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Mercredi 1er juin 2016

Standing Committee on Estimates

Ministry of Health and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé et des Soins de longue durée

Chair: Cheri DiNovo
Clerk: Eric Rennie

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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 1 June 2016

Mercredi 1er juin 2016

The committee met at 1600 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Good afternoon, everyone. We are here to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of eight hours and 30 minutes remaining.

Before we resume consideration of the estimates, if there are any inquiries from the previous meetings that the minister or ministry has responses to, perhaps the information can be distributed by the Clerk at the beginning in order to assist the members with any further questions. Minister: anything? No? Okay.

When the committee adjourned yesterday, the third party was about to begin their 20-minute round of questioning. Madame Gélinas, the floor is yours.

Mme France Gélinas: Thank you. I will go back. Remember that I had said I was at the 40,000-foot level? Now I'm drilling back to some of the smaller amounts that are in the estimates and others.

I had asked you about the $85 million that had been announced in the budget, which is great news, and you have explained to me the guidance documents to show how it was going to be distributed. I'm fine with this, but it does open the door to some issues with nurse practitioners, the first one being scope of practice.

I know that you are a big champion of expanding the scope of practice, and I appreciate that, but there are things such as urine dips, test strips for glucometers, ultrasound for thyroids, X-rays for some body parts—those amendments were done in 2009. We're in 2016. How much longer are we going to have to wait before we give nurse practitioners the right to do that?

Dr. Bob Bell: We'll ask Denise Cole, ADM of health human resource planning and health professional regulation, to respond to this. She has the most up-to-date information.

Ms. Denise Cole: Hi there. I'm Denise Cole—still Denise Cole today. I'm Assistant Deputy Minister of health workforce planning and regulatory affairs with the Ministry of Health.

Those were in the unproclaimed section of Bill 179, Madame Gélinas, and we are currently doing the work required around the scopes of practice to move forward with proclaiming those sections. I'm anticipating that by the fall, we should be in a position to proclaim those sections. We have been engaging with conversations with the nurse practitioners' association around that.

Mme France Gélinas: So you expect this fall, and all of the four that I've mentioned so far—urine dip, the test strip for glucometers, the ultrasound for thyroids as well as the X-ray for all the body parts—

Ms. Denise Cole: We will be taking those recommendations forward to cabinet for proclamation of those sections. But of course, it all depends on cabinet's final decision-making.

Mme France Gélinas: I understand. You'll be ready this fall.

Don't go away; the next question will probably also be for you.

Those were the easy ones. The other ones have to do with controlled substances. Do you have a timeline as to when we can expect nurse practitioners to be able to prescribe controlled substances?

Ms. Denise Cole: The discussions around controlled substances, not only for nurse practitioners but for some other providers, are dependent on recommendations coming forward from the College of Nurses of Ontario. We have started to have some peripheral conversations with the College of Nurses around that. We can get back to you with regard to the specific timelines that they have to bring those pieces forward.

Mme France Gélinas: All right. Was it from your initiative that you went and asked the CNO about controlled substances, or was it the other way around?

Ms. Denise Cole: My colleague Suzanne McGurn would probably be able to give more specifics, but it flowed from the federal government's work around allowing certain professions to have controlled substances. I wouldn't say it was us approaching the college or the college approaching us; it was a joint recognition on the part of both parties that the work needed to be done. But it is the college making a regulation, so they need to draft the reg and then come back to us.

Mme France Gélinas: Once the college has drafted the regulation and is sure that it has the proper oversight to protect the public, what needs to be done at your end?

Ms. Denise Cole: They would present the regulation to us. We have an obligation under legislation to post the regulations for a specific period of time, to invite input from other interested parties. Once that is done, then we

would take it through the formal cabinet decision-making process for final approval.

M^me^ France Gélinas: Okay. And there are drugs that are—I call it facilitated access, but I'm not sure I have the right terminology. Basically, the nurse practitioner can renew once it has already been prescribed by a physician. A lot of those drugs have to do with HIV. Are those going to be captured in the coming changes, or are they still going to be so that a physician needs to prescribe them first before the nurse practitioners can continue to renew?

Ms. Denise Cole: I don't have the answer to that, but would be prepared to look into it, or if Suzanne has the answer, we can switch chairs. Suzanne is the drugs person.

Ms. Suzanne McGurn: I'm Suzanne McGurn. I'm the assistant deputy minister and executive officer for the Ontario public drug program. Thank you for the question. The request that you're making pertains to the Exceptional Access Program. What we need is actually a statutory change to be able to make the change. The barrier that you have identified is in our governing legislation, and we are looking for the first opportunity for that to be addressed. We have spoken recently with the NPAO with regard to that matter, and it remains a priority for us to address.

M^me^ France Gélinas: So would that mean that it would be part of a piece of legislation before this change can happen?

Ms. Suzanne McGurn: The legislation specifically identifies only one provider group as being able to order exceptional access, so we do need a legislative vehicle.

M^me^ France Gélinas: Okay. And is this the same thing where you would then have to go to the College of Nurses of Ontario? No? It's strictly that if we do our work as legislators, it will hopefully go through and then be implemented?

Ms. Suzanne McGurn: Yes, that's correct. It does not require the College of Nurses to make regulations for that change to occur.

M^me^ France Gélinas: Okay. Thank you. The—

Dr. Bob Bell: Just to perhaps add a bit of clarity to that, I'm going to ask Suzanne: Suzanne, that's not about prescribing as much as being able to achieve Exceptional Access Program funding?

Ms. Suzanne McGurn: Correct. Nurse practitioners are currently able to prescribe a wide range of medications, with the exception of the narcotic opioids that you referenced in your question to my colleague. But for drugs that they are able to prescribe, they are unable, because of our legislation, to access the Exceptional Access Program because of the legislative barrier. It is an inconsistency. When changes were made previously, it wasn't captured, so we are working towards that.

M^me^ France Gélinas: Minister, do you see an opportunity in the fall to bring such a legislative change forward?

Hon. Eric Hoskins: Well, it may be that the ministry is in a better position to ascertain when that opportunity might arise.

M^me^ France Gélinas: So no time frame?

Dr. Bob Bell: If I may, Minister?

Hon. Eric Hoskins: Yes.

Dr. Bob Bell: Under the minister's direction, we're looking at developing a vision document that describes a future for the publicly funded drug program of Ontario. As you know, currently we have six different programs. Consolidating that to a single program and looking at a variety of different aspects of what Ontarians will have in the future, it's very possible that the kind of change you're talking about—to one of our smaller programs, but an extremely important one, the Exceptional Access Program—could be something that could be covered in that vision document.

Certainly in the timetable of the Patients First changes that we're looking at, the Patients First drug program is certainly something that is important. The kinds of changes related to who can achieve access for Ontarians through these drug programs would probably be one of the things that play a role.

Hon. Eric Hoskins: If you'll allow me, as well, I think we have 26 regulatory bodies for our health care professionals, so you can imagine that there is tremendous scope to expand scope of practice across a number of health professionals or within the health sector. My parliamentary assistant, John Fraser, is spearheading that effort with the ministry, where we're looking in a slightly different way, as well, at categories—rather than looking at the individual professions, we're looking at the opportunities and the categories for expanding scope, for example, with prescribing drugs.

1610

But as evidenced by the commitment that we've made for RNs prescribing and for death certificates, and as well, the work that we've done with pharmacists with regard to allowing them to administer a greater variety of vaccines, it's something that I'm—I know John feels the same way, the member for Ottawa South. We're very committed to working with all of our health care professionals to expand the scope as much as possible because we see that, quite frankly, as an important mechanism to improve the service delivery for Ontarians, provided that we have the support of the various regulatory colleges or entities.

Dr. Bob Bell: One of the really salutary things under Parliamentary Assistant Fraser and Mr. Hoskins's leadership is to turn the question on its head and not talk about what's right for the profession—as has often happened in the past, this turns into turf regulatory issues—but rather say what's best for patients.

When you think of the problems that people have renewing prescriptions, it's obvious that something like nurse prescribing would serve the interests of Ontarians. These are the kinds of ways that we're looking at these issues now, more from the patient's perspective as opposed—of course, looking at who has scope of practice and capability and training, but oftentimes there are overlaps, as you know, and trying to look at it from the patient's perspective is a fresh approach that's working well.

Mme France Gélinas: I appreciate that. I think that it's a good way forward.

Where do those talks take place? Is there a person in charge in your ministry? Is there a committee in charge in your ministry?

Dr. Bob Bell: Denise Cole, ADM of health system workforce planning and health professional regulation, has day-to-day responsibility for that area. Certainly, from the perspective of the regulation of health professionals—recognizing that 26 colleges are a lot of colleges—could we perhaps look at a different way of thinking through those regulations? There is somebody engaged full-time with a team on the important issues of anticipating what the health workforce will look like and how health professionals will work together. As you know, interprofessional care is a constant theme of workforce planning in the future.

Looking at overlapping scopes of practice, the thought that only one profession would have a scope that clearly delineated—probably only cardiac surgeons should operate on your heart, but there are many things that different professionals can do. That's part of the philosophy that Denise has been espousing. It's an important piece of the work, and she is fully engaged in thinking through the future and how professionals will be working together and how colleges will work together in regulating this practice.

Mme France Gélinas: Is the scope of practice of PSWs, RPNs, nurses and nurse practitioners working at the bedside, sometimes in an interdisciplinary fashion, something that Ms. Cole's ADM-ship—I don't know what to call it—office is looking at?

Ms. Denise Cole: Do I have to say my name again?

The Chair (Ms. Cheri DiNovo): No.

Ms. Denise Cole: No? Okay. You have it.

Madame Gélinas, right now, PSWs do not have a scope of practice as defined under the Regulated Health Professions Act. Within my division, there is a director who is responsible for regulatory affairs and is the point person—and there is a team, as the deputy indicated—who works quite closely with the colleges and the various associations for the professions.

