?" I'm pleased to report that we have had 21 visits. It was an area of opportunity noted in the report. We have come through on that.

With respect to Richard's last comment around nursing wait times, over 95% of our patients in Central receive nursing within five days of being assessed. We have lots of successes that have been achieved, not only through our care coordinators, but with our service providers, and we certainly have lots of metrics that demonstrate the performance of our integrated care teams together.

Mr. Peter Z. Milczyn: I guess another issue that came up through this was the definition of a missed visit. It raises some concerns as to how you're defining that and whether the definition masks the actual effectiveness of the services that you're delivering.

Mr. Richard Joly: Maybe I can start: The question of a missed visit versus missed care is something that we're looking at closely. The Auditor General has noted the issue of missed visits versus missed care, what the definition is and so on. We're working at that at a provincial level to define what missed care is. It's like looking at patient outcome. What's more important, a missed visit or missed care? We've come to the conclusion that missed care is important. Sometimes you don't have a daily visit and it's okay to miss the visit on the Monday, but did you go on Tuesday? Therefore, there's not really missed care.

I know from our experience that it's less than 0.5% of the previous definition of missed visits, so 99.5% of the time we didn't miss that visit. Missing one visit is too many, and I'll agree with that, so we strive to have the 100%. But you have to appreciate that in home care, it's not an institution. On any given day in the northeast, there are 16,000 homes that we care for. So we're in those environments.

Just picture a personal support worker in the dead of winter who sees her or his assignment for the day: "I have to see eight patients." They show up at patient three, an end-of-life patient, and the patient has gone for the worse during the night. Now that PSW is compelled to stay with that patient, but then worries about her next five patients. We then have to work with our service providers to now deploy in that snowstorm to go see those five patients. Sometimes it's not doable. It's challenging.

There are many, many other environmental challenges and so on, but the nurses are the same way. They get to an assignment, they're delayed and now they have to reduce their caseload and their visits during a day to another person.

Those nurses and PSWs do this out of passion, out of their heart. They don't want to miss care, they don't want to miss any visits—

Mr. Peter Z. Milczyn: We have limited time, so I'll stop you there.

Mr. Richard Joly: Okay—just like a nurse in a hospital. It's the same thing.

Mr. Peter Z. Milczyn: Because the deputy's here, I just want to make a quick comment. In my riding of Etobicoke–Lakeshore, three LHINs cover a dense urban area and if you live on the wrong side of Islington, you get a completely different level of home care afterwards. There's no logical reason for that. So I'm just making that comment.

Mr. Rinaldi?

Mr. Lou Rinaldi: Thank you very much. Deputy, I want to go back to your initial comments at the opening of the session. You talked somewhat about a Patients First discussion paper that we've worked on since this winter and the consultations that the ministry has had out there. One of the comments you made is that based on the outcome of those discussions, as we transform, I guess, or go to a different approach, that would address some or a good number of the auditor's recommendations. Can you share some insight on how you came up with that statement?

Dr. Bob Bell: To be clear, the changes that we're expecting and that we look at in the discussion document are one element, we think, of improving integration of services in home and community—one element only.

As we heard from Professor Donner, the most important thing is not structural change but functional change within the delivery of home care services—and I think my colleagues would agree—issues related to some of the things we're talking about here: self-directed care, levels of care, standardized contracts; bundled care post-discharge from hospital; introduction of technology to care, and a special focus on the 20% of patients who have palliative care needs within the home care population.

These sorts of things are the real fundamental changes to home care practice that probably have been going on. Those kinds of fundamental changes have been going on in hospital acute care for the last 10 to 15 years. I think it's fair to say that home care is now starting to undergo those same strong, functional changes that were introduced to hospitals when laparoscopic procedures were introduced that allowed people to be treated as outpatients, for example. Those kinds of measurements of outcomes, those kinds of introductions of new technology, are coming to home care today.

The other thing that Minister Hoskins introduced was the sense of integration of home and community services, because we know that the communication—we know that the best-practice sharing between primary care, for

example, and community support services that you've heard discussed here and home care is essential to make the system more navigable for Ontarians. Those are the structural changes that we're talking about that will still emphasize the need to continue these really remarkable, positive changes that my colleagues are delivering in home care today.

Mr. Lou Rinaldi: Chair, have I got more time?

The Chair (Mr. Ernie Hardeman): You have about four and a half minutes.

