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Mercredi 17 novembre 2010

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Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

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Vérificateur général :
Ministère de la Santé et des Soins
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 17 November 2010

Mercredi 17 novembre 2010

The committee met at 0907 in committee room 1.

2009 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.01, assistive devices program.

The Vice-Chair (Mr. Peter Shurman): Good morning, everyone. The public accounts committee is meeting this morning in public session for the purpose of listening to a further deputation from the Ministry of Health on the assistive devices program, pursuant to a letter written by the Chair of this committee, Norm Sterling, on August 9. Particularly, we want to hear from the ministry on the following items: the ministry does not capture volume discounts; lack of customer service monitoring; lack of interjurisdictional price comparison; price of home oxygen concentrator provisions; lack of comprehensive wheelchair recycling; and the need for appropriate staffing levels.

Deputy Minister, would you, for the purposes of Hansard, please introduce your team and make your presentation?

Mr. Saäd Rafi: Thank you very much, Chair. Good morning, and thank you very much to the committee for this opportunity to address you on the 2009 Auditor General's annual report on the assistive devices program, the ADP.

To my right, I have Patricia Li, who is our assistant deputy minister of a division called direct services, which is responsible for the ADP, and to my left, I have Susan Picarello, who is our director of the assistive devices program branch.

As you all know, the auditor and this committee have made a broad range of recommendations for changes to the program. I think that since March, about eight months ago, or since our last appearance here, the ministry has achieved substantial progress in addressing those recommendations. Before I get into the specifics of our progress, if you'd allow me, I'd like to provide you with some background.

As you likely know, ADP is designed to help people with long-term physical disabilities obtain the equipment and supplies they need to live as independently as possible. Its clients are some of the most vulnerable in Ontario. The program covers 26 types of devices, with more than 8,000 pieces of equipment and supplies. It is a complex, multi-faceted program with over 277,000 clients, about 1,400 vendors, over 6,000 health care professionals and 13 transfer payment agencies.

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In order to address the Auditor General's recommendations, as well as to enhance the transparency of the ADP policy framework, the ministry is currently engaged in an ongoing, comprehensive modernization of ADP. This involves applying strengthened controllership principles with enhanced accountability for how public funds are managed and expended. The program has been reviewing its current business processes and engaging in discussions with vendors, authorizers and the community to ensure that clients receive services in as streamlined and effective a way as possible, and that taxpayers receive value for their investment. The ministry wants to ensure that the program is responsive to the changing assistive devices marketplace.

A key element in improving claims processing is our new IT system, which is under development at this time. The current system, which originated in the 1980s, is severely outdated and not aligned with current business practices. The new system includes modern, standardized and streamlined procedures to process claims as well as vendor and client payments. It is designed to significantly reduce manual and paper processing and to drive efficiencies. Automatic approvals are expected to increase from 50% to 80%. At current levels, this represents an increase of about 88,000 claims.

The application process and forms are also being redesigned to make them more client and vendor friendly. This will facilitate access to ADP funding assistance while improving the program's ability to ensure that funding is only going to eligible individuals. In addition, the system will provide enhanced abilities to track overpayments and increase controllership capacity. So, really, a fundamental business process redesign is under way.

I'd like now to turn to the progress on the auditor's and the committee's specific recommendations.

On capturing volume discounts, the Auditor General's report asked us to do two things: update our prices more regularly and look at the factors that are included in how we set our prices. We're doing both of these.

In response to concerns about the program's funding models, including limitations on our ability to capture

volume discounts, the ministry is committed, wherever possible, to obtaining volume discounts and using a procurement model. In addition, the ministry is conducting an independent external review of how we set our prices. The external review is scheduled to be completed early in the new year.

An overarching pricing and funding restructuring review will cover all device categories, but will take a detailed look at those that represent the highest amount of program spending, which are mobility devices, respiratory devices and sensory devices such as communication, hearing and visual aids.

In other product categories, such as facial and limb prostheses, the devices or components are custom made to meet the specific needs of a small number of clients, relatively speaking; therefore, volume discounts do not really come into play.

The ministry will take advantage whenever possible of ADP's position as the largest funder, by volume, in Ontario for assistive devices. For example, the ministry is considering, expanding the use of the insulin pump model, under which we have negotiated with manufacturers directly the prices charged to the program's clients for pumps.

The pricing and funding restructuring review is also looking at the current supply chain model for ADP-funded devices in which ADP has a limited or, for the most part, no role in the purchase of devices. We are looking at how to drive efficiencies in the supply chain, though.

The funding and pricing model restructuring review will ensure that in cases where procurement opportunities arise, ADP reviews prices and discounts based on volume in order to reduce costs to the taxpayer. At the same time, the restructuring review will ensure that clients with disabilities continue to have appropriate access to the products and services they need wherever they live in the province.

The pricing restructuring must therefore also take into account the need for vendors across all regions of Ontario and ensure they are compensated fairly for their services to avoid economic consequences that might reduce access for disabled Ontarians in various parts of Ontario. It's important to note that many devices require frequent personal interaction between client and vendor. For example, vendors with the home oxygen program must visit the client's home at least once a month to replace the oxygen as well as to check for pressure issues and other related matters in the home. In the case of wheelchairs and prosthetic devices, fittings and adjustments must be made for every new device for a client.

The ministry is completing a pricing refresh in categories where prices have not kept up with market trends and where there is a need for adjustments. The ministry is planning to make changes to the computer pricing model and is exploring other changes, including in the ocular and orthotic categories.

In implementing all these changes, the ministry wants to ensure that the ADP is paying competitive prices while remaining fair to clients and vendors, and ensuring the best value for taxpayers' money. We're still finalizing the review of other products to determine where we can realize savings, as suggested by the auditor.

In addition, you mentioned computer pricing. I'll now provide you with some context and details about the pricing of computers for communication and visual aids, since the auditor and the committee expressed particular concerns about these items.

On average, ADP spends only 1.2% of its total budget—so $4.1 million out of $342 million—on funding for computers that deliver assistive technologies to Ontarians. Last year, ADP funded 750 desktops and 550 laptop computers, for a total of 1,300 units. I think you'll agree that ADP funds a small portion of Ontario's market share of computing devices.

Currently, a desktop computer system, including a large monitor and printer, is funded at $4,127, while a laptop system, including a printer, is now funded at $4,461 under ADP's price guide. The ministry agrees with the committee and the Auditor General that this computer pricing is higher than current market prices.

