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Mercredi 17 avril 2013

Standing Committee on Public Accounts

Special report, Auditor General: Ornge Air Ambulance and Related Services

Comité permanent des comptes publics

Rapport spécial, vérificateur général : Services d'ambulance aérienne et services connexes d'Ornge

Chair: Norm Miller
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 17 April 2013

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The committee met at 1233 in room 151, following a closed session.

SPECIAL REPORT, AUDITOR GENERAL: ORNGE AIR AMBULANCE AND RELATED SERVICES

ORNGE

The Chair (Mr. Norm Miller): I call this meeting to order. Our first witness this afternoon is Mr. Bruce Farr, acting vice-president, operations, for Ornge. Mr. Farr, if you'd come forward, please?

Mr. Bruce Farr: Good afternoon.

The Chair (Mr. Norm Miller): Good afternoon. Just to confirm that you received the letter for a witness coming before the committee?

Mr. Bruce Farr: Yes, I did.

The Chair (Mr. Norm Miller): Very well. I understand you want to swear an oath, so we'll have our Clerk do that.

The Clerk of the Committee (Mr. William Short): The Bible is in front of you there, Mr. Farr.

Do you solemnly swear that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth, so help you God?

Mr. Bruce Farr: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

The Chair (Mr. Norm Miller): And did you want to make an opening statement?

Mr. Bruce Farr: Yes, I do, sir.

The Chair (Mr. Norm Miller): Very good. Go ahead with your 10-minute opening statement.

Mr. Bruce Farr: Thank you very much and good afternoon. My name is Bruce Farr and I'm the interim vice-president of operations for Ornge. I very much appreciate the opportunity to speak to this committee today. It just so happens to be exactly one year ago today that I began working at Ornge on a contract basis as a special adviser to operations. Considerable progress has been made over the past year at Ornge and I'm happy to be able to provide updates to you here today.

I want to begin by telling you a little bit about my background and how I arrived at Ornge last April. I began my municipal career in 1972 here in Toronto as a front-line paramedic, which was then known as an ambulance attendant. I spent a total of 39 years with Toronto Emergency Medical Services, 25 of which were spent in leadership roles within the fields of paramedicine and emergency medical dispatch.

Among some of the accomplishments I'm most proud of, I was directly involved in creating the first advanced-care paramedic position here in Toronto as well as the establishment of the critical-care land transport program.

In 2003 I became chief of the Toronto EMS system, a position that I held for eight years. I have also served as the past president of the Paramedic Chiefs of Canada and I am still currently an active board member as their past president.

I retired from Toronto EMS in February 2011. As it turns out, though, retirement didn't last long. Not long after I left the service, Ornge's former interim CEO, Mr. Ron McKerlie, phoned me and asked me to come in for a meeting with him. Having read much of the news around the service over the previous months, I really thought that I could be helpful in assisting the organization turn the corner. I was asked to join the team at Ornge as a special adviser to operations, and that's a role that I held until I became the interim vice-president of operations several months later.

From my first days at Ornge, I was really struck by the dedication of all the staff. We have high-quality people who come to work each and every day and do their very best under what I think you would all agree have to be very difficult circumstances.

I was also struck by the complexity of the organization and how much opportunity there was for improvement.

I have seen the development of the air ambulance program in Ontario since its infancy in the late 1970s. At one point, the air ambulance even had its headquarters in the same building as Toronto EMS.

From up close, we watched the growth of the program from a single base to multiple bases right across Ontario. Dating back to the very beginning, I believe the plan was to have air ambulance fully integrated into the pre-hospital and hospital system. I think it's safe to say that somewhere along the line, that plan went way off track.

Ontario has one of the finest systems in the world when it comes to EMS and pre-hospital care. My goal is to have Ornge fit efficiently and effectively right into that system.

It has never been more important than now to develop a big-picture vision for the future of Ornge, but we have not lost sight of the fact that important shorter-term goals

need to be challenged within our day-to-day operations to ensure that we're providing the best possible service to the people of Ontario.

Much has happened over the past year to make these necessary improvements, and I am pleased to provide you with a brief update.

One of the most significant areas of concentration has been our operations control centre, or the OCC. This is the nerve centre of our operation. A single patient requiring transport can involve dozens of phone calls among all the different agencies, such as the central ambulance control centres, the sending hospital, Criti-Call, Ornge pilots, paramedics and physicians, and of course, the receiving hospital. All of these calls funnel through our operations control centre. As you would imagine, it's vitally important that this process unfolds in a fashion that is as seamless as possible.

Based on our analysis and the feedback of our crews in the field, as well as health care stakeholders, it became clear that there was much more room for improvement. So among the recent changes, we have replaced the old cross-training model for our communications officers with a specialized training model. We have introduced certification exams for those communications officers, and we require them to achieve a specific standard.

We've brought together our medical call-taking, our flight planning and our flight-following functions, into the same control centre.

That's the human side of the OCC, but for a control centre to function well, you also need to give your people the right information technology tools to get the job done.

The implementation of our computer-aided dispatch system, or CAD, has been a top priority in order to more effectively dispatch our crews and improve our ability to gather data and information. I'm very pleased to report that we have completed an open and transparent request-for-proposals process, and a vendor has been selected, and we will begin the process of implementing this software very soon.

I should stress that the implementation will not happen overnight. We want to ensure that it is working effectively and that our crews are thoroughly trained before we put the system into active operational use.

We've also made progress in terms of the utilization of our vehicles: our fixed-wing aircraft, which are best for long-distance transport, particularly in northern Ontario; helicopters, which are best for on-scene response and inter-facility transfers; and our land vehicles, which are primarily used in our critical care land ambulance—or CCLA—program, whereby patients receive critical care transport between facilities, which are located relatively a short geographic distance from one another.

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We've also had land vehicles located at our air bases, which can be put into service when weather leads itself into unsafe flying conditions. We are mindful of the ongoing critical care land ambulance review by Deloitte, and we're providing them with any information that they require.

Recently, we have implemented some pilot projects to make better use of those land resources. A critical care land ambulance utilization protocol has been established to decrease the dependency on land paramedic services in specific locations across the province. Thunder Bay, as an example, is the trial site for the use of a medical transport service to transport our lower-priority patients between the airport and the hospital. This program has reduced the dependence on the local EMS service, Superior North, and has also reduced detention times for aircraft by 41% during this study period.

In addition, we've launched another pilot project in Ottawa, where we will use specific land vehicles, rather than helicopters, on certain kinds of calls. This pilot has already had very successful results. Recent data has shown an increase of approximately 20% in the use of land ambulances. This has resulted in a decrease, of course, in the number of rotor hours, which leaves the helicopter available to respond to higher-acuity calls.

Another project we're very excited about is something we call our readiness project. Optimal readiness in all phases of our operation results in the best outcome for the patients who we serve. In practical terms, readiness means that when a shift starts, our paramedics and our pilots are standing by with their uniforms and safety boots on beside a fully equipped aircraft that is ready to go immediately when the call comes in. Being ready to respond is what the people of Ontario are expecting of us, and that's the inspiration behind this complex, comprehensive project.

Our overall goals are to improve resource availability, on-shift resource readiness and the overall operation's efficiency of Ornge bases by adding up staff time at no additional cost.

That's the big picture. But, of course, putting those goals into action will require putting together all aspects of the operation. We are just beginning this process. Right now, we're looking at a number of specific solutions, such as the introduction of a new computerized dashboard, which will show crew and aircraft readiness to the operations control centre staff, and it will be changed as their status changes. We're looking at enhancing the efficiency of our weather reporting by improving communication between our flight planners and our pilots.

In summary, we are looking at multiple areas of our operation, including a shift-change protocol, aircraft readiness, dispatch protocol, as well as equipment, on-shift and workforce readiness.

What I've shared with you here today only scratches the surface, and I'm incredibly proud of the work that is being done to improve Ornge's operations. There's much more yet to be done. Rest assured that everyone at Ornge is committed to seeing this through, and I have little doubt that Ontario's air ambulance program is well on its way to becoming something for the province to take pride in in the future. Thank you very much.

The Chair (Mr. Norm Miller): Thank you very much. We'll now go to the three parties for questioning. You have 20 minutes each, starting with Mr. Klees.

Mr. Frank Klees: Thank you, Mr. Chair. Welcome, Mr. Farr.

Mr. Bruce Farr: Thank you, sir.

Mr. Frank Klees: I just want to say that the tour that we had at the headquarters was most informative and eye-opening, in some ways, and encouraging, certainly, in others in terms of some of the progress that's being made there.

Mr. Bruce Farr: Thank you.

Mr. Frank Klees: I just want to confirm that you were invited, as you say, by Mr. McKerlie to come on as a special adviser. It was in May 2012, I believe, right?

Mr. Bruce Farr: It was in early April 2012 when I received the call, and I actually started April 17.

Mr. Frank Klees: Okay. Do you know if there was a job search for that role?

Mr. Bruce Farr: I have no idea, sir. I received a phone call from Mr. McKerlie and was asked if I would come in to meet with him, which I did about four or five days later.

Mr. Frank Klees: So I'm assuming, then, that you and Mr. McKerlie had a relationship of some sort? You knew each other prior to that?

Mr. Bruce Farr: No, sir. I'd never met him.

Mr. Frank Klees: Okay. Why did he make the approach to you, then, to your knowledge?

Mr. Bruce Farr: I can only speculate, sir; I don't know. I've never asked Mr. McKerlie, but I assume that people that were around him had known of my status, certainly, as the chief at Toronto, Toronto EMS being a world-class and well-known high-performance EMS service, and the fact that I was retired. In his words to me, he needed someone who could help him reintegrate Ornge into the province's very fine EMS system, and would I come and help him? That was the kind of discussion we had.

Mr. Frank Klees: So was there anyone else at Ornge that you knew before you went there, on a personal level or professionally?

Mr. Bruce Farr: Well, of course, in my role as chief at Toronto, we operated a critical-care land ambulance component for Ornge, funded by Ornge—originally funded directly by the province. I had interaction with a number of staff at Ornge over the years, in terms of maintaining administrative processes, control of budget back to the city, staffing issues, equipment issues and so on—frequently not directly; one of my deputy chiefs would handle it directly. But of course, I knew people at Ornge. Some of the people that were there in leadership roles were, in fact, colleagues of mine and worked at Toronto as paramedics before they chose to go to the air ambulance service a number of years ago, and they're no longer at Ornge.

Mr. Frank Klees: Who among the executive group did you know there?

Mr. Bruce Farr: I knew Dr. Mazza, I knew Tom Lepine, and I knew Steve Farquhar.

Mr. Frank Klees: Okay.

Mr. Bruce Farr: Both Tom and Steve were paramedics at Toronto EMS previously.

Mr. Frank Klees: I would think it's reasonable to assume that either Lepine or Farquhar would have probably referred you to Mr. McKerlie.

Mr. Bruce Farr: I can't say, sir. I don't know.

Mr. Frank Klees: Okay. On June 11, I put a question to the Minister of Health. As you know, one of the serious concerns about Ornge, apart from the money that was going missing, was the implication to patients and not being able to respond appropriately. We had heard here about single-staffing of medics, then patients having to be refused. I put a question to the minister that day about the fact that the new performance agreement did not have any specific standards of service identified in it. Her response was essentially that all was okay.

I want to ask you this question. We have a new performance agreement. On review of that new performance agreement, there is nothing in that new performance agreement that specifically sets out standards of service. By standards of service—I want to make sure we're on the same page—we're talking about such things as staffing, qualifications of paramedics, and what we in this committee understand are some very rigorous prescribed standards of service that mean that there have to be two paramedics and that those paramedics have to have a certain level of qualification. None of that is incorporated into the new performance agreement. The minister seemed to be of the opinion that that didn't really matter. As someone who has the responsibility of overseeing the delivery of service and someone with your experience, and knowing what happens when those standards aren't met and the implication to patients, do you feel it would be helpful to have those standards of service incorporated into the new performance agreement?