As we're moving forward with the work around the scopes of practice, as the minister and deputy pointed out, we really do want to shift the paradigm around how one deals with scopes of practice. So we are engaging—there is a table, the FHRCO, the Federation of Health Regulatory Colleges of Ontario, where all 26 colleges are around the table. So this is a piece of work, in addition the work that PA Fraser is doing, that we have been engaging with them on, so we can get to a place of a consistent framework to be able to make decisions around scopes of practice.

Mme France Gélinas: Okay. If I drill down on this, specifically—I mean, RNAO put out a report that basically said that only RNs should work in our hospitals. We presently have a mix of PSWs, RPNs, nurses and, sometimes, nurse practitioners all working at the bedside. Is there somebody looking specifically at the scope of practice of the different, sometimes regulated, sometimes unregulated, professionals that work at the bedside?

Ms. Denise Cole: That is an overall part of the work we want to do around what I call the modernizing of our approach to how we do regulation in the province, so that we really are putting the patient at the centre. What are the patient's needs? What are the system changes and transformations required to support the patient's needs? And then what is that continuum? As you would know, the RHPA has been crafted in a way for that overlapping scope. But it's coming at it not only from looking at what are the scopes that the professions have, but what are the competencies that they have to be able to work to optimum scope: Who is best placed on an interdisciplinary team to do what?

That is a part of the work that we're doing, and it is being done in partnership with not only the colleges but the various associations: so the Registered Nurses' Association of Ontario, the RPNAO, the nurse practitioners' association, ONA. Although the PSWs are not regulated under the RHPA, we do liaise with them through their association as well.

Mme France Gélinas: And which association is that that represents them?

Ms. Denise Cole: There's the professional support workers' association of Ontario. They're a very small association, but we do engage—

Dr. Bob Bell: Personal—

Ms. Denise Cole: Did I say "professional"?

Dr. Bob Bell: Yes—

Ms. Denise Cole: Personal support workers.

Mme France Gélinas: I knew who you meant. All right. I'm happy to hear this.

Again, with the scope of practice, another series of professionals that don't have a college are the paramedics. Is this something that is presently being looked at as to the self-regulation of paramedics within a college or within another framework?

Dr. Bob Bell: Why don't I start off? I think it's fair to say that there is a variety of professionals involved in providing health care, obviously, in this multidisciplinary environment, and a number of folks who don't have a professional college, currently. Paramedics are a good example of that.

In point of fact, there are other ways of talking about the appropriate training, skills and scope necessary to undertake safe practice—the professional attributes that are required. There are other ways of defining that without defining a self-governing college approach. Just because—

Mme France Gélinas: Can you name me one?

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have under two minutes left.

Mme France Gélinas: Thank you.

Dr. Bob Bell: Well, they're in other jurisdictions. For example, the National Health Service in England has a different way of aggregating colleges and providing a professional standards association approach toward providing the attributes, training and accreditation necessary

to actually define an individual as carrying out a practice. So defining a practice in training as opposed to a college—

M^me^ France Gélinas: Is this being looked at for the paramedics right now?

Dr. Bob Bell: Sorry, my comment was not so much around the paramedics as to say that we already have quite a few colleges. To think about adding college after college after college, I think it's fair to say that we're looking at that at a high level, looking at whether or not we need to keep on adding colleges or whether we can aggregate colleges, whether we can look at other methods for actually protecting the interests of Ontarians without creating college after college after college.

M^me^ France Gélinas: I'm not familiar with what you're referring to that could apply to paramedics. Can you give me another example of something that is not a college and not self-regulatory that exists in Ontario, or would it be new to Ontario for the paramedics?

1620

Dr. Bob Bell: It would possibly be new to Ontario.

M^me^ France Gélinas: Okay.

Hon. Eric Hoskins: If I could just add—certainly the ministry and myself directly have had quite a substantial number of conversations with the paramedic associations and those who represent them. Plus, we've received advice in past years from the Health Professions Regulatory Advisory Council, or HPRAC, with regard to regulation of paramedics. So I think—

The Chair (Ms. Cheri DiNovo): I'm afraid that is the time for the third party.

We now move to the government side. Mr. Fraser.

Mr. John Fraser: Do you want to finish your sentence on that—

Hon. Eric Hoskins: Only if you'll allow me, only to say that—I know this is off the clock—this is an issue that I think it's fair to say we're very engaged with the association, with paramedics at this time.

Mr. John Fraser: Now that you've gone on to scope, you've got my questions all messed up and I'd rather talk about scope. But I'm not going to, other than to say that I do want to let MPP Gélinas know—because it's some work that I've been doing over some time—that I'd be happy to talk to her about it any time in the Legislature or wherever.

I would like to thank Denise Cole and her branch. It is a change—I know this is the time for me to ask questions—and a transformation in how we're looking at scope that is really focused on the patient and is focused on value in the system. I think it's the right approach. Would it have been better if we'd done it 15 years ago? Yes, but that's where we're at right now. I think it will improve patient outcomes, which is a good segue, because that's what my question is going to be about.

I know it's a priority to make it easier for patients and caregivers to get access to home and community care. Through Patients First: A Roadmap to Strengthen Home and Community Care, I know that plan is going to improve and expand home and community care in Ontario. I think it was mentioned in committee yesterday that there's an additional $750 million over three years for home and community care, and that adds up to—at least the numbers that I have—around 80,000 hours of nursing care, which will make it possible for people with complex needs and complex conditions to get the care they need where they want it, which is at home in the community. This is a really good thing and it's going to improve that care.

One of the things that I have noticed that is a challenge in the system—and if you'll allow me, I'll relate some personal experiences. I know we all, through our constituency offices, get what I like to call the outliers, the things that happen in the system that are concerning, and it's all around transitions. For instance, my mom had her two hips replaced a number of years ago—excellent care all the way through. When she came home, the follow-up—excellent, excellent care. She actually had a heart crisis last year. The same thing: all the way through. Through the Ottawa heart institute, she received stents. We took her to the hospital at 8 o'clock at night and by 1 o'clock in the morning, she'd gone to the other site and had a stent in her heart. We were talking to her in her bed, and the next morning she had another stent in her heart. The thing that was critical was the follow-up after that, and that follow-up was consistent with what her needs were. She developed some complications with regard to a cough. So I was encouraged. You feel good. It makes you feel good as a son and as anybody watching that situation.

I had a different experience with my dad, and that was around palliative care and some of the transitions around—there were a couple of transitions that were particularly difficult between a practitioner and the treatment, and that was an administrative breakdown; the same thing occurred moving into the home care system. Those transitions really have an impact on outcomes. So it's about the continuity of care.

I'm going to use an old grocery store analogy. We had this thing we used to call "Take them to the peas," which is that if someone comes and asks you where the peas are, you don't say, "It's over there, aisle 5, about the middle," because they might not find it. They might not see it. You could be wrong. It might have been aisle 6, but you thought it was aisle 5, so—stay with me; I know I'm going out here. But that's a transition of a sort. How do we make sure that the outcome that we want, which is that person getting to the peas, actually happens? I'm getting there; I know I'm wandering out there.

There are different strategies to look at that in different settings. What I want to ask about is bundled care. Bundled care is a strategy to ensure that we get people to where they want to be, because what is funded is the outcome and not necessarily the activities that are separate and unique in that continuum of care.

My question is: I know that there were six pilot projects. I think, for the sake of the committee, just to understand what those pilot projects are, some background on whatever you can give in some detail on that,

because I think that that is not the only solution to ensuring that those transitions occur, but it's an important way—I think anyway, when I look at it—of incenting an outcome. So it's saying that you're compensated on the basis of getting that person to where they need to be. If you could give some detail around that, that would be really quite helpful.

Hon. Eric Hoskins: Sure. Thank you. I'm not sure if what you're suggesting, that the ministry needs to buy more peas, is part of this or—

Dr. Bob Bell: We're starting to think you're rebranding the initiative.

Hon. Eric Hoskins: Peas, please. Bundled care, for me, is one of the best examples of what we're thinking about and talking about when we talk and think about the patient experience. Right? It's better for just about everybody involved.

I think my first exposure to bundled care was at St. Joseph's hospital in Hamilton, where, interestingly enough, I did a good portion of my internship after graduating from medicine at McMaster. In fact, I did obstetrics there. I also did my surgical rotation, which wasn't particularly valuable to me because the surgeon I worked under was Dr. Butts. He was known as the bunion king. All he did, and so all I did for my six- or eight-week rotation at St. Joe's in Hamilton, was bunions.

Mr. John Fraser: Important work.

Hon. Eric Hoskins: It's amazing what you can learn in committee, isn't it? I learned a lot more in obstetrics at St. Joe's, let me put it that way.

St Joe's, which I think is one of the pioneers in the province with regard to bundled care, the amazing thing about it—and I've had the opportunity on a number of occasions to meet and speak with patients who had been part of the bundled care model there. It's remarkable. The metrics are there in terms of the outcomes. Specifically, they aim at patients who require hip replacement, for example; or knee surgery; cardiac patients, I believe, as well; and lung patients.

From an objective perspective, it's already proven that the rate of readmission, compared to a control group, has improved. The length of hospital stay is less for patients enrolled in this bundled care model. The number of visits post-surgery or post-hospital stay and the number of visits to the ER have gone down dramatically as well. Not just by 5% or 6%; it's in the order of 25% or 30% or 40% for each of those categories. In an objective sense, there's no question just how valuable the approach is.

But when you talk to patients, the remarkable thing outside of the metrics is the level of patient satisfaction—I would call it almost elation. The experience that they have where they know, even before going into hospital, that they will not only be well cared for in hospital, but those same people—there's an individual, often a nurse, who is attached to them for their hospital visit and for everything that takes place post-hospitalization as well, so arranging for the home care.

1630

They're given iPads as well so they know they can email or call literally 24 hours a day, seven days a week, if they feel that they are perhaps getting into trouble or if they've got a concern or a question. That knowledge that there are people that they know who are with them through that whole journey and who are making sure that they're receiving the appropriate level of support at that right moment in time, and then having that security blanket, if you will, of knowing if you—because many of these individuals who they've selected for bundled care are individuals who perhaps don't have a safety net of their own in terms of caregivers or family members who are there with them. But even if they do, knowing that they have an opportunity to reach out to a health care professional at a moment's notice—and the stories I'd hear of, they'd email at 5 o'clock in the morning and at 5:07, they'd get a response to their inquiry. So it's pretty amazing.