As a result, we've reviewed, on a priority basis, computer prices in retail stores—among them, Best Buy and Future Shop—and have reduced the price as follows: We will have priced the maximum cost for a desktop computer, including a large monitor—so that's over 19 inches for these types of clients—and a laser printer at $1,733, with ADP paying a maximum fixed price of $1,300 and the client paying $433—that's 25%—unless they are on the Ontario disability support program, in which case the full amount is paid by ADP. For a laptop with a larger screen, which is over 16 inches, plus a printer, the pricing will be $1,824, with ADP paying a fixed price of $1,368 and the client paying $456. Again, for ODSP clients ADP pays the entire amount.

The prices for the specific adaptive technology required for visually impaired clients and/or clients with communication difficulties will remain the same. Examples of these types of technologies include readers, laser pointers and speech recognition software.

The changes to the computer model will result in over $2.2 million in annual savings to ADP. This will also benefit each ADP client because their proportional share will reduce, with a savings of $599 for a desktop computer and $659 for a base laptop computer—a reduction from the 25%, as I mentioned.

Lack of customer service monitoring: In terms of the committee's concerns around customer service monitoring, the program does conduct biennial customer satisfaction surveys to monitor the services it provides. The last survey conducted in 2008 indicated that 87% of respondents were satisfied with the overall assistive devices program.

The ministry continues to improve on its ability to serve a growing and diverse community of clients through better and more frequent customer service monitoring.

In 2011, ADP will implement a three-pronged approach to better monitor the customer service of vendors

acting on the program's behalf. This approach will include continuing to conduct biennial surveys to maintain consistency, implementing category-specific surveys and tracking client inquiries.

The price of home oxygen: In response to the concerns about the cost of home oxygen concentrators, I'd like to note that the program pays for the rental of a complete oxygen system and the services required to maintain oxygen therapy in the home, such as 24/7 emergency response.

As a result of a government decision in 2008, the ADP conducted an open procurement process that resulted in a vendor of record arrangement for home oxygen services effective April 1, 2010. This VOR, or vendor of record, arrangement includes a new pricing schedule, changes to the funding model and improved mandatory services that the vendor of record must provide to ADP clients.

The new pricing schedule took into account cost drivers established by an independent study and a jurisdictional review of similar programs in Saskatchewan and Alberta.

Along with the new pricing schedule, the change in the funding model will reimburse vendors for service delivery dates only. This is a change from the previous policy whereby vendors were reimbursed for a full month of service, regardless of the actual date when home oxygen therapy was initiated.

The new VOR has resulted in a decrease in funding from $1,342 to $1,172 for a client on home oxygen for 90 days, and a decrease in funding from $7,002 to $6,847 for a client on home oxygen for 18 months. This results in an overall savings to the program of over $2 million per year.

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The ministry conducted a second jurisdictional review recently which found that with the new pricing schedule and the changes to the funding model, Ontario's costs for a 90-day funding period are very close to Saskatchewan and Alberta's: $1,208 in Saskatchewan, $1,155 in Alberta and $1,172 in Ontario.

I'd like the committee to note that as part of the mandatory service requirements, the ADP now requires the physician to perform an annual assessment of the client's ongoing need for home oxygen. During the first year, the physician must reassess the client's medical eligibility for home oxygen therapy after the first 90-day and 12-month period; 49% of clients are taken off home oxygen by their physician within the first 90 days.

You also asked about a comprehensive wheelchair recycling approach. In his report, the Auditor General encourages the ADP to initiate a recycling program for manual wheelchairs, citing programs in Alberta and Quebec that recycle and refurbish manual wheelchairs. The manual wheelchairs that the ADP funds are very complex. They are not at all like the transport-type wheelchairs one might see in an airport, for example. To illustrate, we've brought a picture, to my right, that compares the two types of wheelchairs. Of all the manual wheelchairs funded by the ADP, the most common type—36% of the total—is that tilting wheelchair on the right. This wheelchair requires complex pressure cushions which need to be customized for each individual user. Recycling these types of cushions is difficult not only because they are custom-fitted, but also because they would require disinfecting to meet sanitary standards. Nevertheless, the ministry is committed to improving recycling and is currently negotiating with a community agency to have them conduct a manual wheelchair recycling pilot project.

I would also note that the program does recycle the most complex and costly high-technology wheelchairs under a contractual agreement with Shoppers Home Health Care, which manages a central equipment pool. As with manual wheelchairs, a significant amount of the equipment returned to the CEP, or the central equipment pool, is not suitable for recycling due to the age and occasionally due to the condition. Some equipment is so specific to an individual client that it is not appropriate for any other client.

However, ministry data on the number of recycled high-technology power wheelchairs indicates that the equipment pool has met its targeted 20% recycling rate. From March 2007 to February 2010, 586 wheelchair bases and 652 power dynamic seating systems have been returned to the CEP for recycling, Of these, 199, or 34%, of the bases, and 232, or 36%, of the dynamic seating systems have been recycled and are being used by other ADP clients.

In addition to the specific concerns of this committee that I've just addressed, let me now outline the significant progress the ministry has made in other areas raised by the auditor.

Recovering duplicate payments: In terms of duplicate payments, the ADP currently has an informal process with the Workplace Safety and Insurance Board—WSIB, as you know—to identify program clients who are WSIB recipients in order to recover duplicate payments. The program is finalizing a data-sharing agreement with both the WSIB and Veterans Affairs Canada to share their clients lists in order to speed up the process and enhance accuracy. Once the agreements are completed, ADP will not fund any required devices related to either that particular work injury or the veteran's pensionable condition. It is anticipated that these agreements will be in place later this year, hopefully thereby eliminating any duplicated payments.

The ADP has a letter of intent with the WSIB with the stated purpose to set forth these mutual intentions and to develop and execute a data-sharing agreement. A similar letter is being sought with Veterans Affairs Canada.

Conflict of interest: To increase accountability, the program is in the final stages of implementing an updated conflict of interest policy. The updated policy that vendors will be required to adhere to provides clear definitions and examples of conflict of interest, and will strengthen our business processes and compliance protocols.

Also being developed are guidelines for managing breach of authorizer agreements and vendor contracts.

These guidelines outline the steps that the ADP will take if an authorizer or vendor is found to be in breach of any ADP policy.