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Mr. Bruce Farr: Let me speak to a couple of issues that you've raised. I think, first of all, that we are performing to standards that have been laid out for us. While I don't know the performance agreement off by heart, I certainly know components of it. We are expected to staff the aircraft as per our deployment plan across the province. And as you know, we haven't been meeting that obligation to staff it at the critical care level, although we've staffed it at either the advanced care or the primary care level in terms of paramedic certification.

In terms of standards to respond to a call, we watch those standards very carefully. The time it takes to have our pilots do a weather check, the time it takes for us—if the equipment is not outside—to get the helicopter, let's say, out of its base and outside to ensure that it was previously stocked and ready to go into flight right away are all things that we track as diligently as we can because that really speaks to the performance.

Mr. Frank Klees: I'll rephrase the question. We have had representation that the previous performance agreement provides guidance, and that there were certain expectations in terms of what those service standards would be, and that it would be up to the individuals who

had responsibility for oversight and enforcement to ensure that they were met. That didn't happen, which is why we ended up in the mess that we ended up in.

Now we have a new performance agreement. We had an opportunity to actually incorporate defined levels of service in that agreement. We still don't have them.

You come to this position of yours with good intentions. You have a background in EMS. You may well be conscientious at what you do and say, "Well, we're going to adhere to these standards of service." But once again, it's not in the performance agreement.

And by the way, some of our research indicated that you were in the vortex of an issue at the Toronto EMS. An individual died. There was a report from the Ministry of Health that made 13 recommendations in terms of training, in terms of other issues that should have been able to prevent that death.

We're now at the point where we're trying to put in place improvements to the system and provide as much guidance as possible to avoid possible errors. My question to that end is very simple: In your opinion, would it or would it not be helpful if, in the performance agreement under which Ornge must now work, there were specific defined services levels that you could work towards, that the Ministry of Health could perform its inspection functions against and do its audits against and that the world knows what those defined service levels are? Would that not make it easier and would that not make it more efficient and responsive?

Mr. Bruce Farr: Of course it makes it easier and more easily understood for everyone involved, but I believe that most of it is in place. I mean, I don't need people to tell us in an emergency situation where someone's life is on the line what we need to do to make sure we're ready to deploy a helicopter or a land vehicle or paramedics to assist that person. We know what must be done.

Mr. Frank Klees: And so did the people who were there before; that's my point. They would've told us exactly the same thing, with all respect. What we heard time and time again—and even the minister kept saying, "Well, we didn't have the authority, we didn't have the instruction, we didn't have the details."

There are two sides to this. One is the ability of people to perform conscientiously. You may not need anyone to tell you, but maybe the next guy does. If we have clearly articulated documents that make it clear what those standards are, then I think it's a lot easier for the Auditor General, for an Ombudsman, for a Ministry of Health inspector to have those meetings and say, "By the way, here's where the failures are."

I think what I'm hearing you say is that you agree with me; however, in your circumstances, it's not necessary.

Mr. Bruce Farr: With my colleagues who share the transition executive-level team with me—I think we all understand what we need to do to make Ornge more effective and more efficient. I think that in many cases, those guidelines are written down for us and we do provide daily and weekly and monthly reports, certainly to our principals.

Mr. Frank Klees: How much time do I have, Chair?

The Chair (Mr. Norm Miller): You have about eight minutes.

Mr. Frank Klees: Okay.

I have in front of me the resource availability reports that go back to—I think we got them from September of last year, August of last year.

Mr. Bruce Farr: Correct.

Mr. Frank Klees: You're familiar with these?

Mr. Bruce Farr: I am.

Mr. Frank Klees: Do we have a copy for the witness? I can be confident that you have a working knowledge of these documents, right? Because they basically report on your responsibilities.

Mr. Bruce Farr: They lay out how successful we've been in terms of staffing bases to the expectation, if you will, at that base, because they're not all critical care. It gives us a guide in terms of how we've been in terms of staffing to the critical care level, as an example.

Mr. Frank Klees: Okay. If we could just have a look at the March 2013 report, which is, I am assuming, the most recent that we have, and if we go down to the middle of the page, it talks about the downtime reports. If we look at the first column, it would be the Ottawa rotor-wing division, I'm assuming.

Mr. Bruce Farr: Yes.

Mr. Frank Klees: It talks about the number of hours that base was out of service. The total number for nights, I see there, is 13%. So 13% of the time, the Ottawa base during the month of March was out of service. Is that correct?

Mr. Bruce Farr: That's what it's saying, yes.

Mr. Frank Klees: Or is that—

Mr. Bruce Farr: Well, that's days.

Mr. Frank Klees: That's right; so during the day. During the night, it would have been out of service 5% of the time. Is that right?

Mr. Bruce Farr: That's correct.

Mr. Frank Klees: Then we go across Toronto. During days, it would have been out of service 4% of the time, and 9% of the time during the night. We come across to Moosonee. It would have been out of service 19% during the daytime, 36% in the evening. If we go to Thunder Bay, it looks like 81% during the nighttime, 2% during the day.

Mr. Bruce Farr: That's on the Thunder Bay rotor?

Mr. Frank Klees: That's Thunder Bay rotor.

Mr. Bruce Farr: Rotor, yes.

Mr. Frank Klees: Yes. I'm looking at the same reports that go back to August of last year and I look at those same numbers and they're very close. For example, there's about a 1% to 2% difference here in terms of downtime. It would have been 12% versus 13% for Ottawa; 5% versus 3%, 7% versus 9%. There is a significant improvement during the daytime in Toronto, from 4% to 15%. The others are relatively close.

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The reason I wanted to get your thoughts on this: Can you tell me what 1% represents in terms of the number of hours that a helicopter would be out of service?

Mr. Bruce Farr: I don't have that—

Mr. Frank Klees: Translate that into number of hours.

Mr. Bruce Farr: What 1% would be would depend on—I mean, if you're staffing at 2,080 work hours a year—I don't have the calculation before me, what 1% would be.

Mr. Frank Klees: Okay. I understand it translates into something in the range of 22 hours. We can get those calculations. Nevertheless, it's a lot of hours that the service is not available.

You've been there now for a year, or close?

Mr. Bruce Farr: In different positions.

Mr. Frank Klees: It seems as though there hasn't been a great deal of improvement on the front-line ability to respond. Can you comment on that? What is the reason for that, and what plans do you have in place, and how much longer before we can get to the point where we really can say that we have a reliable air ambulance service here in the province of Ontario?

Mr. Bruce Farr: As I look back in the rear-view mirror and reflect ahead, if I could, I think, given what we were able to do over the last year under some pretty difficult sets of circumstances, under Dr. McCallum's leadership over the next year I'm really feeling very positive about where Ornge can go.

Some of those complexities that I spoke of when I first came into the organization, because Ornge was extremely complex—if I use an example of measuring it between what I had under my command before, at Toronto EMS, 950 paramedics versus 227 at Ornge, that's the kind of complexity that I was able to look at.

I think when it comes to the education of paramedics and the upgrade of paramedics—as I mentioned to you previously, we don't intend on hiring primary care paramedics at Ornge any longer. We are working with our community colleges across Ontario to attract graduates of the advanced care level, the advanced paramedic program, and be able to train them up to Ornge's requirements at a critical care level that much quicker. We're taking the process of only critical care from one that was well over one year to down around a total of 26 weeks to completion.

The issue with pilots and aircraft: They're totally different issues, especially when it comes to the north. I'm not an aviation expert. When aircraft are down and when aircraft are deemed to be down by pilots or captains of the ship, it's not something we question, because safety is first and foremost.

When it comes to pilots, I know we've had issues with pilots at various bases. As we made a decision to upstaff the rotor at the Thunder Bay base, our biggest and busiest base, we had issues. We knew we could staff almost immediately with paramedics, but we're in the process of attracting more pilots and training them up.

Again, sir, don't think I'm any expert on aviation; I'm not.

The Chair (Mr. Norm Miller): We are out of time, so we'll move to the NDP. You have 20 minutes.

M^me^ France Gélinas: It's a pleasure to see you, Mr. Farr, and also, thank you for the most pleasant visit you helped organize for us last week.

Mr. Bruce Farr: Well, thank you. It was a pleasure having you visit.

M^me^ France Gélinas: I learned lots, and it was very well done, so I thank you for that.

Mr. Bruce Farr: Well, thank you.

M^me^ France Gélinas: The question I'm interested in knowing is that all of those reports we have in front of us—are those shared with people within the ministry?

Mr. Bruce Farr: Yes.

M^me^ France Gélinas: And how is that done? Do you fax them over, or once a month you send a pigeon over? How does it work?

Mr. Bruce Farr: I'm not sure. Sorry.

M^me^ France Gélinas: No problem. But you know that the ministry is keeping an eye. Have they ever called you and said, "Oh, we looked at your report, and we're happy," or "we're sad," or "we have questions"?

Mr. Bruce Farr: No. Frankly, we get questions frequently. I wouldn't say daily, but a number of times a week we'll get questions on our performance, our staffing issues, pilot issues and so on.

M^me^ France Gélinas: And who would initiate those questions? Are they because they've received reports? Is it because you flagged it for them? How does it work?

Mr. Bruce Farr: It's typically because they receive our daily reports or these kinds of reports. They're helping monitor our performance in achieving those targets that we've set out.

M^me^ France Gélinas: Okay. You had said to us last week that you have daily, and then every 10 days, and then every—I forgot the—

Mr. Bruce Farr: That's on the investigations?

M^me^ France Gélinas: Oh, yes, true.

Mr. Bruce Farr: The investigations were the 10-day and 40-day, and we do daily reporting to the ministry.

M^me^ France Gélinas: Okay. Was this something that was always there, the daily reporting?

Mr. Bruce Farr: I'm sorry, I don't know. It's certainly something that was started up with the introduction of the Air Ambulance Oversight Office.

M^me^ France Gélinas: Okay. So there are people at the ministry who review those, and every now and again they have questions for clarity, or questions because they're not happy? Can you give me an example? When was the last phone call you got, and what was it about?

Mr. Bruce Farr: It was about one of the questions that Mr. Klees asked me regarding pilot staffing. I had to get further details for them.

M^me^ France Gélinas: Okay. And you were able to answer their questions?

Mr. Bruce Farr: Yes. Not immediately, but within an hour or two, we got back.

M^me^ France Gélinas: You got back? What do you figure would happen if they asked you a question that doesn't put you in a positive light—"You were not able to do X, Y, Z…"—and you didn't answer?

Mr. Bruce Farr: Oh, I don't think that would be acceptable. They'd be looking for us to answer and be able to explain how we're going to improve that or correct that, depending on whatever the situation is. I think the oversight on us is much improved, compared to where it was.

M^me^ France Gélinas: So, even if that was not your best day—they were asking you about something where Ornge really was not shining that day—you feel that you would still have to tell the ministry?

Mr. Bruce Farr: Absolutely.

M^me^ France Gélinas: Okay. And if you were not to do so, you feel that the ministry would follow up?

Mr. Bruce Farr: Yes, I do.

M^me^ France Gélinas: And what leads you to believe that they would do that?

Mr. Bruce Farr: Well, I think it's the number of questions that we get now in terms of our performance. There's a lot of transparency in what we do daily, and a lot of questions asked and a lot of reports that we provide. Frankly, that's the way I like it.

M^me^ France Gélinas: So, continuing on, you have questions coming from the ministry. They're not happy with the answers they're getting from you. Where do you figure they would go next?

Mr. Bruce Farr: Well, depending on the situation, the hypothetical question that you're asking me, I think it's our job to indicate to them why it's like that and what our plan is to correct that, whether it's short-term or long-term—if it this correctible—and all of those kinds of things. I think that's part of our responsibility to them.

M^me^ France Gélinas: Okay. You feel comfortable with having a responsibility directly to the Ministry of Health? Do you figure this is the way it should work?

Mr. Bruce Farr: Yes, I'm quite satisfied with the level of reporting that we have today and the accountability.

M^me^ France Gélinas: How does this compare to where you were before, when you were in Toronto EMS?