And then on the physician and other health care professionals side of things, the team that works at St. Joe's—and it's being duplicated elsewhere—the level of satisfaction—and I would probably describe it as elation as well. They're just so excited about this model. Imagine the frustration if you're a surgeon and you replace a hip, and then you're sending them out into a completely different system, disconnected from your own, where you have to anticipate and rely on a home care service or other supports within the community to be able to provide that post-operative follow-up care or whatever that hospital occurrence might have entailed. And I have no doubt at all that it's saving us money.

So every way you want to measure it, I always think—because every decision that I make, I always try to imagine myself in the shoes of a patient or a caregiver. Patients don't care where the help comes from, where the health care support comes from. What they want to know is that they can rely on it, that it's going to be there when they need it, in a place where they can access it, and it's going to be reliable and of high quality. That's what bundled care provides, maybe better than any other model that I've seen. It's a tremendous opportunity to really imagine, if we can, what is of the highest level of importance. It's that high quality of care, but it's delivering it in a way which is as seamless and coordinated as possible. That really augments the patient experience, often at an exceptionally difficult and challenging time where they can use that support.

I think you can sense how I feel about bundled care and how strongly I believe in that model. It's one model among many. But I'm going to ask, in the remaining few minutes that we have, if Melissa Farrell, who's our ADM for health system quality and funding, can come and perhaps share some more information about bundled care and what we're doing currently and what we're planning to do in the province.

Ms. Melissa Farrell: Hi there. I'm Melissa Farrell. I'm the ADM for quality and funding with the Ministry of Health. Thank you so much. It's excellent to have the opportunity to talk to you about bundled payment. This is, obviously, something we're all very passionate and excited about.

I won't cover off a lot in terms of St. Joseph's, given the fact that the minister has really emphasized all the value and benefits that we really saw from that pilot demonstration project that we started with. We really looked at this as, "Hey, we have a successful initiative here on our hands, one that's clearly demonstrating better outcomes for patients." So we took, really, an innovative approach to figuring out how we could actually scale this up and scale this out for success.

We issued an expression of interest—I'll just give you some of the context about how this all played out—to the broad health care system, highlighting the successes of St. Joe's as an example, and then opening opportunities to explore other, related approaches to support patient transitions from hospital to home through integrated funding or bundled-care approaches. Through the expression of interest, providers—including hospitals, CCACs, direct service home care providers, physicians and others—were really encouraged to submit innovative and solution-driven approaches based on evidence-informed clinical pathways within the policy framework that we had set.

This way of gathering interest from the health system was quite innovative, and it actually led to really high levels of uptake. There were over 1,000 participants in our webcast launch of the expression of interest. We also had 50 expressions-of-interest applications that were actually submitted to the ministry to be a part of this initiative in the first place. We did a multi-phased assessment process to look at each of the submissions as they came through with the LHINs, as well as St. Joe's, who has been a big partner for us, looking at what we thought we could do and what the art of the possible was within these expressions of interest.

This review was followed by readiness assessment visits. We went out to 14 short-listed sites and then, through that collaborative team that I just talked about, we were able to end up with six sites. We actually took all 14, met with the minister, talked about what we had seen in terms of those readiness assessments, and then selected the six that we thought were the most innovative and we thought could see the most success from this.

One thing that's really important to understand is that all jurisdictions are struggling with this concept of integrated approaches and these transitions. You say it's—

Mr. John Fraser: "Take them to the peas."

Ms. Melissa Farrell: Take them to the peas. We call it the warm hand-off. So everyone is really trying to work through that. These six teams are really focusing their work on patients who need short-term care at home and after leaving hospital, but many jurisdictions are actually looking well beyond that: into primary care. Physician payments are part of the bundles as well.

What these teams are actually looking at is that all steps in the patient's journey, including hospital and home care, are funded as one seamless bundle of care, so it's one funding envelope across settings. As a result, patients will transition more smoothly out of hospital and into their homes and will have, we're hoping, fewer emergency department visits and also be less likely to be readmitted to hospital. We're also looking for a reduced length of stay.

All six teams, as of today, are currently enrolling patients and are reporting some outcomes. I have some positive outcomes to talk to you about as well. The six teams are—just to highlight that for you. One of them is Connecting Care to Home, which is focusing on patients with a diagnosis of chronic obstructive pulmonary disease—COPD—and congestive heart failure in London-Middlesex. That includes, just so you're aware of the providers in particular, London Health Sciences, as well as St. Joe's in London.

The second bundled payment project is Integrated Comprehensive Care 2.0. This is the St.-Joseph's-in-Hamilton project beefed up to the full LHIN. All of the hospitals within that LHIN are part of this particular project. They're focusing on hospitalized patients with a diagnosis of COPD and CHF as well, so it's similar. As I've already mentioned, it's all the hospitals in that group.

Hospital to Home is at William Osler and Headwaters. They're focusing on patients with urinary tract infections and cellulitis in that particular LHIN: Central West.

We have Putting Patients at the Heart, focusing on cardiac surgery patients in Mississauga Halton LHIN, and that's a Trillium project.

One team is focusing on Patients Recovering from a Stroke in the Toronto Central LHIN, and that includes North York General Hospital and Sunnybrook as well as Providence Healthcare.

Our final one is Integrated Specialized and Primary Care—that's the name of the project—focusing on patients with COPD and CHF in the Central LHIN. North York General Hospital is the main provider group included within that.

The Chair (Ms. Cheri DiNovo): You have about two minutes left.

Ms. Melissa Farrell: That's great. Even in these early days, the initiative has already seen some quick wins. We have nearly 400 patients who have been supported—that was last year—during the ramp-up period for each of the six sites. For this year, the target is over 4,000 patients who will be treated within the six sites. We know that the relationships are already forming within the home and community care sector, as well as hospitals, as part of this, getting a deeper understanding of the challenges with each, because they're trying to come up with these innovative approaches to addressing these patient groups.

We've also noticed a deep sense of engagement and empowerment from providers who are involved across the six sites. They're really excited about what they're seeing here. In fact, the way that they talked about it at St. Joseph's is that going back to the old way would be like going back to the typewriter in terms of how you would approach patients.

We've also begun to observe a shortened acute length of stay. We're seeing that as a measurable outcome already with these six sites, which I think is terrific.

We obviously know, though, that there's more to be done, so the sites will have their progress and outcomes tracked and will be sharing lessons learned with each other. We have an extensive evaluation of the program which is being conducted by one of Canada's top health service and policy researchers. All of the data points will become public and shared through a community of practice that we have across all of these groups.

1640

I'm really proud to say that the broad implementation team, which includes St. Joe's and ourselves, has also recently been awarded an IPAC/Deloitte Public Sector Leadership Award for the implementation at the six sites, which we're very excited about. The award actually recognizes organizations that have demonstrated outstanding leadership by taking bold steps to improve Canada's health care system. Over 100 submissions were received, and we were awarded the gold award in the past few months for this implementation. So we're very excited about where to take it; after we go from these six sites, hopefully we can go provincial.

The Chair (Ms. Cheri DiNovo): Thank you. Now we move to the official opposition. Mr. Harris?

Mr. Michael Harris: Good afternoon, Minister and staff. Minister, I'm sure you're well aware that I've got a variety of issues, but the first one I'd like to talk to you about is the subject of rare diseases. I think it's important to say off the top that we travelled the province earlier on in the year and met with folks right across the province who suffer from a rare disease and had trouble accessing treatment from your ministry.

I will say that I shared in the disappointment of those patients when your government, along with your colleagues, some of whom had committed to voting for striking a select committee, chose—perhaps for political purposes—to vote against my motion to strike a select committee, a committee that has worked on a variety of issues, like the sexual harassment select committee, developmental disabilities, mental health, etc.

I'll move on from that. There was perhaps one positive, and that was that earlier in the week, prior to my debate, you did commit to strike a working group. I suppose I'd like to start there in getting some specifics of that working group. I'm curious to know if you can tell me the names of folks who have been asked to sit on that working group.

Hon. Eric Hoskins: You're correct that we did, at that time that you referenced, commit to creating a working group. That working group has been created. I'm not sure if the deputy can share the composition; do you want to take that on, Deputy?

Mr. Michael Harris: That would be great. Thank you.

Dr. Bob Bell: Thank you for your leadership and promotion of the needs of children, adolescents and, in some cases, adults with a rare disease. As you know, this is an increasingly complex area that involves so many different parts of the health care system, from neonatal screening to genomic diagnostics to recognizing syndromes, mainly in children, that have not yet been diagnosed, and recognizing the various methodologies across Internet advocacy groups that are often essential to pulling together syndromic conditions that can only be identified by bringing together children on six continents who have these conditions and comparing their genomic backgrounds.

This is a rapidly evolving area of medical practice. We're absolutely delighted that Dr. Cohn, the chief of pediatrics at the Hospital for Sick Children, who was recruited to SickKids about three years ago from Johns Hopkins as an expert in the genomic diagnosis of children with rare diseases, has agreed to chair this panel.

The panel is a pan-Ontario panel that includes expertise from CHEO, the Children's Hospital of Eastern Ontario, which, as you know, has had a long interest in the screening and collection of genomic material appropriate not just for diagnosing children today but, with storage of genomic material, is able to create a registry system that allows population screening and adds Canadian and Ontario data to the international bank of material available. I can't give you the name of the leader from CHEO who has agreed to take on the registry function and the genomic evaluation.

People who are serving as resources on this important diagnostics side include Dr. Stephen Scherer at the Hospital for Sick Children, who, as you know, is an international expert in whole-genome sequencing. Ontario is a centre of international excellence with application. Dr. Scherer's work, for example, in autism, using whole-genome sequencing, has really been a leading international centre.

