ISSN 1180-4327

Legislative Assembly
of Ontario

Second Session, 39th Parliament

Assemblée législative
de l'Ontario

Deuxième session, 39e législature

Official Report of Debates (Hansard)

Wednesday 2 March 2011

Journal des débats (Hansard)

Mercredi 2 mars 2011

Standing Committee on Public Accounts

2010 Annual Report,
Auditor General:
Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2010,
Vérificateur général :
Ministère de la Santé
et des Soins de longue durée

Chair: Norman W. Sterling
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111 Wellesley Street West, Queen's Park
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

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

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 2 March 2011

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The committee met at 0902 in committee room 1, following a closed session.

2010 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 4.11, hospital board governance.

The Vice-Chair (Mr. Peter Shurman): The committee is in open session to consider section 4.11, hospital board governance, 2010 Annual Report of the Auditor General.

I'd like to advise you, Deputy Minister, and the people in the room, that the committee made a decision last week to meet from now until 10:20, for the start of question period, and that's it, because we're only considering two recommendations and your responses. So I would ask you, as usual, to introduce yourselves and your team for Hansard and make the presentation that you have. Depending on how the time goes, we'll go in 10-minute rotations by party.

Mr. Saäd Rafi: Thank you very much, Chair, and again, thanks for the opportunity to be here at the Standing Committee on Public Accounts and to address the Auditor General's follow-up report on hospital board governance.

With me today, to my immediate left, is Tai Huynh, from the ministry. He's the director working on the Excellent Care for All Act. Also present, to Tai's left, is Carol Hansell. Carol is the chair of the governance leadership council of the Ontario Hospital Association and a director on the board of Toronto East General Hospital.

Perhaps by way of introduction, because Carol's background is far greater than just those two titles, she's a senior partner with Davies Ward Phillips & Vineberg LLP, practising law in the area of corporate, commercial and securities. She has a particular expertise in corporate governance and regularly advises boards and their committees in the context of transactions, conflict-of-interest questions, and on governance practices more generally. Of significant note, while it says in the remarks that she is a member of the corporate governance subcommittee of the American Bar Association, she's actually the chair and the first Canadian to hold that position.

So Carol is a person of great eminence and expertise in the area of corporate governance, and we're pleased to have her with us today.

Let me just state at the outset, as I think we have in the past, that the ministry supports the auditor's review of the governance practices and, of course, has agreed in our responses to the Auditor General on the importance of good hospital governance.

The question is, what do we mean by good governance at hospitals? To my mind, it means a shared process of top-level organizational leadership, policy formulation and decision-making. Although the governing board has the ultimate responsibility, the CEO, senior management and clinical leaders in a hospital environment are also involved in top-level functions. Governance is not only a board activity, but, rather, an interdependent partnership of all the leaders in the organization.

The Auditor General's 2008 report focused on two specific areas, which you know: hospital governance and oversight. Today I'd like to talk about our progress to date on both of these topics and the ministry's plans to strengthen hospital board governance even further. I will also focus on the legislation that's already in place and the legislative changes that have been implemented, and the work we're doing with our partners—the local health integration networks, or the LHINs, and of course the Ontario Hospital Association—on guiding and educating hospital board members. I'll share with you some of the exemplary work of some hospitals around Ontario in the arena of governance.

The section in the audit on hospital governance focused on good governance practices and recommended that the ministry work with the stakeholders, including LHINs, to help ensure that hospital boards are following good governance practices.

It's important to note that at the same time that we have been responding to the auditor's recommendations regarding hospital governance, the ministry and the LHINs—especially given that they were one year into their existence when the audit was done—have been working together to strengthen the LHINs' own governance practices to ensure that their boards have the leadership skills and capacity to work with and strengthen the boards of local health service providers, or HSPs.

At the hospital level, the auditor's recommendations addressed such governance issues as encouraging skills-based boards, avoiding conflict of interest, obtaining

community input to inform decision-making, and ensuring that management provides relevant information to boards for decision-making purposes. As well, the recommendation was for the ministry to work with its stakeholders to develop a process for sharing best practices in governance among hospital boards province-wide.

In response to the AG's recommendation, the government has made changes to the regulations under the Public Hospitals Act to minimize potential conflicts of interest on hospital boards. Specifically, effective January of this year, hospital employees and medical staff are no longer permitted to be voting members of hospital boards. The PHA was also amended to require the president of the medical staff, the chief of staff, the chief nursing executive and the CEO to be members of the board, as ex officio, non-voting. This change will ensure that boards have clear and direct access to clinical and management expertise.

To ensure that management provides relevant information to boards for decision-making purposes, the Public Hospitals Act was amended to require each hospital CEO to compile all critical incident data and provide it to the quality committee of the board twice annually for review and consideration. I would note that every hospital must now have a quality committee of the board.

These amendments were necessary not only to respond to the auditor's findings, but also to set the stage for the Excellent Care for All Act, 2010. The Excellent Care for All Act will strengthen the governance of hospital boards, ensure that patient views are part of planning processes and make quality of care a critical goal of hospitals.

That legislation includes requirements for hospitals to:

—establish board-level quality committees, as I mentioned;

—put annual quality improvement plans in place and make them available to the public, by posting them on their website, for example;

—link executive compensation to the achievement of targets set out in the quality improvement plan;

—put patient satisfaction surveys in place, as well as staff and provider surveys, at every hospital;

—seek community input in developing patient declaration of values; and

—establish a patient relations process to address and improve the patient experience.

The implementation of the various requirements of the legislation is currently under way, and the ministry is working with hospitals to help them comply with the requirements of the act. Many of those requirements I mentioned begin April 1, 2011.

0910

Among other strategies, the ministry is supporting the development and distribution of a province-wide training program for hospital board chairs, quality committee chairs and CEOs on effective governance for quality and patient safety. As recommended in the Auditor General's report, this will support best practices in governance processes and support hospitals across the province in the implementation of the Excellent Care for All Act.

