P-3

ISSN 1180-4327

Legislative Assembly
of Ontario

Second Session, 39th Parliament

Assemblée législative
de l'Ontario

Deuxième session, 39e législature

Official Report of Debates (Hansard)

Wednesday 14 April 2010

Journal des débats (Hansard)

Mercredi 14 avril 2010

Standing Committee on Public Accounts

2009 Annual Report,
Auditor General:
Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2009,
Vérificateur général :
Ministère de la Santé
et des Soins de longue durée

Chair: Norman W. Sterling
Clerk: Katch Koch

Président : Norman W. Sterling
Greffier : Katch Koch

Hansard on the Internet

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

Le Journal des débats sur Internet

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

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

Index inquiries

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

Renseignements sur l'index

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

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

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

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 14 April 2010

Mercredi 14 avril 2010

The committee met at 1231 in committee room 1, following a closed session.

2009 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.13, teletriage health services.

The Chair (Mr. Norman W. Sterling): Good afternoon and welcome to the public accounts committee. Today we are dealing with teletriage health services. This hearing results from section 3.13 of the auditor's 2009 annual report, which came out in early December 2009. As you know, the public accounts committee holds a hearing on such matters, and then we will be reporting to the Legislature on our findings and making recommendations, which will be in addition to what the Auditor General's report has put forward and his recommendations.

I'll ask the fairly new deputy minister to make some opening comments and introduce the other people who are with him at the table.

Mr. Saäd Rafi: Thank you very much, Chair. I am pleased to be here, as you note, less than two months in this role. I hope the committee members take that into consideration. I can tell you that I have enough information to make staff very worried.

In all seriousness, before we launch in, I'll introduce the colleagues I have at the table with me. At my immediate right, with the Ministry of Health, is Mary Fleming, our director of the primary health care branch; and on my immediate left is Bruce Woods, who's the president of Sykes Assistance Services. He has two of his team members with him: Gena Horseman, who is the VP of clinical services, and Denis Thibodeau, who is the VP of information technology. Hopefully I got those titles correct.

On behalf of the Ministry of Health and Long-Term Care, I would like to thank the Standing Committee on Public Accounts for the opportunity to present on the Auditor General's report on teletriage health services. I'd also like to thank the Auditor General and his team for what is some thoughtful and very balanced work. I hope that we reciprocated as well with our co-operation. I think the ministry certainly recognizes the importance of providing confidential, timely access to teletriage services that meet the health needs of Ontarians, and also services that are effective and offer the best use of the health care dollars that are available to the province.

The ministry welcomes the recommendations made by the Auditor General, and I'd like to share with you how we're already moving on the recommendations to try to enhance the existing safeguards and processes of the province's teletriage services.

I'll just give you a brief overview of the services and the important role they play within the health system by starting with an update on Telehealth Ontario, then touch on the telephone health advisory service, and, finally, review the Auditor General's recommendations and the ministry's response and next steps in partnership with Sykes Assistance Services in improving and strengthening Ontario's teletriage services.

Telehealth Ontario supports Ontarians using the most appropriate health care services to meet their needs. It provides ready access to confidential and important health information and advice from a registered nurse. It supports consumers in making the best decision to access the kind of care they need when they need it.

Telehealth nurses are available 24 hours a day, seven days a week through a toll-free dedicated number. The services are provided in English and French, with translation support in over 120 different languages. Telehealth nurses help direct callers to appropriate health care options, whether it's self care at home, going to see their family doctor or, in some cases, seeking emergency health services.

Since the program's inception in 2001 to March 31 2009, Telehealth has received more than 8.8 million calls. It has received an average of 2,700 calls per day, and that's based on 2008-09 data. About 50% of those users are repeat callers, from what we know. Callers also have access to medication information services available through the Ontario Pharmacists' Association.

Telehealth also plays a key role in supporting a number of other government initiatives and priorities. Primarily, it is a component of the Ontario Health Plan for an Influenza Pandemic, and it supports the colorectal cancer screening program in screening callers and answering questions about the program, and the provision of fecal occult blood test kits.

Telehealth Ontario also supports Health Care Connect as the primary intake method for getting patients into the

program that helps individuals find a family physician in their area.

1240

I'd like to move now quickly to the telephone health advisory service, or THAS. It's an after-hours telephone triage service that is available to enrolled or registered patients within a primary group practice. It offers access to free health advice and information after hours, on weekends and on statutory holidays.

THAS also offers patients access to an on-call physician. This was designed to support primary care physicians in providing 24-hour access to health care services to their patients. As of April 1, 2009, this service was serving 615 primary care groups, with more than 6,700 physicians and over 8.3 million patients.

The Auditor General makes six recommendations in his report regarding the province's teletriage services. Overall the recommendations focus on the following issues, as you know:

—increasing the use of the service;

—increasing confidentiality measures to better protect private information of callers;

—shortening the time callers wait to speak with a nurse or to be put in touch with an on-call physician;

—ensuring teletriage nurses have optimal experience;

—ensuring that the fees paid to the teletriage service provider are reasonable and comparable with other provinces;

—and, last but not least, expanding the ongoing evaluation of teletriage services.

What have we been doing since the report? I want to assure you that the ministry has been taking steps to address all of the issues raised in the report by the Auditor General, using a range of approaches in which to respond.

In addition to the ongoing public education campaign as part of the health care options advertising—you may have seen some of the commercials on TV and in print—the ministry is measuring the public's awareness and usage of teletriage services. We hope to have those results very soon.

We've also developed a comprehensive survey, which was conducted in March, that captures the awareness and use of teletriage services. It's focused on seniors and especially residents in northern Ontario, in order to better obtain valuable information from the populations noted in the auditor's report.

We're exploring the possible use of an 811 telephone number for teletriage services, as was recommended.

The ministry will review and monitor how long callers are waiting to speak to a nurse and the number who hang up before they are connected to a nurse. The objective is to improve the response time to ensure that all callers' questions are answered in a reasonable amount of time. We've also been working with the service provider to streamline the current call management process, to have requests for phone numbers and addresses of community services potentially handled by non-nursing staff.

As well, the ministry is reviewing ways to ensure that on-call physicians respond to their pages on a timely basis, a key finding of the auditor. We will also review the recommendation to measure wait times for those callers. We're now receiving data from the service provider about the pages that are sent and which of those have gone unanswered. While these are small in actual number, it is important that callers have access to on-call physicians; that's the purpose of the service. This data will be monitored monthly to ensure contract compliance.

The ministry will ensure that requirements set out in its agreement with the service provider are followed regarding the experience and ongoing training of teletriage nurses. We'll also work with the service provider to research and review ways to determine the impact of the advice provided to callers. We've implemented additional reporting requirements that document monthly data on nurse training and a quality assurance program with the co-operation of our service provider. Necessary action will be taken to ensure that all requirements are met. Nurses must also now document when they give advice that deviates from clinical guidelines and explain why.

The ministry has consulted with the Information and Privacy Commissioner, and those discussions continue, regarding the collection of health card numbers for purposes of determining the impact of the advice provided to callers. We're continuing to examine the impact this change would have on the service.

In the area of quality assurance, the ministry has implemented additional reporting requirements that document monthly data on nurse training and quality assurance. We'll act to ensure that the service provider is meeting all these requirements, and we know we have their full co-operation.

The ministry will conduct a formal and external evaluation of teletriage services this fall to measure the overall effectiveness of the program against its identified objectives. This will include independent satisfaction surveys of callers, physicians and emergency department staff as well.

The ministry has also consulted with the Information and Privacy Commissioner regarding regular recording of calls. We have been advised that this practice is allowable as long as callers are advised in advance and are given the opportunity to opt out. The ministry will work with the service provider to ensure that appropriate mechanisms, safeguards and retention processes are in place prior to taking this step. Taping calls will assist with ensuring the quality of advice provided by nurses.

The 2007 procurement process for teletriage services provided assurance that the amount paid for the service is competitive within Ontario. Still, the ministry has consulted with several other provinces about their payment structure, as identified by the auditor, and the provinces were only willing to share a high level of information—we did get some information from them, but not to the level of detail that we hoped for and had expected.

Generally we found that the prices vary based on standards and types of services offered. Only one other province, if I'm not mistaken, offers an almost identical service that is also provided by Sykes Assistance Services. We're currently exploring different ways to streamline the current services, with the goal of making them more cost-effective. I would note that where the other provinces provide telehealth services, they're provided in-house. The preliminary cost information we have is—what we corroborated from what the auditor found from his calls—that we don't believe those costs are fully loaded costs, because they're services that are provided through their allocation from government.

In the area of the importance of teletriage services, we believe that they obviously are an important component in maintaining a health system that is focused on providing access to patients—from an experienced nurse who can serve to allay the concerns of an anxious new mother, for example, and save her and the system an unnecessary emergency room visit.

In closing, we'll continue to work hard to maintain the quality, efficiency and integrity of the province's teletriage services.

We'd be happy to answer your questions in the time we have, or provide Mr. Woods an opportunity for remarks.

The Chair (Mr. Norman W. Sterling): Thank you very much, Deputy. Mr. Bruce Woods, president of Sykes, has asked to say a few words to the committee, and he has provided us with his opening remarks as well. I might point out to committee members that Mr. Woods and the Ministry of Health have provided an update as to how they're meeting the recommendations of the Auditor General, and those reports are with you as well.

Mr. Woods.

Mr. Bruce Woods: I just have a few brief comments to tell you a little bit about who we are and what we do.

First, a few introductions: I'm Bruce Woods. I'm the president of Sykes Assistance Services Corp. Unlike my neighbour Saäd, I've been there for a long time. I've been there since 1987, 23 years. Since about 1995, I've been the president. Just to give you a little colour on my background, prior to joining this firm, I was in corporate banking with the Bank of Montreal, and prior to that I was a bean-counter with Price Waterhouse. In terms of academics, I did my master's in business at the University of Western Ontario, my bachelor of sciences just across the street here, and 30 years later I'm working on a master's degree in public health. That's just a little bit about this character.

On my far left is Mr. Denis Thibodeau, a big Habs fan. He's a business school graduate. He has been with us for about 17 years. Denis is responsible for all our IT and one of the most contentious areas of our business, the workforce management. He's the individual charged with the responsibility to make sure we have the right number of people in the seats, at the right time, to meet service levels. If there are any questions later as it relates to IT and workforce management, Denis will be the guy that can help us with telephony and routing and whatnot.

On my immediate left is Gena Horseman. Gena is a registered nurse. She has been with us for about nine years. She has come up through the ranks. If there are any questions as it relates to nurse recruitment, retention, and quality of health advice, Gena will be happy to help us out.

Briefly, because we are a private-labeled service provider, the name Sykes isn't on the tip of everybody's tongue. We provide private-labeled services to a number of corporations.

I just want to give you a little colour in terms of who we are. Our head office is located in London, Ontario. We currently have about 1,100 employees in Ontario and New Brunswick. That's not including the ICT acquisition. Of that 1,100 employees we have, about 470 are dedicated to supporting the health-related programs. Of that 470, 300 are registered nurses, so we are a large employer of registered nurses.

1250

Overall, as a company, in 2009, we handled about five million calls across all our lines of business; of that five million, Telehealth represented about 20%—900,000 or a million calls. We currently have about 40 corporate clients that we service. Some of those clients are in relation to smoking cessation counselling. There's the telehealth business for Ontario, New Brunswick, Northwest Territories and Department of National Defence. We provide roadside assistance on 52% of all cars sold in Canada today. So if you've ever broken down, you might have called us and we helped you out, depending on what kind of car you drive. We have lawyers on the phones; we service Legal Aid Ontario—that's who our contract is with there. So in that case, if you are stopped by an officer and you needed help, then the officer would call us and we can dispense our lawyers' assistance to you to give you some advice; and outsourcing. That's a little bit of background overall.

Years ago, the team established our mission, our foundation, and it's simply this: Helping people make health decisions. Everybody comes to work every day and that's what our mandate is. The job of those of us who are in the overhead departments is to support the nurses, to get the systems, the information and the support they need to provide this service 24 hours a day, seven days a week.

With respect to what would be our biggest challenges in terms of running the business, in terms of employee satisfaction results, which we measure every year—in Ontario, for example, last year, 90% of the nurses said that overall they were very happy with Sykes as a place to work; so that's good news. However, I'm sure everybody in this room is aware of the nursing shortage and the alternative jobs that are available for nurses. This is somewhat of a non-traditional form of nursing, taking into consideration that the demand on the business is primarily on evenings and weekends, when most of us would probably just as soon be at home with our families. That's the challenge in terms of retaining the nurse workforce, and one of the biggest challenges in

terms of the business: scheduling, recruitment, retention, for those reasons.

As an organization, we were presented with an award this year by the city of London and the London Economic Development Corp. for industry leadership, innovation, economic growth and sustainability in contribution to the community.