Other experts who sit around that table include pediatricians. Because of the frequent association with pain syndromes for children and adolescents with rare diseases, there are experts in pain associated with it. Because of the association with musculoskeletal disease, skeletal anomalies, which frequently play a role in the diagnosis and symptom development of children and adolescents with a rare disease, there is an orthopaedics specialist from the Hospital for Sick Children who sits on that program. Because of the issues related to the importance of rehabilitation and the development of occupational therapy approaches to managing the neurological characteristics, as well as musculoskeletal, there is an expert in occupational therapy. We're very happy that we've been able to link the pediatric expertise that exists at the Children's Hospital of Eastern Ontario, and of course at SickKids, under Dr. Cohn's leadership, branching out as well to the spine service at Toronto Western Hospital.

As a primary focus, and again thank you for your leadership here, the diagnosis and treatment of Ehlers-Danlos disease, EDS, has been a primary focus for this. We recognize that a great deal of controversy exists in the appropriate management of children, adolescents and young adults with EDS. Under the minister's leadership—and the minister has actually stimulated this not only through his ministerial leadership but his personal

engagement and insistence on bringing patients with EDS into the planning of a process that will serve EDS patient needs, meeting on more than one occasion with families of patients who have EDS.

Mr. Michael Harris: Not to cut you off—and I appreciate that; I noticed the movement on the EDS file. That would sum up, I guess, everyone that's sitting on or has been asked to participate in the rare disease working group?

Dr. Bob Bell: There would be other members of it as well who would bring their specific areas of expertise in kind of a secretariat function because of the complexity. For example, Internet searches related to parents who—

Mr. Michael Harris: Would there be patients at all on this actual working group?

Dr. Bob Bell: Absolutely. There are patients involved, as you know, on the EDS working group.

Mr. Michael Harris: What about the rare disease working group?

Dr. Bob Bell: That serves as a subset of the rare disease working group.

Mr. Michael Harris: Aside from the EDS patients, will there be any patients who will sit on the new group that the minister announced back in February?

Dr. Bob Bell: The expectation is, as policies developed for the development of approaches to each—I mean, each one of the rare disease groups is different. Each one requires a different set of not only biomedical expertise, but also expertise in the associated problems of dealing with children and young adults. The minister has been absolutely committed to patient-family engagement here.

Hon. Eric Hoskins: I don't recall a single working group or table that I've asked to be created or been part of its creation that hasn't included a significant patient and/or caregiver or advocate presence. On this working group, there are three patient representatives.

Mr. Michael Harris: Who are they?

Hon. Eric Hoskins: I don't have that specific information. But I think we learned from the EDS working group with patient involvement as well, we believe, and I would hope you would agree, that that served as a highly useful model to be able to develop what has actually become a centre of excellence.

Mr. Michael Harris: So the three patient folks will be a permanent fixture to this working group, or will they be just called in as needed?

Hon. Eric Hoskins: I think both: the permanent presence of these individuals, but in addition, as the deputy referenced, from time to time as the working group looks at specific rare diseases. For example, as we found with EDS, there will be a necessity to bring in individuals who represent that community and have that specific patient expertise.

Mr. Michael Harris: When those patients are actually added to the working group, would you make that available to the committee as to who they are or will there be some sort of list publicly on your website that will be available to show and see who is actually on this working group?

1650

Hon. Eric Hoskins: I don't know traditionally how we approach it. We have a number of working groups and tables that address a variety of issues. I'm not sure how we typically approach that.

Mr. Michael Harris: Have they met yet? Has the working group met yet?

Dr. Bob Bell: Yes. Dr. Cohn has met with members of the working group.

Mr. Michael Harris: I asked another important question about the timeline. You talked about an accelerated timeline. When would you expect that expert panel report to come back to you?

Hon. Eric Hoskins: Go ahead, Bob.

Dr. Bob Bell: I just wanted to respond, Mr. Harris, to your former question of: Do we typically publish the names? With patients' and family members' permission, the time that we usually publish the name is when the report is posted, and then we have the list of members who contributed to the report.

Let me just check and see, Minister, if we know when that first report out is considered.

Interjections.

Dr. Bob Bell: To be straightforward, we don't currently have a time frame for when the first report will be posted.

Mr. Michael Harris: Do you have an expectation that you've set, Minister, in terms of when you'd likely—you talked about how they will have an accelerated timeline, thus you've asked for the recommendations to come back to you within a similar time horizon. You mentioned that in your order paper question that I had.

Do you have any expectation? Do you expect by the end of the year to have—

Hon. Eric Hoskins: Yes, I anticipate. Certainly the full group has—

Interjection.

Hon. Eric Hoskins: All right. The ministry is informing me that they anticipate receiving a first report from the working group towards or by the end of the summer. Again, I would envision that because of the nature of the work, the variety of diseases that we are talking about and the approach that was taken successfully, I believe, with EDS, we anticipate that there would be a number of reports that would come forward.

But to get back to your original suggestion that our—

Mr. Michael Harris: We know what it was.

Hon. Eric Hoskins: No, if you'll allow me: You suggested it was political. It was in fact due to the fact that we believe that a working group of experts, as opposed to politicians, is a much more effective and timely way of developing strategies on these individuals with rare diseases—

Mr. Michael Harris: Would that be similar to the Ontario Citizens' Council that was struck in 2010? Would you concur that it was a similar group of experts

who were brought together to study rare diseases back then?

Hon. Eric Hoskins: That's not a good reference point for me. A good reference point would be, as Minister of Health, the various approaches that I have taken to address issues.

For me, after many, many meetings with individuals suffering from rare diseases, and their families, I felt compelled—and in fact, if you recall, my decision to strike a working group of experts was extremely well received by that community itself. The reason why we chose to take that approach was because I felt compelled to harness the expertise that's available, including that provided by patents themselves, to develop a strategy that was developed by experts.

Mr. Michael Harris: When you talk about that, I'm not sure if that means that you didn't find success with the select committees that were recently struck on sexual harassment, mental health or developmental disabilities, committees that were put to work on important issues.

But I'll remind you that the council that was struck—I'm trying to get the name of it. There were recommendations put forward to the Ministry of Health and Long-Term Care on rare diseases. When you mentioned that, it reminded me that there were 16 recommendations back in 2010. I'm just wondering if you're talking about committees like this, that you found better success in.

I guess I'll ask you: One of the recommendations that was given to the Ministry of Health and Long-Term Care back in 2010 was that drugs for rare diseases should have their own set of funding criteria. I'm assuming that has been acted upon?

Dr. Bob Bell: May I give you a sense of the accomplishments of the working group so far?

Mr. Michael Harris: I'm asking about—and the minister brought it up—taking the politics out of it. It took me back to 2010, when there was a council struck, without politicians, that put forward recommendations. I'm asking you specifically to report to the committee on those recommendations, if you felt that these types of panels actually reflect better results.

Dr. Bob Bell: We can certainly go back to that panel and review, but as you well know, Mr. Harris, the whole environment around rare diseases, with genomic diagnosis, has utterly changed since 2010. You'll be happy to know that the first development out of the working group is to build on the national rare disease strategy developed by CORD, with Ontario-specific enhancements to that.

If we look at the five goals of the national rare disease strategy: "(1) Improving early detection and prevention"—the working group has included an increased emphasis on diagnosis, supported by genetic testing and, importantly, investment in counselling for families who are concerned about their children having unusual conditions; "(2) Providing timely, equitable and evidence-informed care" is the goal of the national rare disease strategy. We're including an increased emphasis on supporting. This is crucial because, of course, all of these children will have a primary care provider, and the way that knowledge transfer to those primary care providers is given is essential to the children being cared for. So we're putting a special emphasis on knowledge transfer to the families—

Mr. Michael Harris: If you want to provide that document you're reading from to the committee, that would be helpful, and perhaps any of the actual, tangible outcomes of the 2010 recommendations—just progress or an update to the committee from those recommendations that were acted upon.

You brought up a national strategy that was developed out of the first ministers' meeting. I know, Minister, you talked about how Ontario is in fact co-chairing and leading that process. I'm wondering if you can tell this committee when that report will be public, I suppose.

Hon. Eric Hoskins: I'll have to discuss that with the ministry to get more details.

Mr. Michael Harris: And I guess there was a commitment to consult patient groups for that national strategy. Do you know if, in fact, that has taken place?

Dr. Bob Bell: The national strategy on drugs for rare diseases—

Mr. Michael Harris: This is the national strategy on rare disease out of the first ministers' meeting back in November. Minister, you gave an answer: "Ontario is in fact co-chairing and leading a process nationally across the country. We've established a committee nationally, specifically to develop a strategy for rare diseases in this country. Ontario is leading that effort."

I'm wondering if you can tell the committee, because you are taking such an active role in that, if in fact patient groups have been consulted or will be consulted, and when you expect that report to be completed.

Dr. Bob Bell: That work which we're co-leading with Alberta certainly has engagement with patient groups and patient advocacy groups at several different levels. It's also connected with the pan-Canadian Pharmaceutical Alliance. The Ontario approach to treatments for rare diseases, as well as other conditions, is informed by the citizens' panel that you referenced earlier, a citizens' panel that was originally created to help inform public policy development around the Ontario drug benefit plan.

Mr. Michael Harris: So the national strategy that's being co-chaired by the province has or will have consulted with rare disease patient groups in terms of building what that strategy or plan will look like?

Dr. Bob Bell: Yes.

The Chair (Ms. Cheri DiNovo): Mr. Harris, you have about two minutes.

Mr. Michael Harris: Two minutes? Okay.

I know we've got one round after this, but a quick question—the Ontario public drug program is roughly $3.8 billion: Is that correct? Is that what the line item would be?

Hon. Eric Hoskins: It's somewhat over $3 billion. That's close.

Mr. Michael Harris: I don't know if anybody would know—excluding the rare cancers, how much would be spent on rare or ultra-rare diseases out of that?

Dr. Bob Bell: Let me introduce again ADM Suzanne McGurn, executive officer of the Ontario public drug programs.

