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05 HOME OXYGEN PROGRAM
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07 New Procurement Process
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09 Vendor Consultation Meeting #1
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17 April 30, 2009
18 12:00 p.m. to 2:00 p.m.
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20 Best Western Lamplighter Inn & Conference Centre
21 591 Wellington Road South
22 Oak Room
23 London, Ontario
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30 SPEAKER
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32 BARBARA CADOTTE
33 Senior Manager
34 Assistive Devices Program
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01 MS. CADOTTE:
02 So I think we'll get started. I want to thank
03 everyone for coming. We have with us a court reporter
04 who's taking notes of the meeting and she's requested

05 that if all of you could turn off your cell phones and
06 BlackBerrys, if you could. And later on in the
07 meeting, if you choose to speak, if you could identify
08 yourself before speaking. Thank you.
09 And I understand that everybody is registered.
10 Heather, I think we'll catch you up at the end if you
11 haven't registered. And I also want to just take a few
12 moments to thank you all for coming to this meeting
13 today. This is the second meeting in our series of
14 meetings with the industry and you might recall that
15 our first meeting was an information session which took
16 place in February of this year, and we had about 39
17 interested parties attending at that time.
18 We at that time just presented information on the
19 process of establishing the RFP for the vendor of
20 record and we responded to some questions at the
21 meeting and also addressed additional questions and
22 posted the responses subsequently. That meeting was
23 also recorded through the use of a court reporter and

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01 the meeting notes were posted on MERX following, and
02 the ADP and OHRSA sites following that meeting.
03 So today's meeting is a focus on the criteria for
04 vendors and the requirements and some of the
05 performance measures, so you might want to look at and
06 turn to the terms of delivery of home oxygen.
07 And I'd like to take this opportunity again to
08 thank you all for coming to this meeting. We did have
09 49 parties submit responses to our online survey and we
10 find that these responses are incredibly valuable to us
11 and they're much appreciated as we move forward in
12 looking at all of the components of the service
13 delivery package.
14 The vendor responses have been reviewed and
15 tabulated and we're currently in the process of
16 analyzing them in terms of what, in fact, if any,
17 depending on the responses and the issue in question,
18 they would have on the RFP that's posted later.
19 In previous meeting we indicated that we're moving
20 to a new procurement process for the Home Oxygen
21 Program and we want to ensure that all vendors have
22 full access to all of the public documents related to
23 the process. All the documents will be posted on MERX

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01 on the ADP website and then forwarded to OHRSA for
02 posting on that site as well, including meeting
03 records, slides, and the questions and answers. And
04 it's important to understand that throughout the
05 process the Ministry is the sole source of information
06 on the procurement.
07 I'd just like to introduce myself. I'm Barbara
08 Cadotte. I'm the Manager of the Assistive Devices
09 Program, and I have with me today Sara Dobner, who's
10 the Senior Policy Advisor with the Ministry, and John
11 Campbell, who's Fairness Commissioner who we invited to
12 participate in this process to ensure fair process.
13 And, I'm sorry, I don't have your name, our court
14 reporter today. I don't have my glasses on.
15 REPORTER:
16 Val Brown.
17 MS. CADOTTE:
18 Valerie Brown. Thank you very much. Now you know
19 I actually need glasses and you're all blurs, but I can
20 read.
21 So I'll just move into the presentation then. In
22 our first meeting in Toronto we actually had a
23 different greeter and then I came forward, so I won't

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01 introduce myself as the presenter because I'm already
02 here. So again, welcome to the first of the series of
03 Home Oxygen Vendor Consultation meetings and, as
04 promised, we did post the response to the questionnaire
05 prior to the first meeting and I'll just go through the
06 overview of today's meeting.
07 We have a standard disclaimer that we will read
08 out and we'll talk about the purpose of the meeting,
09 and we'll go through the overview of the questionnaire
10 and some of our lessons learned by going through that
11 process. I'll provide a summary of the responses and
12 we'll talk about the next steps.
13 The information presented in the following slides
14 is intended for presentation purposes only and is not
15 legally binding. In the event of inconsistent
16 information between the information in this
17 presentation and the information contained in the
18 future Vendor of Record, the information in the future

19 Vendor of Record will prevail.
20 So today we're meeting to provide you with a
21 summary of the consultation survey number one key
22 results, and also we have some additional questions to
23 seek feedback from home oxygen vendors. I'll wait a

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01 moment, we have somebody new who's arrived.
02 MR. FINES:
03 Good, we're at the front.
04 MS. CADOTTE:
05 Now, to talk a little bit more about the
06 questionnaire and our lessons that we've learned from
07 it, it was the first time that we had used that
08 particular software, SurveyMonkey, and we know that it
09 is being used successfully by other areas of the
10 Ministry, and the value of this approach is it really
11 facilitates a very efficient and quick turn-around of
12 the results. So we're provided, following the close of
13 the survey, with a very good summary of the results,
14 and that leaves us the focus time to look at the
15 comments and to actually look at the comments and
16 centre our attention on that.
17 As I said, we did have 49 responses, 47 that were
18 received online and two that were faxed due to some
19 issues with the survey. And so the technical issues
20 that we encountered, you encountered, were there were
21 some time-out problems, and once people had gone in,
22 they weren't able to go back into the survey, and then
23 there were some issues with frozen screens.

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01 What we did was we worked on an ongoing basis
02 until we made sure that we opened the survey and people
03 were able to go back in, but we do know that we have to
04 take some additional steps for the next time around to
05 make sure that you have all the information you need,
06 that you also have time to take the information off and
07 consider your responses. We understand that this isn't
08 just a survey that you can go through and click, click,
09 click, that you do need to spend some time considering
10 your answers and what the impact of your answers are on
11 your clients and your business.
12 So the next time around we're going to include a

13 PDF file of the survey so that that can be printed
14 right out and used to formulate your responses, and so
15 then when you go back in and do the survey you'll have
16 a complete record of what you want to say in front of
17 you and so that should mitigate some of the problems.
18 And we'll also make sure that our instructions are
19 more comprehensive and we'll think through all of the
20 issues, and we're still analyzing the technical issues
21 and working with SurveyMonkey, the company itself, to
22 ensure that we understand all of the issues that arose
23 and what are the steps that we can take to ensure that

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01 they don't happen again.
02 So to move on to the Summary of Responses, we
03 considered that these meetings were an opportunity for
04 us to report back on the replies to the survey and to
05 give you the real time information in response to the
06 questions, because there was some variation in
07 responses, so that's why we think that it's important
08 that we provide you with the percentages of the answers
09 and then some of the comments that we received.
10 Our first question was whether or not it should be
11 mandatory for vendors to have all modalities. And in
12 this first section of the survey we are actually going
13 into the current Home Oxygen Program and confirming or
14 not the deliverables that are already there. So the
15 modalities that we mentioned were liquid oxygen
16 systems, concentrators and cylinders. And the
17 responses were 65% of you said that it should be
18 mandatory and 35.5 said it should not.
19 And the reason why not was that it wouldn't be
20 cost effective, that as vendors you don't require all
21 modalities to service patients, that what you carry in
22 your stock should be up to you, and that there are
23 safety issues in some circumstances. For example, in

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01 long-term care facilities and seniors. And I would
02 expect that it's the liquid oxygen systems that are the
03 ones that have the most, could post the most problems
04 in those areas.
05 The second question was whether or not portable
06 concentrators were a viable delivery system, and 70% of

07 you said yes, 30% said no. And some of the reasons why
08 not are the costs involved, safety issues. Again, that
09 the vendor should be the one to arbitrate, to set the
10 client's, to respond to the client needs. Yes, you
11 would include portable concentrators if you receive
12 more funding and they should be offered as an option.
13 So to continue on a question of portable
14 concentrators we asked whether they should be added as
15 a mandatory modality, and the response was
16 overwhelmingly no by 82%. And some of the comments
17 were, you know, if other systems like liquid were
18 mandatory, then these should be as well. And also that
19 clients do want mobility and independence, and so the
20 technology should continue to improve and come down in
21 price. So from this response I understand that maybe
22 this is something to look at in the future when there
23 are additional changes made in the technology itself.