These education sessions, funded by the Ontario government, were developed by the Canadian Health Services Research Foundation and the Canadian Patient Safety Institute, in partnership with the OHA. They provide a comprehensive education curriculum that supports Ontario hospital boards in their ongoing efforts to improve governance in the area of quality and patient safety. Of course, Carol can speak better than I and in greater detail about this education program.

Another important piece of legislation passed last year that will strengthen hospital board governance is the Broader Public Sector Accountability Act, 2010. This act raises the bar on accountability and transparency for hospitals, LHINs and other broader public sector organizations. It does so by:

—banning the practice of hiring external lobbyists with taxpayer dollars in hospitals;

—requiring large broader public sector organizations like hospitals to follow tough new expense and procurement rules;

—requiring all hospitals and LHINs to report on their use of consultants and to post online the expense claim information for senior executives;

—requiring all hospitals and LHINs to attest to the fact that they are in compliance with the legislation, including new procurement requirements, and posting those attestations on their websites;

—making hospitals subject to the Freedom of Information and Protection of Privacy Act, effective January 1, 2012; and

—potentially reducing their pay as a consequence if senior executives of hospitals or LHINs fail to comply with these new rules.

Undoubtedly, the strength of Ontario's hospital system is built upon the vision, dedication and spirit of the many citizens who volunteer their time as directors, working tirelessly to help improve the quality of care in their communities. Through their efforts, many of the ideals of good governance are put into practice every day in hospitals around the province.

I'd like to give you some examples of that. Back in 2007, the Scarborough Hospital witnessed a prolonged period of instability and poor patient outcomes. Since then, and after an extensive review of measures, community consultation and a revised board that included a diverse knowledge and skills mix, the Scarborough Hospital was able to improve all measures of quality, including dramatically reducing their hospital standardized mortality rate—a good measure indeed.

The Scarborough Hospital's corporate bylaws were developed after surveys of governance practices among hospitals in the GTA and from around the world. The new bylaws include a shift to skills-based boards, as well as open board meetings, a community advisory committee and biannual, board-sponsored community update meetings to enhance that community input.

Another example is the Espanola hospital. Its board of directors has established a policy on education to ensure that all its members get access to conferences, education and training sessions, webcasts and so on, so that collectively they can have the shared knowledge and capacity to help make sound decisions with respect to new requirements in such areas as quality improvement.

Lakeridge Health Corp. has instituted a formal nominations committee for their board to determine vacancies and to establish criteria for preferred candidates, including skills, knowledge and interests which are needed to round out the current board.

These and other hospitals around the province are prime examples of best practices in governance, and the ministry intends to continue to support and encourage this positive commitment.

On the hospital oversight front, the auditor recommended skills-based boards; setting term limits for directors; clarifying roles and responsibilities for the hospitals, LHINs and the ministry; encouraging information sharing between LHINs and hospitals to assist hospital boards in working effectively with the LHINs; and, in conjunction with LHINs, developing processes to share findings of external reviews, such as those from peer reviews, investigations and supervisor appointments.

There are a number of tools and processes currently in place that address these matters.

On the topic of improved accountability, the ministry, with input from the LHINs and the hospital sector, has developed guidelines for health service provider audits and reviews. These guidelines were created: to foster and develop relationships and partnerships between LHINs and their service providers as a key to success; and to support collaboration in working to resolve issues and refrain from assigning blame or taking punitive actions.

The LHINs have undertaken several examples of regular—in some cases, monthly and annual—reviews, and work with hospital boards and all health service provider boards, which we hope to talk about with you in the question-and-answer period.

Being conscious of time, let me just conclude on the last page by saying that we continue to encourage good hospital governance practices, in keeping with enhancing the quality and value of Ontario's health care system. As the Auditor General found, effective leadership in hospitals will ensure the best possible patient care while operating efficiently and cost-effectively.

I'd like to reiterate that the ministry, along with the LHINs and other partners, is committed to addressing all the concerns raised by the Auditor General and to continue working hard to ensure that hospital boards are accountable, transparent and instill a culture of quality and value in their organizations to benefit Ontarians.

Thanks for the opportunity, and we welcome your questions.

The Vice-Chair (Mr. Peter Shurman): Thank you very much, Deputy Minister. Being conscious of time—I'll take it in a minute—we should have sufficient time for two 10-minute rotations for each party, and then five minutes left over to give some instruction to our research person.

Let's begin with the Liberals. Did you have a question or did you want to go ahead?

Mr. David Zimmer: A question.

The Vice-Chair (Mr. Peter Shurman): Ten minutes; go ahead.

Mr. David Zimmer: My question is really for the governance expert. On page 4 of your remarks, Deputy Minister, the second paragraph: "In response to the Auditor General's recommendation, the government made changes to regulations under the Public Hospitals Act ... to minimize potential conflicts of interest on hospital boards. Specifically, effective January 1, 2011, hospital employees and medical staff are no longer permitted to be voting members of hospital boards." That's to eliminate the conflict of interest. But then it goes on, "The PHA was also amended to require the president of the medical staff, the chief of staff and the chief nursing executive to be members of the board." Of course, they're obviously hospital employees. The reason there was, "This change will ensure that boards have clear and direct access to clinical and management expertise."

If I'm a layperson on the board, on the one hand I get a message that hospital employees—chiefs of staff and so on—can't vote on issues before the board, but on the other hand their presence is required on the board because of their clinical and management expertise. I'm getting kind of a mixed message, because, as a lay member of the board, I have to be very careful; there's risk to me as a lay member of the board in not paying attention to expert advice. So I'm apt to say, "This is the expert, so I'll take the advice," and in effect vote on their recommendation, if you will. At the same time, we're telling these people, "You can't vote directly on it." It seems to me that that's kind of a confusing message.