These policies and guidelines strengthen an enhanced claims monitoring and review protocol that will be used to detect abnormal claim patterns. ADP will conduct regularly scheduled reviews of claim patterns for all devices. These reviews will enable the ADP to identify authorizers and vendors who may be in breach of ADP policies.

In terms of accountability agreements with health care professionals, the ministry relies on the services of regulated health care professionals, called authorizers, to determine the assistive device that will best support an individual's independence. The program has been working with the eight regulatory colleges that represent authorizers. To date, six of these colleges, representing approximately 99% of authorizers, have agreed in principle to work with the program to ensure that the professionals providing services to ADP clients have the credentials and professional status to do so.

These new procedures are an important measure for protecting clients and increasing the ministry's accountability. It is also an important step forward to working with the ministry's partners, something that we continuously promote.

I'm also pleased to report that, since November 2009, the ministry has collected $1.147 million in overpayments and $103,000 in duplicate payments, for a total of over $1.2 million.

Since February 2009, after identifying some irregularities, the ministry has been reviewing all claims for personal frequency-modulated hearing systems, known as FM systems. As you likely know, these devices are helpful for an individual to hear conversations in small group situations, such as meetings and classroom training. As part of this review and correspondence with vendors and authorizers, there's been a dramatic decrease of over 80% in claims for FM systems, from over 5,000 in 2008-09 to just over 1,000 in 2009-10.

With the assistance of an expert panel of health care professionals, the ministry is developing updated and more detailed eligibility criteria to assist vendors and authorizers in understanding the requirements for ADP funding of FM systems. Ontarians who require FM systems, of course, will continue to receive funding assistance through ADP.

In response to concerns regarding ministry staff's ability to detect and prevent fraudulent claims, the program has implemented two important initiatives. First, staff at the ADP have received ongoing training in the areas of risk management and risk assessment to allow the program to proactively detect and reroute fraudulent claims.

Secondly, ministry staff have been specifically assigned to examine ADP claims for patterns that might indicate fraud, or, where appropriate, forward supporting documents to the OPP for further investigation.

And finally, we are determined to improve our capacity to increase auditing and evaluation of vendors.

In conclusion, I'd like to say that this is a very significant business process redesign and IT legacy system renewal. I can tell you that my focus since arrival at the ministry in February 2010 has been to re-establish a high standard of modern controllership practices at the Ministry of Health and Long-Term Care. That focus is very much in keeping with the auditor's core business and, in particular, his recommendations and your committee's recommendations around the ADP.

I'd like to reiterate that the ministry is committed to addressing all the concerns raised by the Auditor General and this committee, and to continue working hard to ensure that this program, as all other health care programs, is accountable and provides access, quality and value for money to benefit Ontarians.

Thank you again for this opportunity to speak with you today.

The Vice-Chair (Mr. Peter Shurman): Thank you very much, Deputy Minister. That was a full presentation, and I feel it was a good response to the letter sent to you in August.

For the committee, what we'll do is go around in 10-minute segments to the extent that we have them and allow for questions, starting with the NDP. Madame Gélinas.

M^me^ France Gélinas: Good morning and thank you for your presentation. The first question that arises is on page 18 of your presentation, where you talk about a "dramatic decrease of over 80% in claims for FM systems." Do you have a sense as to who was putting claims before who are not putting claims anymore? Eighty per cent is huge.

Mr. Saäd Rafi: I'll ask, alternatively, on some of the details, if you'll allow, either Patricia or Susan to help me out. Initially, I would say that I should have given the time frame as well. That's approximately over a two-year time frame but, nevertheless, a significant decrease. Perhaps, Susan, you can address that reasoning.

Ms. Susan Picarello: Sure. Essentially, what we found in doing the assessment was that many times the authorizers and/or the vendors were prescribing FM systems when in actual fact the client needed only a hearing aid. So what we've done is, we've actually given more education to the vendors and authorizers, and we're going to have new eligibility criteria that we've strengthened and explained to them in more detail, based on the findings of an expert panel. We've gotten health professionals together to make sure that everyone is clear, and we've come up with more detailed eligibility criteria to make sure everyone is clear on what that is.

But, essentially, the FM system is a bit better. It allows for clearer discussion in a group setting, but not everyone who needs a hearing aid needs an FM system. What we did find when we were doing the search is that many times, clients got an FM system, but because it's a bit more complex and also it's a bit different in terms of the acoustics that you hear, what happened was people were actually getting them but then keeping them in their closets or making very little use of them.

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That's why now, with the decrease, it's really that the 1,000 clients that we have now are the ones who truly need the FM systems, and that's clearer. We are going through and having discussions with the vendors about that.

M^me^ France Gélinas: For this particular, is the authorizer often also the vendor?

Ms. Susan Picarello: In many cases in the hearing aid sector, the authorizers are employed by the vendor, the audiologists.

M^me^ France Gélinas: They are. Okay.

My next question, you didn't address directly; you did when you mentioned the every-two-years survey. I still get a lot of people who complain about—and I get it from two groups. There are the people who have been recommended by a prescriber—we'll take a walker—to get a walker, and the time it takes before they have their approval, and then I get it from the vendor who talks about the time it takes to get reimbursed. Any work done in that area?

Mr. Saäd Rafi: I'll start by saying yes, I think the claims backlog is something that was identified and was discussed previously here, so there has been a significant increase in volume—not an excuse, but a point of fact in data: a 62% increase over eight to nine years.

To address this, we've done a few things. We've added 11 additional staff to develop a project modernization function where we're trying to deal with the claims backlog, through an IT system refresh that I mentioned, which we hope will start its first phase in mid next year. This will allow for automatic claims processing, so it will eliminate the hand-offs and paper manual assessment. That hopefully will reduce claims processing to a large extent. In addition to that, I would say that the business process redesign that Patricia and Susan are putting in place will also help dramatically.

But it does bear mentioning that we do have a six- to eight-week maximum adjudication process to payment in many of our claims categories. However, in the most high-volume categories—that's where I'm sure you're hearing from others in your communities—we are trying to address respiratory, hearing aids; to your specific point, home oxygen and mobility devices. This is part of the business process redesign activity: new staff, IT system improvement and trying to keep pace with the volume of claims, which has really gone from 180,000 to 300,000.