On a personal note, I've had the good fortune of being part of this 10-year evolution of Telehealth Ontario since 1999, when they cut the blue ribbon up there in North Bay. At that time, it was a pilot known as Direct Health. The pilot was positive, and then the program expanded into the GTA, and eventually expanded to the entire province. I've had 10 years' experience in what's been a great opportunity to service the Ontario public. In that regard, I would sincerely like to thank the Ministry of Health for entrusting Sykes with this wonderful opportunity to serve the Ontario public, and acknowledge the Ministry of Health for doing a fine job in managing this program. All I can say is, relative to all the other programs, this is the most complex program that we have. Mary and Saäd have just done a great job managing that program.

We look forward to working with the ministry to see to it that your recommendations are put forth. Speaking of that, I would also like to take this opportunity to acknowledge the Auditor General, specifically Susan Klein. It was about a year ago at this time when we met and, quite frankly, I didn't think Susan knew much about the call centre business. I think that night I emailed a couple of articles about what every senior manager should know about call centre management, because we truly wanted to leverage this opportunity to do better. We wanted to co-operate with the auditor and, over the course of a year, they just did a great job in identifying issues. I just want to acknowledge a job well done. Thank you, Susan.

We've outlined our response to the concerns raised by the Auditor General in our response tables and, quite frankly, subject to the approval of the ministry—because I can't go off half-cocked doing something without the approval of the ministry—I don't foresee any roadblocks in trying to get some of these issues resolved.

I'd like to thank you very much for this discussion today, and I'm looking forward to talking about stuff that I'm so proud of doing for the past 10 years.

I'll turn it over to whoever needs to—

The Chair (Mr. Norman W. Sterling): Thank you very much. Ms. Sandals.

Mrs. Liz Sandals: Thank you very much for both of your presentations. I didn't actually realize that teleconnect was part of the services, and I just note that we've had quite a good response to teleconnect in my constituency office. That seems to be a service that has really been appreciated.

I wanted to focus on the telephone health advisory service side of things, the one where you're working with the primary care providers. These may be more questions for the deputy, I suspect.

One of the concerns that I've sort of identified in my constituency office is that people who are on the roster of family health teams or other sorts of primary care arrangements don't always seem to know about the opportunities that are attached to that family health team for getting service out of hours. For example, we often see people who might be able to go to the family health team walk-in on Saturday or Sunday going to emerg and not being aware that their own docs have a walk-in that they can go to instead. When I looked at the auditor's report, he talked about the low number of calls from people who are part of some sort of primary care service, the failure of the docs to always pick up the pages and, if they do pick up the page, to respond promptly. Those rang true with me because of the experience I see with this business of not using the out-of-hours walk-in that comes with it as effectively as they might.

I guess my question, Deputy, is what requirements do we currently have for family health teams and other primary care providers to provide to the people who are rostered to them information about out-of-hours services? What requirements are there now? And if we don't have requirements, should we, in fact, be stepping up the requirements for family health teams to actually be providing information about these other services? If people don't know about the service, they're not going to use it. In this case, because it's a doctor-specific or group-specific service, it would seem that it should really be the group that's advertising the service to the members of the group.

Mr. Saäd Rafi: I'll break down your question. What are we doing on marketing the availability of this to patients within the primary care group? There are several types of primary care groups in the province. You mentioned one significant one, family health teams. Secondly, what are we doing with respect to the responses where there are weak responses or pages not responded to? What are we doing about that?

Starting with how we're getting the information out, a couple of things: One, the survey we're conducting will help to find out what people's cognition or knowledge of the THAS really is. I think the indicator already is that there aren't that many calls, so knowledge is low. That will give us a better ability to determine what the best marketing methodologies are. We do provide various types of information, whether it's wallet cards, brochures, posters, in primary care groups. Physicians' offices have information and brochures to give out to individuals. Knowledge of the program is an area that we need to work on; there's no question about that. We want to get better information before we go off and spend money on marketing materials that have very little impact or very little effect.

With respect to what we are doing about the variable responses, first off, there's a tripartite contractual arrangement: the ministry, the primary care group, physicians in the group—there could be three; there could be tens of them, depending on where they are—and the OMA, the Ontario Medical Association. We've con-

tacted the OMA, and we're working to see how we can use the OMA to better sensitize their members to understand that they should be telling their patients: "Look, this is a service available to you. Please use this service." It's perhaps the first line of response instead of pitching up at the emergency department.

1300

In addition to that, we're now getting monthly information on which care groups are not or have not returned pages. We found a very small number that actually didn't return a page at all. We can target that, and the auditor's work helped to unearth that information. Now we've got an arrangement where that information is going to come to us on a monthly basis, and you can start to have those conversations, as well as to determine what that primary care group of physicians is doing with respect to who's on call, who's chosen and what their responsibilities are. Again, I go back to that contractual responsibility. Then, we'll continue to work with the OMA. Maybe there are other penalties, and I think the auditor identified both penalty and incentive, because the majority of pages are responded to. Sykes' practices are to call on two bases within 30 minutes as opposed to just one. There are some good prompts available, and I think we're getting that information now, and we will definitely act upon it.

Mrs. Liz Sandals: What about actually actively making the family health teams or other primary care response people responsible for notifying—I mean, I happen to be rostered to a family health team. I think, when I was first being set up and signing the contract, that I probably got a letter from the person who was my family doc anyway and joining the FHT sort of saying, "Here's a bunch of services that are available." You could imagine that, with the amount of paper that I get, that particular piece of paper disappeared years ago. So it would be helpful to get an annual flyer that says, "Here's the current number; here are the current hours; here's the current place." Do we have any requirement that they actually do that regularly?

Ms. Mary Fleming: Not regularly, but their contractual obligation includes the obligation to let the patients know about the service, as well as their extended hours service that you referred to.

There already is a financial disincentive to not notifying patients about the extended hours, but I think one of the things that we'll be working on, as a result of the audit, is making sure that they're being enthusiastic about letting patients know about THAS, the telephone health advisory service.

Mr. Saäd Rafi: In addition, I would think that the survey will also help us to determine what the best mode of information is. As you say, with 14 things available to you in a letter, if that's one bullet point, it can easily get lost. We have other marketing opportunities that will be available to us. I think, more fundamentally, given the call volume, it's examining how many on-call physicians we need, and are there other methods? We'll be working with Sykes on determining what the best way of providing that service will be into the future.

Mrs. Liz Sandals: Okay. My colleague has a question, too, I believe.

Mr. Yasir Naqvi: Deputy, my question is about the 811 phone number and the status. A couple of years ago, I think it was, the 211 service was introduced on the social services side of the area throughout the province of Ontario. I've seen some data in the last couple of years that it has been extremely successful in terms of the intake and the calls that they've been receiving and the population in general using that service. In Ottawa, in particular, especially as it's a bilingual service, there has been some incredible intake. In fact, I think it's a multilingual service. Can you shed some light on the 811 status? We know British Columbia and Quebec have adopted this number, and they've moved forward with implementing it. What's the status in Ontario, and how far are we in getting that number running?

Mr. Saäd Rafi: I would say that it was not on our radar screen until the auditor identified it, for a couple of reasons, though. Telehealth Ontario has been in place for over 10 years. It has a 1-800 number. I think the sensitization and knowledge of that service is better, obviously, than the THAS service, which is much newer, I think—six years, just. So we have to take a hard look at the deployment of 811.

As you point out, there was an uptick in call volume, I think, in Quebec that the Auditor General identified. I'm not sure about BC offhand. That isn't reason not to pursue it. We are pursuing whether we can, and when we should, adopt the change.

We do want to get through this survey to determine whether use of an 811 number will actually be easier for individuals in Ontario and whether they'll feel that, "Okay, it's an easier thing to remember. I don't have to actually find where I put that"—you know, the fridge magnet ideas and all those other good things. We are really just in the throes of investigating that, and we want to rely on the survey results. It's a very deliberate set of questions.

Just to close off, I would point out that we're also trying to do a better job of improving the service when the people do find the Telehealth number, by cycling calls to non-nursing staff, if they're just information-related; by perhaps having demographic information collected by non-nursing staff—you know, just from a business-process redesign point of view, and we're working with our colleagues at the service provider on that.

Mr. Yasir Naqvi: Thank you, Deputy. Just one follow-up question: You talked about doing a survey to determine the feasibility of an 811 number. Do you have a timeline in terms of the process you're following?

Ms. Mary Fleming: The survey results should be available in the middle of April.

Mr. Yasir Naqvi: Okay. So this is more imminent than—

Mr. Saäd Rafi: Yes. It's distinct from the evaluation, which we'll do in the fall. The survey will be used, amongst other things, to determine people's willingness

or their propensity to prefer an 811 approach. Without prejudging that, I suspect we'll see some interesting and positive responses.

Mr. Yasir Naqvi: Thank you.

The Chair (Mr. Norman W. Sterling): Could I just ask, is there any technical problem with using 811?

Mr. Saäd Rafi: Not that I'm aware of.

The Chair (Mr. Norman W. Sterling): Okay. Mr. Ouellette.

Mr. Jerry J. Ouellette: Thank you very much for your presentation. Quite frankly, Mr. Woods, I was surprised that you would come with a presentation in the fashion that you have. Was it designed to agitate certain members of the committee to the point where I don't know if it can be repaired? How can you mention that the vice-president of technology and workforce is such an ardent Habs fan when our Chair is a Sens supporter to no end?

Interjection.

Mr. Jerry J. Ouellette: Good point.

There are a number of questions that I have—

The Chair (Mr. Norman W. Sterling): I'd just interject that in the area I represent, there is one pub that had, out in front of their place, "Free beer for all Leafs playoff games."

Mr. Jerry J. Ouellette: You started that, Mr. Woods, right down that path, didn't you? See what I mean? We'll never hear the end of it.

There are a number of questions I have. I don't know if anybody has seen, or if the members of the committee have seen, the Sony presentation at their recent AGM—last year, I believe it was—whereby the technology is changing so fast that the Internet is the way to go, essentially. The number of hits on Google, YouTube, or Facebook etc. is dramatically changing what's happening in society.

I'm wondering if using a phone service as opposed to incorporating an Internet system—whether it would be the deputy who would answer—would be a way to advance it so that our current usage of this form of providing a service for the people in Ontario would be more advantageous, as opposed to a phone. Something on the Internet may attract those individuals who are not being attracted. Have you looked at that, and any thoughts about that?

Mr. Bruce Woods: Just a comment on that, in the sense of, say, the 10-year horizon I've been there: There is a general transition in this industry from what has been traditionally been known as a call centre, which implies voice, to a contact centre. A contact centre introduces a number of these multimedia devices—Web chat, email, self-service, those sorts of things.

In the auditor's observations, I noticed that there was some reference to the fact that the youngsters don't tend to use the service. However, I think everybody in this room who's got kids—and looking at everybody in this room on their BlackBerrys—texting and all that kind of stuff is appealing to kids. So I would acknowledge your point, in the sense of familiarization and utilization.

1310

However, having said all that, as I will defer to the minister every time on this sort of thing when it comes to the protocols and the guidelines and the safety, our experience has been—for example, with smoking cessation: Running a smoking cessation program like a call centre is not a good thing because there's no trust. If every time you're calling in and you're talking to Bruce one time and then Saäd the next time and Gena the next time, there's no foundation of trust in that relationship. So we have to do it through a callback process. If you're going to get somebody to change their behaviour, it's critical that they trust you. I'm sure you'd be the same, right? If you're talking to somebody and you're trying to change their behaviour, you need to develop levels of trust. So for certain things, sure, that may be very helpful—the young people are into Facebook and all that kind of stuff—but when it comes to the guidelines and the protocols and patient safety, that's another thing.

Mr. Jerry J. Ouellette: We're seeing a lot of information as it pertains to target groups that have underutilized the service, or what I would perceive as underutilizing your service. When I look at what's happening in other jurisdictions and see those numbers, I'm wondering if there is some way that we may be able to reach out to them. With a changing society—and that's why I refer to the Sony presentation—the growth in those areas, as compared to telephone and television as a form of media communication, far outweighs, a hundredfold, what's taking place, and we may need to look to the future to be able to maximize the benefit from that.

Mr Bruce Woods: Just to finish off our example on that note, the same people, Schmitt-Thompson, are the doctors behind the guidelines within the decision support software. The ministry goes to great lengths to make sure that the decision support software we utilize is effective and appropriate and dispensing appropriate health information. I'm only raising that because the nurses rely on that to a large degree. However, those same guys—if you go to symptommd.com, you can self-triage yourself. I'm not suggesting that's what we want to be doing; I'm just saying I agree with your observation and if we want to kind of front-end some stuff, you might want to entertain that.

Mr. Saäd Rafi: I would tend to agree. I think we're interested in a multi-channel approach.

The ministry is trying to use—Ms. Sandals's reference to teleconnect, Health Care Connect, to try to attach individuals to physicians. We've just launched a fairly robust website in that regard. We also use our website for information, and we'll put that into the phone channel as well.

