MINUTES

COMMUNITY SERVICES COMMITTEE

REGIONAL MUNICIPALITY OF OTTAWA-CARLETON

CHAMPLAIN ROOM

04 June 1998

1:30 P.M.

PRESENT

Chair: A. Munter

Members: D. Beamish, W. Byrne, C. Doucet, H. Kreling, A. Loney, M. McGoldrick-Larsen

Regrets: L. Davis, D. Holmes

CONFIRMATION OF MINUTES

That the Community Services Committee confirm the Minutes of the Meeting of 21 May 1998.

CARRIED

1. PRESENTATION BY THE NO NAME SENIORS ACTION NETWORK
- A/Co-ordinator, Community Services Committee report dated 19 May 98

Myrtle Borts & Evelyn Shore, No Name Seniors Action Network. Mrs. Borts shared her experience of being admitted to hospital and the possibility of being discharged home alone without assistance. Initially, doctors were unable to admit her because her condition did not meet the provincial criteria for admission. As a result she was kept on a stretcher in hallway of the Emergency Department. Eventually, she was admitted for one day and two hours/day of home care was arranged upon discharge. This was inadequate for her needs and she had to arrange private care at her own expense.

Mrs. Shore, speaking on behalf of seniors in the Ottawa-Carleton region, expressed concern that the health care required, both in hospital and at home, will be available for

seniors when needed. Everyday they hear stories from people who have been discharged from the hospital, without the necessary home care in place, and end up being readmitted to hospital. Their primary concern is the lack of adequately funded community care programs.

Mrs. Shore stated the Community Care Access Centre (CCAC) expects an increased caseload of 17,000 clients during 1998/99. The CCAC submitted a budget of $68.1 million for 1998/99, an increase of 6.3% over 1997/98 operating costs. Its budget has been static at $62.4 million since 1994, but the needs for service increase every year. The CCAC received $3 million to help with operating costs until the budget is approved but there is still a shortfall of $2.7 million to avoid cutbacks in services for the next year. As well, it is unclear whether the $3 million is a permanent increase or a one time gift. Mrs. Shore iterated that the CCAC is a key component of community care, however other community-based services work in conjunction with the CCAC (for example, Meals on Wheels and Home Support Services) providing services that are not under the CCAC's mandate.

The Ottawa-Carleton Health Services Reconfiguration Committee identified $50 million in services required to fill existing gaps in programs and to offset reductions in acute and inpatient care. Voices for Reinvestment's goal is to ensure that dollars cut out of hospital services are put back into other needed health services including home care, long term care and community health services. This group has identified a need for an additional $22 million for expanded services at home to cope with early hospital discharge and reduced admissions into institutions, to provide increased community-based services in the west and east ends of the Region, and to ensure funding for post-natal programs, daycare services, palliative care, community-based rehabilitation, psychogeriatrics and a quick response program.

The No Name Seniors Action Network requests that Regional Council:
1) advocate to the Minister of Health for the immediate investment to support adequate community care; 2) advocate for the support needed for CCAC to be able to fulfill its mandate without cutbacks in home care, and; 3) advocate for the support needed for other organizations that supply health care to the community.

Anne Hubbert.[1] Ms. Hubbert explained that during March, she made six trips to the Emergency Department for treatment of Addison's Disease. Each time she was treated and sent home. There was no discussion of admitting her because of provincial rules. It was a frightening and frustrating situation for herself and her doctors. She felt alone and unsafe at home without support. Gradually, she realized there was no hospital care, other than Emergency, no community care, so she began to treat herself.

[1] A copy of the briefing note is held on file by the Committee Co-ordinator.

Ms. Hubbert stated she believed this was a deliberate move by the government to cut back on health care without providing adequate replacement in the community. She stated she believed the government was doing this deliberately in an effort to shrink the population and save money. She concurred with the previous presenters, in asking the Region to advocate for better health care services.

A motion was put forward by Councillor Loney that the Committee and Regional Council endorse the concerns raised by the No Name Seniors Action Network: 1) that RMOC request that the Minister of Health immediately provide funding to address the community health needs of seniors and disabled persons, and 2) that the CCAC and other community agencies be provided adequate funding to continue their work and to handle the increased workload caused by hospital restructuring.

Councillor McGoldrick-Larsen, in expressing her support for the motion, acknowledged the concern in the community about the lack of responsiveness of the provincial government in providing adequate care in the community with hospital restructuring.

Chair Munter referred to an previous report to Committee that identified the fact that the situation was not being monitored, and therefore the effects of earlier hospital discharge were not well documented. He stated he had heard many similar stories as presented to the Committee today. The hospital restructuring that the Commission was proposing would leave Ottawa-Carleton with the lowest ratio of hospital beds in the province. He agreed that this Region should raise this concern with the provincial government.