M^me^ France Gélinas: So you are working on it. Let's talk about mobility aids, a walker more specifically, because this is the one I hear about most often. How long, right now, does it take for a claim to actually be approved?

Mr. Saäd Rafi: Sixteen weeks, and we have 3,200 claims in backlog, so we're trying to address those quite deliberately.

M^me^ France Gélinas: What are you aiming for? Do you agree that 16 weeks is too long?

Mr. Saäd Rafi: Oh, absolutely. There's no question about that. That's why we've tried to address it from a staffing point of view as well as a processing point of view. For example, we're trying to apply lean processing, used very successfully in manufacturing processes, to eliminate steps that are unnecessary. Also, I think—since we have vendor representatives here—that's going to be easier from an application process for vendors.

In addition to that, instead of the incremental patchwork kind of changes that have been made over the years to the program, we're really doing this as a fundamental, ground up review, so working with vendors, working with community members and health care professionals to redesign the application process both for clients and for vendors, because the application process is not that easy for the client either, even though authorizers are providing a valued assistance to them—and also, as I mentioned, to put in a systems change. I would say to you that we will not likely see very significant reductions until that system change takes place. So we're targeting June 2011.

M^me^ France Gélinas: June 2011.

Mr. Saäd Rafi: For the first phase of the systems implementation, yes.

M^me^ France Gélinas: And then the 16-week wait for application process could be decreased to—

Mr. Saäd Rafi: Do you want me to commit to a—

M^me^ France Gélinas: You don't have to commit, but give me an idea of what you figure would be a reasonable time from the time the person says, "Yes, you are at risk of falling. You need a walker. Go get it; the sooner the better," and this person has had a fall and is afraid of falling again. How long before?

Ms. Patricia Li: As the deputy said, what we have done is we put a team together to address specifically the backlog in the high-volume areas, which would include mobility devices. We have a 12-week plan, so the plan is to have all the backlog within that longer period rather than the standard completed by January 2011.

M^me^ France Gélinas: That's for the backlog?

Ms. Patricia Li: For the backlog. As Susan mentioned, we have ongoing about 5,000 or 6,000 claims per week, so we are also putting additional staff in to address that so that we don't slip off in terms of the work in progress. That, as an established standard, is between six to eight weeks.

M^me^ France Gélinas: Six to eight weeks?

Mr. Saäd Rafi: Sorry, could I just make one thing clear, though? In your example, I just want to clarify something. The client doesn't wait that period of time in order to get the device. The client gets the device as soon as the vendor can supply the device. If we're disadvantaging someone with a backlog, which I accept that we are, it's the vendor, not the individual who needs a mobility device, a visual aid device or a communications device. I think that's a really important distinction for the record.

M^me^ France Gélinas: I would bring that a step further. Now the vendors are subsidizing so many of

those that they are at the point where some of them will face bankruptcy, some of them are not doing too good and some of them will also hold back giving the device because they can't fund them anymore because they have been waiting for eight months and haven't been paid.

Mr. Saäd Rafi: I would really encourage you to let us know if there are any vendors that are holding back providing devices to clients, because that's something that we will deal with immediately. That is not acceptable. If there are vendors that you are aware of who have concerns about their financial situation or are going into bankruptcy, I would encourage you to let us know about them as well. We will do our utmost to work with them and the association representatives who are here today.

The Vice-Chair (Mr. Peter Shurman): That's 10 minutes. Thank you very much, Madame Gélinas.

Liberals? Mr. Arthurs.

Mr. Wayne Arthurs: Deputy, thank you for your presentation this morning. It's the first time I've had the opportunity to be at this committee with folks presenting, so I appreciate this and I appreciate the presentation. It's helpful.

I've got a question around the new IT system. If I understand—and you can correct me if I'm wrong at this point—from your earlier presentation and your comments so far this morning, you're looking to mid-next year, June 2011 or thereabouts, for the implementation of the new IT system, which will ideally help with the issues of verifying claims and the like.

You speak in your presentation about how automatic approvals are expected to increase from 50% to 80%, and at current levels this represents an increase of 88,000 claims. Two things: One, how is that process intended to work, i.e. the automatic approvals? Is that automatic from the standpoint of the computer giving that approval, in effect, or is it just reducing a lot of the manual work that's done? Secondarily, will it be primarily driven by renewals as opposed to first-time-applicant approvals?

Mr. Saäd Rafi: For those details, I'll ask Patricia to address the questions.

Ms. Patricia Li: The computer system in phase 1 is going to generate a number of things, and then I'll address your specific questions. Basically, it is a 28-year-old system which needs replacing. The replacement and the setting up of the new system will integrate with Ontario public service technology standards; so that's first and foremost, particularly for privacy and security concerns.

The other thing: From a business processing side, we have internal and also external. One is, currently the system does not allow us to generate business management reports for the claims assessor or for program staff. We do need very specific programming. That is very time-consuming. This is going to generate a better reporting system for managing trends and claims management.

On the external side—which answers your question—I think it's both for first-time and renewal applications that they will be electronically processed from an approval process. In addition to the systems redevelopment, we are introducing new business rules which are more streamlined. The forms currently are quite complicated for any individual to fill in manually. Therefore, there are many manual interventions. So the expectation of the system is to—the business side has to streamline its business process and business rules, and the system will help us to automate those processes.

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The result, obviously, is that it would increase from the current 50% automatic approval to 80%. If you look at our number of claims, which was around 290,000 last year, if you are doing 150,000 of those manually and 150,000 automatically, this will increase it by 80% of that number.

Interjection.

Ms. Patricia Li: Automatic approvals? Maybe I'll defer to Susan, who can speak to the details.

Ms. Susan Picarello: For automatic approvals, it will mostly be for applications that are straightforward and are renewals where people have actually gotten the devices before. For example, with the wheelchair category, we allow a renewal every five years for a new wheelchair. So if it's a recurring client and they need almost the same type of wheelchair—because of course it's just wear and tear—that will go through an automatic renewal.

There are also some categories where we get the clients in on a more frequent basis, and those would go through an automatic renewal process as well.

Mr. Wayne Arthurs: So presumably, if I can make a presumption, this would free up human resource capacity to be able to deal with more complex requirements or applicants and to deal with issues of first-time clients: the verification that the need is legitimate and that it's being fully addressed?