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Mr. Bruce Farr: It's very similar. We would provide daily operational reports to our deputy city manager, our city manager, and certainly members of the city council and the mayor's office. We provided regular reporting in terms of our response time commitment and our targets—how we were doing.

M^me^ France Gélinas: Okay. Mr. Klees, when he asked, wanted to see, basically, some of the performance measures directly in the performance agreement, but what you've said is that you have a deployment plan, and this deployment plan—I guess you have the flexibility to change it at intervals as long as everybody agrees with that plan. Is this how it works?

Mr. Bruce Farr: Well, we have the bases, as I mentioned in the presentation that you saw. We have those bases that we're expected to staff each day with pilots, paramedics and aircraft that are equipped and ready to respond. That's a simple process to say, but it becomes very complex to do when you start looking at the different areas around the province and issues in terms of maintaining appropriate staffing levels.

M^me^ France Gélinas: You can see that because of what happened, there's a level of nervousness out there. We want to make sure—what had happened in the past, or what the ministry said happened in the past, is that they would call Ornge and they would get stonewalled; Ornge refused to give answers. Let's say you're not in there, but somebody else is doing your job and refuses to get answers to the ministry. Do you figure it's possible that somebody could stay in their job and refuse to answer questions from the ministry? You seem quite willing to work with the ministry and answer questions. The people that were there before apparently—so the minister tells us—stonewalled them; they would not answer their questions.

Mr. Bruce Farr: No, as I said in my opening statement, I am very, very proud of the efforts that the senior team is putting into this. Under the leadership of Dr. McCallum, it's only getting better every day. It's all coming together. I can't imagine anybody not responding to a request from the ministry or anyone else who's looking for information. It's a very transparent operation.

M^me^ France Gélinas: Okay. So if you get to retire for the second time, and a new person comes in and stonewalls the ministry, what do you figure would happen, knowing the players that are there now?

Mr. Bruce Farr: I don't think there would be any stonewalling. If there's a legitimate question put forward about Ornge's operation, I think that everyone on the executive team, including the CEO's office, is going to do what they can to answer that question.

M^me^ France Gélinas: Okay. You've explained a bit to us as to how complex it is to deploy, the number of phone calls that need to happen. It was quite interesting when we did the tour, basically, to see it live and to see the different pieces of the puzzle that all needed to be put together, and you had put forward for us a live scenario as to how this is done. That leads one to believe, though, that at any one of those action points, things could derail.

I know that people have complained against Ornge before, and certainly people have in the past complained about issues that have happened to Ornge. If there is a complaint right now, directly related to the people you're responsible for, how would that go?

Mr. Bruce Farr: Well, depending on how we're made aware of that complaint, it would be investigated through our professional standards office internally. It might be the ministry that's asking questions; the ministry investigators might be looking at it, depending on the issue. But at every step of the process, we have things that are put in place to check and balance and make sure that things are going along the way that they're supposed to. Certainly, when you talk about the communications centre, the introduction of the new automated system will make it much, much easier to make sure that things are done in sequence properly.

M^me^ France Gélinas: Okay. And if somebody has a complaint that has to do directly with your department,

that has to do directly with what you do, would you be aware of it? Would it come to you?

Mr. Bruce Farr: Absolutely.

M^me^ France Gélinas: It's handled directly by you?

Mr. Bruce Farr: It may not be handled directly by me, but if it was one of my managers or one of my directors, they would of course let me know—

M^me^ France Gélinas: That there's something wrong.

Mr. Bruce Farr: And we do regular reporting on the complaints process.

M^me^ France Gélinas: Just one more: Since you've been there, has anybody from the ministry gone to Ornge and talked to you? Has anybody who works for the Ministry of Health gone to where you're working?

Mr. Bruce Farr: Yes.

M^me^ France Gélinas: Have you seen them there?

Mr. Bruce Farr: Yes.

M^me^ France Gélinas: Who was it and when?

Mr. Bruce Farr: We get regular visits by the air ambulance oversight office: Mr. Jackson. He's in touch with us on a regular basis. We have regular meetings with him in terms of our process and our activity, our operational activity in particular.

M^me^ France Gélinas: And do they come to you or do you go to them?

Mr. Bruce Farr: Both, depending on the situation. If there's a need, we'll contact them and report something.

M^me^ France Gélinas: Okay. Jagmeet?

Mr. Jagmeet Singh: Thank you, Mr. Farr. Mr. Farr, I just wanted to confirm: You're currently employed with Ornge as the vice-president of operations?

Mr. Bruce Farr: On a contractual basis, yes. I'm not an employee.

Mr. Jagmeet Singh: Not an employee.

Mr. Bruce Farr: Correct.

Mr. Jagmeet Singh: And your understanding is that the contractual basis is paid by Ornge directly, when you receive your payment or your salary?

Mr. Bruce Farr: That's correct.

Mr. Jagmeet Singh: Okay. Were you ever asked to disclose your salary or your remuneration to the sunshine list?

Mr. Bruce Farr: I understand, because I'm on contract, it's part of further disclosure, which—I may be wrong; I believe it's disclosed sometime in June.

Mr. Jagmeet Singh: Okay. Would you have any problem disclosing that? You don't have to do it now, but in general, if the ministry asked or if anyone from the sunshine list or the Ministry of Finance asked, would you have any issues disclosing?

Mr. Bruce Farr: None whatsoever. I believe Mr. Klees asked me during the visit last week—it might not have been you, sir, but I think it was—and I disclosed what my earnings were.

Mr. Jagmeet Singh: Okay. Would you be able to disclose that now, then, what your salary is, your compensation?

Mr. Bruce Farr: Last year from April 17 to the end of the year, $135,000.

Mr. Jagmeet Singh: Okay. And this year, roughly the same? Is that the expectation?

Mr. Bruce Farr: I have no idea. It depends on how many days I actually work. How long will they keep me? I'm not sure.

Mr. Jagmeet Singh: Fair enough.

M^me^ France Gélinas: Are you aware that the Legislative Assembly is discussing Bill 11, the air ambulance act?

Mr. Bruce Farr: Yes.

M^me^ France Gélinas: Do you know anything about the bill?

Mr. Bruce Farr: I've briefly reviewed the bill.

M^me^ France Gélinas: Did you? Okay. Are you waiting with bated breath for that bill to come through so that you can do something that you're not doing now?

Mr. Bruce Farr: It's a difficult question to respond to. I think it's a very important bill, a very important piece of legislation. I think it's important to have oversight. But at the same time, I'm confident with where Ornge is heading. I think the bill needs to be there, but hopefully, Ornge will continue to perform beyond expectations that are there today and we'll perform very well.

M^me^ France Gélinas: Okay. You say the bill is important for oversight. The first 10 minutes of our conversation were really about oversight, and you agreed that the ministry was doing quite a bit of oversight, with the phone calls, with the meetings, with the reporting. Do you really see that the oversight will change with the bill?

Mr. Bruce Farr: Well, I think it's—

M^me^ France Gélinas: I can help you by saying that you seem to be doing a pretty good job now. I don't see how things are going to change.

Mr. Bruce Farr: Well, I guess from my perspective, if I may—again, I think oversight is important. We are spending the public's money, and I think it's important that government has a way of saying yes, they have the oversight.

From our perspective, I know, speaking for our senior team, we intend on doing things right, and we intend on making Ornge a service that everyone in Ontario can be very proud of.

M^me^ France Gélinas: I think you're on the right way. A lot of the people who work for your department are the people who were whistle-blowers. It's because of what they did that we became aware of what was going on at Ornge and things were put in place to try to improve, including recruiting you.

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The people who did that, the people who blew the whistle, most of them lost their jobs, most of them were severely punished and most of them paid a pretty significant personal price for having blown the whistle on everything that was wrong at Ornge. It would have been different had there been protection. Do you know if you have whistle-blower protection right now at Ornge?

Mr. Bruce Farr: Yes, we do.

M^me^ France Gélinas: And how does it work?

Mr. Bruce Farr: We encourage people to raise issues, particularly when it involves patient care and safety and all those kinds of things in their daily work environment. It's raised through a third party and it's dealt with, in my view, quite appropriately. They don't need to fear reprisal of any kind.

M^me^ France Gélinas: So right now, if they see something that is wrong, how do they know who to call? How do they know about this third party?

Mr. Bruce Farr: It's been well advertised across Ornge. Employees should all be very well aware exactly how to contact the third party.

M^me^ France Gélinas: And you, yourself, do you feel confident that if you were to call this third party, that nobody would know that it was you who called?

Mr. Bruce Farr: I believe so. I haven't called, but I believe so.

M^me^ France Gélinas: We'll test it, but you feel confident. And the people you work with, are they happy with your whistle-blower protection? Do they feel you got it right?

Mr. Bruce Farr: I've visited every base in the system except Moosonee, and when I talk to our front-line people—our pilots, our paramedics, our maintenance folks—in our bases, I think people are really feeling quite confident about the future, maybe not as confident as I am but they are feeling very confident, and I think it's things like that that help people get the sense that their opinion makes a difference.

M^me^ France Gélinas: That their opinion makes a difference, yes. And because you've now implemented whistle-blower protection, they feel that if things don't go well inside, they could go there and be heard?

Mr. Bruce Farr: Absolutely.

M^me^ France Gélinas: Okay.

Mr. Jagmeet Singh: Could you recap just maybe the two or three—

The Chair (Mr. Norm Miller): You have two minutes left.

Mr. Jagmeet Singh: Thank you very much.

So in the two minutes we have, maybe briefly we can recap the top priorities that you have, moving forward, in ensuring that Ornge gets to the high level of performance that you want to see it at. What are some of the major priorities that you really want to work towards, and, perhaps, what do you need to achieve those priorities?

Mr. Bruce Farr: I think one of the biggest priorities, the one I've probably spoken the most of today, is the operations control centre, to support their change and their ability to track our paramedics and pilots and aircraft around the province so that we know that we're ready, we know exactly where everybody is and what their status is.

Mr. Jagmeet Singh: Okay.

Mr. Bruce Farr: From my perspective in paramedic operations, the ability to recruit and educate paramedics in a timely and efficient fashion, dipping into, as I said, the very fine community college system that's in place around the province and taking advantage of those people and those programs, attracting them to come to Ornge, and to be able to continue to have the confidence of the public that we're there when they need us, and the rest of the health care system.

Mr. Jagmeet Singh: In terms of achieving those priorities, what do you think Ornge needs to do and what assists you in achieving those goals?

Mr. Bruce Farr: I think we're already doing it. I think we're already well down the road, looking at the shorter term and longer term. The executive team, working with our board, has laid out a set of directions for the future. We know the various projects that we need to achieve and the time that we want to achieve those in. We are working on a longer-term strategy, but in the shorter term, I'm very confident it's the right thing to do to put Ornge into a position that I want to see, where there's more of a sense of urgency, if you will, from everyone in the organization.

The Chair (Mr. Norm Miller): Thank you. We'll move to the government, then. Ms. Jaczek.

Ms. Helena Jaczek: Thank you, Chair, and thank you on behalf of the government, Mr. Farr, for the tour last week. I think it was extremely helpful and gave us—certainly, when we saw the dispatch centre and all the various components working together—I'm sure that that new software will facilitate as well.

Now, I just want to get back to the performance agreement. Mr. Klees has raised that issue already. It's my understanding that even if it doesn't set some particular targets, requirements to report on levels of care, staffing mix, availability of shifts and so on—that's all part of what is required to be reported.

Mr. Bruce Farr: And we do report on those. As I said, whether or not it's specifically laid out, I can't recall, depending on which piece of performance you're talking about. But many of them are laid out in the agreement.

Ms. Helena Jaczek: And pursuant to the performance agreement, of course we have the quality improvement plan. I'm just looking at the 2012-13 quality improvement plan, and under "Staffing and Transport" it specifically lays out some objectives that relate closely, in fact, to the document that Dr. McCallum forwarded to us that you have had a chance to look at. The objectives around paramedic staffing are to ensure that each base has two paramedics with a designated level of care, even during off-service hours. As a summary comment in this document, it says, "In January 2013, we reached this level-of-care target (i.e. two paramedics with the right mix of training and certification) 71% of the time." Again, Mr. Klees has alluded to the fact that he hasn't seen much variability over the time period that we have been given.