I think the piece that Mr. Woods was alluding to, as well, is there's a really important feature of the judgment of the registered nurse that we think really benefits the call-in feature.

So it's not to suggest we're not looking at other channels; we most certainly are. I take your point.

Mr. Jerry J. Ouellette: To follow up on that, the communication I see to the doctors, when they follow through the process, is via pager. As was brought up earlier on about the use of BlackBerrys and more direct communication and the delay in times and responses with the paging system, has that been reviewed, in trying to improve that system so we can get direct connect with the doctors and the service?

Ms. Mary Fleming: Repeated attempts to convince the Information And Privacy Commissioner on the use of BlackBerrys for sensitive patient information have been rejected, but we continue to touch base with them about ways that communication can be improved to permit that, and then also to improve response times.

Mr. Saäd Rafi: I think you're also identifying the actual contact to alert the physician as well, not necessarily the provision of sensitive health information, and I think it's something we should think about and how that works. Of course, RIM is a great Ontario company. We'd have to also determine amongst all the physicians, if everybody is using the same technology, whether they have a push or a pull in terms of the email approach or texting and so on. So 6,700 physicians—it will take some time to think about that, but I think it's an interesting suggestion for sure.

Mr. Jerry J. Ouellette: On a bit of a different line of questioning, Deputy: When you look at the out-of-province costs for health care, does this allow for individuals—for example, if this committee happened to be in Quebec, say, in August and somebody had a health care question, would there be the opportunity to call out of province to this service, as opposed to possibly diverting some of the out-of-province costs? Is that available at this particular time?

Mr. Saäd Rafi: I'm not sure I understood the question. Are you saying that—

Mr. Jerry J. Ouellette: We have a lot of snowbirds head to Florida, they get sick, they see a doctor down there, they submit their bills here, they get a percentage paid back. Is there the opportunity to check in with Telehealth to make sure that it may be a necessary aspect of health care?

Ms. Mary Fleming: The service isn't available from outside the province, and I don't know if you'd like Denis to expand on that—

Mr. Bruce Woods: Denis can explain to you the challenges in terms of managing calls coming in from out of the province.

Mr. Jerry J. Ouellette: A Habs fan.

Mr. Denis Thibodeau: First of all, let me apologize for being a Habs fan, I guess.

Mr. Yasir Naqvi: Now it's in Hansard forever.

Mr. Denis Thibodeau: Can I change my answer, then?

The toll-free numbers that exist for Telehealth Ontario and THAS are only accessible from an Ontario number, the way the routing exists. So if you are a snowbird and you are out of province or out of country and you're calling with an Ontario number, you will get access. Currently, that's the only way to get into the service. So expanding it—again, that's something we'd have to work on with the ministry to entertain how we would go about, as soon as we open the channel, allowing callers from outside the covered area.

Mr. Jerry J. Ouellette: Just a follow-up question, then—I know Mr. Shurman has a follow-up question on this as well. Go ahead.

Mr. Peter Shurman: From a technological perspective, this whole thing that my colleague is asking about is doable. For example, if you decided to go, as in some other jurisdictions, with an 811 dial-up that would be accessible only inside Ontario and, say, with the reissuance of OHIP cards, a 1-800 number that would be listed on the back of the card saying, "If out of province, dial this number," that would take care of the whole thing. So it's just a matter of reworking this.

It seems to me, in reading the briefing material that we've been given, that there are a lot of things that could be done by the ministry and by the call centre alike that would enhance this service, simply by taking advantage of some of the technological changes that have become available.

Mr. Saäd Rafi: Yes. I would just add, if I might, that, as you know, we are, based on the Auditor General's recommendations, looking at the need to identify a health number when calling in. So if that's an Information and Privacy Commissioner agreement, then—actually, it may not even need a technology fix on the back of the card. But your examples are good ones and they will go into the mix of things that we'll be talking to Dr. Cavoukian about to perhaps deploy the health number as a way of addressing the points you raise.

Mr. Peter Shurman: What about the 811 idea? This opens up, not just technologically, but generally, a whole area of interest for this entire committee, and that is, there is no secret to anybody who lives in Ontario or anywhere else in Canada that health costs are just going up and up and up and there seems to be no end in sight. That being the case, it strikes me that this service could be of incredible potential if it were widely publicized and if there were a trust built between the population of potential users and the ministry. But that doesn't seem to be happening, if we compare this to other jurisdictions where percentage use is higher, where hang-ups are lower and, frankly, where costs are lower as well. I don't know what the statistics might be, Deputy Minister, but maybe we're talking about hundreds of millions of dollars in saved emergency room visits, something like that, that you could quantify.

The Chair (Mr. Norman W. Sterling): I'm just going to interrupt here. Unfortunately, Mr. Shurman, because you were in another committee, you weren't here, and Mr. Naqvi raised that and there is an answer in Hansard that you can read. The idea of saving money, though, was not raised at that point in time and maybe you want to comment on that specific part of Mr. Shurman's question, as to whether or not there are identifiable savings if this service is used on a wider basis.

Mr. Saäd Rafi: I won't speculate on the potential for savings because it would be just purely that—a speculation. But there is no doubt that one of the purposes behind having Telehealth or the THAS service is to determine whether an individual calling should actually present at an emergency department versus other, very reliable and effective methods of dealing with their health care issue at the time.

1320

So we are pursuing 811, and we do feel that the experience that Telehealth has provided us over the last 10 years or so has represented significant cost avoidance in the range of approximately $130 million over that period of time. It's a very conservative estimate. We need to continue to enhance the service in order to make sure that we can be quite accurate in identifying those savings. It will, of course, depend on the increased take-up as to how much more savings we can undertake and, also, our ability to really determine whether someone has effectively adhered to the advice they've been given. But we're exploring the 811 recommendation that was made, and we're in the throes of doing so right now, as the Chair points out.

Mr. Peter Shurman: At the risk of, again, going over ground that maybe you've covered in the last half hour, what are you thinking—by that I mean, what are you thinking in the ministry—about the underutilization of the service, generally? Because it is underutilized compared to other jurisdictions.

Mr. Saäd Rafi: Underutilized in certain segments is what I thought the finding identified for us. That's why we're in the field now with a survey to determine what would increase the use of Telehealth Ontario and the THAS service. That will help to respond to some of those interests of other Ontarians. Perhaps one of the conclusions will be that a more easily recognizable number—811—is the answer, and certainly we will respond to that survey information because that will be a better indicator of what marketing tools and what changes should be undertaken.

Mr. Jerry J. Ouellette: Just to follow up then on the—go ahead, Mr. Woods.

Mr. Bruce Woods: I was just going to address a couple of your points there with the 811 and the comment about out of province. The auditor has suggested the OHIP numbers—at the risk of bringing in the concept of roadside assistance, when somebody calls us for roadside assistance, we simply ask them for their VIN and then we deliver the service. In both those cases, if we were able to, subject to privacy, get people to give us their OHIP numbers then, first of all, it doesn't really matter where they are. Okay? You've got an OHIP number, you're authorized. Secondly, the challenge that we have—between the pair of us, if somebody calls in and we direct them not to go to emergency, but then they do go to emergency, we don't know that. If we could merge the files from the ministry and ourselves, then we could determine to what degree the patient was compliant with the recommendations. I think you could see the savings much easier than we are today. I'm just making a comment that, again, subject to the privacy thing, I think the use of some sort of identifier would be helpful to address some of the suggestions you make.

Mr. Jerry J. Ouellette: I just have one follow-up question regarding the out-of-province aspect. If somebody has a cellphone that they utilize out of province, and that has a provincial number, would it be applicable, then, for Telehealth—essentially, those individuals who are on vacation and who would be able to use their cellphone in order to access that service.

Mr. Bruce Woods: I think you brought that up, didn't you, Susan, in your report? I mean, there was a concern that maybe we were servicing people we shouldn't have been servicing. Was that the issue? Or was it just that people—

Mr. Jim McCarter: If you have a cellphone with a 416 area code, would you be able to get in from out of province? I think you would.

The Chair (Mr. Norman W. Sterling): The only trouble is you're paying roaming fees of maybe two bucks, and if you wait for 30 minutes that's—

Mr. Jim McCarter: Use the callback option, Mr. Chairman.

Mr. Jerry J. Ouellette: I have some further questions about the prioritizing of calls and the ability to prioritize. Is there some method where there's an assessment made at the start to prioritize a call, or what could be perceived as a priority? And there may be many factors that come into play. For example, in my colleague from Nickel Belt's riding, if somebody in Foleyet, which is a considerable distance away from a hospital—it would be an hour and a half to a local hospital—made a call, is there some priority that's allocated to it by jurisdiction or by response, as things unfold?

Ms. Gena Horseman: The priority call would be classified by priority symptom.

Mr. Jerry J. Ouellette: Simply symptom?

Ms. Gena Horseman: Yes.

Mr. Jerry J. Ouellette: Okay. That's initially done by the first person who receives the call?

Mr. Bruce Woods: Can you walk them through, just so everybody knows, when you call in? Explain to them what the PAR does.

Ms. Gena Horseman: Well, if all nurses are currently on the phone taking calls, then the PAR, or patient assistant representative, would get that call. At that point in time, the PAR would ask the reason for the call. There is a guideline that they would follow as far as priority symptoms listed, and if they present with any one of those symptoms, then they would deem that call a priority call.

Mr. Jerry J. Ouellette: That follows up on another question. You've listed, Mr. Woods, the number of nurses: 300 of them are registered nurses. How many would be on call at any one particular time?

Mr. Bruce Woods: On, say, like a Wednesday evening between 8 o'clock and 9 o'clock?

Mr. Jerry J. Ouellette: Sure.

Mr. Bruce Woods: Denis, can you give me a rough idea?

Mr. Denis Thibodeau: I'd go in the neighbourhood of approximately 50, but I'd have to go and confirm that number. I don't remember off the top of my head.

Mr. Jerry J. Ouellette: So there'd only be 50 on out of the 300?

Mr. Denis Thibodeau: Fifty or more.

Mr. Jerry J. Ouellette: More.

Ms. Gena Horseman: In a busy season, we could have up to 75 or 80 nurses on at any given point.

Mr. Jerry J. Ouellette: Okay. That leads to another question. I recall that there was a non-government study done in the Hamilton area that indicated that 60% of all emergency room cases were non-emergencies, however, cases of convenience. Are you doing tracking of times of day when the majority of calls come in, and staffing is related to the peak periods?

Mr. Bruce Woods: Absolutely.

Mr. Jerry J. Ouellette: You mentioned the one regarding flu. But also, Sunday evening is a very convenient time for a lot of aspects like that that people would utilize; for example, emergency room services. Are you finding the same sort of aspect in the service provider?

Mr. Bruce Woods: I want to make sure I understand your comment. As a call centre, we are very thorough in terms of measuring the volume of calls at every half hour and hourly interval. The majority of the calls come in during the evenings and the weekends. That's when most of a lot of these other alternatives people have to go to aren't there, so that's why we're getting that big demand.

Mr. Jerry J. Ouellette: And your staffing would reflect that, then?

Mr. Bruce Woods: Right. When you're running a call centre—I just want to kind of give you an analogy. The idea is that we want to have the right number of people in the seats at the right time to meet service levels. It's a queue; now, it's an invisible queue. But when I'm training people on the fundamentals of incoming call centre management, if I can just diverge for a minute, my best analogy is if you picture a bank branch. You're the manager of that branch, you're looking out at the branch, and there are two extremes that you don't want to have happen. One extreme is that a bunch of tellers are standing there, and there are no customers; then your productivity is very poor. The other nightmare is you've got a whole bunch of customers standing there and two tellers. Those are the two extremes. When you're running a call centre, you want to try to have just the right number of people in the seats at the right time.

Service level is inversely proportional to productivity. In fact, 10 years ago, when the minister was looking at this, there was talk of having—I have to be careful. I can't remember exactly, but I remember the ministry asked me of my opinion on their service level. They were trying to have a 90% service level, in 20 seconds, answered by a nurse. I said, "It's going to cost you a fortune," because when you have a really high service level, by default, some of the staff are going to be sitting there just waiting for the call to come in. On the other hand, if you have a really low service level, you're going to have burnout, and you don't want that either. So there is a trade-off, when it comes to service levels, between productivity, cost and money.

Mr. Jerry J. Ouellette: Are there options for contractual arrangements that would be on a fee-for-call service by, in this particular case, nurses? For example, in my riding of Oshawa, when the nurses who work full time, say, at Lakeridge Health would finish their shift, they would come in, check in, and say, "Okay, I'm available for the next two hours; plug me into your system." For any calls that are directed to that individual, they would receive remuneration for the call? Or is that something that can be looked at through contractual agreements?

Mr. Bruce Woods: Well, I guess I'll say that anything is possible, but if I was to try—

Mr. Jerry J. Ouellette: You haven't thought of it, though? It's not something that's considered?