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01 And question four, if they were to become a
02 mandatory modality, what would be the cost implications
03 initially and over time. And the responses were that
04 there would be high up front costs and high costs over
05 time. That the service costs related to this type of
06 equipment are high in terms of upkeep. That currently
07 at this stage in time the battery life of such systems
08 is unknown, and so also unknown is the longevity of the
09 equipment or service costs, that they're more costly
10 than beneficial. There is little cost benefit and,
11 again, more costs on the upkeep and the fact that it's,
12 at this stage, difficult to estimate what the cost
13 implications would be.
14 So overall, I think the response was that it was a
15 fairly new modality and that it's difficult to comment
16 on this at this time.
17 So then question five, we asked for a response on
18 the estimate of the breakdown of your client base by
19 modality, and this is not information that we currently
20 gather on an ongoing basis, so it's very helpful for us
21 to know this. Seventeen percent provide stationary
22 concentrator in liquid; 55%, stationary concentrator
23 in cylinders; 17.9%, stationary concentrator and

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01 portable concentrator; three percent liquid only and
02 ten percent other, and that could be a stationary
03 concentrator with an oxygen conserving device with
04 cylinder, a transfill system or just a single system,
05 liquid concentrator and cylinder, etcetera.
06 In the current manual we identify that regular
07 follow-up is advised because of possible medical and
08 operational risks occurring with improper use of oxygen
09 and we asked whether there were any other relevant
10 risks that we should know about. And 80% of you
11 thought that there were other risks, including safety
12 and maintenance of equipment, risks related to changes
13 in the requirements of patients, and also risks related
14 to smoking.
15 So we asked how long after the first setup the
16 initial visit by a registered health professional
17 should take place. And 50% fully said within 72 hours,
18 with 32% saying within 24 hours and the other 28%
19 saying within 72 hours. And then an additional 20%
20 said the maximum should actually be 48 hours. So, and
21 then a small percentage said the first visit should
22 occur within one week.
23 And then we also wanted to know how many visits

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01 after the initial setup were typical or required to
02 ensure that risk avoidance measures were practised by
03 the client. And again there was some variability. As
04 you can see, the breakdown is depending on clients, two
05 visits, two to four, three, six to eight week rotation,
06 weekly and then once a year. And so I think the
07 majority of the respondents identified that it really
08 depended on the client needs, and some individuals
09 require weekly visits for some time and others cope
10 well after the initial one or two visits.
11 And so we also wanted to know generally who makes
12 this first visit to the client, and the majority of
13 first visits are by a regulated health professional
14 only, and then there are a certain number of visits
15 with the regulated health professional in the
16 registered -- and the medical gas technician in
17 combination and, in some cases, just the oxygen
18 technician.
19 In question ten, in the current manual vendors
20 agree to provide 24 hour emergency service and they

21 must return a telephone call from a client within one
22 hour. If the problem cannot be solved over the
23 telephone, the vendor agrees to have an employee attend

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01 at the client's home within three hours, unless the
02 client agrees that attendance is not necessary.
03 We asked for your opinion whether there were any
04 changes needed to this requirement, and again majority,
05 84.6%, said that that requirement was sufficient. For
06 the few who said that, yes, there should be a change,
07 there are just some different response times or methods
08 offered, a telephone call within 20 to 30 minutes, an
09 emergency visit, if it's a rural area the visit should
10 occur within four hours, or not to identify time at
11 all.
12 And when we looked at other community provided
13 services we noted that there would be a guarantee in
14 some of these other services, the four to twelve hours
15 response for different levels of emergency defined to
16 assist vendors in assisting clients. And we asked
17 whether this approach would work, and 64% said no, that
18 approach wasn't necessary in this case.
19 And again, that responses should be looked at on a
20 case by case basis, depending on client circumstance,
21 and that was generally the consensus and responses in
22 this area, and that although it was acknowledged that
23 historically clients who are receiving home oxygen

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01 services really depend on some immediate assistance
02 because of the nature of their health issue and the
03 services being provided.
04 We asked if we were to change the required
05 response time, how would this impact staffing and costs
06 of vendors. And 64% of those who responded, and I do
07 have to empathize, but it's those who responded who are
08 taking the survey, that there would not be any change
09 to the staffing required. Another number of
10 respondents indicated they weren't sure what an impact
11 would be. Some thought that they could reduce or
12 increase staffing. And again, those who support no
13 change in this particular criteria indicate that they
14 do understand that patient safety is their priority,

15 and why would we offer 24/7 service if a patient
16 wouldn't be able to rely on it. And again, vendors
17 indicated that your job is to keep people healthy and
18 out of hospital.
19 Moving on to question 13, in the current manual we
20 indicate that vendors would provide a basic home oxygen
21 supply system along with delivery, setup, inspections,
22 instruction, education. And we wondered if any of the
23 current criteria were problematic on a regular basis.

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01 Eighty percent of respondents said no, and for those
02 who said that there were some problems, basically they
03 indicated that it was around the intensity of labour,
04 administrative costs that weren't recognized, that
05 sometimes clients do decline their home visits. There
06 was some issues surrounding staff retention and pick up
07 of equipment.
08 And then we asked if there were any changes that
09 were required to this requirement and 87.5% of the
10 respondents said no, and then just some who wanted to
11 provide a description of change and rationale. There
12 was a focus on electronic renewals and online
13 adjudication, respiratory assessment on admission to
14 the service and maybe some need to fund a second
15 concentrator.
16 And just to give my ADP plug here in response to
17 the concerns around electronic renewal and online
18 adjudication, I know that I have mentioned that other
19 speaking engagements with the association, that ADP
20 does have the go-ahead to look to rebuild our
21 information technology system and definitely phase two
22 of that project would include having a portal available
23 for online submissions. So we are looking in

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01 conjunction with that to the current business process
02 redevelopment that we need to undertake within ADP to
03 support a new approach in electronic submission and
04 renewal of ADP equipment.
05 So we also asked whether there were any relevant
06 requirements for initial and follow-up visits, and
07 there were some, there was a split, 44% said no, 56%
08 said yes. There was a request for increased funding

09 for high need patients and more regular, ongoing
10 assessments. And again, other comments included making
11 that assessment schedule more frequent and minimum time
12 lines and space for follow-ups.
13 And we also asked for vendors to specify the type
14 of staff member who provides instruction on the
15 operation, care and safe use of the home oxygen
16 equipment. And regulated health professionals are
17 involved a hundred percent of the time, and the medical
18 gas technicians, 73% and some others, including non-
19 regulated health professionals involved.
20 So then we also had a series of questions that
21 were around deliverables or services that you don't
22 currently provide, but based on our research we wanted
23 to ask the vendor community what their feelings and