Furthermore, in this document it says, "[O]ur goal is to increase paramedic staffing and training to reach the target 75% of the time by March 2013 and ultimately to exceed that target in future years."

I'm wondering, in your position—you've mentioned training of staff; you've got a number of initiatives on the

way. Will you be able to reach 75%, and when? When will you get that next batch of paramedics trained? Can you give us some sort of sense of the progress towards improving the figures that we see in front of it?

Mr. Bruce Farr: Yes, I'd be happy to. We're about to graduate a class of critical care paramedics and some advanced-care paramedics at the flight level, which is going to greatly improve our ability to meet those targets. They've been in training for quite some time and they're ready for graduation over the next couple of months. That, in itself, is a big step in the right direction. They will spread out across the system; they're all from various parts of Ornge bases.

We will continue that process in terms of the upgrade education and the use of new students as they graduate in the spring from community colleges that we've been speaking with. We haven't exactly signed agreements, but we have been talking with three community colleges that have responded to us very positively about a process that we could put in place, which would really expedite the training of paramedics who can perform their duties at Ornge.

Ms. Helena Jaczek: Is the ultimate goal to reach 100% in terms of this staffing?

Mr. Bruce Farr: Well, 100%—we talk a lot about that. Is it achievable? When you talk about things like performance and these kinds of targets, there are an awful lot of things that can get in the way. So you might be setting your goal a little bit too high, depending on what you're talking about.

Ms. Helena Jaczek: What are the difficulties? I mean, staff are off sick—can you sort of give us why we're not better? What are the factors that have led us to this current 71% number?

Mr. Bruce Farr: Well, it has a lot to do with the placement of the bases and the staffing at each of those bases. We staff a base with 11 full-time paramedics, and they're on four different lines or four different shifts, if you will. If someone goes off sick, someone injures themselves and they're missing from the rotation, depending on the part of the province it's in, it can be very difficult to backfill those individuals.

Now, we do have part-time paramedics at most of our bases, and it's just a case of everything lining up in terms of being able to fill those shifts. That's probably the number one factor that is an issue when it comes to the staffing.

Ms. Helena Jaczek: Could some of the paramedics be trained to be upgraded to critical care or advanced-care paramedic status?

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Mr. Bruce Farr: Well, we go through that process in co-operation with our unions because it's part of our collective agreement in terms of how long people are in the organization prior to being trained up. We're very aware of that, but we're also aware of the amount of time that it has taken in the past, and we're looking to implement more efficiencies in that entire system.

Ms. Helena Jaczek: But some of the out of service, or not the desirable service level being in place, could be because some are being trained? That would be—

Mr. Bruce Farr: Yes.

Ms. Helena Jaczek: Yes. Okay. You have had a great deal to do with paramedics, obviously, in your 39 years. Every organization has a culture, and we know that paramedics are often faced with critical incidents, especially if it involves a critically injured child and that kind of situation. It's a high-stress job. I think we all acknowledge that. This is why we value the work that they do.

You arrived at Ornge, and I'm sure you met with paramedics. They knew that their organization was subject to a great deal of media interest. Can you sort of explain to us the morale of the paramedics when you arrived and what you've seen over time since you've been there?

Mr. Bruce Farr: My heart goes out to them because, you know, they sit down, particularly if you're one on one, and they open up in terms of the work that they're being asked to do. Yet they look at the walls falling down around them. We've assured them that that's not going to happen. We're all hopeful of a better future. You just can't blame paramedics for the way that they feel, and that, in fact, affects pilots in the same way—you know, people who are at our base locations as well as our maintenance staff who are at those locations. Everybody is affected in the same way.

But to your point about paramedics, yes, they're expected to perform at their utmost best, as are the pilots. You want to keep everybody as sharp as possible. You don't want them to be affected by all these other parts of this issue that are all around them. We've spent a lot of time, as I mentioned to you last week during your visit.

I'm very pleased that our new leader, Dr. McCallum, has been out at almost every base. He has had a lot of face-to-face visits with the staff at the bases. They've heard from our new leader—our new chief, if you will—in terms of the direction that he sees and his vision for the future. I'm hearing a lot of very positive comments back.

We've been trying to do that a lot over the last year as well. As I indicated, I've been at every base except Moosonee, and people are just more than willing to sit down and talk about what we see for the future and where we're going.

Ms. Helena Jaczek: Well, I think in terms of restoring public confidence in the air ambulance system, the type of work and the face-to-face time that you're spending with the medics is obviously going to go a long way because they're going to be able to project that kind of confidence in the system going forward.

In terms of the staffing—you're making all this effort in terms of the training, hiring, community colleges and so on—how do you see the mix, going forward, in terms of critical care versus advanced care? What would be your sort of ideal staffing mix to properly serve the people of Ontario?

Mr. Bruce Farr: I wish I had the answer. I think it's one of those projects that we want to get into in terms of a detailed review of the level-of-care requirements across

the system, because we're striving to staff to the critical care level at all bases. We've had many discussions amongst the senior team to look at how and when we could actually take a more detailed review.

Our experience in the number of times that paramedics utilize their skills in various calls that they're doing around the province—you know, it helps to sort of point us in that direction, saying, "What level of care should we have and how should we best deliver it—helicopter, fixed wing, land vehicle etc.?" So I think all of that needs to be part of a future review, internally, in terms of giving us that information on a go-forward basis.

Ms. Helena Jaczek: Other issues related to paramedic morale: that infamous interior of the AW139 that was not functional in terms of life support and so on. Can you just go through again exactly what has been done in terms of that interior and how the paramedics are working in that environment?

Mr. Bruce Farr: Well, again, we took a lot of what our paramedics were telling us, and we implemented it into what we call an interim interior. That has been installed in all of our AW139s. Of course, that didn't affect the Sikorsky fleet. We've implemented it across the system, and the paramedics have been very quiet on that issue. I think the paramedics that I'm talking to are quite satisfied with the changes that have been made. We haven't given up on that. We still listen to the paramedics; we still look at the EMS industry as a whole. I think, as you heard from a few of us during your visit, we're still looking at other ways to improve and hopefully get to the total roll-on, roll-off system from the AW helicopter.

Ms. Helena Jaczek: Since I have more time, could you expand a little bit: One of the Auditor General's original reports was a request to look at the interface between air ambulance and critical land ambulance. Could you just expand? In your opening remarks, you just mentioned that study that's being done, but perhaps you could tell us more.

Mr. Bruce Farr: That review is under way by Deloitte. Over the last few weeks, they've been visiting our bases in Ottawa, Markham and Peterborough. They have met with the leadership team and the paramedic teams at Toronto EMS, who also operate critical care on land, and they have interviewed a number of folks at Ornge's head office in terms of the data, the finance side and so on. They're going through the process, and I think that, so far, from what I'm hearing from them, they're pleased with what they're seeing.

Ms. Helena Jaczek: Right. So they'll come out with some recommendations if there's potentially a shift in location of base, land ambulance, or whatever mix might be potentially more appropriate?

Mr. Bruce Farr: I would expect that you're right. I would expect that they will produce recommendations and provide them to the ministry in terms of moving forward.

Ms. Helena Jaczek: Well, on my behalf, I certainly find everything you've said very reassuring. Do either of my colleagues have any further questions?

Mr. Shafiq Qaadri: We are similarly reassured.

Ms. Helena Jaczek: Thank you.

Mr. Bruce Farr: Thank you.

The Chair (Mr. Norm Miller): Thank you very much, and thank you for coming in today. It's appreciated.

Mr. Bruce Farr: Oh, thank you very much.

Mr. Frank Klees: Is there any time left?

The Chair (Mr. Norm Miller): There are six minutes left. If you'd mind if Mr. Klees—

Mr. Frank Klees: Do you mind?

Ms. Helena Jaczek: I might want two minutes more.

Mr. Frank Klees: I'd like to take the advantage, if we could, Mr. Farr.

The Chair (Mr. Norm Miller): Mr. Klees.

Mr. Frank Klees: Yes, thank you. You were for how many years head of EMS at Toronto?

Mr. Bruce Farr: In the chief's position, sir?

Mr. Frank Klees: Yes.

Mr. Bruce Farr: About eight years. I was promoted to the position right after SARS, and I was in the position of chief until I retired in February 2011.

Mr. Frank Klees: Okay. During that time, who at the Ministry of Health did you have interaction with? Was it the emergency health services branch of the ministry?

Mr. Bruce Farr: That's correct.

Mr. Frank Klees: And was there someone specifically that you would liaise with?

Mr. Bruce Farr: Well, there were a number of positions. Toronto EMS is the largest municipal land service, so it also has got its complexities. But dealing with the ministry, depending on the issue—if it's an operational issue versus staffing versus a finance issue, there would be different people that we would deal with. I typically would have dealt with Malcolm Bates at emergency health services.

Mr. Frank Klees: Malcolm Bates, of course, was also, at one time, responsible for the air ambulance service, before it was transferred over to Ornge. Have you had any discussions with Malcolm Bates about Ornge since you took on your responsibility?

Mr. Bruce Farr: On a few occasions. Malcolm's role was to be part of the steering committee on the land review. He has since retired, so he's not in that role any longer, but we had some brief conversations leading up to that.

Mr. Frank Klees: When Malcolm Bates testified at this committee, he indicated that the ministry was actually directed not to interfere with the operations at Ornge, notwithstanding that they knew there were some problems there. Did you at any time sense that the ministry would hesitate contacting you if they felt that there was an issue in your service? Did you ever feel that there was any concern that they would be overstepping their bounds? Or did you feel that the ministry was on top of their job when it came to their oversight responsibility of Toronto EMS, for example?

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Mr. Bruce Farr: In my situation as the head of Toronto EMS, relationships were the most important

thing for me and I had a good relationship with the folks at the ministry. We worked well together. That's the position I'm in today at Ornge. We're building and strengthening relationships across the system, particularly with our EMS partners, as we look at how we can work better with them to provide service to our patients and the citizens across the province.

My relationship with Malcolm Bates was very professional, a very strong relationship over the years. We had to go to that office for approval of our deployment plan and our budget that we were putting forward to the city and so on.

Mr. Frank Klees: How—

The Chair (Mr. Norm Miller): Thank you. France, did you wish to use a couple more minutes as well?

M^me^ France Gélinas: I'll leave him to finish his sentence then I'll jump in.

Mr. Frank Klees: I was just going to ask, how many surprise site visits has the Ministry of Health made to Ornge since you've been there?

Mr. Bruce Farr: I am aware of two.

Mr. Frank Klees: Two specifically?

Mr. Bruce Farr: It could be more but I may or may not know about them.

Mr. Frank Klees: Okay. And the nature of those were what?

Mr. Bruce Farr: Where they dropped in on two of our bases at different times.

Mr. Frank Klees: Okay. Thank you.

M^me^ France Gélinas: When you first were called to work at Ornge, you were not in the position of VP of operations, am I correct?

Mr. Bruce Farr: That's correct. I started as a special adviser to operations.

M^me^ France Gélinas: Was Steve Farquhar still VP of operations when you started?

Mr. Bruce Farr: Yes, he was.

M^me^ France Gélinas: He was. So are you assuming the same role and responsibility that Steve had when he was there?

Mr. Bruce Farr: Yes, I am.

M^me^ France Gélinas: You are. Do you know where he has gone?

Mr. Bruce Farr: He left Ornge and upon his departure I was asked if I would step in and fulfill the role until the job was filled. We have plans on doing that in the near future.

M^me^ France Gélinas: Okay. So there's a plan to post a position as a full-time position at some point in the near future?

Mr. Bruce Farr: Correct.

M^me^ France Gélinas: All right. You mentioned that Mr. Farquhar left Ornge because his contract was over or because he decided to go someplace else or—do you know anything about that?

Mr. Bruce Farr: I don't know the details, but he left Ornge.