Mr. Lou Rinaldi: Okay, good.

On the same line of thought about changes through Patients First initiatives that we embarked on, whatever the end goal is, what those changes will be—and hopefully, we'll find out soon—I guess I'm a bit concerned, and maybe you can shed some light, that when we're dealing with folks with issues, and they're already confused and they're under a lot of stress—I want to be clear: I have two CCACs in my riding, and they are different, but I'm not going to dwell on that. I think you've heard enough of that today.

I guess my concern is that a lot of the service you provide—and I want to be fair, because we talk a lot about negative stuff and we don't talk much about positive stuff. You do a great job, and I hear that from folks. You're right: We don't hear as much as maybe we should here, but that's life.

I worry about those folks, that you're providing the right level of service. As we shift to a patient-first process, are we going to make sure that some folks don't fall through the cracks? I guess that's a concern, because change is difficult at the best of times.

Dr. Bob Bell: You're so right, Mr. Rinaldi. Thank you for that question. I think we all recognize that if we're going to change the organization of the system so that home care comes under the integrative leadership of the LHINs, the biggest responsibility for leaders sitting here, myself included, is to ensure, as that transition occurs in each one of the regions of Ontario, that no patient visit is missed because of the change and that no person currently working for the CCACs, should this transition occur, fails to recognize that they have a solid employer in the LHIN and that they know who their manager is.

Those issues related to integration of organizations are well known in health care, but they're also known to be difficult. The rule of thumb is that if communication five times is necessary to ensure that people understand the change and understand they'll be supported by the change—if five times is necessary, we need to communicate 10 times, to make sure it's happening.

So if this change will transpire, we will have a substantial transition team that will include the executives sitting here, as well as large proportions of the Ministry of Health. They will be totally dedicated to that and to ensuring that with each transition that is made, everybody knows what's happening, everyone knows who their manager is, their employer.

1430

Crucially from the patient perspective, the patients are understanding that it will be their same health service

provider who sees them tomorrow who saw them today. That won't be missed because of this transition occurring. That will be an absolute requirement and commitment that we make.

Mr. Lou Rinaldi: I appreciate that. My last statement's not really a question; I just want to reiterate some of the things we've heard today from all three sides. It's consistency. I mean, normally we're dealing with vulnerable people, of an age where they want to stay in their homes. I have a mother-in-law and a mother who really want to be home. Unfortunately, one of them couldn't be home, but that's another story.

I guess I worry about when we're doing assessments and we're having those discussions with these vulnerable folks who are asking for services—faces don't change. That's the hard part to adjust to, because they just get used to somebody even giving them a bath once a week. They have a routine. Routine, I think, is important for folks that need those services, so whichever way we go, my piece of advice that I have experienced with elderly parents is that consistency is really important.

The Chair (Mr. Ernie Hardeman): Hopefully that question will be answered in the next one, because this one doesn't have time. Ms. MacLeod.

Ms. Lisa MacLeod: I know I cut you off, Ms. Brown, so what I would like to do—I guess we didn't really have time; I'll blame it on the Chair for cutting us both off—is just like to go back to my previous line of questioning and just add an extra point that perhaps you and the deputy could both respond to.

We do have inconsistencies in tracking with respect to follow-up and we have, obviously, a very embarrassing situation at the Champlain LHIN—or we did, and it's being rectified. Secondly, we do have an issue with respect to waste—I think many people acknowledge that—and how we address that province-wide. Third, something that I was concerned about reading in the report was the fact that there is a 90-hours-per-month maximum of care that could be provided. I can't seem to find it on my page, but I believe the auditor has suggested that most people would probably only get a maximum of about 50 hours.

I guess the question that I have after we talk about follow-ups and waste is this: Shouldn't the legislation be changed so that we actually talk about minimum standards of care or minimum levels of care rather than the maximum? If I could have both of your takes on that, that would be appreciated. I just only have one other question and I believe my colleague would want to contribute when she arrives.

Ms. Catherine Brown: Thank you; it's a great question. It is a good suggestion. I'll remind, as I said in my earlier comment, that these aren't care standards. These are guidelines for cost and service delivery that the ministry offers. It's not based on an assessed need. It's based on what should be available. It's a good suggestion of what the minimum level of care would be, but I think the way that we talked about it earlier today—it's in the 10-point plan around a level-of-care framework—would

help people to understand what the expectation should be at any of those levels, and then from there to understand what that minimum would be. It will be a hard and challenging thing to define. The ministry is working on it, as are we in partnership with them.