Ms. Carol Hansell: It may be a bit confusing. I think, though, that sophisticated directors are used to understanding where management agendas may influence the recommendations. In truth, directors are entitled to rely in good faith on the recommendations and the analysis and data being provided to them by management. There's ample opportunity for the elected directors to meet in camera, to meet separately, to discuss amongst themselves the basis of the recommendations, whether they think there's an agenda there that they need to focus on.

In truth, members of hospital management are positively motivated and bring recommendations to the board that are in the best interests of the hospital. I believe that sophisticated directors understand the distinction that's being made and can work effectively within that system.

Mr. David Zimmer: My last question, just for a second, is that one of the great problems with boards is getting board members to understand the distinction between oversight responsibilities and drilling into operational issues, particularly in those situations where some of the board members in community hospitals have the idea, rightly or wrongly, that they're on the board to represent a particular community interest. They get on the

board and they are passionate about their narrower community interests and it often puts them in conflict with what's in the best interests of the hospital.

How do you go about training or teaching or sensitizing board members to their proper responsibilities: oversight, not operational?

Ms. Carol Hansell: I think that's a very insightful comment. It is almost irresistible for people who feel as though they're nominees of a particular constituency to want to represent that constituency in the boardroom. I think the message is important for directors to get that it's perfectly fine for them to articulate the views of their constituents in the boardroom; in fact, that's what they're there for. It's only when it comes to making the actual decision that they have to switch to acting in the best interests of the organization. I think that difficulty or that conundrum that people find themselves in is actually fairly well understood, and other directors tend to call people to task if they feel as though they're articulating the views of the constituency in the decision-making process as opposed to in the debate process.

0920

It's an important point, and all directors are required to act in the best interests of the corporation. It does require constant revisiting because of that impulse to want to do the best for the people who have put you on the board.

Mr. David Zimmer: Thank you.

Mrs. Liz Sandals: This may just follow along from that, then—and I think this is still for Ms. Hansell. The OHA has been working with boards with the skills-based matrix, and I wondered if you could tell us a bit more about that initiative in recruiting highly qualified board members.

Ms. Carol Hansell: The objective of the OHA is to encourage hospitals to have the appropriate complement of skills represented on their board, so the skills matrix is one tool that's used in order to identify, first of all, the skills that are currently present on the board; then you look at the skills that you feel you need and do a gap analysis to determine which skills are missing.

There is actually a very large contingent of people who are prepared to and are in fact anxious to serve on hospital boards. I think the call to public service, particularly in the health care sector, is very strong amongst the director communities. So I think the skills are available and the tools that the OHA provides provide an excellent methodology for getting to the appropriate skills on hospital boards.

Mrs. Liz Sandals: I'm not sure if you can directly feed back on that, but do you have a sense of how many of your member hospital boards are actively engaged in using that skills-based recruitment?

Ms. Carol Hansell: I wouldn't be able to give you the exact figure, but I would say that the skills matrix is one that's been commonly used in governance probably for 10 years. I think it's gotten to be a bit of a director instinct. The training that the OHA provides feeds into an existing acceptance of that approach.

Mrs. Liz Sandals: Okay. Thank you very much.

The Vice-Chair (Mr. Peter Shurman): Ms. Sandals, thank you very much. Is that it for the Liberals?

Mrs. Liz Sandals: We'll come again.

The Vice-Chair (Mr. Peter Shurman): That's fine. Progressive Conservatives, Ms. Elliott.

Mrs. Christine Elliott: Good morning, everyone, and thank you very much, Ms. Hansell, for the work that you're doing with the OHA. My question would be to Mr. Rafi. How do you intend to incorporate formally or informally the work that Ms. Hansell is doing with the boards?

Mr. Saäd Rafi: It's probably going to be a long answer, but there's several elements that I should highlight, starting with the changes that Mr. Zimmer referenced to the Public Hospitals Act and the representation on boards. We had a very extensive consultation exercise that I led with Tom Closson, head of the Ontario Hospital Association; Mark MacLeod, head of the Ontario Medical Association; and Doris Grinspun, head of the Registered Nurses' Association of Ontario, to come to an agreement amongst all of us as to who should be the best representatives, because of course doctors are not employees of hospitals, and yet one should have that input, but one shouldn't just presume it should come from doctors. So that's why we included a significant change by adding the chief nursing executive, who typically is an employee. That was a very intense exercise that led to the creation of the regulations.

In addition to that, though, we sponsor conferences with the OHA and vice versa on hospital governance and on the Excellent Care for All Act. There have been simulations, symposiums and webcasts, but perhaps more importantly the LHINs themselves, who have gone through their own good governance exercise, have created a good governance guide and tool kit for all health service providers.

LHINs have monthly meetings with all health service provider board representatives. Those are beneficial because typically in all LHINs, the hospital board representative is the more experienced and skilled because the hospital boards—I would say most—have invested in a skills-based approach to board director recruitment. So they bring value to other health service providers and vice versa. These fora take place across all LHINs. They might happen in educational sessions, they might happen in monthly discussions, they might happen quarterly.

But the piece about governance and how good governance drives integration is key. I would say that the ministry's hand in that has been on the tiller, as it were, to try to guide that work. In some cases, we sponsored it back in 2009 with respect to the good governance guide produced for LHIN boards because they're supposed to show leadership. They must emulate the successes that hospital boards have already had.

A long answer, but those are some highlights.

Mrs. Christine Elliott: My next question relates to one of the concerns expressed by the auditor: that there isn't really a mechanism for sharing information regarding reviews that may be done in hospitals, investigations

that may be done, just so that there's a sharing of best practices and maybe general information sharing. Could you let us know what your status is on dealing with that?

Mr. Saäd Rafi: There are three types of reviews that have been used under the Public Hospitals Act, and the auditor notes all three: peer review, investigators and supervisors.