M^me^ France Gélinas: He left. Okay. Thank you.

The Chair (Mr. Norm Miller): Thank you. Ms. Jaczek.

Ms. Helena Jaczek: Since there have been some questions related to your relationship with the Ministry of Health, at the moment, the head of the air ambulance oversight unit is Mr. Richard—

Mr. Bruce Farr: Richard Jackson

Ms. Helena Jaczek: Jackson. Since he took over, how do you relate to him and his unit? Or do you or your staff—can you just sort of give us a sense—we've talked about daily records going in but how would this look? You were presumably involved in preparing a budget etc., so could you just lay out what the relationship looks like now?

Mr. Bruce Farr: I, in particular, have regular opportunities to speak with Richard having to do with a number of projects that I'm working on, but also the daily operations component. Because we do send a daily report that he reviews each morning and he may, in fact, either phone me or send me an email back with some questions on that report and we respond appropriately. So yes, we do have a regular interaction, if you will.

Ms. Helena Jaczek: Were you involved in the formation of the next fiscal year's budget in your role as VP?

Mr. Bruce Farr: In certain parts of it. It was kind of during the transition time that we were speaking about in terms of Mr. Farquhar's departure and my taking over the position. There were different parts of the budget planning that were going on.

Ms. Helena Jaczek: And this was in consultation with the ministry?

Mr. Bruce Farr: Yes.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Norm Miller): Thank you very much for coming in today. We appreciate it.

Our next witness is Denise Polgar, patient advocate for Ornge. Welcome.

Ms. Denise Polgar: Hi.

The Chair (Mr. Norm Miller): I just want to confirm that you had received the letter for a witness coming before the committee?

Ms. Denise Polgar: Yes, I did.

Mr. Norm Miller: Very well. The Clerk has an oath for you to swear.

The Clerk of the Committee (Mr. William Short): Ms. Polgar, can you just raise your right hand, please. Do you solemnly affirm that the evidence you shall give to this committee touching the subject of the present inquiry shall be the truth, the whole truth and nothing but the truth?

Ms. Denise Polgar: I do.

The Clerk of the Committee (Mr. William Short): Thank you.

The Chair (Mr. Norm Miller): Very well. Did you want to make an opening statement?

Ms. Denise Polgar: I have one, yes.

The Chair (Mr. Norm Miller): Okay, very well. Please go ahead.

Ms. Denise Polgar: Good afternoon. My name is Denise Polgar and I am the patient advocate at Ornge. Thank you for the opportunity to speak today. I'd like to begin by spending a few minutes explaining my background, my role within the organization and what we're doing to better serve those who matter most to us, our patients.

Let me begin by telling you how I came to Ornge in the first place. In many ways, this position brings together a number of skills I have gained over the course of my diverse career that has focused solely on health care. I spent 10 years as a primary care paramedic with the county of Brant ambulance. This position naturally gave me front-line experience in treating ill or injured people in a mobile environment and ensuring patients got to the care they needed in a timely fashion. From there, I worked as a communications officer in the London central ambulance communications centre. Like their paramedic colleagues working in the field, a communications officer's job is demanding and challenging, involving complex logistics under stressful situations. I also functioned as a training officer in this environment, which involved preparing trainee dispatchers in multitasking, critical thinking and decision-making in simulated and production situations.

Later, I worked as a program coordinator and instructor with Fanshawe College, where I designed and implemented curriculum for the emergency telecommunications program. From there I entered the hospital sector, most recently as an injury prevention specialist at London Health Sciences Centre, concentrating on the development and implementation of injury prevention priority programming that was led by the Toronto program.

In sum, I have worked in pre-hospital care, communications, education and the hospital setting, all aspects which you will find within Ornge. I spotted the posting for patient advocate over the summer of 2012 and it immediately piqued my interest. Like many in the health care sector, I had been following Ornge in the news and thought that it would be exciting and rewarding to play a role in the rebuilding effort for the organization. The opportunity to play a role in having regular, interpersonal interactions with patients to help improve their experience is what made this position truly enticing. The ability to get back into emergency health services and utilize my health care experience to help facilitate patient and family concerns was a perfect balance for me personally and professionally.

I believe that having a person dedicated to handling patient concerns, questions and feedback who is committed to ensuring the organization is acting in their best interests is essential in any health care setting.

The position of patient advocate is brand new to Ornge. In fact, it may be brand new to the field of air medical transport. We have not been able to find any organization similar to Ornge with a position like mine. While we are breaking ground in this industry, it is worth noting that there are patient-relations departments working at hospitals across Ontario. We have consulted with many of these facilities for guidance and advice in developing this role within Ornge. I personally know and have interacted with a number of patient-relations specialists at hospitals across Ontario, and I feel this is an important role at any facility.

I was honoured to have been offered the position of patient advocate, and I began this new role in September. In the most straightforward terms, I'm here to serve our patients. Every day I interact with them. We speak on the phone; I answer their emails. Sometimes they are unhappy with our service. Sometimes they want to express thanks to the crew that provided transport to their loved ones. Sometimes, they simply want to ask questions to get a better understanding of how our system works. Whatever the case may be, all of this feedback is directed my way. I track the complaints, liaise with the patients and their families, facilitate the process of providing information and ultimately work with patients to resolve issues.

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At all times, I try to put myself in their shoes, imagining the initial anxiety of going through a serious illness, followed by the added stress of requiring transport to a hospital that's hundreds of kilometres away from home, and ultimately not knowing what the outcome of their loved one may be. What would my expectations be for the care of my family? What would I want to know, and how would I want to be treated?

I'm also mindful of the foundation of my position, which is Ornge's declaration of patient values. It is my job to make sure that the organization upholds this declaration. These values were not chosen at random. In fact, they came directly from our patients themselves. Ornge surveys patients on a quarterly basis, and uses the results to identify what the organization is doing well and what needs improvement.

Descriptive comments from last year's surveys were used as the basis for the first draft of our patient declaration of values. Patients were then asked to rate the importance of each of the proposed components. Based on their feedback, a declaration was established that I would like to share with you now. It reads:

"As a patient being transported by Ornge, it is important to me that:

"(1) I am safe from harm in the care of competent, highly skilled staff who provide excellence in my medical care;

"(2) The urgency of my transport will be prioritized according to need;

"(3) State-of-the-art technology and equipment supports my care;

"(4) Staff respond to my anxieties, fears, concerns and questions in my time of need and in an unfamiliar environment;

"(5) The experience is well organized and seamless;

"(6) The environment is clean;

"(7) My family are involved in care and receive timely communication regarding expectations and responsibilities;

"(8) My comfort needs are met;

"(9) I receive compassionate, kind and considerate care by professionals who respect my privacy, religious and cultural background;

"(10) I receive information on the plan and any changes during transport."

This declaration is posted publicly and demonstrates the commitment to patient care that we all share within the organization.

I want to stress that while I work mainly with patients and their families, I am one part of a larger team that addresses concerns over Ornge's services. If an issue is more serious or involves a more formal examination, I work with Ornge's internal investigations team, which in turn is in frequent communication with the emergency health services branch of the Ministry of Health and Long-Term Care.

I am also frequently in receipt of feedback from other stakeholders, such as health care providers, and I will take the responsibility of directing them through the proper channels. Ornge also has what is known as a care report system, which documents internal and external complaints.

I can't speak too much of what took place at Ornge prior to my arrival, but I am aware that Ornge did not have one central person responsible for interacting directly with patients. Feedback from the public came in to the organization from a variety of different venues, without one person taking ownership of making sure concerns were addressed consistently and timely. Because of this, complaints and concerns were frequently lost in the mix, resulting in lengthy delays in responding to our primary stakeholders, the people of Ontario. This is not acceptable, and I have worked hard to streamline the complaints and patient-relations process to allow people to easily access it. On top of that, we have guaranteed a response acknowledging their comments within two business days of receiving them, with an assurance that their concern will be taken seriously.

Also prior to my arrival, Ornge did not have a central functioning electronic system for tracking and categorizing feedback. Putting such a system into place has been one of my top priorities since arriving at Ornge. This system will allow me to keep an eye on emerging trends and to be able to identify, report and advocate for operational improvements that need to be made. This is an ongoing, long-term goal.

In addition, I recently provided the first of my reports to the Ornge board of directors, which I will be providing six times per year. Because this position is new, it is constantly evolving, and I look forward to seeing what additional steps can be taken to make sure the best interests of our patients are being looked after.

In conclusion, I want to remind everyone that Ornge transports more than 18,000 patients per year. While we'd like to hear from all of these patients or their families, only a small fraction of these patients will get in touch. But when they pick up the phone or type an email with a concern, a question or general feedback, they should expect to be listened to.

That is why I'm here: to listen, to discuss and to facilitate in the hopes of making their patient experience as compassionate and professional as possible. Thank you.

The Chair (Mr. Norm Miller): Thank you for that opening statement. We'll go to the NDP. Ms. Gélinas, you have 20 minutes.

M^me^ France Gélinas: Thank you. It's a pleasure to meet you, Ms. Polgar. Thank you for your opening remarks.

First, could you just give me an example of a call you took recently? Don't share anything we're not supposed to know, but just an example.

Ms. Denise Polgar: I recently received a complaint from a family with regard to medical protocols that were done on their loved one. That was just yesterday, so that's the minimal amount of information that I have.

M^me^ France Gélinas: Okay. Take me through some of the steps that you would go through.

Ms. Denise Polgar: I got a voicemail, so I returned that voicemail to the family. I get further details from the family as to what the complaint is and what their expectations are to determine what steps need to be taken in order to find out the answers for them. From that, I describe the process of the complaint and how that works with what we will do in order to look into those details. I then enter that into our electronic tracking system with all of their contact information, the basis of their complaint. Once I do that, that is then activated to various people in the organization—our investigations team, our VP, the director of operations—so then they're aware of it. From there, that starts the ball rolling in determining what actions or investigations need to take place, depending on the complaint.

M^me^ France Gélinas: In the short time that you've been there—I realize you haven't been there for years and years—has there ever been a complaint where, after you've tried your best, the family was still unhappy?

Ms. Denise Polgar: I haven't had that happen yet. However, when that does occur, if we've gone through the process of follow-up and the family has further concerns, we'll then go back and find out additional information. From there, if they are still not happy with that process, I would then take that to the board of directors for consultation to find out what decisions we need to make. Potentially—did I say to the board of directors or executive team? Both; I have the option of doing both. Obviously, the ministry may or may not be involved at that time, and I would then notify them as well.

M^me^ France Gélinas: The process you've just explained to us, that particular example, looks very much like what they do in the hospital. They don't always call them patient advocates, but it sure feels like it's similar. Would you say that it is similar?

Ms. Denise Polgar: We have modelled this process from patient relations departments in hospitals. So I would say that we mirror what they are doing and we're learning a lot from them.

We have some unique aspects within our organization, but that is the model that we're using and learning from.

M^me^ France Gélinas: Because you're under the Ambulance Act rather than being under the hospital act?

Ms. Denise Polgar: And their patient relations are dealing solely with the patients themselves. Right now, I'm fielding complaints from others as well. Patients and families always take priority; they're always who I deal with first. But I am fielding other complaints from stakeholders, from communication centres—not a lot, but some health care providers, and our hospitals as well.

M^me^ France Gélinas: Okay. I thank you for that. I don't know if you know, but with the process that exists within our hospitals—and you're following something quite similar—there are hundreds of people who are not satisfied with the best answers that they're getting from the patient advocate. Those people tend to turn to the Ombudsman because the Ombudsman is an independent third party who can do investigations for them.

In the process of a patient and family working with the patient advocate, sometimes what happens is that they lose faith in the hospital that did not treat them well, so they start to complain. They deal with a patient advocate who could be very skilled at what they do, but just cannot help this family turn the page.

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The process ends at some point, and the communication is: The hospital has done as well as they can, they've given them everything they could, they tried to accommodate them as best they can. Some of the patient advocates have years of experience and are really good, but there are still some that are not satisfied, and those people turn to the Ombudsman.