Moved by A. Loney

That the Community Services Committee and Regional Council endorse the concerns raised by the No Name Seniors Action Network:

1. That the RMOC request that the Minister of Health immediately provide funding to address the community health care needs of seniors, disabled persons and others. This must be fully in place before more hospital beds are closed, and;

2. That the Community Care Access Centre (CCAC) and other community-based agencies be fully funded to address both current needs and the additional requirements caused by hospital restructuring.

CARRIED

That the Community Services Committee receive this presentation for information.

RECEIVED

REGULAR ITEMS

2. PROPOSED SATELLITE SEXUAL HEALTH CENTRE IN OSGOODE TOWNSHIP
- A/Co-ordinator, Community Services report dated 22 May 1998
- Medical Officer of Health memorandum dated 28 April 1998

Councillor Loney stated his request to have this item on agenda was to receive more information on why the Osgoode site was chosen and what the associated costs were, and not because of a lack of support for the program.

Dr. Cushman explained that the satellite clinics are mobile and responsive to community needs and shifting demographics. This proposal is essentially the relocation of the Woodroffe area clinic which was closed a year ago because the Community Health Centre had increased their services to the adolescent population. A major concern is that the rural areas do not have similar access to health services as the urban and suburban areas. This satellite clinic is one component of a joint venture involving family practitioners, school health nurses and the youth services bureau. He emphasized that in rural communities, access for teens to sexual health services is particularly problematic because teens typically do not like to discuss these issues with family doctors and prefer the anonymity of the sexual health clinics. Data supports having these clinics located locally. Dr. Cushman concluded by stating birth control services are very cost-effective compared to the cost of a teenage pregnancy.

Councillor Loney asked for clarification of why the Osgoode site was chosen over other potential sites. Dr. Cushman responded that the concept of the satellite clinic evolved out of consultation with the public, professionals and the service providers to address a community need. Ms. Manon Morin, Manager of the Healthy Sexuality Branch, added that the school nurse involved with the Osgoode Township had been hearing concern about health services, particularly sexual health services. The clinic in South Carleton High School (Richmond), which shares similar demographics to Osgoode, is one of the

most popular clinics in terms of attendance. Staff are looking for opportunities to expand into other rural areas, for example West Carleton, however the community is not ready yet. Resources were reallocated from the Woodroffe clinic and the base clinic to cover the cost of providing four hours of sexual health consultation per week. The physical location in Osgoode is available free of charge, so there were no additional costs associated with the decision. Ms. Morin confirmed that in addition to the base clinic at 179 Clarence St. which has an extensive draw of clientele from across the Region, there are also satellite clinics in Richmond, Kanata, Vanier, and Orleans.

Councillor Loney reiterated that he would like the following information included in reports to Committee: the current level of service, criteria used to determine new sites, and budget (even if funds are being reallocated).

Moved by A. Loney

That the Community Services Committee receive this report for information.

RECEIVED

RESPONSES TO INQUIRIES/MOTIONS

3. ELDER ABUSE INITIATIVES
- Response to Inquiry No. CSC 08(98)
- Medical Officer of Health report dated 6 May 1998

Barbara Burns, Vice-President, Council on Aging of Ottawa-Carleton.[2] Ms. Burns stated that two years ago, she chaired the Elder Abuse Project at the Council. Generally, she opined there were enough resources, including home support programs, community health centres, seniors centres and the Health Department to deal with elder abuse. However, The Elder Abuse Network recognizes that the resources are not well coordinated. Many agencies deal with elder abuse, but there is a lack of organization in how the cases are handled leading to possible duplication. The lack of organization has also lead to different definitions of elder abuse, particularly the definition of psychological abuse.

Ms. Burns stated the Council on Aging recommends the creation of a short term task force, comprised of service providers currently involved with elder abuse, with the mandate to develop a model for a coordinated approach. With the aging population and the increased responsibility on family members to provide care, the Council predicts there will be an increase in elder abuse.

[2] Supplementary information handed out, and a copy is held on file by the Committee Co-ordinator

Referring to a reference to mandatory reporting in the report, Ms. Burns opined that this was almost an ethical dilemma; that mandatory reporting was based on child care legislation, and if reporting became mandatory for elder abuse, it would enfantize older people. Children have to be cared for, she opined, but older people are autonomous with the right to live at risk if so desired. Also, Ms. Burns explained that mandatory reporting becomes complex as it involves law, supervision and investigation. Experience in the United States suggests it may not be as effective as originally envisioned.