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01 thoughts were on some of these issues, including staff
02 training and education. So we indicated that the
03 organization would have in place a staff training and
04 education program for all staff and we wanted to know
05 whether that would be a reasonable requirement.
06 And 76% of respondents felt that it was reasonable
07 to have a staff training and education program in
08 place. However, some thought that there were some cost
09 and time issues involved, and they also pointed out
10 that we should not be putting in place any additional
11 requirements without additional funding and that staff
12 training and education may not be applicable to all
13 staff, and that some clinical staff do have access to
14 free training. And other comments included that that
15 should be part of an accreditation process.
16 And continuing with that, we wanted to know if we
17 did make this a requirement for the provision of home
18 oxygen services, what would be a reasonable time frame
19 for us to put that requirement in place. And the
20 majority said a year after the vendor records start,
21 April, 2011. Some felt that it was possible to put
22 this requirement in place on the date of the new
23 approach, and others thought that waiting six months

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01 would be appropriate.
02 And we wanted to know, again, if we made this a

03 new requirement, how vendors could demonstrate their
04 compliance with the implementation of a staff training
05 and education program. Sixty-three percent of
06 respondents said that your records would have that
07 information; 17% said an accreditation process would
08 ensure that that was in place. Some felt that they
09 could provide documentation to the Ministry; some are
10 not sure, and some are waiting to receive feedback from
11 other colleagues.
12 And some of the comments, some of the additional
13 comments that we received here were that managers and
14 supervisors should, as a matter of course, have a
15 record or documentation of staff training, and then the
16 question of what should be the frequency on retraining,
17 if that was the case, and that the Ministry should set
18 up a guidelines or requirements document for a vendor
19 to complete in a reasonable time frame and that could
20 be submitted to the Ministry and reviewed by us, and/or
21 other annual feedback processes by vendors regarding
22 some clients within the context of the quality
23 assurance program.

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01 Now, infection, prevention and control was also an
02 area that we asked some questions on, that what would
03 be the -- would it be an appropriate requirement that
04 the organization would develop, implement and update an
05 infection prevention and control program. And again,
06 that programs adhere already to all federal and
07 provincial infection control guidelines. And 83% said
08 that this would be an appropriate requirement, and some
09 additional comments that we received on this was that,
10 at present, best practices for infection control have
11 been sufficient as a guideline to follow. And truth be
12 told, as manager of the Assistive Devices and Home
13 Oxygen Program, I have personally never heard of an
14 issue related to infection with a client who's
15 receiving home oxygen.

16 MR. FINES:

17 That's good.

18 MS. CADOTTE:

19 That's what we thought. So going further, we
20 asked if we did make that a requirement, how vendors
21 should demonstrate compliance, and again, maintaining
22 records, accreditation, Ministry audit and not certain.

23 So moving forward to client record-keeping, we as

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01 an organization have a responsibility to maintain
02 complete and accurate records and people want to know
03 is this reasonable. Eighty-eight percent said
04 absolutely, and some rationale around "No" were more
05 around the type of records, that there should be
06 maintenance repair records kept separate, for example,
07 from client records, that there may be some costs
08 attached to that and that, in time, with an electronic
09 submission program there would be some reduction in the
10 need for this.
11 And we asked whether there should be any
12 additional record-keeping requirements and the majority
13 said no, and that, however, if there were additional
14 requirements, that it would be again that there would
15 be access to maintenance repair records or that signed
16 consent forms would be on file.
17 And once again we asked how vendors could
18 demonstrate compliance with implementation of new
19 record-keeping requirements, audits, vendor
20 responsibility and accreditation, and comments
21 indicated that the MOH could randomly do surveys or we
22 could do inspections.
23 On staff screening, we asked whether reasonable

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01 requirement would be to ensure that all staff,
02 including clinical and non-clinical staff members, to
03 provide service in the home should be subject to a
04 criminal record check every five years. And 91.7% of
05 respondents indicated that was an appropriate
06 requirement, and those who weren't sure wondered if the
07 cost, whether this was a responsibility of the college
08 instead, whether or not in those circumstances whether
09 our collective agreements, whether this might violate a
10 collective agreement, and then again some question
11 about who pays for this.
12 And then another comment we received was that it
13 should be mandatory for all staff providing service in
14 a client's home and that it would be reasonable to
15 assume a five year interval on that. And we also
16 followed up with the question on how vendors would

17 demonstrate compliance, and again, the vendor would
18 keep records, we would do audits, there might be
19 individuals checked and in other ways. And again, it
20 could be demonstrated by vendors having their own
21 policy and procedure manuals, employee files and staff
22 charts.
23 And then we wanted, on a more open ended way,

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01 whether or not there were, in addition to the current
02 mandatory reporting we received from you, whether there
03 were additional reports that vendors could provide to
04 demonstrate outcomes at either or both the personal or
05 system level to clients on home oxygen therapy. Some
06 felt there should not be any additional recording, and
07 again, had a response saying what kind of filing of
08 reporting. Response had indicated that we should look
09 at hospital, emergency room and physician visits as a
10 good indicator of outcome. Pulmonary Rehabilitation
11 Programs could provide some information, and again
12 around equipment, preventative maintenance records.
13 And we do recognize that around reporting that
14 smaller vendors would have limited capacity, it was
15 pointed out to us in some of our comments, and that if
16 we used an online reporting mechanism, health care
17 professionals would have a -- it would be easier for
18 health care professionals to report on client outcome.
19 Then we did ask a question on accreditation and
20 whether, in the opinion of those who completed the
21 survey, should the Ministry home oxygen vendors be
22 accredited by a recognized accreditation program.
23 Sixty-eight percent of respondents said no, and those

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01 who said yes thought generally it should be
02 Accreditation Canada. One respondent indicated ISO.
03 And then a rationale that we received on this is that
04 accreditation is best suited for larger organizations
05 and that in the past there has been bound to be little
06 benefit to increasing patient care through this
07 approach.
08 And then we asked if any of the respondents were
09 intending to become accredited in the near future, even
10 if we did not make this a requirement, and 52% said

11 yes, and 47.8% said no. The majority being pursuing
12 accreditation with Accreditation Canada and, again,
13 those who said no, that they couldn't see a benefit and
14 it didn't really provide better care, and then for
15 those of you who are associated with hospitals, you're
16 accredited through your association with the hospital.
17 And we also asked whether there were any other
18 deliverables that we should consider, and again,
19 electronic submission, that there should be an increase
20 in clinical visits, an increase in price, an increase
21 in funding for provided service in off hours. There
22 should be additional costs, I assume that would be paid
23 by the client, and that there should be opportunities

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01 for additional billing on consumables.
02 Other comments we received in this area is that
03 we, meaning the Ministry, should look again at the
04 hospital replacement program, that nurse practitioners
05 should be able to sign the Home Oxygen Program form due
06 to the shortage of physicians in the province, and
07 again, that we should be looking to e-billing in the
08 near future. And again in the "E" area, that there
09 should be electronic applications along with physician
10 electronic signatures to expedite the application
11 process. And a comment that if reimbursement was,
12 reimbursement levels were reduced, then the provision
13 of consumables will have to be assessed on a client by
14 client basis.
15 In terms of client assessment, what we did, we did
16 look at some additional areas because between the time
17 that we posted the survey and when we were preparing
18 the presentation from responses, of course we were
19 continuing to do our research and to look at other
20 jurisdictions and to consider other questions that
21 arose to us, so we thought that this was also, because
22 we said these sessions were consultations, that we may
23 benefit by having some questions that we would ask to

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01 you. And I'll have to say that in the first session we
02 did not receive any verbal responses, and again, I
03 understand that people do need to take time to consider
04 their responses.