Mr. Bruce Woods: As I've mentioned, we want to be very, very competitive when it comes to looking after the nurses. I think I asked somebody the other day: When I look at the loaded cost for a nurse, it's about $75,000. To be competitive—so if I was to say to them, "Well, listen, would you mind popping in here on Sunday morning and taking a few calls, and I'll pay you by the call?" I'm not sure I would get much reaction to that, if that's what you're saying.

1330

Mr. Jerry J. Ouellette: Okay. How much time do we have remaining?

The Chair (Mr. Norman W. Sterling): I think you're over your time right now.

Mr. Jerry J. Ouellette: Okay. Thank you very much.

The Chair (Mr. Norman W. Sterling): Ms. Gélinas.

M^me^ France Gélinas: I want to apologize for being late. Both Mr. Shurman and I were at another meeting. I snuck out earlier than he did.

I missed your presentation, but I tried to read it quickly. I was impressed with the 90% of nurses indicating that they were very satisfied with Sykes as a place of work. Are you at liberty to share with us what your turnover rate of employees is in the nursing profession?

Mr. Bruce Woods: Sure. I don't know it off the top of my head. Do you know? About 50%?

Ms. Gena Horseman: It's 48% over a rolling 12 months.

M^me^ France Gélinas: So 48% per year.

Mr. Bruce Woods: The context of my opening comments was that despite the fact that they're pretty satisfied, because of the pattern of the demand for the business—a lot of these nurses, I would hazard to guess, are 40 or 45?

Ms. Gena Horseman: Forty-five is the average.

Mr. Bruce Woods: So they would like to be home with their families on evenings and weekends, and it's up to us to provide an incentive for them to come in to work.

One of the things we do to provide an incentive for the weekends is what we call a compressed work week, wherein we would say to you, "If you agree to work three 10-hour shifts," so if you would agree to work Friday, Saturday and Sunday or Saturday, Sunday and Monday—so you work 30 hours—"we'll pay you for 40," because that's what it takes to provide a sufficient incentive for you to come in. That's what we call a compressed work week.

M^me^ France Gélinas: You've talked a couple of times, Mr. Deputy, about the new survey that you are doing to try to get more information to address some of the content of the report of the auditor. You mentioned that it should be ready in mid-April. That's Friday—Thursday, actually, will be mid-April. Are you confident that it will be ready Thursday?

Mr. Saäd Rafi: I don't know. I'll have to get you that answer. It's a survey that covers a wide array of areas. I have not checked with the provider as to what the status is, but the compilation may be on schedule. I'm afraid I don't know.

M^me^ France Gélinas: You will let us know? Okay.

I know that my colleague already asked about 811. You said that you're taking a comprehensive look at it. What is the structure of this decision-making process? Is there a timeline for it? Who would it be reported to? Where is it at?

Mr. Saäd Rafi: Mary can perhaps answer the details of where it's at, but it's a combination of examining the results of the survey to see that there's a case to be made—we'll have to examine the costs associated with implementing it and do a cost-benefit analysis to create a business case. We would then, I'm sure, have to go forward for government approval for the minister and the government's decision-making process, as it's not contemplated in our 2010-11 budget. That would have an impact there as well.

In terms of where the investigation of the viability is at, can you answer that, please?

Ms. Mary Fleming: I would just expand on that to say we're working with the service provider to see which of the cost-effectiveness measures can be introduced at the same time, anticipating that the 811 would result in more calls and then greater expense. So we're seeing if there are corresponding savings that can be realized: the use of the patient assistance representatives more, perhaps use of the registered practical nurses and any other measures that can be found to offset the increased costs associated with greater take-up of the service.

M^me^ France Gélinas: When the government paid for the service, they paid for the service of registered nurses. Am I to understand that if the service provider goes for RPNs, then automatically, savings will be passed on to the government?

Ms. Mary Fleming: Either savings will be passed on or there will be more calls, and then there will be greater costs, if the 811 results in some groups using the service who haven't previously used it.

The other thing that the public opinion survey is trying to find out is what it would take to get groups such as seniors to use it more. The service is primarily used by women in child-bearing years, and they're more often than not phoning for their children.

M^me^ France Gélinas: The idea of bringing in an RPN: Is this something that exists in other telehealth or THAS kinds of—

Ms. Mary Fleming: No, we're not aware of that, so Ontario might be breaking new ground in that respect. But the use of patient assistance representatives, who are neither RNs or RPNs, is very widespread, not just in Canada but in other jurisdictions such as the National Health Service in Britain.

M^me^ France Gélinas: I'll call it the pre-recorded health information that you can send a patient—she wants to know about menopause, she wants to know about different health topics: Who has generated that information?

Ms. Gena Horseman: The authors who have our guidelines and information. Some are internal.

M^me^ France Gélinas: Okay.

Ms. Mary Fleming: I'd just add to that, Gena, if you don't mind, that we have a medical advisory committee with various medical professionals outstanding in their fields, both in medicine and medical ethics, and it reviews the protocols to make sure they're appropriate for Ontario and for what we want to see in terms of service delivery here.

M^me^ France Gélinas: Those are the protocols for the actual calls. I'm talking more people who—

Ms. Gena Horseman: And the information.

M^me^ France Gélinas: And the information, as well? Okay, very good. Thank you.

I know we've talked a bit about physicians in approved primary care models such as FHTs, CHCs etc. for which the clients have access to THAS. The auditor showed us that the responses to the pages are less than what one would expect. You've answered, I think, Mr. Deputy, that you have a tripartite arrangement, including the OMA, to look at this. The same thing: Can you talk to us about the structure of those talks? When are they scheduled to happen? When can we expect decision-making or changes? Do you have to wait for the next round of OMA agreements or is this something you can work on in-house?

Mr. Saäd Rafi: It's something we are working on in-house. We have, I think, a very good relationship with the OMA and they've been open to those discussions. There has not been, to my knowledge, any indication that this has to be a formal part of an ongoing contractual discussion at all. It's not just limited to that interaction, as well.

Again, we want to determine how people prefer to receive information and then we can channel our efforts in that regard. We can send out information to primary care group physicians to remind them of their obligations with the OMA, which has regular interactions with their membership. So there is a multitude of things we can do,

but, again, we want to look at this in a holistic way, just as the other areas you were talking about in terms of cost savings, not just one area of cost reduction but rather holistically balanced on increased demand and other areas whereby perhaps we don't need registered nurses. I think Ontario is quite prepared to break new ground but in a very responsible and careful manner.

As to the pace of that decision, or those decisions, I'd say we are certainly months away from having something actually buttoned down in terms of marketing, advertising, any change in contractual arrangements, if necessary, and certainly discussions with the OMA on how to get their help.

M^me^ France Gélinas: If we come specifically to the issue of physicians being paged twice and not responding to the past calls for 30 minutes, what are some of the solutions that are being discussed and put forward, and how open is OMA in those discussions?

Mr. Saäd Rafi: I'll try and answer the first part and ask Mary to help me on the second. What the Auditor General's findings helped us do was narrow the issue. This is not an issue that exists amongst all primary care groups of physicians, and there are over 600 of those, representing some 6,700 physicians. So we now have a better understanding that there are actually five primary care groups where they have just not returned pages, so that way we can focus our efforts and have conversations directly with those primary care group physicians.

We'll start with that and the other measures I mentioned in the previous response, and then maybe you can pick up the second part of the question.

1340

Ms. Mary Fleming: I think the other issue to be looked at is whether the numbers of physicians on call to the service is inappropriate in terms of how large that number is. Some of the times, as the deputy just mentioned, where pages were not being returned, these people hadn't been paged at all before, so I think they started to fall down on the job because they weren't being paged. So we might be better concentrating the effort of responding to pages on fewer physicians who would know that they were going to be called and to be ready and able to assist the nurse in the disposition of that call.

Both the incentives or the penalties that should fall into place if pages aren't answered will be examined with the OMA, as well as a strategy to see if we've gotten it right in terms of how many doctors should be on call. If in fact there were too many doctors on call and it could be decreased, there would be some corresponding savings also.

Mr. Saäd Rafi: I'd just hasten to add, if I might, that the fundamental belief we have that is proven by response is that physicians are responsive to their patients, and want to be. Since we can narrow the fact that there's a handful of groups—one handful of groups—that have not responded in more than one circumstance to pages, there must be something else at play, and Mary's alluded to some of those things. So we want to make sure we understand the problem before we make a knee-jerk response.

M^me^ France Gélinas: So we know that five primary health care groups have not responded out of the 600 health care groups that exist. How many have actually been contacted? The auditor shows that only 1% of the 67% of Ontarians that are covered by THAS have actually called you. Out of those, not all of them would have needed a backup page to a physician. So we know that five did not return; do we know how many have been contacted out of those 600 health care groups?

Mr. Saäd Rafi: You're asking about geographic dispersion, I think.

M^me^ France Gélinas: No, I'm asking about numbers. How many of the 600 primary health care group clients have actually been paged?

Mr. Saäd Rafi: Just to give you an indication, there are 20,000 pages approximately in a year, 54 per day, that are sent out across the province. Of those 54, a typical 54 day, are they clustered in eastern Ontario, central? I don't know if you know—

Mr. Bruce Woods: I'm assuming we can get the day. If the question is, which of the different numbers got paged and how many of them are—did we just page a few or did we page everybody? Is that what you're trying to find out? The dispersion?

M^me^ France Gélinas: That's what I'm kind of getting at. We know that five are not returning calls.

Mr. Saäd Rafi: Not consistently, though.

M^me^ France Gélinas: Not consistently.

Mr. Saäd Rafi: They are returning them consistently. There were occasions where they did not return a page. I think that's an important distinction.

M^me^ France Gélinas: Enough occasions to make it into the auditor's report. We've all agreed that, according to the auditor, some of the physicians did not answer their page. You've told us that we're dealing with basically five primary health care groups that didn't do this. What I want to know is, out of the 600, how many did? Are the patients calling in out of a group of 50 primary health care groups that use THAS—

Mr. Saäd Rafi: Okay, I'm sorry: 91% of those paged responded, because the auditor found 9% that didn't.

M^me^ France Gélinas: Yes, but the question is, out of the 600 primary health care groups—

Mr. Saäd Rafi: We don't have that at our fingertips.

M^me^ France Gélinas: Is this something we can get?

Mr. Bruce Woods: Well, it's just a matter of the dialled number, right? We would have a record of the number that we paged.

Mr. Denis Thibodeau: But if I understand you, you're trying to say what group do they belong to? So how many of the total population—

Mr. Bruce Woods: How many of those 600 groups did we reach out to and either get co-operation or no co-operation?

M^me^ France Gélinas: Yes. Because many groups will have more than one phone number, more than one pager. On the first week of the month, you page pager whatever,

and on the second week—or whatever their call group is like. So the phone numbers alone wouldn't give me that much—

Mr. Bruce Woods: I think we'd just have to do a sort on the phone bill, identify the different numbers and if there's—basically what you're asking is, what does the distribution look like? Are they getting contacted or not?

M^me^ France Gélinas: Yes.

Mr. Bruce Woods: I think that's the question.

Mr. Saäd Rafi: I don't want to continue to frustrate you, so I'm going to make sure I get the question right. Is the question, how many of the 670-plus physician groups get a page or have been paged to respond to a call—

M^me^ France Gélinas: That's right.

Mr. Saäd Rafi: —in any given period, and we could choose the period, perhaps?

M^me^ France Gélinas: Sure. Use the same period that the auditor has used to come up with the 9% that didn't return.

Interjection: Let's make a note of that.

M^me^ France Gélinas: That would be useful.

The Chair (Mr. Norman W. Sterling): Can I just ask a supplementary question now? With that data, Deputy, you have indicated you're discussing this with the OMA etc. My question, and the question of the committee, is, when will you come to a conclusion and remedy this problem so that everyone who thinks there is a page going out will be answered in some way?

Mr. Saäd Rafi: I don't think this is going to happen at a point in time, I guess, is what I'm trying to say.

The Chair (Mr. Norman W. Sterling): Well, we want it to happen at a point in time because it's a problem.

Mr. Saäd Rafi: But what I'm trying to get across is that maybe much of this can go away quite quickly with just identifying the few that might be seen as having the more serious difficulties in responding, to alert them to the issue, and that could be done in a couple or three weeks maybe. But the overall problem in terms of whether it shifts from one place to the next and the dispersion of that problem is something we need to investigate.

We need some sufficient period of time to diagnose what the challenge is here, not just in the demand but in the response. I'm sorry, but I don't know what other way to answer the question to say that it will be X number of days from today. I can't control the behaviour of an individual physician.

The Chair (Mr. Norman W. Sterling): But part of our function here, what we try to do, is to assist the deputy minister, the director or the assistant deputy minister in stating to associations like the Ontario Medical Association that there's an urgency to fix this problem. We're quite willing to say in this committee—and we have done in the past—we want this problem fixed. That's the issue here. Maybe Ms. Gélinas wants to know the dispersion and all this kind of thing. I just want it fixed. If it's fixed, then it doesn't really matter where the dispersion is.