To the points of my colleagues: The environment in which an individual lives and the supports that they have from their community and their family, as well as what we offer at the CCAC, may vary, and that diagnosis could be exactly the same. So it will be hard to set what that minimum is, as it is to set the maximum. The auditor, in her report, does talk about how the average is around, as you described, 50, which is reasonable in our expectation for that level of service relative to the 90 at the maximum.

Ms. Lisa MacLeod: What about your comments in terms of waste, as well as the follow-up?

Ms. Catherine Brown: On the waste piece and on the follow-up piece, I just wanted to comment that we're looking and do look provincially at how we can better procure and deliver supplies and equipment. One of the pieces on that is that there are not a lot of suppliers who go to the home. In some areas we have depots where clients go and pick things up, which is easier on the waste side because they can then return things, but the difficulty and the cost in going and picking it up—and we are looking at ways to effectively retrieve those supplies, because it is a waste at the local level—and then the cost of retrieving, is also something to consider.

Ms. Lisa MacLeod: I can just imagine at 14 CCACs—

Ms. Catherine Brown: Yes, and 700,000 homes. Yes, it's a challenge.

I did want to say, on the premature discharge, that 25% of people return to care after discharge. We see that as 75% of people do not. For our clients not to return to care is a very, very good sign. That only 25% after discharge—and that could be that someone is stabilized in the home, they are able to have care taken away, they are steady for a period of time, and then there's a fall, an incident or something else, and they're back on care. It's not necessarily that they've been discharged—sometimes it is—but it is not always or necessarily a result of a failure of the system.

Ms. Lisa MacLeod: My concern is, if there is the possibility of premature discharge but you're not following up, then you're not finding that. Putting the onus on the patient—

Ms. Catherine Brown: Yes, I understand.

Ms. Lisa MacLeod: We all do take personal responsibility; I'm not suggesting that we not do that. But I think, in terms of being a health care advocate or an advocate for someone you're caring for, it would be helpful if we were more proactive at the local level.

Ms. Catherine Brown: Right. As we've discussed, there is a provincial approach to look at how we can better and more consistently monitor the follow-ups.

Ms. Lisa MacLeod: Thanks.

Dr. Bob Bell: Perhaps I could speak to the issue of waste. As a cancer surgeon, I used to operate on folks

who had radiation and chemotherapy. A number of my patients used to have wounds that were looked after in home care settings. I was always rather astonished at the differences in wound care protocols that would occur not just across CCACs but within the same CCAC. This is something that's very important for us to address. There is literature, there is evidence, as to the best form of wound care for folks with diabetic foot ulcers, for example, or with various types of surgical wounds. There is evidence that suggests that we could have a standardized Ontario approach. In the work that Nancy referred to, currently being undertaken by the Registered Nurses' Association of Ontario and other groups under the auspices of Health Quality Ontario, we expect we're going to come out with a standard wound care protocol for the province, at least for diabetic folks as a starting point.

Going back to Catherine's comment around provincial procurement, if we have a standard process for wound care, it allows us to do standard procurement as well. Distribution is always a problem. Different areas of the province have different distribution challenges. But if we at least start with a common procurement process for the same stuff, measured and labelled in the same way, that's a huge step forward.

Ms. Lisa MacLeod: Can you keep this committee updated on that as you proceed on that? Because I think that's one of the things that grinds people's gears, out in the community, when they see that there could be less waste.

Just one quick question, because we are splitting our time—and this has been a very informative session. I just want to talk very briefly about PSWs and the wage subsidy. In 2014-15, I believe it was, \$52 million was allocated to CCACs in order to deal with that funding increase for staff wages. The auditor pointed out that the CCACs that she had visited didn't do spot checks or site visits to ensure that that was trickling down. I'm just wondering—I know that both the ministry and the CCACs have responded to this, in order to establish some common provincial audit practice, but there did seem to be some challenges with a lofty goal and then a funding announcement. It didn't seem to roll out exactly the way we all thought, at this assembly. Is it possible for you to provide some clarity on that?

Dr. Bob Bell: I'm going to ask Nancy to respond to that.