05 We have established a date of May 11th for
06 responses to the additional questions and we are
07 already receiving some formal submissions around our
08 additional questions.
09 So the first additional question that we wanted to
10 ask you and have your feedback and thoughts on is
11 around client assessments. And while we were doing our
12 jurisdictional review, I think most of you would know
13 that we looked at Canadian and American and some
14 international jurisdictions when we were doing our
15 initial work to understand what the different models of
16 delivery of home oxygen services. And I'm looking at
17 some of the Canadian jurisdictions. We looked at Home
18 Oxygen Programs in British Columbia, New Brunswick,
19 Saskatchewan and Alberta, and then did a comparison to
20 our own Ontario model. And I'm sure you're aware that
21 in many areas the programs are comparable in terms, for
22 example, of client requirements and assessments. There
23 is a lot of comparability across Canada, but there is

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01 some differences as well.
02 So three of the jurisdictions there, the
03 utilization of independent assessments by staff
04 employed by regional health authorities. And so we
05 asked a question about if such a model were adopted in
06 Ontario, what would be the impact for this approach, of
07 course, on you as vendors.
08 We also asked an additional question around
09 utilization and concerning the ABG measurements that
10 are required for first time applicants. We wanted to
11 know if they were of significant or marginal value when
12 compared to oximetry studies in terms of accuracy.
13 Now, these are questions that we, as a program, are
14 being asked when our program is being reviewed. And we
15 also wanted to know whether ABGs were significantly
16 costlier than oximetry studies. We wanted to know
17 should ADP require ABGs at all reassessments for
18 eligibility for funding, and that if we did take the
19 step of requiring ABGs, what would be the best method
20 for initiating the test and securing the results.
21 And then we have three examples of ways that that
22 could be done. The ABG would be done in a medical
23 facility and analyzed in a medical facility. ABG could

01 be done in the client's home and analyzed in a medical
02 facility. It could be done in the client's home and
03 analyzed utilizing a portable blood gas analyzer.
04 And then the final question in this area was
05 whether or not the -- what would the cost implications
06 be to the vendor if we did go to option number three of
07 purchasing, maintaining and calibrating a portable gas
08 analyzer.
09 We also had an additional question on eligibility.
10 Of course after the final eligibility examination of
11 clients we don't require additional eligibility after
12 12 months of a client receiving continuous home oxygen.
13 We wanted to know what would be the impact of
14 implementing yearly testing and reports for continuing
15 client eligibility. We wanted to know how results of
16 yearly testing, if that was the case, how they should
17 be communicated to ADP. And if there was ongoing
18 yearly testing, if a client was reassessed and found
19 not to meet the medical eligibility criteria, how
20 should this information be communicated to the
21 patient's physician and what the next steps would be.
22 Two more additional questions. We also asked
23 around compliance and quality assurance. Two of the

01 four Canadian jurisdictions we looked at, British
02 Columbia and New Brunswick, require that vendors be
03 accredited. However, as you have just heard, our own
04 survey responses indicate a somewhat low level of
05 support for accreditation. So the question is, how
06 should Ontario ensure that you, as vendors, are
07 complying with all program requirements and providing a
08 high quality service to clients if you aren't
09 accredited.
10 And then additional questions would be should the
11 ADP develop a specific quality assurance inspection
12 program; should we increase the number of audits
13 conducted on vendors, or is there another approach to
14 this that we should consider?
15 And the last additional question around recycling,
16 I do admit that I was writing these slides on Earth
17 Day, but this is a question that has been on my mind
18 across the ADP program since I joined the program

19 almost two years ago. As you can well imagine, ADP
20 provides the funding for over 8,000 pieces of
21 equipment. We do have some high intensity recycling
22 programs in place and it's a very specialized area, but
23 basically we're funding a lot of equipment that may end

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01 up in landfills.
02 So we hope that by adding this question we could
03 start getting our head around what could we do with
04 recycling, or how should we be thinking of recycling.
05 In some provinces we're aware that there are equipment
06 recycling programs that are funded. However, when we
07 looked at those in the past, they do not seem to be of
08 good benefits to clients in the sense that once the
09 piece of equipment is resold or re-used by different
10 clients, then the initial warranty is void. In some
11 cases, any additional warranties are for short periods
12 of time, and what is the quality assurance of re-used
13 equipment. So we have many questions about that.
14 However, we feel that we do have a responsibility,
15 since we're such a major funder of equipment in
16 Ontario. So we asked how Ontario's home oxygen vendors
17 could contribute to a reduction in the amount of waste
18 going into landfills associated with home oxygen
19 equipment that's no longer usable, and whether or not
20 we, as a program, should require that vendors
21 demonstrate how they have reduced the amount of waste
22 going in landfills. And I'm looking forward to your
23 responses on those five questions.

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01 So our next steps are that we'll have a -- we had
02 added up to three consultation meetings in addition to
03 the Toronto meeting on vendor criteria. I believe that
04 currently we have no vendors registered for Timmins,
05 which is next Friday. I believe we will cancel that
06 venue. However, we will be going to Ottawa next week.
07 As I mentioned earlier, we have posed additional
08 questions. We do invite written submissions on these
09 questions to be received by ADP no later than 5:00 p.m.
10 on May 11th, and they can be directed to me or faxed,
11 by fax or email. Faxed at 416-327-8192, and email,
12 Barbara.Cadotte@ontario.ca.

13 We will continue to be partaking in our research
14 and analysis. I will say that the research on the
15 first part of the complication is closed. Right now
16 our work on the first part is to complete the
17 consultation meetings and to analyze the results of our
18 survey and the written responses on the additional five
19 questions. We are also looking forward to the approach
20 for the next step of this process, which is to address
21 the issue of pricing, and I know from some of the
22 meetings I've had with vendors, this is an area of
23 interest to everybody in the room.

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01 And so all communications will be through MERX. I
02 also have to admit that when we had the survey posted
03 for the additional part for a number of reasons outside
04 of our control, we had a shorter time for vendor
05 responses than is either reasonable or what we planned
06 on. We'll ensure that for the next section on pricing
07 there'll be a full two weeks for vendors to review the
08 survey and respond, as well, as I said, we'll be
09 addressing technical issues and ensuring the smoothest
10 process.
11 And I think that at this point I understand that
12 people have been provided with cards. In the Toronto
13 session we did receive the questions and we read them
14 into the record and we're working on the responses.
15 It'll be posted on MERX, and I'd like to take that
16 approach again today. If you do have additional
17 questions on this part of the consultation that you
18 would like us to consider and respond to, please feel
19 free to write the question down and we will read it
20 into the record.
21 Also, if you do have any preliminary thoughts on
22 the additional five questions that you would like to
23 share with us, we're certainly open to receiving them,

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01 but we do understand if you would prefer to wait and
02 consider these questions for a longer period of time
03 and to provide a written response. So at this time I
04 think we'll break for ten or 15 minutes and provide you
05 an opportunity to write out your questions.
06 MR. FINES:

07 Can I just ask a couple of brief things here?
08 MS. CADOTTE:
09 Could you identify yourself for the reporter?
10 MR. FINES:
11 I'm sorry, I'm Doug Fines from Medichair, Med-E-Ox
12 in Goderich and Owen Sound. And seems to me there were
13 49 responses, but a number of -- when you're totalling
14 up the answers or the responses they're, you know, 22
15 to 30, so approximately half of the people responded,
16 how does that, how is the math working here?
17 MS. CADOTTE:
18 Not only ...
19 MR. FINES:
20 There's only half the people have responded with
21 answers.
22 MS. CADOTTE:
23 Yes. Not everybody answered every question and I

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01 don't believe that we had many totally completed
02 surveys. I think many people just focused in on the
03 questions that were of concern to them.
04 MR. FINES:
05 Right. And again, my second inquiry here, it's
06 not a question, there's no response for this kind of
07 meeting in Timmins or Northern Ontario because they
08 needed, the company's providing home oxygen in Northern
09 Ontario are all provincial-wide companies and they've
10 already responded in Toronto or here or will in Ottawa,
11 is that...
12 MS. CADOTTE:
13 I don't believe ...
14 MR. FINES:
15 ... does that make some sense?
16 MS. CADOTTE:
17 ... that's the case. I think there are -- we're
18 aware of two large vendors in the Timmins area, but
19 there are also small vendors up there as well. So
20 either they are attending a different meeting, maybe
21 Ottawa or perhaps Toronto, or they're just waiting to
22 read the material online.
23 Yes, Shane?