Mr. Saäd Rafi: Understood.

The Chair (Mr. Norman W. Sterling): So what I'm trying to say to you is, we will say to the OMA, "Get down, negotiate, tell your people, but let's get it done."

Mr. Jim McCarter: Let me just jump in too on the numbers. I think we have the data that you're looking for, Ms. Gélinas. So if Mr. Thibodeau could contact Susan, we can probably work together on that and get you the data.

M^me^ France Gélinas: Thank you.

Mr. Saäd Rafi: To respond to the supplementary then, Chair, we will expedite those discussions and reinforce after this committee meeting the position of the committee and the Chair in that regard.

The Chair (Mr. Norman W. Sterling): Thank you. Ms. Gélinas.

M^me^ France Gélinas: You said that the ministry will initiate vulnerability and penetration testing for the service provider. Do we know if this has taken place or when it will take place? This has to do with security.

Mr. Bruce Woods: Have we done the threat risk assessment, Denis? And when was it done?

Interjection.

M^me^ France Gélinas: You did one in 2008.

Mr. Bruce Woods: Yes, we've done one and now there's another one to be scheduled, but I'm not sure when we're going to do that.

Ms. Mary Fleming: This year—the second will be scheduled and done.

M^me^ France Gélinas: Okay. It says that the most recent threat risk assessment for teletriage services was completed in 2008, and the ministry's planning to initiate vulnerability and penetration testing for the service provider. It seems like we're talking about something a bit different from the threat risk assessment that you had done initially. Or is this exactly the same thing that you will redo now in 2010?

Ms. Mary Fleming: It's part and parcel of it. So that aspect will be repeated in 2010.

Mr. Bruce Woods: It's like a subset.

M^me^ France Gélinas: Okay.

Mr. Bruce Woods: You've got the threat risk assessment, and penetration testing is one component of multiple steps in that. And just to make sure that our systems are tight, it's probably appropriate that they do it again.

1350

M^me^ France Gélinas: Okay. You've mentioned that the ministry will "work with the service provider to research and review ways to determine the impact of the advice provided to callers." Is this being touched upon with the survey that is going on right now?

Ms. Mary Fleming: No; I think that will be demonstrated more in the formal evaluation that will be undertaken. We will be starting a procurement process in the fall of this year to do that evaluation.

M^me^ France Gélinas: So if you go out to procure this this fall, do you have a time frame in mind as to when it could be done?

Ms. Mary Fleming: I think we'll try to have it done probably by the end of April. Some aspects of it may stretch out longer, depending on what they're trying to evaluate.

Mr. Saäd Rafi: When she's saying April, it's end of fiscal 2010-11.

M^me^ France Gélinas: Okay. So it will be done within fiscal 2010-11?

Mr. Saäd Rafi: Well, hopefully, but I think we'll have to seek the advice of the evaluators as to what they feel is a necessary time frame. But we'd rather it not drag on and on.

M^me^ France Gélinas: Have we done a review to determine the impact of the advice before?

Ms. Mary Fleming: In 2005, there was a longitudinal evaluation of the program done. Earlier, the deputy was telling you about both some of the cost-avoidance as well as the cost savings that we learned about through that evaluation. We also learned, during that evaluation, ways in which the standards might be improved as well as learned a great deal. This was confirmed by the Auditor General's own survey about the satisfaction with the service.

M^me^ France Gélinas: I know that I missed some of the talks, but has a decision been made whether some of the calls will be allowed to be taped under the right conditions?

Ms. Mary Fleming: We haven't made that decision, but I think we're close to doing so. We had earlier been given advice that it was inadvisable to tape calls. We've now learned that as long as callers are told that they can opt out of the taping, it would be a good thing, both in terms of patient safety and quality management. So I suspect that we will move that way quickly.

Mr. Saäd Rafi: Just in addition, it might seem pedantic, but the retention of those tapes is something we need to consider. The interjurisdictional information is all over the map in terms of how long they retain. We'll have to work with the Information and Privacy Commissioner to make sure that she and her staff are comfortable with that.

M^me^ France Gélinas: There was a discrepancy about the number of calls the service provider had referred to the Ontario Pharmacists' Association for medication information. I know that the number was incorrect. It was then corrected, and you assured us that the payments made to Ontario pharmacists were never an issue. What has brought about this discrepancy?

Ms. Mary Fleming: The manner in which the record-keeping of the transfer of calls to the Ontario Pharmacists' Association was taking place had to be corrected.

M^me^ France Gélinas: What were they doing wrong?

Ms. Mary Fleming: They weren't recording them all.

M^me^ France Gélinas: They were not recording them all?

Ms. Mary Fleming: The way they were recording them, they weren't being tabulated correctly. But they were being transferred.

M^me^ France Gélinas: Okay. They were being transferred. So the pharmacists' association came up with a higher number than the service provider had?

Ms. Mary Fleming: That's right.

The Chair (Mr. Norman W. Sterling): Can I break in, and we'll come around again? Is that okay? Is this a good, natural time?

M^me^ France Gélinas: One more, and then I would go into the next document.

The Chair (Mr. Norman W. Sterling): Okay, fine.

M^me^ France Gélinas: My last one basically had to do with the pay. Maybe it wasn't—I'll save it for the next turn. Never mind: It's going to be a long one.

The Chair (Mr. Norman W. Sterling): Mr. Ramsay.

Mr. David Ramsay: I'll remind the Chair it's anti-bullying day today. I'll move on now.

Welcome, everybody.

The Chair (Mr. Norman W. Sterling): Your time's up.

Mr. David Ramsay: Point made.

Deputy, I'll address this to you, but I know you weren't at health at this time, so please be free to direct it to the appropriate person. I'm very interested about how the service handled the pandemic we had in the fall. Obviously, this was something extraordinary, and you had to gear up knowing this was coming. This was particularly true because none of us really understood this. There were conflicting stories, so I imagine your service was being used to try to find out, with all the questions we had. Guys in my demographic were very lucky because we were told we were immune, but we all have children and grandchildren and that, so even people like me might have been calling to find out what advice we should be giving our families and this sort of thing.

I'd be wondering how you maybe anticipated, knowing this was coming; how you adapted during it; and then, from your experience—because we think this may not be the only one in our lifetimes—what are you thinking about when something like this comes again.

Mr. Saäd Rafi: Thank you. I will just maybe make some introductory remarks, and I think Mary and Mr. Woods would have a far better ability to answer.

Just to give a sense to the committee of the point that Mr. Ramsay makes with respect to volume, by the third week of October, the increase in the call volumes was approximately 110% over the forecasted call volumes and continued to be 100% above forecast into the second week in November. It peaked at 550% over forecast on October 28.

Mr. David Ramsay: And these were forecasts anticipating you would get an increase in volume because of the pandemic, yes.

Mr. Saäd Rafi: So a 550% increase. Now, I would also note that in Mr. Woods's comments, he identified that the working relationship between Sykes Assistance Services and the ministry at the time—and of course, I can take no credit for this—was quite exceptional, not only during H1N1 but also during SARS, an even more

challenging time in Ontario's experience with health-related matters.

Perhaps Mary, and then to Bruce?

Ms. Mary Fleming: I'll just expand on what the deputy said. In early October, Telehealth began experiencing an increase in call volumes. By October 25, the call volumes were approximately 110,000 more than they might have expected had H1N1 not happened. By the second week of November, the increase had peaked at the 550% that the deputy just alluded to.

The impact in the increase in volumes, of course, resulted in tremendous wait times to speak to a Telehealth nurse, but this wait was worth it and appropriate, given that the volumes had increased in the manner that they had, because it kept people from visiting emergency departments, which were also very, very busy, or making a visit to their family doctor, where they might be exposed to other people with symptoms. So, many people, while they weren't happy to wait, waited for the callback. The standard for the callback under our contract with Sykes is 30 minutes, but many people were waiting more than an hour, and sometimes even more than that. But again, I think that the people were happy for the assistance from the nurses.

The company, the service provider, implemented all types of strategies to try to mitigate the impact of the surge in calls. Those included having staff work additional hours; redirecting all available nursing staff to answer Telehealth Ontario calls rather than some of the other services that we've talked about them offering; adjusting shifts to have more people on the peak times rather than overnight; and suspending any training activities or anything that staff was available for. They immediately created, with the assistance of other people in the ministry who were working on a response to the pandemic, an audiotape library that was just about H1N1, so people could listen to that. They added additional voice mailbox capacities so that the telephony didn't just crash.

While we would have hoped, as I'm sure they'll say—the service provider, that is—that they could have responded more quickly and to more calls, we were pleased with their efforts during that time.

Mr. Bruce Woods: I'm going to have Gena touch on it, but I think one of the lessons coming out of this experience is that when you have a situation such as H1N1 and your system gets tested to the peak, to me, it kind of indicated a problem in the agreement that we currently have.

In the agreement we currently have, the intention, I think, was for a state of normalcy, where the public is trying to call a nurse and looking for some advice or health information. When we get hit with these huge volumes, it becomes apparent there's an awful lot of those calls that we don't need a $75,000 nurse to answer. But Sykes only gets paid when a nurse answers the phone.

1400

As we go forward—and we're talking with Mary and the team about this—if we can introduce other players into the equation—for example, if you're just calling to find out "Where are the clinics? What hours are they open?", we don't need a nurse for that.

We're working on different levels. I've always used—Mary referred to them earlier—NHS Direct as my mentor. They have basically four levels. When you call in, you push 1 and you're going to 911; push 2 and you're going to talk to a nurse, because you need an answer in 60 minutes; push 3 for this; and push 4 for that. I'm just saying that the benefit of hindsight in that learning experience is that, prior to that, I think I would admit when we talked about trying to provide the most appropriate level of care, there was a propensity in my brain to be thinking externally, to be thinking, should I send them to emerg or should I send them to the family doctor? Now it's time for me to look in my own house. Should I have a patient assistance representative or should I have an RPN, on different levels, providing the most appropriate care most cost-effectively? That's my learning lesson. Gena can touch on the all-hands-on-deck deal, when it was happening, but that's just my experience coming out of it to go forward.

Ms. Gena Horseman: With the pandemic, too, when we implemented the recording messages at the front end, I think that helped quite a bit, because there were people who did not necessarily want to speak to a nurse. They just wanted to know, "Should I worry? What if I'm pregnant and I've been exposed?", just very general information. It was right there for them and they could access that information immediately.

Mrs. Liz Sandals: Okay. One of the things you've mentioned is surveying clients and various groups and seeing if they're happy.

One of the things that the auditor seemed to be identifying was that on the surface of it at least—and I think one of you mentioned this in your remarks, maybe—that the cost per patient in Ontario or the cost per call in Ontario would appear to be higher than the cost per call in some of the other jurisdictions. I'm wondering in the work that you've been doing as a follow-up to the auditor's report, if you've looked at some of those other jurisdictions and seen whether that's an apples-to-apples comparison or what range of services other jurisdictions provide: what's in, what's out of those costings. As public accounts committee, if we see the cost per call in Ontario is higher, then obviously we've got some questions. Whoever can respond to that, it would be helpful.

Mr. Saäd Rafi: I'll try. I think we spoke to BC, New Brunswick, Alberta and Quebec. We weren't, perhaps, as successful as the auditor was in getting information out of our colleagues in Quebec. But BC and Alberta provide their own teletriage—Telehealth, I believe they call it—services in-house. We calculated those costs to be between $26 and $29. I think the Auditor General states in their report approximately $20. For the sake of discussion, we can say we're in the ballpark; I believe we are. Since they're provided in-house and since those ministries don't use activity-based costing, I'm pretty confident in saying they're not fully loaded costs.

Mrs. Liz Sandals: Could you talk about what you mean by that?

Mr. Saäd Rafi: Yes. There's overhead that would be absorbed. The financial supports, the HR supports and the infrastructure needs would be absorbed in the overall budget. Now, I'm not trying to be provocative and debate whether that gets you to the call costs in Ontario or not, but the second thing we weren't able to get a good handle on was the performance measures associated with that level of service, and I think that's even more important in the context of what we're paying for.

We procured this original contract in 2001 and then re-procured competitively in 2007. It took effect in 2008, because it was the first tranche of the seven-year contract, if I'm not mistaken. We asked for and were assured that it was the most competitive cost, and our process willed that out in Ontario.

We were told confidentially by New Brunswick—and I don't want to put any proprietary information for Sykes Assistance Services into the public realm unnecessarily—that their costs are higher than Ontario's; they have the same provider. Again, we don't know their performance measures, but what we do know is public satisfaction, what we do know is employee satisfaction as represented by SYKES. The public satisfaction was corroborated by the auditor in the main; again, perhaps not at the exact same levels, but roughly so.