Do you see a role for something like this for Ornge, if it ever happens that it doesn't matter—all your experience, your skills, your goodwill and your directive—that if a family is not satisfied and turns to the Ombudsman, that they could have the Ombudsman do an investigation for them?

Ms. Denise Polgar: The first thing that comes to mind is, we internally would like to exhaust all opportunities—

M^me^ France Gélinas: Of course, yes.

Ms. Denise Polgar: —and go through all the appropriate leadership channels to see if we can resolve the issue with the family. Then, we would also work with the ministry and their guidance for suggestions and recommendations that could be changed depending on the complaint.

As for the Ombudsman, I would personally be happy to have any help that has to do with improving the patient experience if the policy-makers feel that that is something that needs to be done. If that is what's deemed as appropriate, then I would work with that person and any department that could help improve the patient experience.

M^me^ France Gélinas: Okay. We'll let it go around, and we'll have our second round of questions after.

The Chair (Mr. Norm Miller): Okay, very well. We'll move to the government, then. Ms. Jaczek?

Ms. Helena Jaczek: Ms. Polgar, just to get back to some of your experience—originally a primary care paramedic?

Ms. Denise Polgar: Yes.

Ms. Helena Jaczek: And then moved, was it, to dispatch?

Ms. Denise Polgar: Yes.

Ms. Helena Jaczek: That was in London, was it?

Ms. Denise Polgar: Yes.

Ms. Helena Jaczek: I'm just trying to get from your background—you have a very good understanding, then, certainly, of land ambulance and of all the steps in the process, in terms of whether it be inter-facility transport or whether it be from a scene to an emergency room, and so on. Would you say that that's fair, that you understand the system?

Ms. Denise Polgar: I understand the system, but I think that Ornge has some unique aspects that I'm learning about every single day that differentiates it a little bit. But the basis of emergency medicine, yes.

Ms. Helena Jaczek: That intrigues me. What is so unique about air ambulance?

Ms. Denise Polgar: I'm honestly still learning how that works, but even with the triage process—they have transport medical physicians, which is a whole new world for me to understand in the communications centre; the resources; the time that it may take to do one particular call; the matrix of the paramedics and the levels that they have, and how that works, all make some of those things unique, that I'm still learning about.

Ms. Helena Jaczek: So they actually, in essence, have some additions. When we went on our tour, I hadn't been aware that there was a 24/7 physician sitting right there in the dispatch—

Ms. Denise Polgar: Yes.

Ms. Helena Jaczek: The intensity and concentration and focus is beyond what I'm used to in terms of the land ambulance system, so that, no doubt, does provide extra—as you've said—issues, potentially, for you to deal with.

You do have a background in teaching and education, as well?

Ms. Denise Polgar: I do, yes.

Ms. Helena Jaczek: Have you found that helpful in terms of your role as patient advocate?

Ms. Denise Polgar: I think I've taken a little bit from every little part of that to help me in this role right now. Getting reintegrated into health, back into the emergency services, is going to take a little bit of time. There's a lot I need to study. There are new people that I need to meet, relationships that I need to build, and a better understanding of that happens every day. With every complaint I deal with, I learn a little bit more.

Ms. Helena Jaczek: In terms of the complaints that you're dealing with: As we know, Ornge deals with many, many inter-facility transports. Could you give us some numbers? How many are related to almost routine transfers? How many are connected to emergency on-scene? How many are from some of these other stakeholders that you've mentioned? Could you just give us a breakdown with some numbers since you've started—

what we're dealing with in terms of numbers of complaints.

Ms. Denise Polgar: With complaints?

Ms. Helena Jaczek: Yes.

Ms. Denise Polgar: I've started tracking data in that electronic program. There's more opportunity and additional fields to break down. Are the bulk of our complaints coming from inter-facility transfers, or emergency transfers? That's not something that I've done just yet. But we have been tracking who does the bulk of the complaining and has issues with our service.

It's important for me to also say that I don't think I have an accurate number at this point, because they used to come in on all different kinds of venues. As my role increases and people are more aware of what I'm doing, that's starting to be filtered. But I don't think that my numbers are perfect. But it really actually is our stakeholders who have the bulk of concerns with our care.

Ms. Helena Jaczek: Rather than patients and families?

Ms. Denise Polgar: From the last information, a report that I provided to the executive and the board of directors, 12% came from the patient, 7% came from the family, 50% came from our stakeholders and whatever's left there actually came from the general public.

Ms. Helena Jaczek: I see. Your position in Ornge is well-known to the whole organization, I assume, the paramedics—I mean, there was an announcement, I presume, when you started?

Ms. Denise Polgar: Yes.

Ms. Helena Jaczek: Because you said now your office is becoming better known, obviously calls are coming directly to you.

Ms. Denise Polgar: Yes.

Ms. Helena Jaczek: But I presume everyone in the organization has the ability, if they hear some sort of rumbling or unhappiness in general, that they know that you're there and they direct people to you. Would you say that's sort of the feeling that you're getting?

Ms. Denise Polgar: Yes.

Ms. Helena Jaczek: You're hearing from people.

Ms. Denise Polgar: I'm hearing from people, to the point where they may call me and even ask, "Is this something that you should be dealing with?" or "Is this something that we give to you?"

Ms. Helena Jaczek: Yes.

Ms. Denise Polgar: Sometimes it's just general questions, but, yes, I would say every day that that's increasing and getting better.

Ms. Helena Jaczek: What I'm trying to get at here is sort of a culture of openness, of addressing issues. Would you say that that's the way you're finding it now that you're there in Ornge?

Ms. Denise Polgar: I actually think that there's some relief by the staff that my position is in place so that I can handle that properly and through the proper processes, so I have had nothing but transparency from everybody within the organization.

Ms. Helena Jaczek: Of all these complaints that you've had to date, how many, or what percentage have you perhaps not been able to resolve?

Ms. Denise Polgar: We do have open cases that are still continuing. I'm just starting to track the satisfaction from the stakeholder or the family or patient. It hasn't come about yet where they haven't been pleased with the outcome—yet.

Ms. Helena Jaczek: That sounds very positive. Now, you mentioned developing your program, your role, very much modelled on what we all know is available in hospitals, in patient relations and so on. In terms of that process, can you just sort of outline to us how that worked, how you modelled your position on their process? I mean, you've talked about tracking and so on. We know hospitals do patient surveys. Was this part of what you instituted? Just sort of lead us through the parallels between the two.

Ms. Denise Polgar: Okay. Yes, some of it was developed by the surveys from the patients with the feedback that they've been providing. We also use a process map, similar to what the hospitals use, to help direct us, depending on what the issue or complaint is on how that process is going to work. That process was developed before I came. I have been asked, or consulted with the executive team on that process, if there needs to be additional changes. But it's very much modelled by the hospitals.

Ms. Dipika Damerla: Thank you. I just had a couple of questions. I was trying to follow your answers. I don't think we got a number on the volume of calls you field. Would you be able to give me some idea monthly, weekly?

Ms. Denise Polgar: Sure. When we started the electronic program—it was in March 2011 to March 2013—all the numbers all together, compliments, complaints and inquiries, because there is distinction between them, has been 246.

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Ms. Dipika Damerla: Two hundred and forty-six over a two-year period.

Ms. Denise Polgar: Yes.

Ms. Dipika Damerla: Okay. I was very intrigued by the fact that—I did the quick math—80% of the calls or requests that come to you are not patient related, because 12% are patients, 7% are family, so that's about 19%, 50% are stakeholders and then the balance, 30%, is the general public.

Ms. Denise Polgar: Yes.

Ms. Dipika Damerla: So given that 80% of it is non-patient directly, I'm just curious, given your position as patient advocate, how does this 80%—how do you deal with it or do you find that the calls are invariably or mostly still patient related? I'm just intrigued by the numbers and the breakdown.

Ms. Denise Polgar: Some of them are patient related, some of them aren't. And we are working with the executive to determine the extent of my role with the stakeholders and what that means. But at this point, I'm able

to review the incident reports and see if there's any opportunity for a systems improvement when it comes to those complaints that are stemming outside of the family and patient area. Does that answer your question?

Ms. Dipika Damerla: Not quite. So the stakeholders, when they call you, they're calling you on behalf of patients or with their own concerns? Have you sort of become a patient advocate cum stakeholder advocate? That's what I'm trying to figure out.

Ms. Denise Polgar: Sometimes the stakeholders may have a concern about a patient; sometimes it may be completely non-related to a patient.

Ms. Dipika Damerla: And you're able to respond to stakeholder concerns even though they are not patient related?

Ms. Denise Polgar: I'm able to facilitate the process. At this point, that's what my role would be, to facilitate the process, activate the proper process and get the appropriate people involved.

Ms. Dipika Damerla: My second question is that when you were answering Madame Gélinas, you gave an example of a patient call by family which was of an operation or a procedure done on a patient.

Ms. Denise Polgar: Yes.

Ms. Dipika Damerla: Would that procedure have been done on an Ornge plane or would it have been done at a hospital?

Ms. Denise Polgar: For this case, it was done at the hospital.

Ms. Dipika Damerla: I'm just curious why the call would come to you and not to the patient advocate at that hospital?

Ms. Denise Polgar: Because they questioned our medical protocols and what the crew was doing while they were getting the patient ready for transport.

Ms. Dipika Damerla: So you have well-defined protocols to ensure there's no duplication between what a hospital advocate would be doing and what you as a patent advocate at Ornge is doing?

Ms. Denise Polgar: Right.

Ms. Dipika Damerla: That's what I'm getting from your answer.

Ms. Denise Polgar: If there is question about something that the hospital has done, then we could work with the hospital and their appropriate leadership in the entire complaint process, depending on what that complaint is.

For example, I have dealt with a hospital up in the north. When it came to deciding or determining if a patient was eligible for transfer, it was literally a teleconference between our communications centre leadership, the hospital and ourselves to discuss that and come to a consensus together on what was best for the patient. It hasn't happened yet, but tomorrow we have that teleconference to provide those findings with the hospital, myself and the family.

Ms. Dipika Damerla: Okay. Thank you. Any questions?

Ms. Helena Jaczek: We'll have some more, but I think we—

The Chair (Mr. Norm Miller): Very well, we'll move on to the opposition, then. Mr. Klees.

Mr. Frank Klees: Yes, thank you.

An interesting responsibility you've taken on. Can you tell me how you were hired? Was there an open competition for the position?

Ms. Denise Polgar: There was an open competition for the position. I found it online. I had two interviews. The first interview was with human resources and the VP of clinical affairs, and then the second interview was a larger panel that also included the interim president.

Mr. Frank Klees: Given your experience professionally as a primary-care paramedic and the other things that you've done, how much input did you have in actually shaping the role itself?

Ms. Denise Polgar: There was a framework, when I first came into place; however, I am finding that leadership and staff are open to suggestions. In my opening statement, I talked about having a system to electronically track and analyze and then report on the data; that was my recommendation. Improving our time frames was also my recommendation. So I have found that they've been very open with evolving the role and improving it.

Mr. Frank Klees: Your experience as a dispatcher obviously places you in an excellent position to evaluate the improvements that would be needed in order to make Ornge 24/7 ready. I can imagine that, you being on the front lines, there can be nothing more frustrating than to dispatch a call and to find out that a crew isn't ready or that equipment isn't ready. From what I read, one of your responsibilities is to make recommendations.

My question really is twofold: First of all, are you engaged at this point, in terms of liaison, with dispatchers in your communications centre to get some input from them in terms of how things are going, or are you picking up from some calls that you're taking, as the patient advocate, that that continues to be an issue? Finally, when you receive those calls, have you been able to have some input to management on areas that you feel can be improved?

Ms. Denise Polgar: I think you asked me three questions—

Mr. Frank Klees: I did.

Ms. Denise Polgar: Just let me know if I don't answer each one, okay?

Mr. Frank Klees: Okay. I'll keep track.