Mr. Saäd Rafi: Yes, and I would also add that what we have witnessed, not only due to audits and program reviews in the past, is that the technology changes are fast and dramatic. So a need for continuous improvement of the program, as opposed to waiting for events or backlogs to develop—just to build on your point, we're hoping to stay ahead of those and keep pace with those changes as well as to meet the needs of the clients in that regard. So, a long yes.

Mr. Wayne Arthurs: Thank you. Much appreciated.

The Vice-Chair (Mr. Peter Shurman): Thank you very much. I have a couple of questions—

Mrs. Liz Sandals: Okay.

The Vice-Chair (Mr. Peter Shurman): Oh, I'm sorry.

Mrs. Liz Sandals: Did I use up my time?

The Vice-Chair (Mr. Peter Shurman): You haven't used your time. Go ahead, Ms. Sandals.

Mrs. Liz Sandals: I wanted to talk a little bit about the oxygen program, because the committee, when we did hearings before, spent a fair bit of time on the oxygen issue.

There were a couple of concerns there: one was the whole business around whether people are being re-

viewed, and if they no longer need oxygen, is that being terminated in a timely way? I think you addressed that.

But the other discussion that I think both the auditor and the committee had was around comparative pricing. You've noted that you went out and did some more comparative pricing. I think we still get into difficulty understanding the apples-and-oranges aspect of this. What's included in Ontario's price; what's included in some other price? How do you arrive at the comparables to see how we really stand up, relative to other folks? I wonder if you could give us a little bit more information about what you did when you went out this time, in terms of looking at other provinces and how we compare.

Mr. Saäd Rafi: Sure. Again, I'll try to begin that response, and colleagues can step in where I falter or leave out details that are necessary.

I'd start with sort of the overall price review on the home oxygen program that we did in mid-2009. This was, I think, essentially a financial survey of vendors to collect data on the costs that they incur in order to be able to do an apples-to-apples, as you rightly point out, comparison. Some of the key findings from that review—we had a very high vendor response, a 96% vendor response, so we have some confidence in the data as a result. We got a lot of co-operation.

Forty-four per cent of the costs incurred by vendors were for staffing, including the professional and non-professional staff. That's not surprising; in many businesses, people are where our costs are, so that increased from about 10 years previous from 33% to 44%—a significant increase. I think 12% of costs incurred by vendors were related to vehicle costs and just visiting homes in order to assist clients; 14% of costs incurred by vendors were for the purchase of the modality equipment.

Based on that cost analysis, what we did was take a look at the reimbursements, and we made some slight adjustments—and by the way, there are different costs in the north versus southern Ontario, I think for geographically obvious reasons. We adjusted prices just slightly up, by $8 in northern Ontario and $10 thereabouts or less—$8—in southern Ontario as well.

We also examined, then, what the prices were across other jurisdictions and what they were paying for. They have a monthly rate, a set-up fee—the actual oxygen systems—the assessment of the clients themselves, in terms of what they need exactly, and what were the funding periods, because perhaps we were looking at the wrong funding periods for the program, because of the oxygen needs. As I mentioned, 49% of people have a three-month need.

I would say that, just to give you some comparisons, where we could compare and get information across jurisdictions—I mentioned our southern Ontario monthly rate of $397. Saskatchewan had an at-rest rate of $459, and Alberta at $331. The set-up fee: We don't have a set-up fee; Saskatchewan has a $73 set-up fee; Alberta has a $178 set-up fee.

For the oxygen itself, the systems we provide, along with Alberta and BC, are the most complete systems, as opposed to Manitoba and Saskatchewan, which provide only the concentrators. We provide the concentrators, the liquid oxygen cylinders and the transfill systems.

I think the service components are essentially the same across all jurisdictions: set-up and delivery, home inspection, education and training, maintenance and, of course, emergency needs.

Then, assessment of clients: Actually, three jurisdictions—Manitoba, Saskatchewan and BC—didn't do the assessment, in the sense that the vendor wasn't involved; it was carried out by a hospital or what we would call an authorizer or a respiratory therapist or technologist.

Mrs. Liz Sandals: And that person would have been billing the OHIP equivalent for the assessment?

Ms. Susan Picarello: Actually, for the other jurisdictions that will do them, you actually have to go into the hospital for the day, so it would be a hospital billing.

Mrs. Liz Sandals: Okay, so it ends up on the hospital books?

Ms. Susan Picarello: Yes. So it's a much more expensive system.

Mr. Saäd Rafi: And then lastly, just to close it off, the funding periods varied all over the place, but we were very much in line with that—

Interjection.

Mr. Saäd Rafi: Sorry.

The Vice-Chair (Mr. Peter Shurman): No problem.

Mrs. Liz Sandals: He's telling me.

The Vice-Chair (Mr. Peter Shurman): I was telling her no more questions, but please complete your answer.

Mr. Saäd Rafi: Just to say that our timelines were the same as other jurisdictions: three months, nine months and annually; BC, three to six months and annually; Alberta, the same etc.

The Vice-Chair (Mr. Peter Shurman): Thank you.

Conservatives, since my colleagues just joined, I'll ask a couple of questions that are on my mind but not take the full 10 minutes.

If you were to nail this down as a process, the overview, from what I'm hearing, is the setting of criteria, data management, and control and pricing. If you have those in balance, is it fair to say that you then have a good assistive devices program?

Mr. Saäd Rafi: Establishing the right criteria, effective data management and the right—

The Vice-Chair (Mr. Peter Shurman): And pricing and control on these devices?

Mr. Saäd Rafi: I would say yes, and I'm presuming in data management, it's effective systems as well as processes.

The Vice-Chair (Mr. Peter Shurman): I'm going to go there, yes. That begs the next question. You've touched on the updating of a computer system that I believe your colleague said was—what?—28 years old originally? In the world of data processing, that might as well have come from the Stone Age. I'd like some amplification on that data management system or computer system for control of who's getting these

devices approvals and management of where they are. Where are we at now, with regard to the rebuilding of this system, and what's the ultimate hope and time frame?

0950

Mr. Saäd Rafi: From my previous visits here, I know you have a background in this, so I'm responding with some trepidation with respect to—

The Vice-Chair (Mr. Peter Shurman): Let's just say I fool people.

Mr. Saäd Rafi: —being at a disadvantage at the outset.