The survey we want to get at is the motivators and/or barriers to using the service, which speak to satisfaction, which speak to knowledge and awareness. Would you use it into the future? If not, why not? And if you would, why would you? Also, what's your perceived value of the service? Because we can make improvements. As it then relates to costs, calls and volume, whether we move to another number or not—Mr. Woods has talked about PARs, RPNs and other methods—suggestions have been made about other channels. So I think those are all opportunities to have a good discussion with an organization that's behaved like a partner with us, and not just a contract service provider, to examine the overall cost structure.

Mrs. Liz Sandals: That raises a couple of other issues in my mind. One is, if you're looking at the performance measures—and I don't think it's a performance measure in the contract. From the point of view of public policy, are people diverted away from a more expensive form of health delivery because they've used some form of Telehealth teletriage? We've had this, "Should we have OHIP so you can really match it up call for call?" I'm not sure I'm keen on OHIP or not, just from trying to imagine the mum with the crying baby: "I want some emergency information. I'm not sure I really want to figure out which purse I left my OHIP card in." So I'm not sure about that, but how, if any way, can you actually get a handle on whether the whole enterprise is effective in diverting people away from doing something that would be more expensive?

Mr. Saäd Rafi: I must confess, I think the initial response to using OHIP has been as you've characterized it. You want to deal with the needs of the caller right then and there, you don't want to force them to divert their attention. If it is a mother—that's a predominance of calls—you don't know if she has support there. There's a myriad of potential challenges. I'm not sure—and Mary, you'll have to correct me—we have another connection or a nexus between advice given and advice taken, except to match up through OHIP, and I'm not certain whether we've come to ground with the privacy commissioner on how to effectively deploy that. I believe one other jurisdiction does do that. Is my research correct in that regard?

1410

Ms. Mary Fleming: I don't know whether they make the connection using their health number as to whether or not the advice was followed, but we know of at least one other jurisdiction that collects the health number. I had always felt the same way as you, Ms. Sandals: that the last thing we needed to do was to send people rushing off to get their health number. But in Health Care Connect, the new service, or teleconnect, as you mentioned it as, they do ask for the health number, and people have surprised everyone in terms of being ready with it when they call. So we're getting some good experience on that.

The provider does ask if people intend to do what they've been told is the best thing for them to do at the end of the call, and they give that information. But, then, most of us have probably left the doctor's office saying we fully intend to do what we've been asked to do also, so that information isn't completely reliable, particularly because people don't always have the wherewithal, say, to get to the doctor the very next day or something like that. But we do collect that information.

Mr. Saäd Rafi: On the other end of that, in the suggestions that have been offered by Mr. Ouellette, I think it was, other channels could also help in terms of the cost per call, if it's more information driven. As we think about how we're going to get more information out, whether it's 811 or 1-800, we might be able to alert people to, if at all possible, "Have your OHIP number ready," and some other examples Mr. Shurman has mentioned as well. Try and look and that, but that will take time to evaluate and assess as to its efficacy.

Mrs. Liz Sandals: Okay. The other thing that you mentioned in passing was procurement, and then my colleague Mr. Leal has a question, too, I think.

You mentioned the procurement process, and obviously procurement and the Ministry of Health have been a topic of some interest lately. I think you did mention that it was a competitive process, but I wonder if you could talk a bit about how that procurement process actually worked and how that plays out.

Mr. Saäd Rafi: Sure. Again, I'll start. The contract was ending in 2008, so in 2007, the ministry started a competitive procurement process and, I believe, had a quality score, and then looked at costs for the bid. You had to reach a certain quality level. There were five bidders, I believe; three passed the quality test. So three were taken forward, and then their financial—you're

smiling at me, which tells me I've got some of this wrong—

Mrs. Liz Sandals: So if I could interrupt, Deputy, in the RFP documents, then, would you have outlined the performance? To what degree would the RFP that people had to respond to have nailed down the requirements for the service delivery?

Mr. Saäd Rafi: I should have answered that in the first instance—

Mrs. Liz Sandals: You may have Mr. Woods, here, who remembers this.

Mr. Saäd Rafi: —and then Mr. Woods can give his perspective of being a participant in that process, which we rarely get a chance to hear from.

Ms. Mary Fleming: As the deputy said, in October 2006, we received Management Board approval to issue an RFQ; we did a request for qualifications. It was issued in March 2007, closing on April 19. Four submissions were received for teletriage services, and the RFQ, the request for qualifications, demanded that respondents receive 60% in order to be eligible to submit a request for proposals. All of them did so, so they were invited to respond to the request for proposals.

We established a four-member evaluation committee with expertise from the government's and the ministry's I&IT cluster, information and information technology; the nursing secretariat of the Ministry of Health; current program staff for Telehealth Ontario in the ministry; and former Telehealth staff who had gone on to work in the policy group in the ministry.

The RFP had been released on August 1 with a closing date of September 6. One of the respondents notified us and said that they weren't going to be able to make the closing date, and another one responded and said that they were withdrawing. So in order to have a truly competitive process, we let all of the people who were responding have more time in which to do so; otherwise, it wouldn't have been a real competition. Ultimately, three proposals were received for the provision of teletriage services and they all passed the first stage, which is the mandatory requirement check, and moved on to the evaluation of the rated criteria. Then, two proponents moved on to the evaluation of the price component and the preliminary cumulative score.

We engaged a fairness commissioner to oversee the entire process, including the site interviews and demonstrations that took place on October 25, 2007. Following that interview and presentation, a cumulative score and weighted criteria were all accumulated and Sykes Assistance was deemed to be the successful vendor.

Mrs. Liz Sandals: Did Mr. Woods want to qualify as one of the proponents?

Mr. Bruce Woods: I just wanted to comment on our experiences with Ontario from a purchasing perspective. It's pretty tight, because when the RFP comes out they're basically saying, "Here's the deal," and there's a contract attached. I don't know how many pages the contract is—

Ms. Mary Fleming: Many.

Mr. Bruce Woods: —but it's quite a bit. So if you've got your sales hat on and they indicate, "If you've got any indigestion with this, speak now or forever hold your peace," as a salesperson you're not exactly going to say, "Oh, I hate that and I hate that." I think, from a procurement perspective, it's pretty tight. In fact, if I recall correctly, I think the ministry has prices committed from us for eight years and we've got a 120-day deal. I live for 120 days. So with all due respect to the ministry, when I said that they ran this program well, I think they managed it well.

The Acting Chair (Mr. Jerry J. Ouellette): Thank you. Seven minutes ago, you said that Mr. Leal was going to get a chance. He can come back in the next round. We're going to change the rotation a bit and go to the third party at this time.

M^me^ France Gélinas: Already? Okay. Thank you.

I want to come back to the comments made by the auditor regarding the price per call, which averaged, in Ontario, close to $39. It's averaged in other provinces at way lower. I understand that you get what you pay for, that not all calls are considered equal. Could you elaborate a little bit more as to how there could be a $20 difference in the average per call from one service to another?

Ms. Mary Fleming: Upon learning that information, and even prior to the audit, we always attempted to keep up to date with the way that the service was being delivered in other provinces. The information obtained regarding the service in other provinces and their cost per call, as well as their performance standard—it isn't always as easy to obtain the similarities between those programs as one might think. In fact, we were not able to get very much information at all about the service in Quebec or about the standards in some of the other provinces.

I would also note that two of the provinces mentioned by the auditor are provinces where these services are delivered by government organizations, so the costs don't necessarily reflect all the costs associated with delivering the service. For example, some IT costs, some human resources costs and things like that wouldn't necessarily be represented by the price per call.

The competitive process I just described ensures that Ontario got a competitive price for provision of this service in Ontario. We also know that our service provider provides the service to an eastern province at greater price than it is in Ontario.

M^me^ France Gélinas: And you know this from a phone conversation with the people in New Brunswick?

Ms. Mary Fleming: That's right.

M^me^ France Gélinas: So the only elements that make a call worth $20 more than another call that you have brought forward are because if you use government employees, then you use government IT and government human resources. Are there other elements that could justify a $19-per-call difference between what Ontario pays and what other providers pay?

Ms. Mary Fleming: The standards could be different. They could be letting their service provider—be it their

own employees, in the case of some provinces, or the service provider that they contract with—return the calls back at a much longer time. They could be giving them an hour to call back as opposed to 30 minutes, or they could be having a longer standard for the caller speaking to a live voice. Any of the standards could be adjusted so that the service would be cheaper.

1420

Mr. Bruce Woods: Another issue with who is answering the phone: As I said earlier, with the contract with the ministry, a registered call has to be handled by a nurse. We know that in certain other jurisdictions, not all calls are handled by a nurse. So if you've got a $30-an-hour nurse versus a $10-an-hour PAR, and a $10-an-hour PAR is handling—

M^me^ France Gélinas: What are those other jurisdictions, and who is answering the call?

Mr. Bruce Woods: In Alberta and BC, you mean?

M^me^ France Gélinas: You said, "We know that there are other jurisdictions where it is not nurses who answer the call." So what are those other jurisdictions?

Mr. Bruce Woods: I meant to say, there are other jurisdictions where nurses don't answer all the calls. All I'm trying to say is that in our jurisdiction, a registered call is defined in the contract as being a call that is handled by a nurse—period. I've tried to share the fact that I think there are a lot of calls coming in for which we don't necessarily have to have a nurse. I think the ministry agrees with that. So we're going to go to some lengths to try to identify what that appropriate level is. Some of the other provinces are doing it now. I can't speak to what they're all doing, but I know some of them are. The combinations of service level, the mix of people taking the calls and the absorption of overheads—I don't want to get into an accounting exercise here. I'm not sure what diligence or if my associates up at the front of the table ran those numbers, but I think there would be a considerable amount of work to take into consideration to compare those numbers. That's all.

M^me^ France Gélinas: I can tell you that our auditor goes through quite an extended amount of work, and when he talks to auditors in other provinces, those people know how to compare oranges with oranges and apples with apples. I've always been very confident that when our auditor puts something on paper for us, he is comparing apples to apples and oranges to oranges. To a certain extent, you've brought some points forward. You said you know that in some other provinces, they use other levels. Mind you, when I ask if anybody uses RPNs, you all said no, that Ontario would be the first where you would be doing it very carefully.

Ms. Mary Fleming: They might be using clerical staff for the collection of demographic information, not for the triage of patients. That's included in the list of things that we're looking at in conjunction with the possible implementation of 811, to make sure that the service doesn't become tremendously more expensive. The difference in price, for example, in Alberta, could be related to the fact that callbacks are permitted to be made within 120 minutes, as opposed to our 30 minutes.

Mr. Saäd Rafi: If I could, just for the record, Chair, no one is disparaging the auditor's due diligence. I've worked with Mr. McCarter for many years, so I don't want the committee to feel that we have some fundamental disagreement with the findings, but rather to say, and more importantly, perhaps, that if we're going to get down to a very deliberate dollar-to-dollar, cent-to-cent comparison per call, we need to do that in a way that explores every aspect and every facet of the service provision in one jurisdiction versus Ontario. I don't believe that time permitted to do such a detailed comparison, but I stand to be corrected.

Mr. Jim McCarter: Just an example: When Quebec got back to us, they said they have 15 call centres and basically said, "We're paying $14.48 per call, plus an admin fee of $5.56 per call, which is about $26." But in our report, we did say that, for instance, things like infrastructure—we weren't sure how they were picking up something like infrastructure. But what we said to the ministry was, because the difference is so big between $20 and $40, that we think it's worthwhile that you have a look at this and see if they're doing something differently or most cost-effectively, because it is a pretty big spread, if I could put it that way. The three jurisdictions came and indicated they're in the $20 area. But it was difficult to get a lot of additional information with respect to who was paying, say, for the building that they were housed in. That's quite a big spread. We were essentially saying, "We think it warrants a look" to the ministry.

M^me^ France Gélinas: All right, because so far, to have a secretary take the demographics, I can't see $20-per-call's worth of savings coming out of there. And to have HR under the bureaucracy of the government, here again I have a hard time putting the numbers together. This is what public accounts does: We look at numbers. That's what we're there for and that's what we do.

All right, I'll let this one go, but if you can think of other arguments to justify the gap, I'm open to listening at any time.

One piece of information to me—I'm looking at time to call back. We've all heard about the 30 minutes. For the client, if I was told that the service is to be provided within 30 minutes, in my mind I would say, "From the time that Telehealth answers the phone to the time I talk to a nurse, this is 30 minutes." But we found out that it's not from this; it's from after the PAR has put the call in the queue that the 30 minutes start. Then we were given nine other wait times that will now be collected, but none of them are—from the caller's point of view, from the time your call is picked up to the time you talk to a nurse, it should be 30 minutes or less. I'm wondering, out of the nine average times that you will be collecting, how come you don't collect that one?

Ms. Mary Fleming: We don't have a standard with respect to—I just want to make sure I understand your question. You think we should both collect the time and hold the provider to a standard from the time the person called in.