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01 MR. GAUTREAU:
02 Rick, Rick Gautreau.
03 MS. CADOTTE:
04 Oh, Rick, sorry.
05 MR. GAUTREAU:
06 I just want to follow Doug's -- because I did
07 answer all the questions and there's a lotta comments
08 and I notice both my comments are not on these slides,
09 so I assume there's a database somewhere that will --
10 is that accessible to the group or it's just something
11 for internal use? You picked certain comments and I
12 must admit, I found many of the questions, I sat
13 thinking these are not yes or no questions, and I'm
14 concerned, well, I mean, beyond my purview, but my
15 impression was that this is not replacing a dialogue.
16 Many of these questions are not yes or no
17 questions, but you're forced to choose yes or no, and I
18 tried to clarify my thinking when I picked answers
19 because whether I picked yes or no on many of these
20 would depend on further discussions with the people
21 formulating the questions, because in many cases I sat
22 thinking the person who formulated this question
23 doesn't know what question to ask. So I think there's

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01 questions behind the questions, and I guess my real
02 point is I put comments that are not here and
03 doesn't say, so is that in a database somewhere and is
04 it going to be available to the group?
05 MS. CADOTTE:
06 We are analyzing the responses. The comments that
07 we've included in the presentation were the ones that
08 were representative of the majority of the responses to
09 the questions. So these are the, these are the
10 responses of where there were more than one or two or
11 five comments that were similar. But, yes, we do have
12 a record of all of the comments and we will consider
13 them in our analysis. I cannot guarantee that every
14 single comment will be posted, but we will be analyzing
15 the responses and posting a final summary.
16 MS. NICOLSON MORRISON:
17 I guess I should identify myself as I was late.
18 Heather Nicholson Morrison. I'm CEO of OHRSA and I'm
19 also the lead person in what's called the HOP Alliance
20 right now.

21 Barbara, I just wanted to highlight for you, I
22 talked to people in Timmins and I know there are
23 businesses up there who are no longer, even though they

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01 may have an agreement with ADP, they are not providing
02 oxygen and, therefore, are not commenting. So I've
03 spoken to them, so that may be part of your problem.

04 MS. CADOTTE:

05 Okay, thank you. Well, it's good to know that and
06 thank you for your ...

07 MS. NICOLSON MORRISON:

08 And actually I have that list I can give to you...

09 MS. CADOTTE:

10 Yes.

11 MS. NICOLSON MORRISON:

12 ... because people who, who may have -- I don't
13 know if you call them licensed, if that's the right
14 word. There are some out there who have an agreement
15 but are not providing oxygen and, therefore, are not
16 participating in any of this because they're just, they
17 have no clients.

18 MS. CADOTTE:

19 So there's still vendors registered with the
20 Program, but they're not actually providing ...

21 MS. NICOLSON MORRISON:

22 And they're showing as your vendor, but if you
23 look at your records, I guess, and I don't know if

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01 you've had time to do that, you'll see that there's
02 nobody under them, or also there are some that are
03 closing and I have a list of those, too.

04 MS. CADOTTE:

05 Okay. Much appreciated.

06 MS. NICOLSON MORRISON:

07 Sure.

08 MS. CADOTTE:

09 Thank you very much.

10 MR. POND:

11 I'm Jeff of London Respiratory. I notice that you
12 have 80% of your vendors don't want to get
13 accreditation, but the next line, 55% were going
14 through it. It just leads me to believe that because

15 we have companies that can send in extra, like some of
16 the larger companies have different offices, right, but
17 once bigger company's going through it, wouldn't it
18 make sense that 58% because of the bigger companies are
19 already going through it? Wouldn't that make sense?
20 MS. CADOTTE:
21 Yes, it doesn't make sense. It does make sense...
22 MR. POND:
23 For the right ...

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01 MS. CADOTTE:
02 ... I understand that many of the larger companies
03 are not just delivering home oxygen services, they're
04 delivering possibly other services in the community
05 where possibly accreditation is mandatory.
06 MR. POND:
07 Well, I just mean it doesn't really accurately
08 reflect the 80% that doesn't want to do it. It only
09 accurately requesting people that are actually doing it
10 and that was generally the same company, possibly, that
11 has a lotta different offices.
12 MS. CADOTTE:
13 Yes, I agree.
14 MR. O'FARRELL:
15 Name's Terry O'Farrell from Medigas in Sarnia.
16 Are you allowed to put in more responses for the amount
17 of offices that you have or is it one per company?
18 MS. CADOTTE:
19 Well, that's an interesting question, because we
20 did leave it open and we know that we had more than one
21 response from some companies, and we're going to address
22 that question and provide very detailed instructions on
23 that, because on the one hand we see that if it's a

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01 single company with a single head office, should not
02 there be a single response. But on the other hand, if
03 you have a company with offices in Southern Ontario,
04 Toronto and Northern Ontario, then possibly the
05 responses might be shaded according to the conditions
06 of service. So that's what we'll be considering for
07 the next go round and we'll make it very clear what our
08 expectation is in terms of vendor responses.

09 When we initially set up the Toronto consultation
10 meeting on the process we limited that meeting to two
11 vendors per company, the reason being that we were only
12 holding that one session on the information of the
13 process and we had a limited amount of space. But
14 these sessions allow more flexibility of that and we
15 also, it's like going to an online survey, there is
16 more flexibility to that. So as I said, we're still
17 considering that question and we will provide a very
18 detailed instruction in that regard.

19 MR. O'FARRELL:

20 Just as a follow-up, because in that situation a
21 lotta the results that you're getting just show, like,
22 liquid O2 as a percentage, it may not reflect the
23 actual number of people doing it.

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01 MS. CADOTTE:

02 It's true. I understand that. I think that the
03 question on the actual modality and use, it gives us a
04 sense of what is out there, but unless we actually
05 started collecting that information formally as the
06 seven other jurisdictions, then we don't really know
07 what the equipment is that is being used with all
08 accuracy, but it does give us a sense of what's being
09 used and I think that that has value in itself.

10 MR. GAUTREAU:

11 Barb, just a question on the additional questions.
12 Sorry, Rick Gautreau. I just, I'm looking at these and
13 a few things popped into my head. Just a question, you
14 know, historically, the last three or four or five
15 years there's been this joint utilization committee
16 that looked at issues around requalification, those
17 sorts of things, that, as you know, include the
18 Ministry, industry and a government appointed
19 arbitrator and the hospitals, and they looked at these
20 things and they looked at scientific information and
21 made decisions.
22 In your view, is that gone? Because I'm looking
23 specifically at the ABG page and thinking that there

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01 are very few people in this room that have access to
02 this data to answer those questions. So it's like,

03 back to my earlier point, you're asking a question of
04 the wrong people. It may be the right question, but
05 very few people in this room can tell you what it costs
06 to do a blood gases. They're all, all done in a
07 hospital. So you're asking me to comment on the cost
08 comparisons between the hospital doing blood gases and
09 me doing oximetry, and I don't have the data to answer
10 that. So just an example of a question, I think,
11 that's still in place.

12 MS. CADOTTE:

13 And I think that that would be an appropriate
14 response. I have to say that, as I said, in some of
15 these questions it specified that the question comes
16 from research. In others, these questions, the
17 question comes from questions that are being asked us
18 of the program. So in that case we're looking to you
19 as our partners and our vendors to assist us to develop
20 an appropriate response to questions that are being
21 asked of us.