Investigator and supervisor reports have typically been made public after being tabled with the Minister of Health and accepted, typically because if a hospital has gotten to that point, it's a matter of significance in that community. So it's a way to give back to the community what changes were made and why they were made. I'll take the work of Graham Scott—who is also a former Deputy Minister of Health, the former chair of a law firm and a governance expert in his own right—at Quinte hospital. He involved the community right away and got them to appreciate the changes that he was making in the board as a supervisor.

Peer reviews, which are typically—by their nature and by their title—done more as a bit of guidance and advice to the existing hospital management, I would readily admit have not been widely circulated. But typically, they are available in the hospital community—not necessarily publicly, because you're not at that stage of intervention.

We try to get these documents out, but in terms of best-practice information sharing, I lead a monthly meeting with the LHIN CEOs and my management team a day a month, and we talk about these issues. Yesterday we had our March meeting. We spoke about this presentation here, and they're very keen to make sure they're being profiled in a way that demonstrates their commitment to governance.

So information sharing happens in many different forms.

The Vice-Chair (Mr. Peter Shurman): You have about five minutes more, if you want to continue.

Mrs. Christine Elliott: Okay. One of the other concerns that has been expressed is with respect to community engagement processes, and I note that there is a document that has been produced. Can you tell me when it's going to be shared more widely?

Mr. Saäd Rafi: Can you repeat which document you're referring to here?

Mrs. Christine Elliott: The rules for community engagement; I see that they have been posted on websites and so on. Is there a plan for disseminating that information more widely? It doesn't seem to be really well known, and there seems to have been a lot of confusion in many communities about what community engagement means and the ways that the community can become engaged in that process.

Mr. Saäd Rafi: Thank you. I think there are two pieces, actually. The OHA has a website devoted to how community members and communities can get involved in hospital affairs. I think you might be referring to the LHINs' community engagement piece.

Mrs. Christine Elliott: Yes.

Mr. Saäd Rafi: They do have, on their website, their community engagement approach. I think that the variety and the variable nature of 14 LHINs, based on geography and population and various hospital and other health service providers, means that they are going to take their community engagement approach differently.

I would have to get back to you with some details on either dates or what the status of all 14 LHINs is with respect to their community engagement practices. I'm not as conversant right now with what they have done to roll that out, but I can get back to you on that if you wish.

Mrs. Christine Elliott: Okay, thank you. I appreciate that.

The Vice-Chair (Mr. Peter Shurman): Over to the NDP and Madame Gélinas.

M^me^ France Gélinas: I'm guessing my question is for Ms. Hansell also, but if it's not, feel free to share it among yourselves.

The first question I had was more a comment that the auditor made in his report. Basically, it had to do with community corporate members. I understand that the great majority of hospitals have community corporate members, and they elect the board of directors of the hospital, and some use another way to get to their board of directors. Is there any comparison that you have through your work as to which one leads to better boards?

0930

Ms. Carol Hansell: I think the issue in the hospital sector is probably a bit different than it is in the private sector. The concern with what you refer to as an open board, where it can be elected by the community, is that constituencies can grow up within the community and basically exert influence over the hospital that feeds into a particular agenda as opposed to the greater good of the community from a health care perspective. So that's the concern.

The solution to that is to have a board of directors that basically re-elects itself, which seems instinctively to be non-democratic and therefore not the right way to go about it, but it does work. It works, and it's probably the best approach in the health care sector, because we have the ultimate oversight of the government. So that approach to electing boards of directors is not—it's done in some cases in the not-for-profit sector. It's certainly not done in the public company sector, but it is, in my view, the best way to go about it in the health care sector.

M^me^ France Gélinas: What percentage of hospitals right now have community corporate members versus hospitals that don't?

Ms. Carol Hansell: I think it's about 20%.

M^me^ France Gélinas: So 20% hold—which way does the 20% go?

Ms. Carol Hansell: So about 80% of the hospitals in Ontario have what I just referred to as an open board.

M^me^ France Gélinas: Community corporate members and—

Ms. Carol Hansell: Exactly.

M^me^ France Gélinas: And are there certain patterns in the 20%? Are they mainly bigger hospitals or teaching hospitals or rural or northern or whatever?

Ms. Carol Hansell: I'm not aware that it's a pattern, but I'll give you a good example of Toronto East General Hospital. When it went through its governance crisis, that was largely attributable to the fact that it had an open membership, and I think the perception is that the board had become quite polarized by various interest groups who had managed to gain representation on the board.

Once we went through the supervisor process and a new governance structure was established, it became a closed board system, if I can use that term, with a skills-based board, and it has been highly effective since it has come out from under the oversight of the supervisor.

M^me^ France Gélinas: Okay. So of those 20% that will use the closed board—because I don't know how to label them—that use that system, then the existing board members go out on a candidate search and then select a slate and the positions are offered?

Ms. Carol Hansell: What will happen, if I can use Toronto East General as an example, when we're using the skills matrix that we discussed previously, when we have an opening and we identify a need for a new director, what we'll do is analyze what kind of skills we need. We typically use a search firm to help us to identify the best-qualified, most connected people to the hospital agenda available and then conduct interviews, invite people to join the board, and then we as a board would elect them. So it's a self-perpetuating process, the closed system.

M^me^ France Gélinas: And are you seeing a shift toward this? Is it that the 80% that have community corporate members are happy with them and the 20% that have the other system are happy, or is there movement?

Ms. Carol Hansell: I think there's a growing shift towards the closed system. From a governance perspective, I think the general sense is that that is the more stable way to govern a hospital. You obviously can't take open situations and simply say, "Now we're going to close them." It takes a lot of socializing the issue, and sometimes it takes a crisis to precipitate moving towards what in my view is a more stable system.

Did you want to—

M^me^ France Gélinas: Go ahead.

Mr. Saäd Rafi: I would just add on that point. I think the OHA and the OMA have done a really good job in providing advice, which I think the auditor recognizes in his 2008 report on page 309, especially the OHA's report and work on hospital governance and accountability in Ontario, where they've tried to make clear to all hospitals and hospital boards that representative appointment of board members, as the auditor says, based on specific interests is inconsistent with recognized best practices, because it can create a real or perceived conflict of interest, as Ms. Hansell said.