In response to a question from Chair Munter, Ms. Burn acknowledged that in some provinces there is mandatory reporting based on an adult protection model. In Ontario, there is no clear model. She reiterated that elder abuse is a very complex issue. Ms. Burn suggested that the Council on Aging should coordinate the development of the model because it is a neutral third-party. She believes educating seniors is a big part of dealing with the elder abuse issue.

Councillor Doucet stated the problem has been described in the report, however asked Dr. Cushman to discuss the next steps. Dr. Cushman responded that there has been a lot of dialogue about the issue in the past five years. The next steps should be towards increasing awareness, public education, and the identification of abuse cases.

Ms. Burns acknowledged that there were already programs and services dealing with seniors now, and that seniors want to go to where it is familiar (i.e. an agency or program that they have experienced before and trust). Therefore the Council recommends getting these service providers together to develop a co-ordinated approach. She opined that there will need to be more funds available to these agencies to deal with elder abuse. Chair Munter suggest it may be appropriate to put forward a proposal for a Health Grant to develop such a model.

Councillor Loney inquired about the status of the Elder Abuse Directory. Ms. Burns stated it was an outcome of the Elder Abuse Project and published once with funds from the Ontario Trillium Foundation grant. Councillor Loney suggested a proposal be put forward for funds to republish the Directory.

Moved by C. Doucet

That the Community Services Committee receive from the Health Department an annual report which describes the elder care and elder abuse situation in Ottawa-Carleton and the steps being taken to reduce elder abuse and improve elder care.

CARRIED
(dissent D. Beamish)

Moved by C. Doucet

That the Community Services Committee receive this report for information.

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4. PREVENTATIVE MEASURES FOR HEPATITIS C
- Response to Inquiry No. CSC 09(98)
- Associate Medical Officer of Health report dated 24 April 1998

Chair Munter clarified that this report was not about compensation for Hepatitis C victims, but about the public health response to the disease.

Staff Presentation

Dr. Ed Ellis, Associate Medical Officer of Health, explained that the reportability of Hepatitis C became law in Ontario in 1995 and since then 2300 cases have been reported in Ottawa-Carleton. The number of actual cases is unknown. The Canadian Association for the Study of the Liver estimates that 0.5-1% of the population is infected, which when applied to Ottawa-Carleton, estimates between 3750-7500 cases. Dr. Ellis stated that the majority of people infected are asymptotic or mildly fatigued, therefore do not realize they are infected and do not seek medical care or testing. His understanding is that 70-80% of cases will develop chronic infection; 20% will develop cirrhosis of the liver within 20 years; 30% will develop cirrhosis within 30 years; and eventually 5-10% of those infected will develop liver failure or liver cancer after 15 years. People become infectious soon after exposure to the virus and a blood test will turn positive 6-20 weeks after infection.

Dr. Ellis stated the major risk factors are having received a contaminated blood transfusion, sharing of needles through injection drug use, or being from a endemic country. Dr. Ellis acknowledged that it was beyond his expertise to comment on current risk through blood transfusion, but suggest it was probably minimal. He also explained

that the Health Department is part of a national multi-health unit study doing intensive follow-up of reported Hepatitis C cases. The study is scheduled to begin in August 1998 and will provide valuable information regionally and nationally.

Dr. Ellis confirmed for Chair Munter that there may be 1500-5000 residents of Ottawa-Carleton infected with Hepatitis C and unaware of this fact. He stated that similar to HIV, early testing for Hepatitis C is a priority for early treatment and preventing the transmission of the disease. Testing is available through all physician's offices and Health Department clinics including The Site (needle exchange program).

Public Delegations

Dr. Michèle Brill-Edwards, MD, FRCPC.[3] Dr. Brill-Edwards stated she has been involved in advocacy work for blood injury and is aware of the issue Hepatitis C in the Ottawa-Carleton community. As a physician she is concerned about the discounting of Hepatitis C as a supposedly benign disease. She emphasized that Hepatitis C is a serious disease and is an emerging epidemic and public health threat. Hepatitis C is the leading reason for liver transplants in Canada and other countries. The Centre for Disease Control in Atlanta, Georgia estimates that there are approximately 8,000-10,000 deaths/year due to Hepatitis C in the US and those figures are expected to triple over the next decade or so. Adding to the comments by Dr. Ellis on the pathology of the disease, she emphasized that people with the virus may not feel unwell early in the course of the illness, but medical evidence shows that their livers are deteriorating leading to cirrhosis.

Dr. Brill-Edwards opined that the legal liability issue surrounding blood injury-induced Hepatitis C tends to cloud thinking; that there is a vested interest within some levels of government to downplay the seriousness of this disease. She emphasized that the Committee should consider the public health role of municipalities and acknowledge the seriousness of this illness, regardless of any legal implications.