Ms. Suzanne McGurn: I don't have the number that you asked for at my fingertips, but I can give an example in the past year.

I know we are often asked in the large group. Again, you pointed out one of the challenging parts of the observation, which is rare, ultra-rare or some other category. But just as an example in the past year—and this is one of a number, but we can go back and look to provide further detail in that area—there could be one product that provides support to less than 75 people that would be over $20 million.

1700

So, there are a number of products that would be in that space—

Mr. Michael Harris: Would you be able to give a number to the committee in terms of roughly how much of the public drug program would be spent on rare and ultra-rare diseases, say, for the last couple of fiscals or the last fiscal? And then would you have a projected cost, perhaps, on what it would cost to fund all orphan drugs for patients with rare diseases in Ontario? Have you done any costing, perhaps, on that?

Ms. Suzanne McGurn: We're certainly happy to look into that and get back to you. With regard to the future, there are a lot of products in the pipeline and, again, the notional numbers would be probably quite substantial. That being said, we are certainly happy to look into it for you and—

The Chair (Ms. Cheri DiNovo): And I am afraid that is about it. Thank you. We now move to the third party and Madame Gélinas.

M^me^ France Gélinas: The first question is a bit weird, but see what you can do with it. When CIHI talks about how much we spend on our hospitals—as in how much the government of Ontario spends on our hospitals—they use $19 billion.

Minister, when you speak about how much the government spends on our hospitals, through the LHINs and all of this, you use $17 billion.

Where does the $2 billion fall?

Hon. Eric Hoskins: Okay. I'm not sure whether I've personally ever used that figure. I'm assuming you're referencing the estimates itself.

Dr. Bob Bell: This is largely an accounting issue, in that our provincial programs budget, for example, which would include funding to Cancer Care Ontario and the Cardiac Care Network, plus programmatic funding to our psychiatric hospitals, is often expended in the hospital sector. CIHI, when they do their work, in order to make it consistent from province to province to province, each one of which attributes various elements to different accounting buckets—so to give you an example, with our roughly $16.6 billion—

Interjection: That's ours, and that takes us to $19 billion, and that's the list.

Dr. Bob Bell: Thank you. I won't even bother to ask Nancy Naylor to come up.

What we attribute to hospitals relates to about $16.4 billion of funding. Other related hospital funding includes psychiatric hospital funding, Cancer Care Ontario funding, and capital and consolidation effects to the overall hospital funding picture, which brings us a further $2.578 billion. So a total of $18.968 billion would be what CIHI would report, in comparison to other provinces.

M^me^ France Gélinas: Okay. That—

Dr. Bob Bell: That was the 2015-16 printed estimates. The 2016-17 printed estimates would total $19.217 billion.

M^me^ France Gélinas: That works. Thank you. I was interested in listening to what you had to say about bundled care and in-home care in the new programs. I hear that the home care contracts are presently frozen until 2017, as in: They roll over but they don't get renegotiated. Is this just a CCAC decision, or is this something that comes from your ministry?

Dr. Bob Bell: Associate Deputy Minister Nancy Naylor, who—

Hon. Eric Hoskins: —is best placed to answer this.

Dr. Bob Bell: Absolutely.

Ms. Nancy Naylor: Thank you. I'm Nancy Naylor. I'm the associate deputy minister for delivery and implementation.

We do have contract guidelines for the service provider contracts. They are the main way that CCACs deliver home care services, as you are aware. The contracts have been renewed every year, or re-documented every year. by our partner, the OACCAC. So there are contract provisions that come into those contracts every year, following discussions with the service providers.

The price has been fairly static for most of them, but some of them have been reopened by the CCACs, and they have procured, for example, for new care models, new cluster care models where they assign certain PSWs for buildings; new models like eShift in southwest Ontario, where PSWs and RNs use technology to communicate. That's largely a palliative care model that supports families with palliative care overnight in shifts for patients.

As part of the road map, we are working on a contract working group to modernize those contracts. We've had really good input from the service provider community. Home Care Ontario and the Ontario Community Support Association have been participating with a number of their members. We've been looking, particularly in our first year, at PSW contracts. They've supported us with a good data survey, understanding the cost structure of how they support their staff and their workers.

Our interest is making sure that the PSW wage enhancement investments that the government has supported over the last couple of years—those are going to be close to $190 million this year, we expect. We're working on folding those into the contracts to reinforce

the government's policy direction that $16.50 is the minimum—

Mme France Gélinas: You're going farther and farther away from my question. My question was: Except for when the CCAC initiated a change in contracts because of a new program, is it true that the contracts are being renewed but are not being renegotiated throughout? Is this a government policy?

Ms. Nancy Naylor: They are being renewed. I think the service provider community has had a lot of volume continuity and a lot of business continuity as a result. That has supported them in offering the continuity that we want to see for PSWs.

They have been renewed effectively at the same price. One of the problems that we're trying to address is the complexity that's inherent in the pricing structure left over from the former home care program boundaries. Some of the rate boundaries followed those providers into the new structure, and they've maintained those.

There are a number of rates. They're quite closely clustered, for example in the PSW world, within a few cents of each other, and yet providers are maintaining multiple rates for slightly different boundaries within the CCAC boundaries. We're trying to resolve some of that complexity, and we're getting excellent participation from the community for that.

Mme France Gélinas: When I hear that the contracts are basically not going to be renegotiated until 2017—what's going to happen in 2017?

Ms. Nancy Naylor: I have to say that the deadline of 2017 isn't one that I'm familiar with. We do have very succinct contract management guidelines, but the direction is that they renew it at the price.

I think the main investment, which has been substantial, is the support that we're flowing for the PSW wages directly. We are asking them to make sure those flow through to the staff. We're following up to make sure that happens and we're working to bring it in to our goal of a harmonized PSW rate.

Mme France Gélinas: Okay, thank you.

Hon. Eric Hoskins: If you'll allow me?

Mme France Gélinas: Sure.

Hon. Eric Hoskins: I think this came from Gail Donner's report from just under a year and half ago. Also, when we began the process of implementing the wage increase for PSWs, we learned of the complexity that exists among contracts across the province, across different CCACs, even with different third-party contractors within the same CCAC.

What we've been working on with this contract working group, with the support of our partners—quite enthusiastic support—beginning with PSW-related contracts, is to create a greater uniformity and simplicity across them. The example where you may have a service provider working in different CCACs, providing the same work, but under different contractual circumstances: That kind of disparity is what we're working to eliminate.

Mme France Gélinas: Where is that work taking place?

Dr. Bob Bell: While Nancy is coming up to give you the details, I'll say that Nancy Naylor's division is really focused on this within a home care branch with a fairly substantial advisory group, comprised of patients, caregivers, terrific advice from Gail Donner and input from the associations of home care providers, as well as CCAC leaders.

Nancy, do you want to describe that a little better?

1710

Ms. Nancy Naylor: Sure. In the overall project governance structure, as the deputy has mentioned, we have an advisory group with the representation he's described. We have a number of project committees underneath that, and one is the contract working group. That's a group where we're working with individual service providers and their associations.

Mme France Gélinas: Do you think what I hear in the field, that CCACs are waiting to see the recommendations coming out of that working group before they renegotiate—they renew, but they don't renegotiate.

Ms. Nancy Naylor: I should mention that the CCACs are participating on that committee because operationalizing, for example, the harmonized PSW rate will require some changes to their IT system and their billing system. They welcome it, the way the service providers are being very receptive, because it will eliminate a lot of complexity from their system and then allow us to free up some resources, we think, for patient care.

Mme France Gélinas: Sounds good. Thank you.

I'm back to the paramedics. Just to know, is there work being done to change the Ambulance Act to allow paramedics on fire trucks?

Hon. Eric Hoskins: No.

Dr. Bob Bell: No.

Mme France Gélinas: Okay. So the Ambulance Act is not up for review or being discussed right now or being worked on?

Hon. Eric Hoskins: Just as I have had a number of conversations with paramedics and their associations—and you've asked the question, so you're obviously well aware that there are discussions under way, including with representatives of our firefighters, to look at ways to enhance the delivery of care. Any such proposal, we examine through the lens of patient care and quality of care, including any proposal that might come from firefighters with regard to an enhancement of the services that may be provided through their service delivery model.

Mme France Gélinas: So when you say you look at it through the view of patient care and quality of care, who are the people who are looking at this, and how involved is their work?

Hon. Eric Hoskins: The ministry, of course, and the deputy may be able to provide more specifics of precisely within the ministry. But certainly, if any consideration were to be given ultimately to this proposal, it would be following the benefit of an extensive consultation

basically with all stakeholders that may be impacted one way or the other by this, including our paramedics, for example, but also municipalities, obviously, would be impacted in addition. That would be the process.

But in terms of specifically within the ministry, I don't know if the deputy has—

Dr. Bob Bell: Yes, I can just summarize. We've co-ordinated a review to evaluate and assess the implications of enhancing services the minister has described. It obviously has interministerial implications, and we're in consultation with the Ministry of Community Safety, the Ministry of Labour, and the Ministry of Municipal Affairs and Housing crucially.

Some of the considerations being discussed, while developing options, are initial and ongoing cost, capacity in the field, labour relations and the operational impact.

Of course, AMO is very interested in this—consultations with them. We're committed to co-operating with the municipalities and consulting through the signed agreements that we have with AMO when considering any new legislation and regulation that could have a municipal impact. I think it's fair to say that this is purely at the consultative phase at this point, Ms. Gélinas.

M^me^ France Gélinas: Okay. Thank you. How much time do I have?

The Chair (Ms. Cheri DiNovo): Six minutes.

M^me^ France Gélinas: Six minutes. Okay. I will try that one in six minutes or less and see what happens.