M^me^ France Gélinas: From the time the phone is answered to the time I talk to a nurse, to me, this is relevant. Set it at 30, set it at 45, set it at whatever you want, but this is pertinent to the people who call so you can say to people, "I guarantee you, you will talk to a nurse within 30 minutes. The stats show 90-some per cent of the time, they call you back within 30 minutes." But you don't count the 30 minutes the way the consumer would count 30 minutes. The consumers would count 30 minutes from baby wailing in arms, somebody answers the phone, I talk to a nurse. But you don't do this that way; you start the 30 minutes later. We were given nine new times: the average time the caller waits for the time they connect; the average time spent waiting to talk to—anyway, you're now collecting way more things, but not the one that matters to people.

Ms. Mary Fleming: Yes, and I think that was something we learned from the audit. It hadn't previously been something that had been pointed out to us. We now have worked with Sykes to make sure that they have the capacity to collect that so we can see how much time that is that's added to the time from, as you say, you're waiting with your child who's complaining of something to when you actually get to talk to a nurse. We understand from them that most people only have a tolerance to wait about six minutes before they'll opt for leaving a message for a return call.

The company has a good record in terms of returning those calls within the standard. But I think that the auditor, and also your questioning as well as others', has highlighted to us that in fact, we weren't necessarily seeing it the way consumers see it—that the time starts when you make the call.

M^me^ France Gélinas: All right. So from that conversation, can I take away that this is now something that we can expect you will discuss and do something with?

Ms. Mary Fleming: We're looking at the numbers to see what difference it makes to people and whether that's something that should be looked at in terms of a contract amendment. We haven't made a firm decision.

M^me^ France Gélinas: And do we know if a firm decision is forthcoming or when those talks take place—at the renewal of contracts, or do they take place on an ongoing basis?

Mr. Saäd Rafi: Opening a contract is a complex thing, as you know, so we want to be judicious about it. I think we have a good partner that's willing to look at different ways of how they deliver the service based on certain standards we might mutually set; based on findings we receive; and based on survey data that comes in.

Survey data has not come in. It's being analyzed if it has come in, as I mentioned to you earlier. It will take some time to crunch through all those things. These are not things that we're going to wade into quite recklessly or too quickly, because, again, nothing is cost-free. But we want to respond to patients' needs.

1430

M^me^ France Gélinas: Okay.

Mr. Denis Thibodeau: If I can just add that the nine data points we referred to—those are just different data sets that we're going to work with the ministry on to measure so we can get a guide as to what the impact is of those wait times so we can make some decisions on how we're going to proceed from there. We wanted to highlight that our system currently can measure those distinct nine data points—and I believe there are nine; I didn't count them. That will help us make that decision.

M^me^ France Gélinas: I would like to see a 10th one, which is the only one the consumer cares about. But anyway—

Mr. Bruce Woods: Can I just—I want to make sure that I'm understanding what you're saying the consumer cares about. From the time they hit the switch till the time that the nurse calls them back: That's what you're—

M^me^ France Gélinas: From the time you pick up the phone to the time the nurse calls her back or talks to her.

Mr. Bruce Woods: In contrast to what you understand we currently do today, where the PAR takes the message, and from the time the PAR finishes taking the message, the 30-minute interval begins.

M^me^ France Gélinas: Correct.

The next one is translation services. I might have missed this, but where are the translation services located? I understand they're not all from Ontario.

Mr. Bruce Woods: Gena, do you want to talk about that?

Ms. Gena Horseman: Correct. CanTalk is who we use, and they are located in Winnipeg.

Mr. Bruce Woods: So during the course of the discussions, as they relate to the PHIPA sub-agent agreement, it came up that we didn't have a PHIPA sub-agent agreement with CanTalk. We began to enter into discussions, and exactly the point you're making became apparent. So they went through legal—our legal, the ministry's legal—and it was agreed that it wouldn't be provided that it could be for Canada as opposed to Ontario. Is that what your question is?

M^me^ France Gélinas: Yes, kind of. I was not looking at PHIPA as much as I was looking at Ontario, with the diversity we have and the interpretation service capability that exists within the health care field in Ontario for the multi-language. I was kind of surprised that we would go out of province for this.

Mr. Bruce Woods: I don't know. Are there other—

Ms. Gena Horseman: We currently are looking at other alternatives, but there has been no decision made as of yet.

Mr. Saäd Rafi: I shouldn't presume this, but if you're aware of services that exist in Ontario that have 100-plus multilingual capability, we would like to receive them and then we can talk to Sykes Assistance Services about that, pending their own contractual obligations.

M^me^ France Gélinas: Sure. There's a community health centre right here in Toronto that provides 112 different languages and specializes in health care.

Ms. Mary Fleming: The difference is—and I don't say this to contradict you, but just to make sure everyone understands—they do it within 90 seconds, because we're trying to offer to those people who speak that wide

range of languages as close to the service that we can expect in English and French.

Mr. Saäd Rafi: That's the bar. But we'll certainly investigate that.

M^me^ France Gélinas: When we talked about the original RFP, where you talk about the workforce having a minimum of three years' experience, including at least one year of acute care or clinical experience, we know that this was not met for reasons that you've explained. But I think there's a renewed endeavour to try to meet those. Here again, do we have a timeline as to when you figure those standards will be met?

Mr. Bruce Woods: As of immediately, we are no longer hiring anybody with less than three years' experience. Is that correct—

M^me^ France Gélinas: But all of the ones who are already there—I'm talking for your entire enterprise—when do you figure you will have all of your staff have three years' experience? I understand it's for the new hires. I don't expect you to lay off anybody out of this, so how long before it gets done?

Mr. Bruce Woods: We currently have 22 nurses, so is your question what we're going to do with those 22 nurses to bring them up to speed or what we're going to do with the 22 nurses to remove them from employment?

M^me^ France Gélinas: I have no intention of asking you to remove anybody; I'm asking you what's the plan for the ones who are not in compliance.

Mr. Bruce Woods: What we tried to allude to in the documentation was that notwithstanding, we acknowledge the limitations. In the recruiting process, there is very extensive testing done. Gena, who has been in operations—we actually went to work in HR for a while and introduced a number of new tests for the purposes of assessing critical thinking objectively. This was a step above our old recruiting process.

Basically, you go through a process. There is some fundamental skill testing done in terms of keyboarding, English and Windows. Once you past that test, then there's also skill testing in terms of critical thinking. These individuals have passed that test.

I think what we're trying to be careful—because I don't want to undermine anybody here. Some of these people are as good as or better than the people with three years.

We can't assume that just because maybe a nurse has 12 years of work experience, they're better. There are a lot of competencies around computer literacy. Given that this is a non-traditional type of nursing, you can't be trying to find the D on your keyboard while you're focusing on what the patient is saying. If they get through these tests, we're pretty comfortable that they're delivering the service. However, I'm out of compliance and I'll get back into compliance.

M^me^ France Gélinas: Okay. You did mention that you now have a new recruitment strategy and that the dropout rates in orientation have improved by 50%. I take it that during orientation, quite a few people realized, "This is not for me" and left. What was the drop-off rate before and what is it now?

Ms. Gena Horseman: I don't have that at my fingertips.

Mr. Bruce Woods: But it wasn't a point we're trying to make here. Pursuant to having a more finely tuned recruitment process, we're finding more people are successfully moving through the system, as opposed to "Have you got three years?" and you're in—

M^me^ France Gélinas: No, I realize.

Mr. Bruce Woods: —and then you drop out.

Ms. Mary Fleming: We can get those numbers for you.

M^me^ France Gélinas: Okay. I'm going to have to go.

The Chair (Mr. Norman W. Sterling): Okay. Mr. Shurman.

Mr. Peter Shurman: I have a comment to make, first of all, and I wouldn't mind hearing a reaction to it.

I've got to say, I've been listening to this for about an hour and a half, and I'm not that impressed with what I'm hearing. What it sounds like to me is a bit of a love-in between the call centre and the ministry: a ministry that doesn't put or attach the kind of importance to this service that it really should, and a call centre that has statistics that are not being disclosed. That's what I'm hearing. I'd like to know where I'm wrong on this.

I'll tell you, I'm going to zero right in. From all sides of this table, you've been getting questions on why there's an obvious disparity between jurisdictions on the cost per call. I'm not going to call into question what the auditor did. I know his work and I think that, by and large, we're probably looking at something akin to apples-to-apples, given the fact that we've got different jurisdictions.

So tell me, gentlemen and ladies: Why have we got a call cost that is somewhere approximating double in some jurisdictions? We've got this superior call process here, or maybe better call-handling capability, yet we're dropping in terms of the use of this service. Ontarians are just not calling as much as they are in other jurisdictions. They're growing; we're dropping. How do we explain this inverse relationship? I don't get it.

Mr. Saäd Rafi: I would say that we have some differences in the costs but that's at the margins; there's no point in debating that. We think it's $26 to $29; the auditor said $20. Fine. It's a large delta, is what you're getting at. I'm not going to dispute that.

We haven't dug into the issue that you're talking about, in terms of comparing performance standards to jurisdictions. I think we've been clear in saying that we're prepared to do so. We're going to examine how we can reduce our costs. One of the requirements is that RNs answer every call. I think we've talked a fair bit about that, and in an open manner, we hope, that tries to address some of the mid-course corrections, if I can put it that way, that we want to make and are prepared to look at, as well as the volume, or the consistent increase.

It has been a fairly flat line of demand: registered calls, 900,000 to one million, over the last eight or nine

years. That's a large number but not necessarily entirely representative of the population, and perhaps there's an opportunity to increase that. We spoke of some methodologies in which we want to undertake to examine how to increase that call volume.

1440

Mr. Peter Shurman: I'd be happy to see the cost of this thing rise. It's $35 million, approximately, right now, that we're spending per year. I would rather see this at $100 million or $200 million with a commensurate drop in the use of more conventional services by people who don't really need to go to a hospital or a doctor or whatever. That comes down to how you market the service, basically, if I can just use commonplace language, go out and advertise it. Whatever's necessary.

Why has the ministry not put the emphasis on that that I seem to feel should be there? Why is this utilization rate not of as much concern, and why wasn't it of concern before the auditor dug into this?

Mr. Saäd Rafi: Well, I'm sorry, I can't accept that it wasn't of some concern. I don't know what your expectations are in effective marketing, in terms of spend against dollars expended. So—

Mr. Peter Shurman: If I can clarify for you, I'm not trying to tell you to go out and spend more; I'm saying I would be happy to see you spend more if there was a continued increase in utilization and a commensurate drop in other service usage.

Mr. Saäd Rafi: Thank you. What I'm trying to drive at is to say that we are trying to move on many fronts. I think we've been open in accepting very good suggestions and willing to examine those. We're trying to determine, what is the utility of this service to the public? If there's a poor utility, we will examine how to improve that. If there's a high utility, but it could go higher based on some connection of OHIP number to actual use, then you're right: That will be a clear indication of cost avoidance, cost deferment.

I'm sorry you don't agree, Mr. Shurman, but I think we've been fairly open in indicating that we're wanting to do that. As far as an effective partnership goes, it's my fervent belief that it's of no value to the taxpayer to have a contract with a supplier that is simply then taken out and beaten—the supplier—to death with the contract. What we have here is a willing contract partner who has decided and agreed to come to this committee to share—unscripted, I dare say, and without prompting on our part—their own views about what it is we can do to improve the service together. I hope that that's going to meet with the committee's benefit.

Mr. Peter Shurman: Well, it would meet with the committee's benefit. But I want to get, for my own clarification—and I can't speak for others—more specifics. I'll start by asking some questions that require specific answers.

What's the average call length, in minutes?

Mr. Bruce Woods: Ten minutes.

Ms. Gena Horseman: Yes, about 11 minutes.

Mr. Peter Shurman: So the cost per minute, if I could bring it down to that, would be somewhere in the $4 range? Is that fair? The $3 range? How do you calculate that?

Mr. Denis Thibodeau: I couldn't tell you off the top of my head.

Mr. Peter Shurman: I know what the cost per call is, so you could divide it by minutes, but maybe that's not your math.

Mr. Denis Thibodeau: I would have to go back. I would be guessing, and I wouldn't feel comfortable making that guess on the number.

Mr. Peter Shurman: Well, I'll tell you what I'm getting at—

Mr. Denis Thibodeau: It's per registered call, then we can just—not every call gets registered, so I'd be hesitant to give you that number at this point.

Mr. Peter Shurman: I'm sorry, I didn't get that. I didn't hear you.

Mr. Denis Thibodeau: I said we have the number of registered calls, we'd have to go back and include all the phone calls and minutes that are involved with that and give you the cost per minute.

Mr. Peter Shurman: So you don't have statistics available that tell you what your return per minute is?

Mr. Denis Thibodeau: Not at this point. Not in front of me.

Mr. Peter Shurman: Could you get them?

Mr. Denis Thibodeau: Yes, we can.

Mr. Peter Shurman: Okay. My next question was going to be whether that's monitored, and I see that it's not.