As you would know, and as the committee would know, the IT part of this is the enabler to execute on changes; so, garbage in, garbage out, as the adage goes. Really, what we're trying to do, where we have manual processes, is determine whether they're all necessary. There are several steps and hand-offs in any manual process, as one can imagine. That's step one. If they aren't necessary, that helps to address processing time and backlog issues.

Secondly, what's in the form itself? Are all the elements in the form necessary? The amount of manual assessment of the form also costs time because there are errors on the form—not in all cases, but on occasion. That is rework, and as we all know, in any business process, rework is time and cost. So trying to eliminate rework through an electronic assessment that would identify those types of errors and get them back to the vendor right away, instead of receive it, log it, mail it and, after having identified it and having it approved by somebody, mail it back to the vendor, and the vendor has their own processes. Obviously, the more electronic interfaces we can provide to our vendors, the lower cost they are going to have, the lower cost government is going to have and, therefore, the lower cost taxpayers are going to have. That, I hope, is some of the type of amplification you were looking for.

The Vice-Chair (Mr. Peter Shurman): It was, and the one piece I had asked about that I would like to get from you is: In your perfect world—we're talking about futures—when would you be able to say conclusively, "We know where every piece of equipment is, we know what the approval stage is for applications and this computer system is working as well as can be expected in a computer world of 2010/2011"? Best guess.

Mr. Saäd Rafi: Well, the realistic answer is probably underwhelming, in the sense that the first phase of our technology upgrades, along with our business process changes, starts to roll out January through to June. Pardon me, I misspoke: the business process backlog assessment. The backlog assessment starts to see results in January. The business process that continues to try to align with the first phase of the IT execution would be June. To know to the level of detail you have identified, Chair, I would say, would be early 2012, at a very ambitious level.

Now, increments in small and large doses are taking place throughout that time. To me, this is not necessarily about a switch being turned on and we have everything we need, but rather month over month of heavy lifting and slogging by these people and the staff they have brought on will show demonstrable change throughout that time frame.

The Vice-Chair (Mr. Peter Shurman): Thank you. One other comment: It was remarkable to me to see that when you went to Best Buy and Future Shop, it looks like you were able to bring the prices down by about two thirds. While it's funny, it's not so funny, because I remember that in the original hearing somebody said, "Well, why don't you go to Future Shop?" Ultimately, you did. So I'm glad we were able to effect that.

Let me turn it over to my colleague, Mr. Ouellette.

Mr. Jerry J. Ouellette: First of all, I apologize for being late. I have already talked to my staff as to why it was listed at 9:30 as opposed to 9 a.m.

What I wanted to talk about was price structuring. Prior to the program coming in, the individuals I met with who are heavily dependent on assistive devices stated to me that what they saw when the program came in was that the program funding support equated to the proportional rise in the cost of units. Have there been any studies to indicate that? All they said was that instead of paying $1,500 for a unit, when the support came in for $500 on a unit, the price went up to $2,000. Have we noticed any indications of this at all?

Ms. Patricia Li: We've undertaken, in general, a pricing review. We did undertake a pricing review on all the high-use categories, and we noticed that there need to be some adjustments, because devices differ. So, in the prosthesis category, there will be some adjustments to the price increase, because it's a small market, there are only a number of suppliers and it is a quite service-intensive category.

In more massive categories there will be some price decreases, so computer is one of them.

I don't know whether I addressed your specific question.

Mr. Jerry J. Ouellette: Well, it was prior to the program coming forward, the price of goods at that time. Once the program was implemented, there was a proportional raise in the cost of materials.

I've gone through your presentation and you mention about the lack of comprehensive wheelchair recycling. Specifically, on page 14 you state, "Some equipment is so specific to an individual client that it is not appropriate for any other client." That only deals with wheelchairs. What about other devices that may be utilized, specialty equipment? When I met with individuals on this topic, they were concerned that there was no ability to reuse some of the goods that were utilized for short periods of time, not specifically wheelchairs but other components as well. Has there been any look at recycling or re-utilizing some of the other goods that may be available out there?

Mr. Saäd Rafi: Do you have any examples, by any chance?

Mr. Jerry J. Ouellette: Beds—

Mr. Saäd Rafi: Beds.

Mr. Jerry J. Ouellette: —and specifically the assistance to lift individuals to beds and those sort of things were the ones that they brought to my attention.

Ms. Susan Picarello: I'm sorry. The ADP program doesn't actually include the funding of beds or the equipment to lift people. That is really funded by the CCACs if people need that at home. The assistive devices program does not cover it.

We do the wheelchair recycling for the high-tech wheelchairs, but many of our other devices—for example, hearing aids and prostheses—can't really be recycled because they're made specifically for the person. The area where we can do the most recycling is in the wheelchair category. We do it for the high-tech wheelchairs, and we're looking for a pilot for the manual wheelchairs.

Mr. Saäd Rafi: One of the reasons I think we've focused on manual wheelchairs was a finding of the auditor's report as well, to say that you have an opportunity that you're not taking advantage of. There's a significant volume. For example, there are 62,000 claims for all mobility devices, but the number of manual wheelchairs is about 17,000. There's an opportunity there, so we're trying to get a vendor. Other jurisdictions we looked at that do this, Alberta being one of them, actually physically warehouse these wheelchairs and they have some success with that. That's not a model that we wanted to embrace, just because of the high upkeep costs. Quebec, it's my understanding, provides them—is it through hospitals?

Ms. Patricia Li: Yes.

Ms. Susan Picarello: That's correct.

Mr. Saäd Rafi: We've been talking to a group called Stride, March of Dimes, and a third—

Ms. Susan Picarello: Red Cross.

Mr. Saäd Rafi: —Red Cross, to determine whether we can engage in a pilot recycling project. The point we're trying to make is that that's not the wheelchair we're providing; that's the wheelchair we're providing. It has very specific components to it, and hopefully we can find some pieces, parts and elements of it that could be recycled.

Mr. Jerry J. Ouellette: So the recycling that takes place, the programs—because I know you mention Red Cross, which I've worked with in other recycling, but they've taken the goods out of country. Are they to be utilized in country once they're recycled, or out of country?

Ms. Susan Picarello: They will be utilized in country, and they actually do have a program at the Red Cross now that recycles walkers, standard wheelchairs—not specialized wheelchairs—and some toilet seats, that sort of thing. So they do have depots in Toronto, I believe Thunder Bay, and one other location where they actually rent to people who need it for a short term. In the assistive devices program, people are only eligible if they're going to have their disability for longer than six months. It's a long-term type of disability program, so people who have, say, hurt their hip or have hip surgery often do go and rent the equipment or get it through the CCAC.