You all know that on September 15 last year we got a freedom of access to information that looked at the acute bed occupancy rate. I can read some of them into the record, if you want. Lennox and Addington County General Hospital was at 103%, 103%, 109%, 115%, 104% occupancy. Peterborough regional hospital: 104%, 107%. We have Blind River at 120%, 127%; they presently sit at 122% occupancy. Should I keep on or do you get the idea of where I'm going? We have Toronto Rouge Valley, the Ajax and Pickering hospital site, 109%, 115%, 118% occupancy; Belleville Quinte Healthcare Corp., Bancroft North Hastings site, at 112%, 114%, 103%, presently at 100% occupancy.

My question really has to do with, when the freedom of access of information came back—and I'm quoting from it: "Please be advised that the ministry does not have standards, guidelines, policies or best practices with respect to hospital bed occupancy as it relates to hospital operations. You may wish to contact each hospital regarding their standards, guidelines, policies or best practices with respect to hospital bed occupancy. We also know that many other jurisdictions do have standards, guidelines and policies regarding best practices of hospital bed occupancy."

I was wondering why we don't.

Hon. Eric Hoskins: Go ahead—oh, why we don't?

M^me^ France Gélinas: Yes.

Hon. Eric Hoskins: I think, as you can appreciate, the occupancy rates of hospitals across the province, the vast majority of which have been maintained at less than 100%—there is a portion which in fact has been decreasing over the last several years, but there is a small proportion that has, at a point in time, touched or exceeded 100%. To give you an example, I think there were four that were referenced in the Globe and Mail article, and two of those four have dropped below 100% subsequent to that article.

There's also seasonal variation, and I think I've spoken to this issue, where particularly the reference point that the Globe and Mail used was the last fiscal year or the first three months of this calendar year, which typically often see capacity issues because of the nature of the illness that Ontarians tend to experience in the winter months.

That being said, we also have seen in recent years an increase in the number of acute care beds in hospitals across the province. I know your question was—and perhaps the deputy might be able to speak to this. But with regard to standards or policies with regard to capacities, and of course, as you know, hospitals are independent corporations but we monitor very closely, and our expectation is that the quality of care and the outcomes that Ontarians would expect to see and receive are achieved. In fact, when you look at the hospitals in question that have been referenced or that you referenced yourself—and I've got examples that demonstrate the outcomes we would expect to see, that demonstrate and reflect that a high quality of care is being achieved by those same hospitals.

Deputy, I don't know if you have anything to add in particular to that or not.

Dr. Bob Bell: If I may, Minister. The number of acute care beds in Ontario over the last three years has increased by almost 5%. The thing to remember, as someone who used to run a hospital, is that what we're talking about is the midnight census for bed occupancy. That's the standard that we use and that CIHI uses. What sometimes accounts for hospitals having over 100% occupancy is that patients are seen during the late afternoon, early evening and will require admission to hospital. They are receiving excellent care within the emergency department, and a bed is not yet available. We measure these times very, very carefully. And what happens is, the next morning when the patients are discharged, new patients are admitted for elective surgery and the patients who are admitted to the emergency department move into those beds. But for a period of time the hospital is over 100% occupancy and—

M^me^ France Gélinas: But, Deputy, you know that this is not true. I'm from Sudbury. You can go to the north tower, fourth floor, and what used to be a beautiful sunroom is now a room for six patients, and it's packed all the time. I had the unpleasant experience of walking by this beautiful sunroom and seeing somebody on a commode. I don't think this is good patient care. They're stuck in there, there's no bathroom and there's nowhere else to put them because our hospital is at overcapacity.

1720

I know that sometimes the statistics do things, but I also visit a lot of hospitals, and I've seen a lot of hos-

pitals try to put patients anywhere they can because they're at overcapacity. I know that it is important to you because you keep track of it, because you were happy to tell me that for some of them, it has gone down. So you know that it's bad when it's over 100%; otherwise, you wouldn't be proud to tell me that the number has gone down.

We have standards, guidelines and policies on everything. We have a standard as to the temperature of the soup in our long-term-care homes, but we don't have a standard as to occupancy rates in our hospitals?

The Chair (Ms. Cheri DiNovo): I'm afraid, Madame Gélinas, time is up. Thank you.

We're now going to move to the government side. Mr. Fraser.

Mr. John Fraser: Thanks again. I promise you there will be no more peas analogies. I won't drift off there again. But I do have to say that one of my colleagues, MPP Vernile, said—no, she told me this is the truth—that she got her kids to eat their peas by threatening to sing the pea song, and the pea song is, All We're Saying Is, Give Peas a Chance.

Laughter.

Mme France Gélinas: We'll have to get you a T-shirt for that.

Mr. John Fraser: I know; there we go. Yes, I bought the T-shirt.

My question is about outcomes. I know that we have the Excellent Care for All Act, which puts patients first by strengthening the health care sector's organizational focus and accountability to deliver high-quality patient care. It helps define quality, it reinforces a shared responsibility around quality of care and it helps support boards' capability to oversee the delivery of high quality care.

I want to go back to shared responsibility because in my riding of Ottawa South we have the Ottawa Hospital, which has a fairly vigorous continuous improvement program. They've put a focus on a number—and they've been working on it for quite some time. They've been having some success, and I'm pretty proud of the fact that that's happening in my riding.

But we do know that it's a challenge across the health care system to ensure quality in outcomes. I had the opportunity on a break week to read The Checklist Manifesto, which I'm sure a number of you are familiar with. The premise is that we have all these great medicines, we have great practitioners, we have hyper-specialization, we have great drugs, we have great facilities, and yet we still can't get it quite right. There are still things like infection rates and outcomes that are not quite there. I think that as we're investing a lot of money in health care, it's important for us, as we do through the Excellent Care for All Act, to put a focus on trying to ensure that we have a quality of care, that we are meeting the expectations for outcomes, that the rates of outcomes are better and that the incidences of errors or poor quality are diminished.

My question really is around the Excellent Care for All Act and the goal of that legislation—but also Health Quality Ontario was established around the same time, and it obviously has had an impact on that public reporting. I think it's very important that those things are visible, that people see what their health care providers and their institutions are doing to ensure that they get the kind of quality of care they expect and that there is indeed a shared responsibility of all those people practising and working in the system to ensure quality.

Can you just give us an overview of the ministry's work and Health Quality Ontario and how it's impacting getting better results here in Ontario?

Hon. Eric Hoskins: Thank you. I appreciate you raising this very important question. I think, for all of us, the highest priority of a society, and certainly the government within it, is to ensure the provision of the highest-quality care and for Ontarians to be able to have the assurance that when they intersect with the health care system, their experience is one that elevates and provides them with that highest quality of care.

HQO, Health Quality Ontario—which, I think it's fair to say, has proved its value over the short period of time that it has been in existence in this province—in many, many ways, effectively informs and advises the health care system on how it can improve, and how not only to measure outcomes and measure quality, and make that publicly available, but to do it in a fashion which is very specifically geared to assisting those who are charged with improving the health care system—that we have the data and expert advice that we need to be able to make those positive changes.

I invited Melissa Farrell up here once, to deepen the discussion on bundled care. I think that I'll ask her as well to talk a bit more specifically about the important work that Health Quality Ontario has done and is doing in this province.

Ms. Melissa Farrell: Thanks. I'm very excited to be here to talk about the quality agenda. I guess I'll start off first, though, just by talking about the implementation of the Excellent Care for All Act, which was landmark legislation that laid the foundation for health care quality in Ontario. I'm really excited to talk to you about that, and HQO's work too.

That act articulated a high-quality health care system, which is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient-centred, population-health-focused and safe. It put in place a series of levers, requirements and capacity-building structures—which I'll talk about in a moment—to enable and strengthen the health care sector's organizational focus as well as accountability for delivering high-quality patient care. So ECFAA really made a commitment to patient-centred care.

We feel like the minister has taken this commitment even further, through Patients First, which outlines a strategy for putting Ontario patients first by improving health care experiences. Specifically, it articulates a commitment to not only providing better and faster

access to quality health services, but also protecting health care services for generations to come.

The quality agenda has been further strengthened recently through the creation of Ontario's first Patient Ombudsman. The creation of the Patient Ombudsman was also a key element of Patients First. Through the recruitment process, which involved public consultation, Christine Elliott has been selected to fill this role for a term of five years. Once in place, the Patient Ombudsman and her office will help meet the needs of current and former patients of hospitals; clients of community care access centres; and long-term-care home residents and their caregivers who have not had their concerns resolved through existing complaints mechanisms.

She'll also be able to investigate a health sector organization on her own initiative, make recommendations to a health sector organization that is the subject of an investigation, and then, of course, report to the minister on her activities and recommendations annually, as well as to local health integration networks as appropriate.

That's the foundation in terms of ECFAA, and part of what we've recently made changes to in terms of ECFAA, related to the Patient Ombudsman.

I do want to talk to you, though, about Health Quality Ontario.

One of the key results of ECFAA was the expanded mandate for Health Quality Ontario, which is the operational name for the Ontario health quality council. Its statutory mandate was expanded under the Excellent Care for All Act on April 11, when several previously provincial-funded programs were consolidated to enable HQO to fulfill its new statutory mandate. It's a crown agency, accountable to the Ministry of Health, whose primary responsibility is to monitor and report to Ontarians on the quality of the province's health system, to encourage continuous quality improvement and to promote health care that is supported by the best available scientific evidence. HQO's legislative mandate is really within those three functions: reporting to the public, supporting quality improvement and making evidence-based funding recommendations to the minister on health care services and medical devices and recommendations to the field on standards of care.

1730

As of recently, through the passage of the Public Sector and MPP Accountability and Transparency Act in 2014, HQO's mandate was further expanded to include the following, yet to be proclaimed, which is patient relations—monitoring and reporting on the performance of health sector organizations with respect to patient relations; the promotion of enhanced patient relations in health sector organizations through the development of patient relation performance indicators and benchmarks for health sector organizations; and providing quality improvement supports and resources for health sector organizations with respect to patient relations. Really, those elements were included to support the Patient Ombudsman, because this will be a key element for her. HQO is also providing support to the Patient Ombudsman in carrying out her functions, so they're providing the back-office supports for the Patient Ombudsman.

HQO is really executing its mandate so that it can deliver a better experience of care, better outcomes for Ontarians and better value for money.