22 So, yes, the work of the joint utilizations
23 committee states the requalification process and we

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01 understand, I understand, because I came into that
02 process kind of halfway through, that there was a lot
03 of clinical support for the approach that was taken,
04 and we're additionally asking because we are being
05 asked about that, and so any information that you, as
06 vendors, can provide us, even the answer that you're
07 unable to answer given a lack of information would
08 actually give us an approach for how we should address
09 this. So perhaps we need to do extra research in
10 there. But if somebody does have that answer, if
11 somebody does know what the costs involved are, then we
12 would appreciate receiving that information.

13 MR. GAUTREAU:

14 And have you taken a decision on the future of the
15 joint utilization process? Is that off the table?

16 MS. CADOTTE:

17 I can't respond to any future because right now
18 we're just focusing on the vendor of record approach
19 that we'll be establishing in April, 2010, and at that
20 time we can make decisions about what other frameworks
21 or working groups or collaboration is required.
22 And if you'll recall, I just want to say one more

23 thing about the joint utilization group, is that it was

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01 well understood within that group that the group had
02 taken that topic as far as possible at that time, and
03 so that was the reason why that group at that time
04 ended.

05 MR. GAUTREAU:

06 I just noticed a lotta the sort of suggestions and
07 additional questions are throwing us back to the way
08 things were 15 years ago and now they're coming back,
09 and they were all sort of taken away because the data
10 at the time showed that that was the right thing to do,
11 and now we're back to talking about annual blood gases
12 and all those things that, that were taken away, you
13 know, you -- sorta questions in here, asking about
14 different modalities, and that was all streamlined
15 years ago because it was cheaper for the government and
16 now they're sorta throwing things back to 20 years ago
17 and...

18 MS. CADOTTE:

19 I think that ...

20 MR. GAUTREAU:

21 ... the question ...

22 MS. CADOTTE:

23 I think it's very appropriate to always come back

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01 to questions about the program that you have in place,
02 even if they are questions that were resolved 20 years
03 ago or ten years ago. I think from the perspective of
04 continuing quality improvement and improvements in
05 technologies, I think that, from my perspective in
06 running a government program, we should always have all
07 questions on the table for review and evidence in terms
08 of our going forward.

09 Okay. So we're now at about ten after 1:00. If
10 we could take ten or 15 minutes to, if you have any
11 additional questions that you would like to post on a
12 card and we'll read them into the record and then again
13 provide an opportunity for any additional discussion.
14 Thank you.

15

16 SHORT BREAK: 1:10 P.M. TO 1:30 P.M.

17

18 MS. CADOTTE:

19 Okay. I'm going to read the questions into the
20 record. Just for my very, very quick review, these are
21 quite detailed in most respects and we will be posting
22 the responses on MERX, but for the record I will read
23 them out so that they are posted initially on the

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01 meeting record.

02 In the Home Oxygen Program administration manual,
03 Section 441, registered Home Oxygen Program vendors
04 must have in their inventory liquid oxygen systems,
05 concentrators and cylinders. Will the new procurement
06 model be as specific regarding systems or more
07 generalized in what vendors must provide, ie. a basic
08 system defined as -- dot, dot, dot. As well as a
09 portable system capable of meeting client mobility
10 needs?

11 Once the relationship between the new procurement
12 model and the newly established LHIN, when the sales
13 pricing approach is modelled, will geographics be
14 considered along with intensity of needs?

15 Mandatory reporting to the Home Oxygen Program in
16 conjunction with or as a replacement for audit by the
17 Home Oxygen Program is mentioned in the new procurement
18 process. If this has value to the Ministry of Health,
19 can vendors anticipate some form of reimbursement?
20 Association is referred to in numerous of the
21 literature provided to date. Do vendor of record
22 anticipate this being a requirement by the end of the
23 first contract?

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01 Would the Home Oxygen Program consider an alliance
02 with an organization like the Ontario Home Respiratory
03 Services Association to develop a quality assurance
04 system to monitor vendors?

05 Would it not be then appropriate to utilize a co-
06 pay system of Ministry and vendors? This could be a
07 reasonable alternative to Home Oxygen Program audits
08 and vendors having to utilize Accreditation Canada.
09 The new procurement model indicates repeated ABG
10 requirements for criteria renewals. Who is the

11 consulting body advising this as the route of choice
12 and with what authority?
13 What is the medical justification to subject a
14 client to this level of risk?
15 Ministry of Health has not mentioned any changes
16 related to the expenses the vendor incurs and if we can
17 expect any change. Some specifics. Vendor financing
18 pending Home Oxygen Program approval, costs incurred in
19 unlimited supply of cylinders/liquid disposable or the
20 high intensity needs when a physician requires a client
21 be seen weekly.
22 The issue of portable concentrators. Is this
23 question coming as a result from clients' inquiries or

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01 manufacturer driven?
02 Is there consideration for an adjustment in
03 reimbursement for clients on high flow? Example, is
04 this 12, 1-21 p.m.?
05 MR. GAUTREAU:
06 Probably 12 litres per ...
07 MS. CADOTTE:
08 Twelve litres per minute, thank you.
09 MR. FINES:
10 Litres.
11 MR. GAUTREAU:
12 Litres.
13 MS. CADOTTE:
14 Twelve litres. I have a hearing problem. Twelve
15 litres per minute, thank you.
16 REPORTER:
17 Can you just ...
18 MS. CADOTTE:
19 So let me just start that question over again.
20 REPORTER:
21 Okay. I need to know who it was -- there were two
22 people that spoke. Who was the first one?
23 MR. GAUTREAU:

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01 Rick Gautreau. It's not my question, but I
02 just...
03 REPORTER:
04 No, but you answered, so.

05 MS. CADOTTE:
06 Thank you.
07 REPORTER:
08 And then you did?
09 MR. FINES:
10 Doug Fines.
11 REPORTER:
12 Thank you.
13 MS. CADOTTE:
14 Okay. So I'm going to start that question over.
15 Is there consideration for an adjustment in
16 reimbursement for clients on high flow? Example, 12
17 litres per minute, such as lung transplant candidates
18 waiting at home, and then the litre flow can be ten to
19 15 litres per minute.
20 Before finalizing your summary, will you be
21 willing to have an open forum to discuss in detail
22 concerns, questions and comments with vendors with
23 regards to what they see and know, provide quality

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01 client centred care and cost drivers for administration
02 and policy and procedure and client driven care?
03 Have you discussed and understand that many
04 patients desaturate with certain oxygen conserving
05 devices and portable concentrators? They are not all
06 the same. Most portable concentrators do not have the
07 flow rate for continuous flow for nighttime use.
08 If you move to port -- I believe this is portable
09 submissions, or portal, pardon me. I will start that
10 question again. If you move to portal submission and
11 e-file for submissions, will you complete a financial
12 and human resources study prior to choosing the program
13 you use if it requires system compatibility between
14 vendors and ADP?
15 Will you fund a second system for a client? I
16 believe ten percent of clients receive care and use two
17 systems. The service providers provide this system at
18 no additional charge to government or client -- I'm
19 sorry. Please print in future. I'm going to try and
20 read the writing.
21 Will you fund a second system for a client? I
22 believe ten percent of clients receive care and use two
23 systems. The service providers provide this system at

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01 no additional charge to government and client.
02 Examples of two systems. One, two concentrators are at
03 work and at home. One when it concentrator, one
04 portable concentrator. One base concentrator -- I'm
05 sorry, I can't read -- would the person who wrote this
06 question just ...
07 MR. FINES:
08 Can I just ...
09 MS. CADOTTE:
10 ... read this out, please?
11 MR. FINES:
12 I'm sorry.
13 MS. CADOTTE:
14 Thank you.
15 MR. FINES:
16 So examples of two systems are two concentrators,
17 one at work, one at home or vacation property. A base
18 concentrator and one portable concentrator for travel.
19 A base concentrator and 20 to 40 "C", "Ds" and "E"
20 cylinders on a monthly basis, so they're taking eight
21 or ten a week. A base concentrator and a liquid
22 concentrator or liquid system for portability. That
23 would be normally what's happening in a nursing home.