Ms. Nancy Naylor: Thank you. We're actually just starting the third year of that funding announcement. In the first year, we put out a \$1.50 wage supplement with statutory benefits. We did the same thing last year, which was year two. This year will be the third year of that commitment, so we're adding a dollar to that.

One of the things that's really positive is we've been following up in two ways. One is to survey what the state of wages is amongst PSWs who deliver home care. What's really encouraging is we see those wages not only tracking at least commensurate to the investment but actually outpacing our investment a little bit. Our explan-

ation is that that type of wage enhancement is helping service providers retain staff so they are, in a sense, climbing the grid that their own employer may be maintaining. We are seeing good progress towards, first of all, the \$16.50 minimum, but also closer to the \$19 top of that range that was defined as eligibility for it.

1440

There has been quite a significant follow-up in terms of compliance, and this is at the insistence of Minister Hoskins, so we have been following up with the CCACs and with the other providers that have been eligible to make sure that that funding flowed to PSWs. We've also asked for attestations from CEOs, and LHINs are doing spot checks. A very small number of employers are still outside of that initiative—

Ms. Lisa MacLeod: What do you do in that case? I'm sorry to interrupt. It seems as if they're just thumbing their nose at the assembly and thumbing their nose at the ministry.

Ms. Nancy Naylor: Do you know what? Out of several hundred employers, I think we're down to about five or six very small providers, largely in the private school area, who have very specific caseloads. In those cases we have been engaged with them. Last year we asked LHINs not to allocate any new service volumes to employers unless they were fully compliant, and in the third and final year we'll be addressing some of those.

In some cases we have been working with employers who were well above the maximum so it turned out to be, in a sense, a record-keeping issue, that kind of thing. We have had, overall, very good compliance and our sense is that we have gotten substantial wage enhancement investments to the 35,000 PSWs who are supporting the programs that you see represented here today.

Ms. Lisa MacLeod: Thank you.

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

Mrs. Julia Munro: How much time do I have?

The Chair (Mr. Ernie Hardeman): You have just a little over six minutes.

Mrs. Julia Munro: Oh, okay.

I want to come back to the issue around home care because it's generally agreed that people, when given the choice, would rather be at home. There are a lot of challenges to having that as well, in particular looking at family obligations and neighbourhoods and really a whole series of complex things before you can walk away and say, "We've got home care there."

I just wanted to get a response from you with regard to how you are viewing the future on the issue around patient care being provided at home and the role of whoever is available to provide that. Generally speaking, the people who are available to provide it are probably elderly and it may be a toss-up between which one of them is going to look after the other one. I see this as an issue for us as the future unfolds and I really want to know what ideas you have on how we are going to cope with that.

Mr. Richard Joly: That's a great question. As we move forward in Ontario with an aging population it will get more complex and so on. You're absolutely right; I

don't think I've ever spoken to a family or a patient that says, "I don't want to go back home." "I want to stay home." That's our goal: to keep them at home.

I can tell you that from a care coordination point of view I think that's the success of home care. They bring all of those aspects and develop a plan of care that is flexible and very customized to that family, in that environment, in that community, to keep them at home. I've spoken to many families and the term they use with me is, "My care coordinator is the 'angel' of home care. I don't see them all the time, but there seems to be something being coordinated all the time on my behalf." They call them their angels for a reason. They come to their rescue when they need it the most in their lives.

I think the linchpin of home care is the care coordinator, and that will continue in the future, and I see that more broadly connected with primary care and connected with others in the system. I think we can just have better results of utilizing the right expert at the right time, whether it's a physician, a nurse or a dietitian, and if that care is integrated around the patient, I think we will see more success in the future.

Mrs. Julia Munro: Okay.

Ms. Catherine Brown: I'll just add to that, if I may. I think the other piece that folks have spoken to today and that you alluded to is the role of the caregiver. We've talked a lot about what we can be doing differently in providing patient care, but the supports to caregivers enable that system to continue. Without caregivers, the system would not exist as it does today. Families want to care for their loved ones. It's not that we rely on them, but rather, they want to be there. Everyone goes into it with an open heart when they begin. When someone says to you, "Your partner is being discharged and here is the care they need," people say, "I'll be there." A year and a half later, when you're not sleeping nights—we need to be mindful of what the needs are of those caregivers in order to enable them to be there for their partners, for their parents, for whomever they are.