Mr. Saäd Rafi: If I might just elaborate, I would defer to the auditor, but when looking at the categories and elements, we have:

—Mobility devices: We've talked about wheelchairs and other ambulation aids;

—Prosthetics and orthotics: very difficult, very specialized, and they're not the orthotics that you and I might need, or I'd certainly need;

—The home oxygen program and the medical supplies that go with that: definitely not recyclable, although the tanks can be refilled, and they are; and

Sensory devices: communication, hearing and visual aids.

So the real opportunity, I think, lies where the auditor provided that finding and that recommendation.

1000

Mr. Jerry J. Ouellette: Those are all my questions for now, Chair.

The Vice-Chair (Mr. Peter Shurman): Thank you very much. Anything further from Madame Gélinas?

M^me^ France Gélinas: Yes, actually. I will keep on on what he was saying, that if you go to Shoppers right now to buy a walker, the first thing they will ask you is if your physician or your physiotherapist has given you the little paper, and if not, then the same devices are not the same price. So if I go in and decide to buy a walker for my aunt, who I feel would be more secure and I want her to try it, I can buy a walker at a much cheaper price than if I come into the same Shoppers Drug Mart on Lasalle Boulevard in Sudbury and say, "Aunt Lou has been referred by her physiotherapist. Here's the little paper that says she needs a walker." Have you looked into this at all?

Mr. Saäd Rafi: I'll just start by saying that, as Susan mentioned, ADP clients are with us for typically longer periods of time. I don't think it's a surprise to think and expect that we would want our vendor to supply a new piece of equipment, because that client, regrettably, will be with that piece of equipment for a long period of time. It's their business decision as to whether they wish to supply a gently used, previously enjoyed—whatever term you want to apply—walker for a non-ADP client. That's not our requirement.

I don't know if you want to elaborate.

Ms. Susan Picarello: We do set maximum prices for most of our categories so that the prices cannot be exceeded by the vendor. In order to avoid marking up of the costs or the prices, we do set maximums for most of our categories, like wheelchairs and the like. We do set those maximums so that the prices can't be marked up significantly.

M^me^ France Gélinas: What is the maximum for a walker?

Mr. Saäd Rafi: We'll have to get you that. I don't have that on my list right here.

Ms. Susan Picarello: We have wheelchairs but we don't have walkers.

M^me^ France Gélinas: In your talks with the vendors, did you identify—and this is something that the auditor

had talked about also—how many of the vendors don't actually collect the 25% cost share from the client?

Ms. Susan Picarello: No, we haven't actually had that discussion. Our expectation is that they would collect the 25% from the client, because our prices, for the most part, are based—there are some categories, for example hearing aids, where we only pay a $500 flat rate, regardless of how high the cost of the hearing aid goes. But for those categories which we split 75-25 with the client, our anticipation is that the vendors do charge the 25% to the client, unless, of course—

Mr. Saäd Rafi: And I would imagine that it's unrealized revenue for the vendors, so they're motivated to collect.

M^me^ France Gélinas: Of the 62,000 mobility devices, 17,000 were wheelchairs—

Mr. Saäd Rafi: Manual.

M^me^ France Gélinas: —manual wheelchairs. Can you give me the breakdown as to how you make up 62,000 mobility devices? I take it it's for this last year.

Mr. Saäd Rafi: Those are 2009-10 claims, yes. Again, I have the grossed number of claims against mobility devices, so we'd have to get you that in the following breakdown: manual wheelchairs, power wheelchairs and scooters, ambulation aids, and then positioning or seating devices.

Do you have that breakdown here?

Ms. Susan Picarello: We can get that. Basically, what happens is the wheelchairs are 17,000 and change, but each additional wheelchair requires a lot of seating, head rests, seating with cushions and that sort of thing, so that makes up a large portion of the 61,000.

I also did get the maximum price for the walkers: $416.

Ambulation aids is actually where we put the walkers and pediatric frames. When we talk about ambulation aids, we can get that breakdown for you, but the full type is manual wheelchairs, the power scooters and wheelchairs, the power-tilt wheelchairs, then the ambulatory aids and then the seating.

M^me^ France Gélinas: I would say that the one where the ADP becomes most visible to the people in our constituency office is at the low end, at the walker level. We have a growing older population, and more and more of them will require walkers to prevent falls and be safe. They are astute shoppers, and they like to come to their MPP. We have the perfect mix here, because they will go to the drugstore, find out how much a walker is and then go through ADP and find out how much more.

How come they are able to identify that the province is not getting value for their money, but when I talk to you, I don't get the same answer? You seem to be happy. You've put a fixed price of $416 for a walker, and you seem happy with this, when we have people who do qualify for ADP—lots and lots of seniors who have done their shopping; they go to those places regularly, and they have seen the prices—and are astonished to find out how much the province will pay through ADP for something they are convinced they can get way cheaper.

Ms. Patricia Li: First of all, I just want to give you additional information on walkers. We have two types. The one that is quoted by Susan is type 3, which is $416. There is another type that is $306. That's the current fixed price. Based on what Susan is saying, that's the ADP pricing structure for walkers.

As illustrated by the deputy in his opening remarks, we do have to look at these categories, including walkers, and refresh the prices based on market conditions. I think the Auditor General also pointed out that we're supposed to do that every two years. I think that particular activity, which we are committed to doing in the next two months, will bring some of these prices up to the competitive pricing, shall we say. But also keep in mind that we have to balance needs in terms of regional competition. That is part of our commitment, and we are committed to doing that.

Mr. Saäd Rafi: So a walker is not a walker is not a walker; I think that's one thing. I think it's easy to generalize on a product.

M^me^ France Gélinas: I'm a physiotherapist; I prescribe walkers. I know that all walkers are not created equal, and I recognize that. I'm talking more that we have an optics problem, where this mass of seniors who need this device are coming to my office and telling me that we are getting ripped off. We have an auditor who comes forward and says we are not getting value for money here, and I'm happy to see that within two months, you will have looked at those.