I would also agree that it does take time to work through that. But when they go out to look for community members, I think many hospitals are also trying to guide the community representatives to look for those among them who have not only an interest but also skills, some training and some willingness to receive that type of input. I think the glass is very much past half-full in regard to change in that way.

Ms. Carol Hansell: If you don't mind my just correcting, I have some additional information. I'd just flip those numbers that I gave you. About 75% or 80% adopt the closed membership approach that I described as being the more stable. So the movement has been very definitely toward the closed membership. I'm not sure if you were asking about open board meetings, though—

M^me^ France Gélinas: No, not open board meetings. I'm talking about nominating of members. So the correct answer is, 75% of hospitals in Ontario now have a closed nomination process on the boards?

Ms. Carol Hansell: That's correct.

M^me^ France Gélinas: That's a big switch. We went from 80% of hospitals—

Ms. Carol Hansell: Yes. I don't have the statistics in front of me. I'm not the keeper of the numbers.

M^me^ France Gélinas: Okay, no problem.

My other question has to do with the comment the auditor put in his report back in 2008 that said two thirds of the boards felt they were doing a good job at evaluating their CEOs and one third didn't. I think we'll all agree that one of the functions of a board is to hire, supervise and give feedback to the CEO. How are things working out? The data is almost three years old. Is it better? Are one third of the hospitals out there still struggling with supervision and evaluation of their CEOs?

Ms. Carol Hansell: Without being able to quote numbers to you, I think that more and more hospital directors are comfortable with their ability to evaluate the CEOs and the management team, and that's largely as a result of the educational programs that are sponsored by the Ontario Hospital Association.

I think the challenge for many private sector directors, when they come to sit on a board of a hospital, is that while they bring with them a wealth of experience and knowledge about governance and about running businesses, they don't necessarily know a lot about health care. So the educational programs sponsored by the hospital—the in-house education systems or programs offered by the hospital itself—as well as the outside programs offered by the Ontario Hospital Association are actually quite important in getting directors comfortable enough to know what the metrics should be, what the issues are that they should be pushing on and what the challenges are that face a hospital CEO. When you understand, for example, that the doctors don't work for the hospital, that's a pretty big change from what people are used to in the private sector. You really need to get their minds switched over into the health care way of thinking in order for them to be effective in monitoring, evaluating and incentivizing their management teams.

Mr. Saäd Rafi: It's also fair to say that over 90% of the chairs responding to the survey indicated that their CEO's most recent evaluation compared actual perform-

ance with expectations. So 90% said that they did some evaluation against expectations. Almost all board members responding to the survey indicated that evaluating hospital management performance was an important part of their role.

What you've quoted is to say that 63% of members strongly agreed. Oftentimes, when one reports survey results, you would look at "strongly agree" and "agree"—in other words, those in the "agree" category—so I'd have to believe that that would be the majority, beyond 63%. I see that as a very positive indicator that hospital boards have reached the point of sophistication of other boards in other sectors, including the not-for-profit sector, where there are some very notable examples of very sophisticated governance models. One example I have some familiarity with would be the Metro Central YMCA board.

The Vice-Chair (Mr. Peter Shurman): Over to the Liberals, Mr. Zimmer.

Mr. David Zimmer: This is sort of a looking-into-the-future question. This morning in the Globe or the Star, on the first page, there was an article about how one of the hospitals in the London area, the London Health—

Ms. Carol Hansell: Network?

Mr. David Zimmer: —Network, whatever, was responding to—I mean, all hospitals and hospital boards are under great pressure now. They're always under the microscope and so forth and so on. They have to manage in that pressure cooker, under-the-microscope world.

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But they are finding increasing pressures now because of this whole social media stuff. Folks in a community or employees within a hospital have an issue or they're upset about something, or they think things should be this way or that way, and with social media—Twitter, BlackBerry, email—a whole campaign gets started.

The story said that, as an exercise in management, the hospital up in that area was struggling with how they were going to respond to this additional, instant pressure, being instantly under the microscope and having to respond to these social media campaigns, which can raise an issue out of nowhere and in a couple of days—overnight, literally—there are huge pressures on management to deal with these issues.

As a governance expert and to the deputy minister, do you see challenges there developing?

Ms. Carol Hansell: The social networks, I think, are presenting challenges to all of us in all aspects of life, but I can tell you that at Toronto East General, the approach is to make sure that the hospital knows what the patient thinks as early on in the process as possible. There are some very interesting innovations in team meetings and in team huddles to make sure that the entire medical team knows what's going on with the patient at various points in the day. There's a very rigorous program of phoning the patient after discharge to check and see what the hospital experience was like. All of those matters are reported up to the board, and the responses and remediation, if anything is necessary, go through the full cycle of governance.

So I think sensitivity to the nature of the immediate need of the patient, and to make sure that it's being fed properly into the communication process in the hospital—you're not going to change social media, but the important thing is for the hospital to know and to respond to what the patient is thinking.

The Vice-Chair (Mr. Peter Shurman): Over to—sorry. Do you have more, Mr. Zimmer?

Mr. David Zimmer: I think the deputy had a comment.

Mr. Saäd Rafi: I have a very long answer on this and its impact on public policy. All of you know the impact of multimedia with respect to governing and providing value to your constituents. The Globe reports on blogs. Print journalists post stories at 3 a.m. There is no news cycle; it is a news cycle constantly.

I don't think this is unique to hospitals, as Carol has more eloquently indicated, but I do think that protocols, as she has also said, are critical to make sure that the right information is given, such that those with agendas—advocacy organizations, as an example in the story reference—are not necessarily influencing the entire discourse, particularly on a very sensitive subject such as the one that you referenced in the Globe today.

However, I won't bore you with my other views on multimedia.