The direction of the ministry and the work that we're doing on looking at what other supports can be made available for caregivers to give them that critical respite that they need to continue to be there—there is no place to discharge. To go back to one of Marc's comments at the opening, home care doesn't have another place to send people. It's either back to hospital or on to long-term care, and neither is a good option. The best option is to be able to maintain them at home, and that is entirely reliant on finding ways to better support caregivers as well as deliver the care to patients.

Mrs. Julia Munro: And that's my concern. I appreciate that the system is designed to look after the patient, but the caregiver is a big part—

Ms. Catherine Brown: Huge. Yes.

Mrs. Julia Munro: —of that support network, and obviously there needs to be an understanding of their limitations.

Ms. Catherine Brown: Absolutely. It's part of the assessment that care coordinators do when they're looking at a patient's needs. They also look at who is avail-

able to provide additional care in the home: neighbours, children who are close by or who may be living in the home. When we reassess, we also look at the wear and tear on those caregivers and whether that support is diminishing over time, whether the one who is living with them is getting burnt out and what supports can be offered to them. It's a constant challenge. I think as Megan—well, all three have mentioned that there just isn't enough support out there for caregivers. The ministry has taken that head-on, to look at how they can be offering more supports to caregivers so we have more places to refer them to get that much-needed time.

Mrs. Julia Munro: I think that's a very important element to the whole discussion.

Ms. Megan Allen-Lamb: If I could just add a little bit to that. As you're well aware, in our Central Local Health Integration Network, we have the highest absolute number of seniors and the second-highest growth in seniors aging. As we think of a future home care system, that's very much integrated. We are connected with all 12 of our family health teams. We have two community health centres, as you would be well aware. Working in partnership and in different integrated ways, it will help us in terms of the demand that's on home care as we experience it today and as our care coordinators experience it every hour of the day.

I think you've heard a number of examples where we're using technology across the CCAC, whether that's through e-notification—certainly we're working much differently with family physicians than we ever have before, because we need to in terms of those patients having a seamless experience, whether that's coming home from hospital or receiving a referral from a family physician within the community. I think also what's extremely encouraging is the clinical standards that we've heard the deputy speak to today. We've had clinical standards and protocols that have sat in acute care, but now we're looking at those across the continuum. It's all of those different innovations that the CCACs have been at the table with with their partners and with government that are going to help us in terms of meeting the needs, especially within home and community care.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. I'm sure there's much more left to be said, but we haven't got time to say it. Thank you all very much for making the presentations this afternoon and helping us out with our deliberations as we review this section of the Auditor General's report.

For the committee, as we clear the room, we will be having our discussion in camera following a small recess.

The committee continued in closed session at 1451.

CONTENTS

Wednesday 11 May 2016

2015 Annual Report, Auditor General.....	P-351
Ministry of Health and Long-Term Care; North East Community Care Access Centre; Central Community Care Access Centre; Champlain Community Care Access Centre; Ontario Association of Community Care Access Centres	P-351
Dr. Bob Bell	
Mr. Richard Joly	
Ms. Megan Allen-Lamb	
Mr. Marc Sougavinski	
Ms. Nancy Naylor	
Ms. Catherine Brown	

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Chair / Président

Mr. Ernie Hardeman (Oxford PC)

Vice-Chair / Vice-Présidente

Ms. Lisa MacLeod (Nepean–Carleton PC)

Mr. Chris Ballard (Newmarket–Aurora L)

Mr. John Fraser (Ottawa South L)

Mr. Ernie Hardeman (Oxford PC)

Mr. Percy Hatfield (Windsor–Tecumseh ND)

Ms. Lisa MacLeod (Nepean–Carleton PC)

Ms. Harinder Malhi (Brampton–Springdale L)

Mr. Peter Z. Milczyn (Etobicoke–Lakeshore L)

Mrs. Julia Munro (York–Simcoe PC)

Mr. Lou Rinaldi (Northumberland–Quinte West L)

Substitutions / Membres remplaçants

M^{me} France Gélinas (Nickel Belt ND)

Ms. Ann Hoggarth (Barrie L)

Mr. Randy Pettapiece (Perth–Wellington PC)

Also taking part / Autres participants et participantes

Ms. Bonnie Lysyk, Auditor General

Clerk / Greffière

Ms. Valerie Quioc Lim

Staff / Personnel

Ms. Erica Simmons, research officer,
Research Services