In response to a question by Councillor Byrne, Dr. Brill-Edwards opined that if a working group was established, one of their priorities should be to increase awareness among physicians that this is a disease they should be screening for and monitoring.

Jo-Anne Manser, Ottawa Chapter of the Hepatitis C Society.[4] Referring to the report, Ms. Manser stated that the community is just starting to come to grips with what is an emerging health concern. In Ottawa-Carleton the number of Hepatitis C cases is rising annually.

At the grassroots level, 80-90% of people in contact with the Hepatitis C Society are experiencing symptoms that range from mild to severe. The majority of these people

[3] A copy of briefing note is held on file by the Committee Co-ordinator
[4] A copy of briefing note is held on file by the Committee Co-ordinator

receive no counselling and report that some specialists may deny many symptoms. Primary care physicians have very little education about the care and management of Hepatitis C and there is a real need for education in this area. In Ottawa, there are only a few liver specialists and infectious disease specialists who are treating Hepatitis C.

Ms. Manser expressed hope that the current national focus on Hepatitis C would ultimately help to motivate initiatives needed to develop a province wide strategy. In Ottawa-Carleton, there is an opportunity to provide leadership in how this community responds to Hepatitis C. She opined that based on past experience, such as the HIV/AIDS epidemic, the response to Hepatitis C should be fast tracked.

She proposed that a Hepatitis C working group, comprised of representatives from the Health Department, Hepatitis C Society, AIDS Committee and the Hemophilia Society, can have valuable input and dialogue to help assess the needs of infected individuals, identify resources, issues and gaps in the system that need to be addressed.

Chair Munter observed that there are a lot of parallels between Hepatitis C and HIV, and hoped that the community had learned from the experience with HIV, such as the opposing views taken by the community and the Health Department. He suggested that there were four things that needed to be done: educate physicians (Health Department mandate); promote testing and early detection; prevent the spread of the virus by educating those infected about behaviour modification, and; support those living with Hepatitis C (e.g. counselling, information, and supports they require to remain healthy). He stated his support for close community collaboration and that there are complementary roles for the Health Department and community organizations

A motion was put forward by Councillor Byrne. Speaking to her motion, Councillor Byrne acknowledged the increased awareness of the devastation of the disease. She supported a shift in focus from the compensation issue to education, early detection and early treatment.

Moved by W. Byrne

That the Health Department be directed to work with the Hepatitis C Society, Hemophilia Society, AIDS Committee of Ottawa, OASIS Health Clinic and other interested parties to prepare a report for the Community Services Committee to outline a joint strategy the Department and community partners can develop to address the growing public health issues related to Hepatitis C, in particular detection, and that this report come back to Committee by November 1998.

CARRIED

Moved by W. Byrne

That the Community Services Committee receive this report for information.

RECEIVED

COUNCILLOR'S ITEM

5. SOCIAL HOUSING WORKING GROUP: TERMS OF REFERENCE
- Councillor Alex Munter report dated 26 May 1998

That Community Services Committee and Council approve the Terms of Reference for the Social Housing Working Group, attached.

CARRIED

INFORMATION PREVIOUSLY DISTRIBUTED

1. Deliberations of the Allocations Committee for 1998 Project Grants for Health and Social Services
- Medical Officer of Health & Commissioner, Social Services memorandum dated 14 May 1998.
2. Collaborative Project with the Children's Aid Society
Medical Officer of Health memorandum dated 12 May 1998.

3. Healthy Babies, Health Children - Family Visitor Program Update
- Medical Officer of Health memorandum dated 19 May 1998

Councillor Loney inquired about the status of provincial funding for public health programs and specifically, the likelihood of such funding continuing. Dr. Cushman stated that new innovative programs are currently be funding, but he does not know for how long. Councillor Loney inquired about the consequences for staff working in these programs, should the funding be discontinued, and what steps have been taken to reduce the corporation's liabilities. Ms. Claudette Nadon, Director, Child and Adolescent Division, responded that all the staff positions are based on year-to-year contracts dependent on program funding.

Councillor Loney explained that he raised the issue in a generic fashion, because he believes the Department should be aware of the implications of potential budget cuts for staff. He recommended that new programs should be handled as a contractual agreement for a period of time for which funding is assured. The RMOC and staff are vulnerable if the province discontinues funding.

In response to questions specific to the Family Visitor program, Ms. Nadon explained that the guidelines for the program are very specific and uses one-to-one visits to reach high risk families. She explained that this program is only one component of the whole post-partum program. The public health funded component uses many other population health strategies.

ADJOURNMENT

The meeting adjourned at 3:15 p.m.

NEXT MEETING

25 June 1998 starting at 10:30 a.m.

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CHAIR CO-ORDINATOR