Mr. David Zimmer: Will there be specific training on managing social media pressures as a part of board management skill sets or tools?

Mr. Saäd Rafi: Go ahead.

Ms. Carol Hansell: I think that's an interesting idea. I think ultimately it will be integrated. I'm not aware of specific initiatives at this point in time, but it's a great point.

Mr. Saäd Rafi: Yes, and I think most organizations put operational leaders in front on particular issues' management, because board members would not be conversant with the operational needs or the care needs, especially in a hospital. But the sophistication in the hospital sector in Ontario with respect to its communications abilities and with guidance from the OHA, I think, is first-rate.

Mr. David Zimmer: Thank you, Chair.

The Vice-Chair (Mr. Peter Shurman): Can I take Chair prerogative and just make a comment—and if you want to respond to it, that's fine—on social media? There are privacy issues as well, so from a confidentiality perspective, board members would need to know that what happens in the boardroom stays in the boardroom, to coin a phrase, and that kind of training, I think, would be useful.

Mr. Saäd Rafi: I agree, absolutely. I'm pretty certain that the strictures of the Public Hospitals Act, the Personal Health Information Protection Act and—there's a couple of other acronyms I can't remember that have to do with hospital and patient information. That is a key

part of training, not only for management, but obviously for boards, as you say.

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

Mrs. Liz Sandals: I just wanted to touch on something new that's coming up under the Excellent Care for All Act, which is this whole idea of having a quality committee as part of the board and a quality improvement plan being posted annually—and presumably, progress on the quality improvement plan.

I was wondering—both Deputy and you, Ms. Hansell—if you could comment on how the implementation of that is going, because that's a new idea. Presumably you both would be interacting with boards to help them know what the expectations are and how to implement it.

Mr. Tai Huynh: The implementation is ongoing right now. The legislation, the Excellent Care for All Act, passed in June. We put regulations in place that took effect January 1, 2011, so all hospitals across this province, all 154, are now required to have quality committees. The regulations are very clear on who should be on a quality committee as a minimum.

All hospitals are now embarking on the process of developing quality improvement plans. They need to have those plans ready by April 1, 2011. So by that date, all 154 hospitals would have quality improvement plans in place, made publicly available, and hospital executives will be held accountable, through pay-for-performance or pay-at-risk, for meeting those objectives.

Mr. Saäd Rafi: And in addition we have provided, again, to the Ontario Hospital Association and developed with an expert panel the key indicators that should go into a quality improvement plan. Right now hospitals have accountability agreements with their LHIN that establish some of those same indicators, so we have tried not to duplicate efforts, but also tried to embellish the quality of the quality improvement plans.

Health Quality Ontario, which is a new organization that the government has created and is an expansion of the Ontario Health Quality Council, will do the reporting and the monitoring of performance against those quality improvement plans. That will get posted such that you, as an individual, will be able to see the quality measures and the responsiveness of every hospital against patient surveys, provider surveys, their values and their quality indicators as well.

So it isn't just something that we have put as a burden onto hospitals. We've tried to really work hand in glove with the association and with experts in the field of quality. Dr. Bob Howard, for example, is a notable one.

Ms. Carol Hansell: The point that I'd like to make is that the quality committees aren't really necessarily new. I think part of the reason that the Excellent Care for All Act will be effective is because it doesn't necessarily invent new governance concepts; it pulls out of the hospital community what were perceived as being the strongest governance tools available. For example, at Toronto East General we already did have a quality committee, and I happen to be the chair of that committee. So a couple of tweaks, frankly, were all we really needed to make to come onside with the act.

The quality committee approved our quality plan at our meeting about 10 days ago and it will be going forward to our board in time for approval in April. The exercise, I think, was a very positive one from the hospital's experience; it's not entirely new, but taking on board the new aspects of that approach that have been introduced through the legislation has been a very positive experience.

Mrs. Liz Sandals: And what sort of indicators—not just specifically in East General's plan—would the public expect to be seeing embedded in those plans?

Ms. Carol Hansell: We, as many other hospitals do, have a balanced scorecard that is published. The indicators that are in those plans reflect the reporting that's required by the ministry, by the LHINs and, actually, by our own strategic plans. So all of the indicators that are mandated, as well as the ones that we think are important for monitoring the operation of our own hospital, given the specifics of its issues, are incorporated into the balanced scorecard, which is made public.

Mr. Tai Huynh: Just to answer that, the ministry worked very closely with the hospital sector, as well as the LHINs and the Ontario Health Quality Council, to establish a core set of indicators for this round of the quality improvement exercise. The indicators span four key domains of patient safety; so indicators like hospital infection rates, C. difficile etc. are all part of that domain.

We've got indicators on effectiveness that measure mortality rates, like HSMR, as the deputy mentioned earlier. We have measures of access that include ER wait times and, more importantly, in my opinion, measures of patient satisfaction, patient feedback. Those are all core indicators that are part of the quality improvement plan. We expect hospitals to be developing improvement plans corresponding to those indicators.

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Mr. Saäd Rafi: I'd like to emphasize the one that most people forget about, and that's financial probity. It is a key indicator of quality.

Mrs. Liz Sandals: Thank you very much. That's very helpful.

The Vice-Chair (Mr. Peter Shurman): Progressive Conservatives, back to Ms. Elliott.

Mrs. Christine Elliott: I also have a question regarding the implementation of the Excellent Care for All Act, and that relates to the tying of executive compensation to the achievement of some of the performance goals. Could you give us some indication of where that is? I know that there has been some concern expressed by some of the hospital boards about how they're doing vis-à-vis some of the other hospital boards.

Mr. Tai Huynh: Sure. Much like what Carol mentioned around the quality committee, these are long-standing practices within the sector among many hospitals. Many hospitals do have pay-at-risk for their executives, so for those hospitals this is a mere reflection of what's been going on in terms of best practice. There's a small segment of hospitals that do not have any sort of

pay-for-performance scheme or pay-at-risk scheme, and those hospitals have been some of the ones that are facing some challenges in terms of moving from their current compensation structure to one that's contingent upon achievement of quality improvement goals. So that's where some of the difficulties or challenges have been coming from.