Ms. Denise Polgar: Okay. My focus right now has been on getting a system in place in order for me to be able to track and then analyze what those issues are. Without a program of that nature I won't be able to provide the facts and reveal things that are of issue in our organization. My other has been working on time frames. What I mean by time frames is not call response time frames. Time frames, for us, in order to get back on the complaint, are follow-up and the resolution process. Sorry I didn't specify what those time frames may be.

When it comes to systems improvement quality initiatives, that's a long-term goal. Once I'm able to analyze that information and report on it, I'll then be in a better position to provide those suggestions and recommendations moving forward.

Mr. Frank Klees: Okay. We have, as part of our volume of documents here, one particular document that caused us a great deal of concern at this committee, and that was a number of incidents—it was an incidents document that was a cabinet document presented to cabinet monthly, from what we understood, that listed numerous incidents that were reported in which Ornge was not able to respond or Ornge responded and they weren't able to take the patient on board because the paramedics declined them because they were single-staffed and weren't capable of taking them on, or incidents where the communications or the dispatchers got it wrong. So, my question to you is, since you've been in your position, of the 246 calls that you've had, have any of those calls involved similar incidents? Let's deal first of all—have there been any incidents where a patient was not able to be taken on the aircraft because of whatever the circumstances were?

Ms. Denise Polgar: From those 246 complaints, I've only been part of a fraction of them. They occurred before I came into play. So I can't recollect, from those 246, what the findings were for all of them.

Mr. Frank Klees: So the 246 are not the ones—you haven't been there for all of those 246?

Ms. Denise Polgar: No. that was from March 2011 to March 2013.

Mr. Frank Klees: Okay. From the time that you were there, my question is did any of the calls that you're familiar with—because I'm assuming that all of the calls in the time that you came on are now coming through you?

Ms. Denise Polgar: Yes.

Mr. Frank Klees: You see them all.

Ms. Denise Polgar: Yes.

Mr. Frank Klees: Did any of those calls involve circumstances where a patient was not able to be taken on the aircraft because of single staffing or any other circumstances, as we've had in the past?

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Ms. Denise Polgar: I'm not recollecting any specific complaint about staffing and them not being able to go, but maybe this will help you a little bit: I have been tracking what the complaints are in categories, and our two major concerns are delay and communication.

Mr. Frank Klees: When you say delay and communication, so that we understand correctly, that would be a delay in communication on what end? Is that from the time that Ornge gets the call to the time the call goes out? Please help us with defining that.

Ms. Denise Polgar: Delays may be time to get to the sending facility; it could be time on scene, so how long they're spending in the hospital. The communication may be that the stakeholder was not provided an update with when we would be arriving, or something to do with medical care. There has been a variety, and I've actually been asked through our executive team to break that down even further, so that's something that I'm going to start tracking in the future.

Mr. Frank Klees: Do you provide a daily, weekly or monthly report to your executive team?

Ms. Denise Polgar: I just got approved to provide a report to our executives six times a year or as required. If there is a complex case where consensus cannot be reached, I can call upon the executive to meet and get consultation from them on further action.

Mr. Frank Klees: Six times a year seems a not very frequent reporting time. If I was on the executive of this organization, knowing the history, seriously, I'd be asking for a weekly report from you so that I could properly monitor the progress. I'd like to know what the complaints are, how they're going. But that's interesting.

Ms. Denise Polgar: Something I didn't include was that I do have a weekly meeting with my VP as well.

Mr. Frank Klees: And your VP is?

Ms. Denise Polgar: For clinical affairs, Jo-Anne Oake-Vecchiato.

Mr. Frank Klees: So do you provide her a written report every week?

Ms. Denise Polgar: I provide her a summary sheet of outstanding complaints or inquiries. That includes some information about what the complaint is and where we are in the progress or the process.

Mr. Frank Klees: Okay. Could we get a copy of those weekly reports that you're presenting to your VP?

Ms. Denise Polgar: I think the only thing that would concern me is patient confidentiality, because those reports have patient names and confidential information on them. But if I'm instructed to do so by the powers that be, then—

Mr. Frank Klees: We're happy to have the names redacted; that's not the issue. I think what is important for us is that we know what the flow of information is and what the nature of that information is. We don't want any personal health information, but I think it certainly will give us a sense of what is in place to have that information flow.

Can I ask you your opinion? You've been there now a few months—

Ms. Denise Polgar: A little bit.

Mr. Frank Klees: —and you've made some reports. Obviously, some of them, I would think, with your background, would be concerning. Delays—all of these things—impact on patient outcome. Can you share with us an example of an incident where, as a result of input that you've had, you have made a recommendation as to an operational change or a system change that would prevent or would help fix what's wrong?

Ms. Denise Polgar: The one case that sticks into my mind is, I got a call from a family concerned that they weren't eligible for transfer under our criteria. I then had conversations with the hospital to discuss the patient's current condition, what has happened in the past with our communications centre and what they were told. From

that, I was able to agree with our communications centre that this patient was eligible for transfer, and that the next time that she has a treatment set up—for a treat and return—that she will be transported by Ornge based on her current condition.

Mr. Frank Klees: Good.

The Chair (Mr. Norm Miller): Sorry to interrupt, Mr. Klees, but just for clarification for our Clerk's sake, what you were asking for from the—

Mr. Frank Klees: Yes, I was asking for the weekly reports that are being delivered to the vice-president of the incidents that she has received in the course of that week, from the time that the witness took on her responsibilities there.

The Chair (Mr. Norm Miller): Fine, and if I understand correctly, with the personal health information redacted?

Mr. Frank Klees: With the personal health information and the names redacted.

The Chair (Mr. Norm Miller): And the names redacted. Very well. Sorry for the interruption.

Mr. Frank Klees: Am I finished or were you just interrupting me?

The Chair (Mr. Norm Miller): I was just interrupting you.

Mr. Frank Klees: Okay. Can you, apart from—I'm assuming hospitals are one of the stakeholders?

Ms. Denise Polgar: The main stakeholder.

Mr. Frank Klees: The main stakeholder from whom—any other stakeholders that you're getting calls from?

Ms. Denise Polgar: Sometimes the complaint may come through in an electronic form. Sometimes we may receive complaints from local EMS services as well, but it's mainly hospitals that tend to use that form.

Mr. Frank Klees: And the nature of the complaints that you would be getting from local EHS would be what?

Ms. Denise Polgar: They may question the priority of a call; they may question a delay in response. Just off the top of my head, those are a couple of things that they may complain about.

Mr. Frank Klees: Okay. You indicated that you can report to the executive team and/or the board of directors.

Ms. Denise Polgar: Yes.

Mr. Frank Klees: And is that at your will? Should you feel the need, you can make that appointment and be there to report?

Ms. Denise Polgar: Yes. It has been communicated to me many times that I have access to the executive team, the board of directors and the president, with an open-door policy, if I have any concerns that need to be addressed or if we've reached a stalemate or have stalled in the process of dealing with this complaint. At no time have I felt that I don't have that option when I need it.

Mr. Frank Klees: Good. That's very positive. Paramedics: Have you had occasion to take any calls from paramedics on any matter?

Ms. Denise Polgar: At this point, it's professional practice standards that deals with complaints from paramedics that are non-patient related. So if I even did receive a call, I would then forward that to the professional standards department.

Mr. Frank Klees: Okay, and if the paramedic felt that it was an incident that involved a patient matter, they couldn't call you?

Ms. Denise Polgar: They could.

Mr. Frank Klees: They could?

Ms. Denise Polgar: Sure, they could.

Mr. Frank Klees: And you would accept their call?

Ms. Denise Polgar: Absolutely.

Mr. Frank Klees: I'm just trying to get a sense of whether people get channelled where they don't want to be. If they say to you, "Look, I really would like to talk to you because I think I'll get a hearing from you," you won't turn them away?

Ms. Denise Polgar: Absolutely not. Like I said before, I'm one part of the system. So even if a complaint comes in, it activates more than just myself. So even if they called somebody else and it went into our system, I'm immediately alerted of that issue, and I can get involved if I feel it's a patient-care issue or something about the patient experience that can be improved.

Mr. Frank Klees: Okay. Back in June of last year, Ornge was about to request a lowering of standards from the Ministry of Health. Specifically, it had to do with the issue of a single-paramedic response or the type of paramedic qualification that could be on a flight. The rationale for Ornge at the time was, "We'd rather make a flight with unqualified or lower-qualified paramedics than not being able to make the flight."

My understanding is that that didn't happen at the time. We challenged the minister on it. We know that the application for that watered-down standard had been prepared. Are you aware of anything within Ornge that is in the works now? Is that something that you, with your background as a paramedic and certainly the work that you're doing now—would you support or think it would be appropriate in any way to water down the standards of care that are currently in place?

Ms. Denise Polgar: That is really beyond my level of expertise and my mandate within the role at Ornge, so I don't think I'm in a position to answer that.

Mr. Frank Klees: Well, let me ask you then, as a paramedic or a former paramedic, do you think that it would be appropriate for an organization—or would you, as a paramedic, want to be placed into a situation where you're asked to go out on a call, knowing that the standards of care prescribed by your profession are being compromised?

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Ms. Denise Polgar: I think I would look to my leadership to determine what best works for the organization. My job as a paramedic was to do what I could for those patients in whatever circumstance I was in. So I think that's probably the best thing that I would do; I would do what I could for my patient at the time.

Mr. Frank Klees: Can I rephrase this? Standards of care are set by a profession. Do you believe that a paramedic, a nurse, a doctor has a first responsibility to the profession and the professional standards, or to the employer, who may decide that the standard of care set out is too high, isn't necessary? Who rules here? Is it the employer or is it the profession, in your opinion?

Ms. Denise Polgar: For me, the driving force is always the patient and doing what's best for the patient. I think morally, a paramedic is driven by providing the best care they can to the patient and providing a really high patient care experience for those people who they care for.

Mr. Frank Klees: And those standards are set by the profession?

Ms. Denise Polgar: Yes.

Mr. Frank Klees: Thank you.

The Chair (Mr. Norm Miller): Thank you very much. We'll move on to the NDP. Ms. Gélinas.

M^me^ France Gélinas: I only have some odds-and-sods questions. They have no relationship to one another.

The first one is, you are report to the leadership—that is, the board of directors or the executive director; I'm not too sure—six times a year. Have you done a report so far?

Ms. Denise Polgar: Just to clarify, I report to the executive six times a year, and then a report is provided to the board of directors six times a year. And yes, I have.

M^me^ France Gélinas: And who prepares the one that goes to the board?

Ms. Denise Polgar: I prepare it.

M^me^ France Gélinas: You prepare both?

Ms. Denise Polgar: Yes, I do.

M^me^ France Gélinas: Okay. Would you mind sharing those with us?

Ms. Denise Polgar: I can't see any reason why not.

M^me^ France Gélinas: Okay. How many have you prepared since you've been there?

Ms. Denise Polgar: Since I've been there, it's been three.

M^me^ France Gélinas: Three? Okay. Very good.

Ms. Denise Polgar: But before we determined how often this was going to take place, it was my recommendation to set up some sort of process so that it happened on a regular basis. For right now, what we agreed upon was six times per year, and then any time I feel it's necessary that they get pulled together; and I provide those reports.

M^me^ France Gélinas: When you were first hired or since you've been hired, have you heard anything about a whistle-blower policy?

Ms. Denise Polgar: Yes, I have.

M^me^ France Gélinas: How did you find out?

Ms. Denise Polgar: I believe it was emails through our communications centre about a whistle-blower policy, how we can access it and what it meant.

M^me^ France Gélinas: Do you remember what it said?

Ms. Denise Polgar: This is where things get cloudy for me, probably because I wasn't really concerned about it at the time. But I know that it's very visible on our website if I want further details about how to report. I know it's from a third party and I know the process of accessing that policy if I want to talk to anybody.

M^me^ France Gélinas: Have you referred anybody to the whistle-blower policy?

Ms. Denise Polgar: I haven't felt the need to provide that information, but if it came about, then I certainly would.

M^me^ France Gélinas: All I have to say is, thank God.

Coming back to your job—forget the whistle-blower; they're a bunch of questions that are not related—if a patient goes to your website, how easy is it to find out how to put in a complaint with you?