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01 And then there's the high flow cases like lung
02 transplants and people at end stage where they're using
03 five plus, up to ten and 15 litres, and so they need at
04 least two concentrators or you're needing two liquid
05 systems in there to provide enough oxygen for a week.
06 And then there's cases like the liquid oxygen and,
07 for a base and they're usually 20 or 30 "Cs" and "D"
08 cylinders, again for portability. Some of these people
09 just don't trust concentrators to continue to work all
10 the time. Maybe they've had a failure at some time in
11 their past. We, in particular, have a person that will
12 only take the very large two cylinders and we're
13 delivering three or four of these cylinders to him
14 every week. Okay?
15 MS. CADOTTE:
16 Thank you so much.
17 MR. FINES:
18 So, but none of those second systems, none of

19 those high use clients are being funded. Each vendor
20 across the province has ten percent of them like that
21 and a prime example is, is our own advocate that works
22 with OHRSA. This is a lady that's trying to live the
23 best she can and she has the least consistence.

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01 MS. CADOTTE:
02 Thank you. Thank you for ...
03 MR. FINES:
04 And nobody's paying for that.
05 MR. GAUTREAU:
06 And fix your writing.
07 MR. FINES:
08 I'll take a writing -- I know what you're
09 talking about. Thank you.
10 MS. CADOTTE:
11 Are you reviewing the emergency response time
12 requirement based on actual geographic locations and
13 variance between rural, remote and urban, and including
14 adverse weather conditions, as you may be able to reach
15 a client's home in 20 minutes, but it could take three
16 to four hours to get to another client's home because
17 of their geographical location?
18 I agree that liquid portables in nursing homes can
19 present problems. High pressure cylinders are a safe
20 modality for portable oxygen, but were banned from
21 facilities nursing homes, and nursing homes. Cylinders
22 and oxygen conserving devices are used in hospitals
23 across the province. They need to be looked at.

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01 Do you have a current list of current vendors? Do
02 you have a plan to add additional funding from high
03 needs clients such as those waiting for lung
04 transplants or requiring high flows?
05 Would you consider having a northern meeting in
06 North Bay or Sudbury?
07 In the Ministry consultation process is there any
08 provision for a dialogue outside of yes/no surveys?
09 In jurisdictional comparisons, has the Ministry of
10 Health considered that we have -- that perhaps
11 Ontario's model is superior?
12 Will you re-evaluate how or if ADP will fund

13 clients who smoke in the presence of oxygen and are
14 deemed by the vendor to be a safety risk to themselves
15 and the general public?
16 Given that you know which vendors responded to the
17 survey, could the survey results be weighted based on
18 size of the vendor?
19 Comments on all questions included in this survey
20 should be allowed whether or not answer is yes or no.
21 For a registered nurse, extended class, to
22 prescribe oxygen, I believe that a registered
23 respiratory therapist cannot accept this order today.

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01 And then there's a question about the statement
02 made regarding liquid oxygen being the most dangerous.
03 What information was used to validate this?
04 Will vendors with more than one location be
05 allowed to submit more responses to the survey, not
06 one, especially accreditation and use of modalities are
07 skewed?
08 Will the existing vendors be considered for
09 operating over the years from a budget of 90 million to
10 approximately 55 to 60 million looking after sicker
11 people?
12 MR. GAUTREAU:
13 Oh, Barb, you missed one. It's not mine. I just
14 noticed it ...
15 MS. CADOTTE:
16 Is the Ministry of Health considering putting
17 limitations on vendors with respect to their
18 obligations in the event of power failure, pandemic and
19 natural disasters?
20 As I indicated, these questions will all be
21 considered and responses will be posted on MERX when we
22 have had an opportunity to review them in greater
23 detail. I don't have my subject matter experts with me

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01 today and I feel that it's more appropriate to work
02 with my staff in responding to these questions. Are
03 there any other comments or questions that you'd like
04 to ask before we close?
05 MS. NICOLSON MORRISON:
06 Barb, how long will it take for them to be

07 posted...
08 MS. CADOTTE:
09 Could you identify yourself ...
10 MS. NICOLSON MORRISON:
11 Heather Morrison. How long do you expect it will
12 take before they're posted? There was concern last
13 time that people who couldn't make it to the meeting,
14 but were relying on this process took three weeks and
15 they were concerned that they were kind of out of the
16 loop for three weeks, not sure. So I just wondered if
17 I was asked that question again if I could say it will
18 be on in three weeks, will be on in two weeks.
19 MS. CADOTTE:
20 Okay. I'm sorry, Heather, I can't give you a
21 specific response because the person working on the
22 responses isn't in the room today.
23

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01 MS. NICOLSON MORRISON:
02 Okay.
03 MS. CADOTTE:
04 But I can commit that it will not be three weeks
05 before the responses ...
06 MS. NICOLSON MORRISON:
07 Okay.
08 MS. CADOTTE:
09 ... are posted, and will endeavour, if possible,
10 to post our responses by next Friday ...
11 MS. NICOLSON MORRISON:
12 Okay.
13 MS. CADOTTE:
14 ... and that's the commitment that I'll make, but
15 if it's the following Monday, please bear with me.
16 MR. GAUTREAU:
17 Barb -- sorry, Rick Gautreau. I made the point in
18 other forums, but it's the first we've ever had a court
19 reporter in the room, so just to get it into the
20 record. It's my belief that this approach, not only
21 are you doing the job you have to do, but I'm fearful
22 that the whole approach is going to miss important
23 information, maybe not, arising from test results, and

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01 I can give you examples, for sure they were examples of
02 things said today that that was, I think, that there
03 was truly a dialogue, that different answers, different
04 conclusions would be reached.

05 I just wanna get that into the written record,
06 that I think this approach is a poor substitute for the
07 dialogue that has happened for the 20 years that I've
08 been involved in this industry. I just wanted that
09 into the record.

10 MS. CADOTTE:

11 Well, thank you. And again, this is a new process
12 for us and we are continuing to review it and adjust
13 it from a continuing quality improvement approach
14 ourselves on an ongoing basis, but we will be
15 considering comments, all comments regarding the first
16 and in terms of responses as we move forward to
17 the second stage of the consultation.

18 MR. FINES:

19 And I'm Doug Fines. I would just like to comment
20 that I know in the 30 years that I've, you know, 28 or
21 nine years I've been providing home oxygen, I know of
22 no work stoppage, job action or any of those kinds of
23 things that have taken place in the home oxygen

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01 delivery from the vendors' side, and yet in CCAC and
02 health care providers, providers are having trouble
03 hiring and keeping human resources like personal
04 support workers, nurses, therapist. There's a job
05 action going on right now with at least one company, if
06 not more. There were job actions in the past.
07 And when you have a system that's providing good
08 health care in the oxygen sector and to change anything
09 that's going to then end up with job actions,
10 unsatisfied staff working in these organizations or
11 this new organization that evolves because of an action
12 you take, you know, those are the things that I would
13 ask you to think, you know, whatever we do, how is that
14 going to affect and what are the results going to be in
15 five years, because once this egg is broken, you won't
16 be able to put Humpty Dumpty back together again, you
17 know.