The act itself is very clear that hospitals need to have that in place corresponding to the quality improvement plan. By April 1, for the next fiscal year, all executives—not just the CEO, but members of the senior management team that report to the CEO—will have to have a certain portion of their pay at risk for achieving the goals and targets set out in the plan.

Mr. Saäd Rafi: But I would also hasten to add that what we were careful to do, we think, was to allow the hospital board, in its own responsibilities with its relationship with management, to determine the percentage amount and how much it would put in terms of emphasis. As you would well know, many performance or pay-at-risk plans have a combination of factors or a matrix in place in terms of overall organizational performance and individual performance. There is a fair bit of discretion there under the requirement for the hospital board, depending on the nature of the board, the size of the board, the issues in that community etc. So it tried to strike the right balance.

Mrs. Christine Elliott: If I'm understanding it correctly, would you say that the majority of hospital boards already have something in place? Is it a small group that you're really dealing with here?

Mr. Saäd Rafi: Again, specific indicators of quality, I don't know. But I would say most hospitals where there is a pay-at-risk plan for their executive definitely have, as part of their performance evaluation process, a fairly sophisticated approach to examining both the performance and the pay-at-risk.

Mrs. Christine Elliott: I've also just been reviewing the summary status table that you've provided us with, with respect to the province-wide training program on governance, and I see that you've got sessions scheduled between March and May. I wonder if—I'm not sure if it's Ms. Hansell—who could speak to that, or if you could speak to the finalization of the program and how that's going to be rolling out in those communities.

Mr. Tai Huynh: Sure. The intent there is that it's a ministry-sponsored initiative with the primary intent being to educate boards across the province in patient safety and quality, two major areas of focus for us under Excellent Care for All. That program is being rolled out across the province, and the expectation is for all 154 hospitals to sign up to attend those sessions. We try to make it as accessible as it can be. Rather than being staged here in Toronto, like most things are, we are actually bringing it into the communities to encourage as maximal participation as possible through those five regions.

The faculty is an elite group of patient safety and quality improvement experts. The program itself is built on a program that was developed by the Canadian Health Services Research Foundation, and it's well regarded. It's internationally renowned. We're building on best practices here, and we believe that's going to set the stage for all of Ontario's governors to be on the leading edge of governing for quality and safety across the country.

Mrs. Christine Elliott: So they're all scheduled now? You've got the dates for each community?

Mr. Tai Huynh: Yes, that's right.

The Vice-Chair (Mr. Peter Shurman): Madame Gélinas.

M^me^ France Gélinas: When my first rotation ended, I think Mr. Tai Huynh wanted to comment a bit. At the time I was talking about boards assessing CEO performance, and you were about to say something, but we ran out of time. Did you want to add to it?

Mr. Tai Huynh: I think we just went through that around the executive compensation. Through the framework that's been established through the Excellent Care for All Act and its regulations, there's a bit of standardization around how boards can assess their executives for performance. It has to be tied to core improvement plans, there's a core set of metrics etc. So we believe that's going to push the envelope even further in terms of board evaluation of executive performance.

M^me^ France Gélinas: My next question has to do with term limits for directors. This is an issue that the Auditor General brings forward as being part of good governance. Do any of you have comments regarding whether this should be embedded in law or regulations? Is it already being done? Do you agree that it's part of good governance?

Ms. Carol Hansell: I think to a large extent it is already done being done.

I'm not necessarily a fan of embedding all aspects of governance into laws, because laws are necessarily inflexible and you're not able to take into account the particular needs or the unique circumstances of an individual organization. I think that using the approach of what I would refer to as "generally accepted governance practices" articulated through organizations—in particular, the Ontario Hospital Association—to provide guidance to hospitals and their boards as to what effective governance is, and then reviews and basically peer standards to ensure that good governance practices are being followed, is far more effective.

Mr. Saäd Rafi: We have leaned toward the reliance on best practices on guidance from the Ontario Hospital Association. I would agree with Carol that ensconcing some details like that into legislation would probably mean that we would have the GTA standard across the province. There are some practical limitations in certain hospitals with respect to the level of community availability, the time people can devote. It's hard to have a one-size-fits-all, given the 154 corporations that exist in Ontario amongst hospitals. They vary quite dramatically. So we have leaned toward trying to provide and keep the corporations legislation requirements for minimum and

maximum number, but rely on best practices and provide that flexibility.

M^me^ France Gélinas: Right now, if you were to do training, what kind of term limits do you suggest?

Ms. Carol Hansell: I think it depends a bit on the size of the hospital and the circumstances. But if I can talk about Toronto East General Hospital, we have a limit of three three-year terms. I think for an organization of that size, you want people to be committed for a minimum period of time. You don't want people kind of rotating on to boards for the board experience and then getting off before they're really able to make a meaningful contribution, but you want to have some end period to it.

I would say that getting people to commit for between two and three years is an absolute minimum, and then asking them to find some other activities and moving them off the board somewhere between eight and 10, is probably the right number for an organization of that size.

M^me^ France Gélinas: The next comment kind of shows the ministry under not the best light, but I'm not about laying blame. I have a question, and I'll read from a report. It says:

"It is an established practice that when the auditor tables his annual report, ministry auditees ... receive a letter from the committee clerk asking for a response to the auditor's recommendations, setting out the ministry's action plans and timetable for addressing the auditor's concerns.

"In June 2009, the committee clerk sent this letter to the acting deputy minister of Health and Long-Term Care.... A response was requested by August 24. It has been determined that the committee clerk received no response from the ministry."