A few examples of some of the great work that HQO is doing that I'd like to highlight for you: They're working with partners to develop a strong culture of continuous quality improvement, for example, through the Improving and Driving Excellence Across Sectors—it's called the IDEAS program, a catchy name. IDEAS is an Ontario-made quality improvement, change management and leadership training program that has been created in Ontario. The IDEAS program brings together the best components of the improvement, knowledge and learning programs from Ontario, Canada and other international jurisdictions, like IHI in the US. It's one cohesive and comprehensive program delivered in a way that is readily accessible to the clinical and administrative workforce from the boardroom to the front line across all sectors, disciplines and institutional levels to yield better quality care for patients.

Since its launch in 2013, over 2,000 learners have participated in this very unique program. These learners have been supported with specialized training and resources on quality improvement, and they implement a quality improvement initiative within their organization, in their local care setting. Over 100 projects have been implemented across these learners since 2013, really focused on system priorities such as quality-based procedures, and many of them have actually been focused on the implementation of health links.

HQO also reports—and you had mentioned this—publicly on health system performance. Transparency, when used appropriately and responsibly, really is one of the greatest tools we have to enhance performance and patient safety. HQO releases a yearly report on how Ontarians' health care system is performing, titled Measuring Up. This report is required under ECFAA and tabled each year in the Legislature.

HQO also reports in an in-depth manner through a series of theme reports that they started in the past few years. HQO has six reports on priority topics, such as caregiver distress, health equity and antipsychotic prescribing. HQO's website also includes a series of sector-based reports and sector-based performance indicators. For example, they have some for long-term care, primary care, home and community care, as well as patient safety.

As a foundation for the reporting activity, HQO uses something called the common quality agenda, all of which is available on their website. The common quality agenda really sets out key performance indicators selected in collaboration with health system partners and patients and aims to focus the system on priority areas for each of the quality improvement activities within sectors. It provides a comprehensive picture of measures across a number of domains, all those domains that I started with when we were initially talking about quality, so access

etc. It includes indicators related to performance of a specific sector, and I'll just give you some examples: for primary care, same-day or next-day access; for hospital care, ED length of stay; for home care, caregiver distress; for mental health, readmission rates; for long-term care, waiting for a bed. It also includes system integration measures, which are also quite important, such as alternate-level-of-care rates in hospitals. The common quality agenda also includes broader categories such as health status, like life expectancy; health workforce, such as the number of health professionals; and health spending, such as expenditure per capita.

In addition to that, HQO also promotes health care that is supported by the best available scientific evidence. Since it was created, HQO has made over 75 recommendations to the minister and system on evidence-based care, delivery and service provision. This work has really taken many forms, including the development of our clinical handbooks that we use for our QBPs, five of which have translated into ministry-funded, quality-based procedures in COPD, in stroke, and in hip and knee surgery, for example.

Dozens more recommendations have been accepted by the minister—and informed funding and service delivery changes, such as changes to the schedule of benefits to reflect best available evidence for a given test or procedure. Key examples include new funding for epilepsy surgery and changes to the OHIP schedule of benefits to reflect appropriate preoperative testing and annual health exams—all very important.

Another critical lever, though, that came out of ECFA—and this one is worth spending some time on—is the development of standardized quality improvement plans. A quality improvement plan is a formal, documented set of quality commitments that a health care organization makes to its patients, clients, residents, staff and community on an annual basis to improve quality through focused targets and actions.

Hospitals were the first sector to complete quality improvement plans, and in fact, they're required under the Excellent Care for All Act to do so. But since then, the ministry has expanded the requirement to include all long-term-care homes, all community care access centres and all interprofessional primary health care teams like community health centres and family health teams, for example.

As of this past April—we are incredibly proud of this—more than 1,000 different organizations—it is truly more than 1,000 organizations—are developing quality improvement plans. They've made them publicly available to patients, families and their communities and they've submitted them to Health Quality Ontario for analysis and ongoing learning.

This covered over 140 hospitals; over 600 long-term care homes; over 280 primary health care groups; and over 14 CCACs. HQO has also supported—and this is more recent, as of this year versus previous years—integrated views of system planning. On April 1 of this year, when the quality improvement plans were submitted, 22 integrated quality improvement plans were submitted to HQO. These were sent from leading organizations that are working across—based on those transitions we were talking about earlier, so, working across together—to plan for integrated, high-quality care in their local system.

So quality improvement plans really are a critical lever for focusing organizations on improving quality and really just one example of how the ministry, HQO and the sectors are really working together to embed the quality culture at the system level.

Mr. John Fraser: Great. How much time, Chair?

The Chair (Ms. Cheri DiNovo): We have about two and half minutes.

Mr. John Fraser: About two and half minutes. Okay. I've got a few more questions than that, but I'll just start. The Patient Ombudsman: When do we anticipate that, and when do we anticipate the measures around patient relations?

Ms. Melissa Farrell: The public commitment that was made when Christine was announced as the Patient Ombudsman in December was that it was this summer, around July.

Mr. John Fraser: That's what I thought. I just wanted to be reminded of that. Around—

Ms. Melissa Farrell: Patient relations reporting?

Mr. John Fraser: Yes. That would be—

Ms. Melissa Farrell: That will be shortly after. You got it.

Mr. John Fraser: The quality improvement plans are institution-specific. So just for my own edification, are they under broad categories where there are certain measures they have to look at? Or do they look at their own institution uniquely and say, "Here are what the expectations are. Here are what the challenges are"?

Ms. Melissa Farrell: HQO provides guidance to organizations in terms of core indicators that they should be considering when it comes to their quality improvement plans. Then each organization has the opportunity to select additional indicators or additional areas of focus.

1740

Dr. Bob Bell: Maybe I can explain. From a big-hospital perspective, this has totally changed the culture of care and really changed the governance of quality in the hospital, in that the management of a hospital consults with its clinical staff as to where the problems are that need to be worked on for the next year and works with the medical advisory committee in developing a program that will look at the appropriate metrics and the projects that will be undertaken. Then they have to bring that for both MAC approval—Medical Advisory Committee—but also for the quality committee of the board and for board approval.

When it was first started, the board was surprised that they were being asked to approve something that came through the Medical Advisory Committee but, with smart governance, very rapidly figured out that if they were going to do this every year, if they asked the same question every year, they would see whether there was

improvement in the metrics being analyzed. So it has really got the board quality committee's—

The Chair (Ms. Cheri DiNovo): I'm afraid that is the time. We are now moving to the official opposition: Mr. Harris?

Mr. Michael Harris: Minister, you brought up the pCPA. I imagine, Ms. McGurn, you'll want to come up here and help fill in for some of the questions that I have.

But you mentioned the pCPA. Some suggest that this is a very bureaucratic organization that has been set up. There's really no transparency, little oversight, and the timelines are not clear whatsoever.

As of April 30, there are 23 negotiations currently under way at the pCPA. Can you explain how this process works? How do you prioritize negotiations within the pCPA?

Hon. Eric Hoskins: I think you're right in your suggestion that Suzanne will shortly be making her way up here.

But I can say that since, or as of—I think it's now well over 100 joint agreements that have been successfully concluded by the pCPA. The savings nationally, including to the province, amount to hundreds of millions of dollars per annum. Being able to negotiate on a national basis, and bringing the federal government in—they announced earlier this year that they would be joining the pCPA, as Quebec did, prior to that, as well—really does give us a degree of leverage and ability to negotiate the best possible prices.

But also, it's much more than just bulk purchasing and the potential for that, the pricing. It's also about a more streamlined process, which Suzanne can speak to, which enables us to make the right decisions in an appropriate fashion and, hopefully, on a national basis, based on science and clinical evidence.

Dr. Bob Bell: Before Suzanne starts, I want to mention that Ontario is proud to host the secretariat for the pan-Canadian Pharmaceutical Alliance. Suzanne has provided tremendous leadership to this.

As somebody who has looked at pharmaceutical pricing for a long time, the negotiations would go much more quickly if pharmaceutical companies were willing to bring their prices to levels that were reflective of what we consider value is, based on advice we receive from organizations like CADTH, that evaluate evidence with respect to cost-effectiveness. The process of negotiations is one that we think is very important for Canadian taxpayers and Canadian patients, to assure that value is being received.

Mr. Michael Harris: I guess my question was, there are 23 negotiations currently under way. How do you prioritize negotiations?

Dr. Bob Bell: Suzanne has got the details—

Mr. Michael Harris: We've got about 19 minutes, and I've got a lot to get out, so I'm going to—

Interjections.

Mr. Michael Harris: Less than 19 minutes. Okay.

Ms. Suzanne McGurn: Suzanne McGurn. I'm the executive officer and ADM for the Ontario public drugs program.

Your question is very timely. I think it's important to recognize that the pCPA is an emerging and a maturing organization. Up until the fall of 2014, this was a voluntary collaborative between the provinces. It wasn't until late in 2014 that there was a commitment by the province to formalize it and move into a more permanent structure, and part of that permanent structure was the establishment of the pCPA office. It's important to recognize that those additional individuals have come on as recently as this fall and earlier this calendar year—

Mr. Michael Harris: What is it—about five staff?

Ms. Suzanne McGurn: Five staff in the office. There's an important context to your question about the current negotiations. Probably if you'd been having this conversation 18 months ago, you would have been commenting about a queue at the organization that does the evidence-based reviews at CADTH. Significant effort was put forward over the last number of months at CADTH to be able to add capacity and move products through their queue, as well. We are now at that bulge, for lack of a better term, moving out of the CADTH organization and into pCPA for active negotiations.

Moving on to how we prioritize, it's not quite as simple as that. The question previously was always that there has been a considered approach of "first in the door, first out." As we've been working collectively together to achieve the pan-Canadian objectives, which were increasing access and increasing consistency while driving down prices, we have determined that there are strategic opportunities for us to do business differently, and we are learning through some of those opportunities right now.