18 I urge you, it's the, there's the big companies
19 that, that have certain standards right across the
20 province, and then there's a lotta small ones, to keep

21 them operating and, and working to provide the best
22 care for the clients, because the clients have choices,
23 if there isn't a place in Ontario they don't have four

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01 or five reputable choices to make, and if that's what
02 keeps our service provision out of the newspapers, out
03 of -- you don't have to worry about that, is what I'm
04 trying to say.
05 You said it earlier, no one's ever been infected,
06 there's never been an infection of any oxygen client
07 that, you know, made the news, and just going through
08 this thing with the swine flu now, that's, you know,
09 top of minds for everybody, because all, everything
10 else except hockey, semi-finals, that's probably the
11 only news besides the swine flu, you know. That, that
12 would be my key comment to you, to keep that in mind
13 when you're thinking about what you think should be
14 done.

15 MS. CADOTTE:

16 Thank you very much for your comments.

17 MS. NICOLSON MORRISON:

18 Heather Nicolson Morrison. One final question and
19 it's a question of clarification. Barb, when
20 everything's said and done and all these notes and
21 questions and concerns have kind of been compiled and
22 they're available on MERX, will there be an opportunity
23 for one last go round for people to comment to the

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01 final document?

02 An example being in the survey, last survey, one
03 of the questions was in regards to criminal checks, and
04 I received feedback already where people could not
05 believe that people actually said no, they didn't think
06 this was important. Not that I'm saying there are
07 items in there that I know a lot of HOP providers feel
08 very strongly about and I think my question would be,
09 when it's all there, this massive questions, answers,
10 consultation notes, will there be a provision made that
11 we can respond to that one more time with those kinds
12 of concerns, before you make your decisions as to
13 whether that's an in or an out, kind of why we think
14 things should be in and maybe why we think things

15 shouldn't be in?
16 MS. CADOTTE:
17 Heather, I'm going to consider your question to be
18 read into the record to be considered and responded to
19 in addition to these other additional questions, and I
20 also actually have to add that in that case we will
21 actually have to receive the transcription ...
22 MS. NICOLSON MORRISON:
23 Um hmm.

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01 MS. CADOTTE:
02 ... before we can adequately respond to that.
03 MS. NICOLSON MORRISON:
04 Right.
05 MS. CADOTTE:
06 And any question that's been asked that's not on
07 cards.
08 MS. NICOLSON MORRISON:
09 And I guess, I guess, or if that isn't the way
10 that the Ministry wants to work it at the end, at what
11 point can we comment back to those issues? Would it be
12 halfway through the process before we get into talking
13 about rates, because there are some concerns with items
14 within the survey the way they were answered, and I
15 know Rick had said that you couldn't always answer yes
16 or no. Other people, I mean, I must've had five
17 contacts now talking about the criminal check item,
18 that they -- what was said to me is they cannot believe
19 that somebody would be in this business and not have
20 that in place.
21 So that's a huge concern and I wanna make sure
22 that the Ministry's well aware that that would be a
23 concern of OHRSA, that's concern of the majority of the

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01 people and they'd want it in, how do we let you know
02 that, now that that kind of survey is
03 MS. CADOTTE:
04 Thank you.
05 MR. GAUTREAU:
06 Barb -- sorry, Rick Gautreau -- I think maybe
07 Heather made my point better than I did, and quite
08 I'm fully supportive of the work that you're doing, but

09 I see that question and others and I'm thinking
10 somebody didn't understand your question and that's my
11 problem with sort of this approach is that you're gonna
12 act on that information and I'm sure people could
13 clarify the question and then answer differently, and
14 that's where I think it's a poor substitute, in my
15 mind, for a dialogue because there were at least a
16 dozen questions here that if you were in the room I
17 would have clarified the question with you before I
18 answered.
19 And I'm afraid somebody's gonna take that bulk of
20 information and make decisions based on it. You can't
21 tell me there's six people in this room that believe
22 that good infection control practices aren't essential,
23 but I just, I just -- in the past we've always had the

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01 opportunity to sit across from the government and say
02 we're not quite sure what the question is, clarify.
03 That's all off the table and every time before
04 well, we can't answer that because we're in a
05 transference process and we need everybody to have the
06 opportunity to consider it.
07 And there's a lotta these questions that that's
08 one example, but there's so many questions here that I
09 think you're getting information that'd be different if
10 people could have clarified the question, and that was
11 my point, and maybe Heather made it better than I did,
12 but not that I'm not supportive of the work you're
13 doing, just that yes and no questions on a piece of
14 paper leaves themselves open to all the individual
15 interpretations and you act on those answers.
16 MS. CADOTTE:
17 Thank you.
18 MR. MILLAGE:
19 Just in following ...
20 MS. CADOTTE:
21 Could you identify yourself, please?
22 MR. MILLAGE:
23 Joe Millage. And when you look at the survey the

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01 percentages are skewed because people didn't answer all
02 the questions. If there was a thing to say "no

03 answer," at least you would know where the stand would
04 be. You look at accreditation and 62% said they don't
05 think it's essential, but on the next line 52% say
06 they're going after, like, that just doesn't make
07 sense. So when not everyone answers every question it
08 can skew the results enormously, that if two people
09 answer one question, 50% could be in favour of
10 something that the rest of the industry really didn't
11 think was important.
12 MR. POND:
13 I'm Jeff Pond, London Respiratory. In your
14 survey, you know, I wish you guys had put in a question
15 that would address something that we could write in
16 saying what do you believe as a vendor would be the
17 possible outcomes for a positive, for something
18 positive that comes out of this or something negative,
19 and what are the ramifications to us as vendors and to
20 the patients. So, I mean, if this comes out as a
21 negative all the way across, like, how -- I'd like to
22 be able to write in and say, "Well, this is what's
23 gonna happen to my company and to my employees, and are

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01 we gonna end up following the B.C., the way B.C. has
02 been funded?" Be nice to be able to voice our opinions
03 to a question like that.
04 MS. CADOTTE:
05 Thank you. Any additional questions or comments
06 before we close the meeting?
07 MR. FINES:
08 Just follow-up of what Joe was saying, I don't
09 believe anybody is going to make the decision to be
10 accredited when we don't know where we're gonna be in
11 two years. So for 52%, they weren't answering that
12 question. You know, there are people that are already
13 accredited and they're gonna try and continue to keep
14 their accreditation, but if accreditation is not a
15 requirement in the future, most of those people are,
16 are gonna drop it. But the unbelievable expense and
17 the bureaucracy for, for accreditation relevant to the
18 decreased outcomes for, for patients, it just isn't
19 there.
20 MS. CADOTTE:
21 Thank you. Okay, then. I think with five minutes
22 to spare, we'll close the meeting, and as I said, we

23 will consider all the questions and we'll post

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01 responses as soon as we can with a target of next
02 Friday, but given that some of the questions will be
03 responded to will be contained in the records, it may
04 not be possible to meet that target, because we will
05 have to have the record provided to us before we can
06 extract the additional questions from that record.
07 Thank you very much for coming today. It's been a
08 pleasure to meet with you and thank you very much for
09 sharing and being open with both your questions, your
10 comments and your concerns.

11

12 MEETING ADJOURNED: 2:00 P.M.

13 *****

14

15 THIS IS TO CERTIFY THAT THE

16 foregoing is a true and
17 accurate transcription from
18 the record made by sound
19 recording apparatus, to the
20 best of my skill and ability.

21

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23

24

25 Valerie J. Brown,

26 Certified Court Reporter

27