I'm not here because I want to blame you for not having responded. I'm more curious about, do you see a usefulness in this? We all know that the auditor will go back after two years and he does a follow-up on all of his audits. We have the clerk who sends those letters and asks. Is this something useful? Is this a one-off that got forgotten? What is your view on this practice?

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Mr. Saäd Rafi: First, I can't accept any blame because I wasn't in the role—

M^me^ France Gélinas: Fair enough.

Mr. Saäd Rafi: —and I'm not an apologist for my predecessors.

Second, I can say that we have rededicated and recommitted to be responsive to the time limits that your committee has asked of us for information. I'll continue to speak frankly in front of the committee and say to you on your question, with the opening you've provided me, on the usefulness of that, if you deem it to be of necessity to have that information, then I deem it to be useful. However, I would suggest that some of these questions, in the context of the subject of health and long-term care, are not, "Yes; no; one; five; six; 11." There are 154 hospitals. You'll recall that at estimates we had some very sophisticated, very detailed requests that cut across the entire sector, broken down hospital by hospital.

If we had buttons we could push to regurgitate that information, you would have it in the same real time. I appreciate that it's 2011, but we do not have that. So I would ask the committee—and I thank you for the opening—to bear that in mind when making very voluminous and sophisticated requests, and, I would dare say, not just this committee but other committees of the Legislature. That certainly is not in the deputy's manual, but I appreciate you allowing me the opportunity to respond.

Laughter.

M^me^ France Gélinas: Fair enough. I had opened the door; I wanted your opinion. Thank you. No more questions, Mr. Chair.

The Vice-Chair (Mr. Peter Shurman): I see a hand over here. I just want to remind the committee: It's 10 o'clock; we don't have time for additional 10-minute rotations. What I'd like to do is go around the room. If you have a two-minute or three-minute wrap-up, we'll do it and then we'll go into closed session. Mr. Zimmer of the Liberals.

Mr. David Zimmer: This is a wrap-up, or a quick question?

The Vice-Chair (Mr. Peter Shurman): This is wrap-up. If you have two minutes, fine.

Mr. David Zimmer: All right. I'll wrap it up with this quick question, coming back to stakeholder input on the hospitals: Right now, community stakeholders are elected to the board, and that's where they bring their community input. There may be a school of thought that says that community input is better directed to or taken in by the LHIN so that the LHIN can absorb the community input in the broader context of LHIN responsibilities. Do you think that stakeholder input should go directly to the board or to the LHIN?

Mr. Saäd Rafi: I think you have to strike the right balance. What I'm going to say may look like equivocation, but one LHIN is not the same as the other. Again, related to the term limit question, actually, and Ms. Elliot's question about community engagement—I had a bit of a mental block and I've sort of elucidated a little bit more on that question. The Ombudsman reported that LHINs should have more public reporting on their community engagement, and now that is being posted publicly as to how they're engaging their communities. At the LHIN level, you have several communities; not just health service providers but then, of course, the broader community and communities of interest.

I think hospitals, too, need to benefit from that input. Some of that depends on the nature of the hospital. For example, you might have the person who is head of the voluntary committee. I'll take a hospital like Sick Kids here on University Avenue: They have thousands of volunteers. That's very, very important to every hospital. They deem it to be very important to them, and so they have the head of their volunteer association—I'm not getting the right nomenclature—as an ex-officio, non-voting member of their board. I think every board must exercise its judicious approach to that.

Carol would probably have views as well.

Ms. Carol Hansell: Organizations are a bit like families; they're all different and they all have different needs, and we have to be responsive to those. I'd be reluctant to be siloing the way in which communities can interact with the health care system. Where it works for the community and for the hospital to have that input coming in directly, that's terrific. The LHINs were obviously there for a similar purpose. I think we can, as was already said, strike the right balance if we're mindful of the different needs of different communities or organizations.

Mrs. Liz Sandals: May I just add a comment?

The Vice-Chair (Mr. Peter Shurman): You have a quickie? Go ahead.

Mrs. Liz Sandals: Having come from doing some rural and northern consultations, I think the observation that LHINs are very different is absolutely crucial because, if you think about the two northern LHINs, North East and North West, what the LHIN might get as input could be completely different from what you would get as community hospital input, which is much more localized. In those very large geographic LHINs, it's important to be able to drill down into local communities to get the input.

Ms. Carol Hansell: I think that's right.

The Vice-Chair (Mr. Peter Shurman): Ms. Elliott, anything final?

Mrs. Christine Elliott: I have no further questions. I'd just like to thank you all for appearing before the committee today. We're really grateful for the work that you're doing, Ms. Hansell, with assisting the ministry and the hospital association.

The Vice-Chair (Mr. Peter Shurman): Madame Gélinas?

M^me^ France Gélinas: I think I already know the answer, but I'll give you the opportunity to say it for yourself. You've made it clear that you don't think that governance issues should be in laws or regulations because of the need for flexibility. Are there any issues right now where you would like a change of law if you could rewrite it the way you want it? Specific to governance; let's limit ourselves to governance.

Interjections.

The Vice-Chair (Mr. Peter Shurman): What do you think of life, in 25 words or less?

Ms. Carol Hansell: I think there are a lot of different ways of looking at an issue from a governance perspective. While there may be things that I would have done differently if I were writing the legislation, I think where we currently are with governance legislation in the health care sector is completely workable. With the guidance of organizations that are spending a lot of time on education and developing templates and trying to make boards more effective, I think we'll all be able to manage with the changes that have been made recently.

Mr. Saäd Rafi: Just for the record, I would say that it's my personal view, and I think it's the view of the government, that regulatory and legislative instruments to address governance needs in hospitals are an appropriate tool or instrument of government, but I think striking the right balance within that and not codifying things that might need some flexibility across geographies and size, scale and scope was the distinction I was hoping to draw.

M^me^ France Gélinas: Thank you, and again, thank you very much for coming this morning.

The Vice-Chair (Mr. Peter Shurman): Thank you all. That concludes our open session.

The committee continued in closed session at 1006.

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