Ms. Denise Polgar: This is where I think a huge improvement has been made since I've started. If they go to our website, there are multiple ways to make complaints, requests or inquiries. Through our main webpage, there's "Contact us" information, and they can click on that; or they can click on a "patients" tab, which opens up my profile and what I do. From there, they can either call me by direct line, there is a direct email address, or they can fill out a form—whichever one they prefer.

M^me^ France Gélinas: The concern that comes from the general public—which seems to be a big percentage of the concerns; you said 12% patient, 7% family, 50% stakeholder, and the rest of them being—that's still a fair amount.

Ms. Denise Polgar: Yes.

M^me^ France Gélinas: Who are they, and what are they talking about?

Ms. Denise Polgar: Some of them may be making noise complaints about our vehicles. Some of them may be inquiries about our academy: "How do I become a paramedic? What do I need to do? Who do I need to talk to?" Some may just have general questions about our system: "I'm an organ recipient; when things happen, what services do you provide?" General questioning, mostly. Those are probably the bulk of the ones that I can think about right now.

M^me^ France Gélinas: Okay. No more questions.

The Chair (Mr. Norm Miller): We'll move to the government. Ms. Jaczek?

Ms. Helena Jaczek: You've now got your electronic database, and it's being sent to various people. In terms of the Ministry of Health, what's the reporting relationship? Do you have a direct reporting relationship?

Ms. Denise Polgar: When the complaint comes through on the system, our investigations department determines if it meets criteria for the ministry to be notified immediately. I've presented in front of the ministry once about my role and how we're doing there, and I attended one investigations meeting to meet all of them and start to learn about what that process is. Then I've had a couple of conversations about a few complaints and, if they're running their own investigation, what's happening with that—what has the communication been with the family, and how will we work in conjunction with each other to communicate with the family.

Ms. Helena Jaczek: So this is where they've called you?

Ms. Denise Polgar: Or I call them.

Ms. Helena Jaczek: So you feel totally free to have that kind of interaction.

Ms. Denise Polgar: Yes.

Ms. Helena Jaczek: Who is on this investigations unit? You said it goes there.

Ms. Denise Polgar: There's a director, a manager and a coordinator for investigations. They do all the fact-finding and develop the report, then that goes to the leaders and me for review to find out what happened in the process of the complaint.

Ms. Helena Jaczek: That always comes back to you, and you can decide whether you're satisfied with the investigation?

Ms. Denise Polgar: Well, it's not my determination. The family needs to decide if they're happy with that—

Ms. Helena Jaczek: Yes. You're their advocate, so you convey to them, "This is what we found," and then they respond to you.

Ms. Denise Polgar: Yes, and I'm not the only one involved. If families have questions about the process, I certainly can't answer to operational decisions of what happened, so the most appropriate, or what we call the most responsible person is almost always on the telephone call, as well, to explain those particular operational decisions to the family or to the patient. I then facilitate that process.

Ms. Helena Jaczek: Right.

This Quality Improvement Plan—are you familiar with this document?

Ms. Denise Polgar: Somewhat. I have some homework to do.

Ms. Helena Jaczek: There is something here in appendix A that I find interesting. Every year, it is the expectation of the ministry that a quality improvement plan is produced, so this is the one that was produced for 2012-13, and what it says is:

"The annual quality improvement plan must be developed having regard to at least the following:

"—The results of the surveys;

"—Data relating to the patient relations process."

In terms of these surveys, does something go out to every single patient served by Ornge?

Ms. Denise Polgar: The process for sending out patient surveys is that they can only get the survey once, and it has to be within six months of transport. I think we've been averaging between 800 and 1,000 patients every three months, and that goes out to them to provide feedback to us, then all our results are posted on our website as well.

Ms. Helena Jaczek: What sort of response rate do you get to that survey?

Ms. Denise Polgar: In general, if you wrap them all up—I'm only taking a guess, but it was very high.

Ms. Helena Jaczek: It was high?

Ms. Denise Polgar: Yes.

Ms. Helena Jaczek: Did you develop that survey, or were you involved at all?

Ms. Denise Polgar: The survey happened before my time, but I'm now leading the metrics of that survey, and I review the questions from time to time to see if there's a different question we need to ask, or if it needs to be rephrased, or if the question is valid—if it's been validated. It does evolve and it does change, depending on what feedback we're looking for.

Ms. Helena Jaczek: And, presumably, what you're hearing out there. If there's some new aspect that hits you, you might want to zero in on a particular aspect, I presume.

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Ms. Denise Polgar: Yes. I can give you an example of that: We saw that the patients responding were starting to get a little concerned about blankets that they were receiving in the winter. So then from there, I can work with the operations managers to say, "Are we providing enough blankets? If we're not, this needs to be reminded." We can put that in a newsletter; I could put that out in one of our weekly updates, to remind the paramedics about meeting basic care needs and keeping our patients warm and what that means.

Ms. Helena Jaczek: Do you know if you're going to have input to the quality improvement plan, the 2013-14?

Ms. Denise Polgar: I think that's a great question, and I will definitely ask my vice-president to be on that.

Ms. Helena Jaczek: Okay, thank you.

The Chair (Mr. Norm Miller): Any other questions from the government?

Mr. Phil McNeely: What kind of staff do you have to handle all these complaints—

Ms. Denise Polgar: I am it, but I work with various other departments that help me. So I don't have to run the investigation on my own.

Mr. Phil McNeely: Somebody else does that.

Ms. Denise Polgar: Somebody else does that. And depending on who the most responsible person is, I work with them. So even though I'm the only patient advocate, I have a good amount of team members to help me throughout that process.

Mr. Phil McNeely: Thank you.

The Chair (Mr. Norm Miller): We'll move back to Mr. Klees. Go ahead, Mr. Klees.

Mr. Frank Klees: You were in your job on November 23, 2012, I'm assuming?

Ms. Denise Polgar: Yes.

Mr. Frank Klees: Do you recall the incident in the region of Waterloo? There was a situation where Ornge responded to an incident and we had that incident of a single paramedic responding. I'm going to read a quote from John Prno, who is the manager of the Waterloo EMS:

"The air ambulance knew it couldn't transport the woman found trapped in her rolled over car before it left London.

"He was concerned by what happened....

"'Ornge has had some significant staffing woes ... sometimes they launch aircraft with one paramedic on

board, without enough to care for a critical patient like that,' he said.

"'Having a speedy response with a lower level of care, that's a problem.'"

Do you recall getting a call from the EMS in Waterloo regarding that particular incident?

Ms. Denise Polgar: I have no recollection of that call or any involvement in that. It's not ringing a bell to me, no.

Mr. Frank Klees: Well, what's interesting about that is that this made the news—I think it was on television, it was in print media; it was very widely reported—and you, as the patient advocate, or the point person, wouldn't have known about this?

Ms. Denise Polgar: With the information you've provided me, it's not coming to me. Without looking at my records, without looking at my data, I don't know if I'm aware of this—

Mr. Frank Klees: I would think that what you may want to do is get a newspaper clipping service or something for your department, because we certainly knew about it, and I would think you would want to.

Here's a quote from Mr. Farr, who was asked about this: "From time to time, we find ourselves in a situation where a staff member either books off sick or they're not feeling well and they have to go, so we're left short. (In those cases) we believe it's in the best interest of our patients across Ontario to launch a helicopter to assist the land EMS crews."

This goes back to the issue that I was following up with you just a bit earlier, and that is standard of care. The EMS manager was not impressed. The EMS manager is saying, "Look, it's not good enough for you to send a single paramedic. That doesn't help us."

What I'm concerned about, and the reason that we continue these hearings, is that I would think, obviously, you're providing value-added to this organization. We want to make improvements. The job of Mr. Farr, in my opinion, is not to make excuses about people being off sick; the job is to staff up so that we know that 24/7 we do have the appropriate number of people on staff so that when the calls come in—you'll be out of business. You shouldn't have a job, with all due respect. You should be on the front line providing the paramedic service. We shouldn't have to have a full-time job to take complaints about an emergency helicopter service in the province of Ontario.

This has got nothing to do with you. I'm hopeful and I think you're already providing some help in getting this organization levelled out, but it concerns me, as a member of this committee, to continue to hear, even today from Mr. Farr, that that's the way it is. People get sick; we know they do. Because we know they get sick and because we know that there are going to be incidents when people aren't going to show up for a job, surely we have the ability to staff up and surely we have the ability to make the necessary arrangements so that people in Ontario who need air ambulance and call are not going to be disappointed.

I wish you well in your job, but I hope soon enough you'll be out of a job.

Ms. Denise Polgar: Okay.

The Chair (Mr. Norm Miller): Thank you. The auditor had a question?

Mr. Jim McCarter: Just a quick follow-up question—something Mr. McNeely was saying. We were talking about staffing, and you mentioned that you've got a lot of complaints and no staff, and often when you get a complaint you would refer it to one of the areas in Ornge to investigate and report back to you. It's a little bit like sometimes the situation we auditors get into. We go out and people report back to us. Often they tell us what they think we'd like to hear. When you go to, say, the Thunder Bay base and you'd say, "We got this complaint; could you report back to me, Thunder Bay, on what happened?", do you see any risk that what they report back to you might be slanted, in a sense, to—how could I put this?—to protect what they did and may not be totally accurate? Do you see any risk there, and how do you handle a situation like that? I'm just curious, because we face that as auditors all the time.

Ms. Denise Polgar: Okay. I think the processes are set in place in order to get the appropriate and factual information. One of those is through an incident report. That is governed through the Ministry of Health. There are certain criteria that the paramedics have to provide within that. We can look at medical records, which are factual. The investigative report is also only factual. So, if that's listening to audio tapes or looking at other transport records, a combination of all of those facts are all brought together for the report.

Mr. Jim McCarter: I think I understand you'd do something similar to us. As well as getting a report back from them you would actually go back often to the original documentation just to see: What did the flight log say? What was the audio? So you would actually go back to follow up on that just to sort of get some corroborating evidence.

Ms. Denise Polgar: Yes. If I read the report but then I look at the family complaint and there's still an outstanding question there, I can ask for additional information, particularly through the investigations department, to say, "Can you ask the medics this particular question?" just to make sure that that information is consistent.

Mr. Jim McCarter: Okay, that's great; thank you.

Ms. Denise Polgar: You're welcome.

The Chair (Mr. Norm Miller): Thank you. We'll move to the NDP: Ms. Gélinas.

M^me^ France Gélinas: Just a very quick question. I understand that there's only one of you.

Ms. Denise Polgar: Yes.

M^me^ France Gélinas: I serve a large district in northern Ontario. Close to 30% of the population I serve are French speaking. I know that your website is in English only and that the complaint form is in English only.

Ms. Denise Polgar: Yes.

M^me^ France Gélinas: How do you handle French callers?

Ms. Denise Polgar: I haven't had that yet, but I know that there have been discussions with the executive team about making changes to our website in French. I don't know all the details to that, but I think that's a valid question and that's something that we can potentially make improvements with, depending on what we need to comply with. I haven't dealt with that yet. I do know that we're looking into trying to find a delegate who can provide translation services so that I can still be involved and still advocate for the patient or find out what happened. That hasn't happened yet. It's something that I know there has been some initial discussion on what we can do to improve that.

M^me^ France Gélinas: So, if you go back to work this afternoon and a French caller calls, what happens?

Ms. Denise Polgar: I would probably connect with my VP and ask for some direction on what we do to communicate with this individual. My understanding is that we have a translation service, but I would need to identify where to reach those services and how we could utilize those. And that's something I will do when I go back.

M^me^ France Gélinas: Okay.

Ms. Denise Polgar: Thanks.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Norm Miller): Thank you. Any further questions from the government? Very well. I believe we're done. Thank you very much for coming in this afternoon.

Ms. Denise Polgar: Thank you very much.

The Chair (Mr. Norm Miller): We appreciate it.

I guess we're adjourned until next Wednesday at 8:25 a.m.

The committee adjourned at 1451.

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