No disrespect: I realize that a walker is not a walker is not a walker. An arthritic who cannot use their wrist will have a completely different walker. I realize all of this. But the older person who qualifies for ADP, has done his shopping and ends up with an off-the-shelf walker from Shoppers will come to my office and say, "I could have bought this for that price, but because the government helped me, look how much the government is being taken for."

Mr. Saäd Rafi: Fair enough, and I'm not trying to be trite either. So, beyond the pricing review, perhaps we need to do a better job of communicating the differences among MPPs' offices so that, unlike yourself, because not everybody will have the extensive background you have, they will be able to respond to constituent needs with respect to variable pricing and variable product categories. The same could be said about going to Best Buy versus Future Shop. I can negotiate at Future Shop; I may not be able to negotiate at Best Buy. Full retail is full retail, and discount prices can be had from there.

I think we also have to set—and I think it's important to state this—vendor agreements across the province. Not every vendor has the ability a Shoppers would have in terms of reach. We also don't want to disadvantage clients who can't actually get to vendors outside their communities, and you, as MPPs, know better than anybody that they don't want to go outside those communities for that service, because there are all kinds of limitations on them.

Nevertheless, I think the important message we should leave you with is that we are proceeding to look at those

prices, product by product, and trying to review them, as recommended, to make sure we're keeping competitive.

1010

The Vice-Chair (Mr. Peter Shurman): Thank you, Deputy and Madame Gélinas.

Liberals, anything else? Mr. Arthurs.

Mr. Wayne Arthurs: I want to go to a section in your presentation around customer service monitoring.

To preface my query: On one side of the equation, at least in part, there's the client/customer, whether it's an ODSP client as such or someone else in an assistive devices program, where they're in a co-pay scenario, so there's a need issue and an eligibility issue, and authorization, verification, approval, payment and a follow-up—all those kinds of queries we have a particular interest in. But maybe as much, on the other side of the equation, is customer service monitoring and the satisfaction level of the actual client and customer.

In your presentation, you made reference to the 2008 survey—some 87% of respondents indicating overall satisfaction—and you referenced the intentions in 2011. I presume it's the next biennial, although it obviously takes time to get the data, verify it and tabulate it. So, at some point, probably in early 2011, you'll be looking at your survey process and looking at two or three different things you want to achieve in that: the continuation of it, implementing category-specific surveys and tracking client inquiries as an approach to better customer service.

I think it's important that we keep our eye, as well, on how satisfied the customer is with the service they're getting, as well as doing our job to query about verification, authorization and any overpayments, which are important, but the client also is a very important part of the picture.

Can you talk to me a little more thoroughly about the customer service part of it, as you move into 2011 and beyond?

Mr. Saäd Rafi: Sure. If you'll allow, I think it might be helpful to talk about what 87% overall satisfaction means, which I took to be part of your question.

Mr. Wayne Arthurs: That would be helpful as well.

Mr. Saäd Rafi: Eleven hundred surveys were mailed out. As a survey methodology, some might suggest that that doesn't get an effective response rate, and that's certainly a challenge, but we had a 30% response rate. For mail surveys, that's quite high. We're quite pleased with that, to start with.

Another data point that relates to the survey return would also be that 92% of the respondents indicated that they actually got what they needed from the program—important, because that would be a problematic to start with—and 96% reported that they were actually using the device or medical supply. That's consistent, survey over survey.

We had, I think, four categories or key elements.

Our service delivery process—how services are provided by either ADP or one of our partners—actually received the highest overall satisfaction, at 85%.

Communications about the program and devices or medical supplies received the second-highest satisfaction, at 84%.

Some other specific areas, as I mentioned: "Are you receiving the device or medical supplies recommended?" Yes, 87%.

"Did you get what you needed?" Yes.

Having questions answered: 87% satisfaction.

"Was there use of clear written and verbal language in the material?"—86% satisfaction.

Service staff being knowledgeable and competent: 84% satisfaction with that. That's very important to us, of course to our partners—vendors and those authorized, deliver the program.

Where we need to improve, as I think Ms. Gélinas pointed out, is that people don't like how much they have to pay. There was only 56% satisfaction with the contribution component. I would venture to guess that that might be true for many things we have to pay for. What we funded, I guess, is the corollary to that: 59% satisfaction.

Getting through to an agent without difficulty: 74%. Actually, for the person they dealt with most going the extra mile, there was 77% satisfaction.

I think that with each subsequent survey we need to get a little bit more sophisticated about what our clients need and who our clients are. All clients are more sophisticated in their use of technology; this is not an age-dependent issue at all. In fact, if there was a skew it would be the other way. We want to think about how we actually engage in surveying as well as the instrument; in other words, the types of questions. So to, I believe, your earlier question, Mr. Arthurs, it is part of our continuous improvement, to write the program in terms of its business process so that we can continuously improve as opposed to waiting for an event like a biennial survey.

Mr. Wayne Arthurs: If I could go to your lowest satisfaction number, 56% or thereabouts, I would respectfully suggest and validate or add to it that it is probably driven by two or three things. One would be the sense of some clients or customers that they shouldn't have to pay at all; the provincial program should pick up the full cost. Two, inability to pay: There may be those who are not ODSP clients but may not have the full ability to pay. Maybe thirdly, the point that Ms. Gélinas was raising: They see in the marketplace what they think is a better price point. I would suggest that those are three things that might drive that number to the level it's at. Would that be something you might agree with, and/or do you have some further comments on things that would drive that number at the lower rate, which is close to one out of two?

Mr. Saäd Rafi: Well, I could only say anecdotally, because we haven't assessed that nor do we have a statistically significant set of data. Certainly, we do know anecdotally and we're hearing that people—I don't dispute that at all, because I myself do it; I think we all comparison shop. But I might venture to guess that there's probably a higher propensity for people to feel they shouldn't have to make a contribution. I say that

because in other ministries I've worked in where there are copayments of various types, I think that people generally feel there's a correlation between their contribution to society and what their government or the state should provide to them. I want to be very careful about making gross generalizations about people, but I'm just giving you what I would surmise anecdotally.

The Chair (Mr. Peter Shurman): Thank you very much, Mr. Arthurs. We've exhausted the time for questions. I'd like to thank you, Deputy, for coming here this morning with your staff. The committee will now go into closed session for about 10 minutes to consider its next moves.

The committee continued in closed session at 1017.

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Mr. Trevor Day

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Ms. Susan Viets, research officer,
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