Certainly where we are focusing our time now is that we'll be meeting very imminently with pCPA colleagues to have conversations to talk about how we define that prioritization, how we make sure that not just the manufacturers but also patient groups understand how we make choices.

An example perhaps could be in the hepatitis C space. A product that might have been prioritized a year ago because it was the first product in a space for a disease that was potentially curative would be very different than a product that is now perhaps the third, fourth or fifth product coming into the space; you may want to take a more strategic negotiating opportunity.

We've had our first entries of subsequent-entry biologics or biosimilars. Those products bring significant value to provinces based on the European experience, so our historical approach—first in the door, first out—perhaps doesn't work anymore when we have some of these very value-added products in the system. Again, there are products that are in spaces where there are clinical gaps or there is availability of alternative products for patients, or they may already have alternatives. But we have not yet able to actually articulate in a formal way what those prioritization criteria are.

Mr. Michael Harris: You mentioned the biosimilars. Are they getting preference or prioritization over others?

I guess there have been some concerns that the legacy products on here don't have the ability to renegotiate in the marketplace. I'm curious as to why the government would choose not to sit down and negotiate with some of those folks, be it that there's a loss of substantial rebates back to the government. Do they feel that the biosimilars will likely, on a year-to-year—you know, I guess I'm curious on that.

Hon. Eric Hoskins: If you'll allow me to jump in on biosimilars, as well: I would argue that the brands that—and is it one or is it more than one? I think just one biosimilar has been approved in Ontario.

Mr. Michael Harris: Yes.

Ms. Suzanne McGurn: We have two now, and another is—

Hon. Eric Hoskins: We have two now and another on its way. The brands that have been affected had ample time, I think, to offer a price. For them to wait until a generic was made available at a substantially reduced price and then suggest that they could meet that price suggests to the government and the ministry that the amount that they were asking us for as a brand was excessive.

Mr. Michael Harris: On that note, and it just was coincidental you brought that up on the biosimilars, does the government have an actual plan to take people off of the existing drugs and put them on the biosimilar? Will they be transitioning arbitrarily to that?

1750

Hon. Eric Hoskins: Suzanne will speak to this in detail, but one thing that we believe is extremely important is to review the scientific evidence with regard to biosimilars. There's a great deal of discussion and debate out there in terms of the issue. That being said, we do—

Mr. Michael Harris: Was that a maybe or a no or—

Hon. Eric Hoskins: No. So for the one that—I know Suzanne may be able to talk about the second one as well. For the first biosimilar, which was perhaps the one that got the most attention because it was the first in the province, I know that there were specific indications and conditions that were brought into place and that Suzanne can talk to which address specifically the issue.

Mr. Michael Harris: I was just curious if there are actually plans to actually take folks that are on the non-biosimilar for treatment and move them to the biosimilar arbitrarily.

Hon. Eric Hoskins: No. That, specifically, is not being considered for—

Mr. Michael Harris: All right. Back to the negotiation process, because there has been a lot of concern that pCPA is just another level of bureaucracy—it's a third level, perhaps—and that it's just a black hole that they sit in. We're seeing a significant delay in some of these products going through negotiations and getting final approval. What would you say to that?

Ms. Suzanne McGurn: Thank you very much for the question and to give the opportunity to clarify a couple of your comments. Again, I don't have the statistics in front of me, but the volume of products that is coming through over the last five years is growing. So what might have been a handful of products five years ago, where the industry may have expected an answer within a few weeks to a month of product moving through, there are much more deliberate and strategic conversations about getting greater value from the negotiations. That is a collaborative effort across the country that does require time and effort to be able to be more strategic to get that value out.

Mr. Michael Harris: Does Ontario actually sign agreements, or will they sign agreements with manufacturers outside of the pCPA?

Ms. Suzanne McGurn: When products are brought forward, the first pass is with regard to whether there will be a pCPA negotiation. There are three potential outcomes for that conversation. The rarest is that we will not proceed to negotiate at all. The most common is that we proceed to negotiate as a collective, with often most of the provinces in, but sometimes one or two out. In those circumstances, where someone chooses not to participate in a pCPA negotiation, the principal rule is that you cannot go out and negotiate separately. That is inconsistent.

There are circumstances—and I would give an example. I believe there were new indications for a product, such as Botox, in a particular clinical indication related to bladder circumstances. There were already sufficient numbers of contracts in other provinces that were highly variable that it was determined in that circumstance, if I've recalled my drug correctly—it was determined that in that case, the provinces would negotiate individually based on their previous circumstances. But the vast majority are together, and you are obligated not to proceed with a separate negotiation.

Mr. Michael Harris: So does the pCPA establish criteria in terms of what needs to be met for the patient to access some of these drugs?

Ms. Suzanne McGurn: Again, building on the comments that the minister made, when we receive information that comes through the evidence-based review through CEDAC, the Canadian advisory committee for drugs and health technology, often those reviews do come with very specific information included in them about where the evidence does demonstrate sufficient strength that we should consider funding it. Often it indicates that there are areas where there is lack of evidence.

Additionally, when we are proceeding to negotiations, we do have the value of input of a number of clinicians who work with us, from a variety of ranges of organizations; for example, in Ontario, historically we have used our Committee to Evaluate Drugs as well as individual clinical experts in the field. So when products are brought on, particularly products that are very complex with evidence that is good for some and highly uncertain for others, we do list the funding criteria with very specific clinical criteria.

Mr. Michael Harris: Okay. So we may come back to this another time, because we could go on forever with this.

A couple of things before we leave for the day: Minister, word has it that there may be about eight cardiac centres across the province that had approached the province mid-way through their fiscal year about some of their procedures that they had basically maxed out on. The government had made a commitment then to make them whole, perhaps at the end of the year. The fiscal year ends March 31. They report June 9. Can you tell me if you are aware of any cardiac centres in the province that will in fact run a deficit?

Dr. Bob Bell: The starting point is that most of the cardiac centres' budgets are within general hospital budgets. The only one outside of that is the Ottawa heart institute. So in answer to your question, the Ottawa heart institute, I believe, had a balanced position, as far as we know, for 2015-16, and we're anticipating the same in 2016-17. Other cardiac centres' budgets are consolidated within hospitals.

The usual issue that comes up relates to volume management and volume attributions. For most cardiac procedures, we work on a volume base, do the case, and the funding is provided. We start off with an estimate of what hospitals will be undertaking for that year. We review that estimate at Q2 and in some cases increase the volumes, in some cases decrease the funding because they aren't meeting their volumes. That's the kind of discussion that occurs mid-year.

I'm waiting for Lynn Guerriero to come up here, who manages the Cardiac Care Network on behalf of provincial programs. The Cardiac Care Network is engaged in a fulsome, transparent capacity planning exercise with all hospitals doing cardiac.

Minister, would you like Lynn to comment on that?

Hon. Eric Hoskins: Of course, yes. Sure.

Ms. Lynn Guerriero: Hi. It's Lynn Guerriero. I'm the assistant deputy minister for negotiations and accountability management.

First, I'll just add to what the deputy was saying in that for the most part, cardiac procedures are done out of a hospital's global budget. Where there are specific complex cardiac procedures that perhaps are done at a smaller volume, we do fund those procedures provincially out of the provincial programs branch at the Ministry of Health.

It's fair to say that last year—you're correct—there were some hospitals that struggled with maintaining within their funding envelope with respect to the volumes that they had originally been allocated. We did some reallocations throughout 2015-16. We moved some volumes around. Hospitals that went above their volumes were made whole by the end of the year to compensate them for those procedures.

Mr. Michael Harris: So all of them by March 31? They would have known by now if they had been—

Ms. Lynn Guerriero: Correct.

Mr. Michael Harris: That's all been rectified. Will or do you know, Minister, if any hospitals throughout the province will post a deficit when they report on June 9? I guess they can't, but they will. I'm assuming you'd know by now, right?

Hon. Eric Hoskins: Yes. I think that that's a possibility—

Ms. Lynn Guerriero: Wrong. We don't know.

Hon. Eric Hoskins: We don't. So we don't know whether that is the case or not, but just sort of combining the two pieces that the deputy said about the regular interim review that we do looking at volumes based on their allocated volumes and their actuals to see if we need to step in with additional support, or less if they're doing fewer volumes, plus combined with the comment about how the Cardiac Care Network is currently evaluating every facility where cardiac surgery is undertaken—

The Chair (Ms. Cheri DiNovo): Mr. Harris, you have under two minutes.

Hon. Eric Hoskins: —and doing capacity planning to look at the distribution of volumes and what the requirements are—

Mr. Michael Harris: So the CCN, is it? CCN?

Hon. Eric Hoskins: Yes.

Mr. Michael Harris: Do you have the ability to provide wait-lists for cardiac procedures across the province in the cardiac centres? Those wait-lists would be available—

Hon. Eric Hoskins: They're publicly available.

Mr. Michael Harris: Publicly available, the wait-lists for cardiac procedures?

Ms. Lynn Guerriero: Yes, on the public website with respect to wait times.

Dr. Bob Bell: Surgical wait times are virtually all online, so cardiac surgery wait times—most of them are online except for very rare procedures. The more medical aspect of, for example, cardiac care for congestive heart failure doesn't really have a wait time.

Mr. Michael Harris: ICDs: Would they be posted online?

Dr. Bob Bell: Yes, I believe ICDs are posted.

Mr. Michael Harris: Wait times?

Dr. Bob Bell: Yes.

Mr. Michael Harris: Okay.

Dr. Bob Bell: There are a couple of different indications for intra-cardiac defibrillators. I can't remember if they're posted with each of those indications separately or whether they're a harmonized wait time.

Mr. Michael Harris: Pacemakers etc. are all posted online?

Dr. Bob Bell: I can't remember. Pacemakers?

Ms. Lynn Guerriero: I don't know if they're individually broken out to that level, but the cardiac procedures themselves are posted online.

The Chair (Ms. Cheri DiNovo): I'm afraid that is time.

We stand adjourned until next Tuesday at 9 a.m.

The committee adjourned at 1800.

CONTENTS

Wednesday 1 June 2016