The reason I'm going down this road is that a per-call charge would encourage curtailed calls, in minutes. It's just natural. The longer you take at a flat rate, the more cost you're incurring and so forth. If you were charging on a per-minute basis, that would encourage, in my mind, a more needs-based type of call which would then be appropriate in length to the issue being discussed. If it was something simple, it might be a call that lasted only two minutes. If it was something fairly complex, you might have a registered nurse talking to a caller for half and hour. The averages would have to work out, and you'd have to cost it on that basis. Has any consideration been given to that? Anybody?

Mr. Bruce Woods: We're not averse to doing it.

Mr. Peter Shurman: I'm asking you, have you considered it?

Mr. Bruce Woods: We haven't considered it. We responded to the RFP, which was acquired at cost per call. If the ministry would like to come back and modify that and say, "Hey, listen, why don't you give us a price per minute?" that's fine.

Mr. Peter Shurman: Well, let me ask the ministry representatives. Have you looked at that as a possible model?

Ms. Mary Fleming: No, not at this point, but we'd certainly take it under advisement. We're looking at all kinds of ways to save money, excluding reopening the

contract, as a result of the audit, and changes that should be made.

Mr. Peter Shurman: How are the nurses and doctors paid? Are they paid per call as well?

Mr. Bruce Woods: No.

Mr. Peter Shurman: How are they paid?

Ms. Gena Horseman: The nurses are paid by the hour.

Mr. Peter Shurman: By the hour.

Ms. Gena Horseman: Yes, they are.

Mr. Peter Shurman: So in other words, the questions that I'm asking have some relevance, in the sense that the people who are the ultimate respondents are time-based, whereas the call centre's compensation is call-based. So the statistics I've asked for—and you kindly offered to supply—have to exist somewhere, because you've got apples and oranges going on here. I think in there, you may find the answer to these questions which have come around the table about the cost per call in this jurisdiction and the cost per call in others. Just a comment from me, but I have some experience in this and I think I know a little bit about what I'm talking about.

You have something you wanted to say?

Mr. Saäd Rafi: If I might, I think you've actually come right around to the issue that we've been trying to identify, if perhaps not as well as you've captured it or to your satisfaction. I think a judgment was made in 2007 as to how we wanted to price this service, because it is more of a contact centre than a call centre. I'm going to now be careful and defer to your experience, Mr. Shurman, with respect to call centre activities, but this is obviously not outbound, it's inbound. This is about retention of clinically skilled individuals, and we've seen how challenging that can be quite recently, as the company has indicated.

We also want to have a respect for people's health needs, and not create a perverse environment: "I want to get off the call because I'm going to make more money with the more calls I take." This is not a volume business, it's a quality business.

Maybe that was the wrong choice to have made back in 2007. I think, as Mary has quite rightly said, we're prepared to revisit that should it be in the best public policy interests of Ontarians.

Mr. Peter Shurman: That's a good answer. I think that part of what we do at the committee is to dialogue a little bit, so that maybe we can shine a light on some of—I'm not looking to be adversarial here. I'm looking to bring some of this to the surface. Obviously, in the last couple of minutes, we have.

Let me focus for a second on wait times, which are detractors—it's a major detractor—from the use of the service. What happens when you have heightened wait times is that you push people to go and use some other service. What would another service be, if you can't get somebody on a phone? Almost anything in the range of services available would be an expensive person-to-person intervention somewhere. So the wait times are not a positive thing, and from what we are seeing, about 25% of people in the wait queue fall off. They just never make it; they don't wait. You have a high service level on the people who do get through. Is that a correct characterization?

Mr. Bruce Woods: It's correct, and I believe that 25%—I think we are arguing. Nineteen per cent to 25% of the people in the live queue, at approximately six minutes, are saying, "I've waited long enough." I'm sure we can all relate to that. If you're sitting there in a queue for six minutes and nobody's answering the phone, you might go—

Mr. Peter Shurman: "The hell with it." That's what you do.

Mr. Bruce Woods: Or, "I'll call back and see if they'll call me back."

Mr. Peter Shurman: I'm told that we don't have accurate—or any—statistics available to us on the waiting queue; that you can't supply those. Is that true?

Mr. Bruce Woods: We did not supply those.

Mr. Peter Shurman: You did not.

Mr. Bruce Woods: Right. But we can supply those, and we have since supplied those. They weren't supplied because—I mean, what's that expression? What gets measured gets managed?

The goals of the program are outlined. We try to live by the goals of the program and we've met the service level. If, however, there's some indigestion with the fact that this isn't being measured, we've come back to Mary and said, "Here's the data for"—I don't know. How many months? Was it 12 months?

Interjection.

Mr. Bruce Woods: It was 14 months. And if you look at this, on average, it looks like it's about six minutes.

Mr. Peter Shurman: Six minutes before somebody leaves or six minutes before somebody gets answered?

Mr. Bruce Woods: No, that's their abandonment point. You're always wanting to challenge the expectations. Our expectations will vary depending on the alternatives available.

The analogy I might use is, if you were calling to buy a new computer from a computer company and they were slow answering the phone, you would be pretty impatient, and then you'd just go over to the other guy. But if you were calling the computer company because your computer's broken, you might be prepared to wait 15 or 20 minutes.

Mr. Peter Shurman: I've done it, and so have you.

The question here is, when you give me six minutes, is that the average wait time to abandon? Is that what you're saying?

Mr. Bruce Woods: In the live queue.

Mr. Peter Shurman: In the live queue.

Mr. Bruce Woods: Yes.

Mr. Peter Shurman: And is the—

Mr. Bruce Woods: Am I correct, Denis?

Mr. Denis Thibodeau: If I can correct the—the average wait to abandon in that time period was 6.7 minutes, and the average wait to the call being answered was 6.4.

Mr. Peter Shurman: That's weird. How can that be? If the average wait was 6.4—

Mr. Denis Thibodeau: Of those answered.

Mr. Peter Shurman: —and the average time to abandon was 6.7, that's kind of at odds with what you'd think.

Mr. Denis Thibodeau: Of the calls that were answered, they were answered within 6.4. That's an average. Obviously, some are higher and some are lower.

Mr. Peter Shurman: Yes, I understand.

Mr. Denis Thibodeau: And of those that abandoned, their tolerance level, on average, was 6.7 minutes.

Mr. Peter Shurman: And what's your percentage of total calls that hit the switch that were abandoned?

Mr. Denis Thibodeau: Six per cent of total calls.

Mr. Peter Shurman: Okay. Let's move to another question that came up before, and that's recording. We've heard some allusion to privacy issues on recording. In the call centre world, loggers, now digital, are pretty standard. Are you able to digitally log these calls? Anybody?

Mr. Denis Thibodeau: Well, we were in recent conversations with the ministry, and we have permission to proceed. We have some procedural issues to work out in terms of how long we can archive some of the recordings. Now we're in the process of evaluation, evaluating a couple of solutions.

Mr. Peter Shurman: So what you're telling me is that the equipment exists, the ministry is provisionally saying, "Go ahead," you haven't implemented but you will?

Mr. Bruce Woods: Yes.

Mr. Peter Shurman: Well, that's a good thing.

What else have I got? Quality-of-service review: In other jurisdictions—

Interjection.

Mr. Peter Shurman: Do you want to clarify something?

Mr. Saäd Rafi: We should clarify that, because I don't think we've come to ground yet on whether we can tape the call. We will be guided by the privacy commissioner. We've had some positive discussions. I won't speak to the technology available in order to do so and the length of time in order to retain. Those are decisions we have to make, and then we'll inform the service provider.

Mr. Peter Shurman: So my word "provisionally" would be provisional upon these various concerns?

Mr. Saäd Rafi: Fair enough. I just wanted to be accurate.

Mr. Peter Shurman: Okay. The last element of my questioning would be this quality-of-service review, which seems to be fairly loose to non-existent in Ontario at this time versus some other jurisdictions—things like mystery callers or whatever form of quality-of-service review might be appropriate. Where do we stand on this at this time?

Mr. Bruce Woods: Susan brought up the fact that, basically, in our operation, we look at things one off. Say you're a nurse, I'm monitoring your call, and there's a deficiency in that process; we address that. Or if there's a complaint, we address that.

I think the point Susan was trying to make was, "Don't you, as the big cheese, Bruce, want to be able to sit there and say, 'Systematically, across the entire domain, what are the burning issues?'"

What we've been doing is taking all the complaints, consolidating them and attempting to identify what the reason codes are, for the lack of a better word, for those complaints. If I recall correctly, what I saw last month was basically customer service empathy or something from the nurses. Is that correct? What was the number one point of indigestion for the nurses on complaints?

Interjection.

Mr. Bruce Woods: Anyway, we consolidated all this complaint data. So that's what we're trying to do. Then we're going to work with the ministry. So we would go out and talk to Seetha and say, "Seetha, what would you like to see in the way of this reporting?" We want it, from an internal point of view, from Six Sigma and variance and all those kinds of reasons. We weren't desirous of it, but we were guilty of not doing it.

Mr. Peter Shurman: I think that's an interesting aspect and I applaud you for it, but what you're talking about is responding to complaints. I think we could say about almost any discipline that complaints are the ultimate outlet for anybody who really wants to take things to completion. What I'm asking about is a quality-of-service review that is not based on complaints. Maybe I can ask the ministry people where we stand on that.

Ms. Mary Fleming: We'll be undertaking independent satisfaction surveys of individuals who have used the service or individuals who are affected by the service. As well, we have a range of committees that we convene in order to learn more about how the service is affecting people in different parts of the province. We will also be working with our own internal audit branch to make sure we're finding out as much as we can about the quality of the service.

Mr. Peter Shurman: Thank you.

Mr. Jerry J. Ouellette: A couple of quick questions, Chair?

The Chair (Mr. Norman W. Sterling): Sure.

Mr. Jerry J. Ouellette: The first one is, during your presentation, Deputy, in the opening remarks, you mentioned that the service provides one aspect that—since we've been here, we've done some checking. There are a number of MPP offices here that we've checked with and nobody seems to know the fact that you aid and assist in providing doctors for individuals—full-time docs. How do you convey that information to the members, because, quite frankly, I imagine other members' offices are just as inundated as we are with individuals looking. We had no idea—my office didn't—and I've got a substantial number of MPP offices that have said, "We didn't know that." How do you convey that so that we can get that information out and provide that service? And where else is it provided of the various services that you provide?

Ms. Mary Fleming: Are you referring to Health Care Connect?

Mr. Jerry J. Ouellette: Yes.

Ms. Mary Fleming: I'm disappointed to hear, as my ministry colleagues will be, that you're not aware of the Health Care Connect program. But I will certainly be taking back the fact that we have to get a communication out to all MPPs about the service. Also, we have a CCAC nurse in every CCAC, and we'll put them in touch with the members.

Mrs. Liz Sandals: Can I just comment on a point? I was quite aware that the service, Health Care Connect, existed; it was just that I didn't realize that it was you that was doing it. But I think if you go to the ministry website, there's information there about Health Care Connect, isn't there? I think the information is on the ministry website. I just didn't connect it with you.

Mr. Saäd Rafi: We'll take that as feedback that we could do a better job of making members in all parties aware. Fair enough.

Mr. Jerry J. Ouellette: I think the time is up.

The Chair (Mr. Norman W. Sterling): The time has expired. Thank you very much for coming today. I don't know whether we can ask members to stay for a few seconds after to try to give any instructions—

Mrs. Liz Sandals: I've got a call waiting upstairs.

The Chair (Mr. Norman W. Sterling): Okay. Just keep your memories active so we can—

Interjection.

The Chair (Mr. Norman W. Sterling): Yes. We can talk briefly about this as we're doing our report writing at 9 o'clock next Wednesday morning.

Thank you very much for your appearance. Thank you very much for coming, Mr. Woods.

The committee adjourned at 1454.

CONTENTS

Wednesday 14 April 2010

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Chair / Président
Mr. Norman W. Sterling (Carleton–Mississippi Mills PC)

Vice-Chair / Vice-Président
Mr. Peter Shurman (Thornhill PC)

Ms. M. Aileen Carroll (Barrie L)
M^{me} France Gélinas (Nickel Belt ND)
Mr. Jerry J. Ouellette (Oshawa PC)
Mr. David Ramsay (Timiskaming–Cochrane L)
Mrs. Liz Sandals (Guelph L)
Mr. Peter Shurman (Thornhill PC)
Mr. Norman W. Sterling (Carleton–Mississippi Mills PC)
Mrs. Maria Van Bommel (Lambton–Kent–Middlesex L)
Mr. David Zimmer (Willowdale L)

Substitutions / Membres remplaçants
Mr. Yasir Naqvi (Ottawa Centre / Ottawa-Centre L)

Also taking part / Autres participants et participantes
Mr. Jim McCarter, Auditor General

Clerk / Greffier
Mr. Katch Koch

Staff / Personnel
Mr. Ray McLellan, research officer,
Legislative Research Service
Ms. Susan Viets, research officer,
Legislative Research Service