Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

INDEPENDENT HEALTH FACILITIES

(Section 3.08, 2004 Annual Report of the Provincial Auditor)

1st Session, 38th Parliament
54 Elizabeth II

The Honourable Alvin Curling, MPP,
Speaker of the Legislative Assembly.

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Norman Sterling, MPP,
Chair.

Queen's Park
August 2005

STANDING COMMITTEE ON PUBLIC ACCOUNTS

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PREAMBLE

The Auditor General (the Auditor)* reported on Independent Health Facilities in Section 3.08 of his *2004 Annual Report*. The Standing Committee on Public Accounts held hearings on this audit report on February 24, 2005, with representation from the Ministry of Health and Long-Term Care.

The Committee endorses the Auditor's 2004 report on Independent Health Facilities and recommends the implementation of his recommendations by the Ministry of Health and Long-Term Care. The Committee has prepared supplementary recommendations based on its findings during the hearings. This report is a record of those findings and the Committee's recommendations.

The Committee extends its appreciation to the officials from the Ministry for their attendance at the hearings. The Committee also acknowledges the assistance provided during the hearings by the Office of the Auditor General, the Clerk of the Committee, and staff of the Legislative Library's Research and Information Services.

Ministry Response to the Committee's Report

The Committee requests that the Ministry of Health and Long-Term Care provide the Committee Clerk with a written response within 120 calendar days of the tabling of this report with the Speaker of the Legislative Assembly, unless otherwise specified in a recommendation.

1. OVERVIEW

The Ministry of Health and Long-Term Care licenses and regulates 955 independent health facilities (IHFs) under the *Independent Health Facilities Act (IHFA)*. Most facilities (924) are diagnostic, providing services (e.g., radiology, nuclear medicine, ultrasounds, pulmonary functions, and sleep studies) that can be helpful in diagnosing various medical conditions. Seven of these facilities provide magnetic resonance imaging (MRI) and computerized tomography (CT). Twenty-four licensed facilities provide surgical and therapeutic services, such as dialysis, abortions, and cataract, vascular, and plastic surgeries.

The technical or facility fees paid to IHFs cover the costs of providing services, such as the cost of medical equipment, and administrative and occupancy costs. In 2003/04, technical fee payments to diagnostic facilities totalled approximately $257 million, and fees paid to facilities providing surgical and therapeutic services totalled approximately $16 million.[1]

* Formerly the Provincial Auditor.

2. AUDIT OBJECTIVES AND SCOPE

The audit's objectives were to assess whether the Ministry had adequate procedures in place to ensure that

- the Ministry and the facilities licensed under the *IHFA* were complying with applicable legislation and policies for the licensing, funding, and assessment of the quality of services provided by facilities; and
- the program was fulfilling its mandate.

The audit was substantially completed in March 2004.[2]

2.1. Overall Audit Conclusions

For the most part, the Ministry had adequate procedures in place to ensure compliance with applicable legislation and policies for the licensing, funding, and monitoring of facilities. However, for the program to cost-effectively fulfill its mandate, action was still required to address a number of issues which were identified in a 1996 audit.[3]

3. REASONABLENESS OF FACILITY FEES

Diagnostic services have professional and technical components. Physicians bill for the professional component on a fee-for-service basis through OHIP in accordance with the *Health Insurance Act*'s Schedule of Benefits.

The technical or facility fees for most diagnostic facilities are listed in the Schedule of Facility Fees for Independent Health Facilities and are claimed on a fee-for-service basis.[4] They cover operating costs but are not adjusted for factors that can impact on cost, such as the volume of services rendered annually. Technical fees for facilities offering surgical and therapeutic services, and for MRIs, are funded through negotiated budgets based on the actual costs of providing a certain volume of service.

The Auditor's 1996 report recommended assessing the reasonableness of facility fees by studying the relationship between volume of services and costs. The Ministry agreed and replied that its staff was developing "a protocol to be used to examine the appropriateness of the fees and the applicability of volume discounts."

In a 2000 report, the Committee on Technical Fees, with members from the Ministry, the Ontario Medical Association (OMA), and the Ontario Hospital Association (OHA), noted that cost reimbursement should be the underlying principle for funding technical components of diagnostic services. Most fees had not been set through a rigorous costing process. This committee also noted a lack of information on the extent to which current fees deviate from real costs, that the fee schedule should be reviewed, and that an appropriate costing methodology should incorporate factors such as economies of scale. It suspected that the

introduction of new technology and equipment meant that some fees did not accurately reflect current costs.

The OMA and the Ministry agreed in April 2003 to establish a Diagnostic Services Committee (DSC). Committee responsibilities would include developing and setting up the process for evaluating and administering technical fees. As of April 2004, the DSC had not been formed.[5]

The Auditor recommended that the Ministry objectively determine the current cost of providing each type of service, and examine the relationship between the volume of services provided and the costs of providing services.[6]

Committee Hearings

The Ministry and the OMA agreed to establish the DSC as part of their 2003 memorandum of agreement (MOA). It was described as a multi-partite committee. Participants were said to be ready to proceed with their work in the near future. Representatives were being nominated. Preliminary results from the DSC's efforts were expected within the current fiscal year. Because significant work had already been undertaken and representatives would have familiarity with the issues involved, the DSC was said to have an incentive to act expeditiously.[7]

The DSC will function as an advisory body to the Minister for planning and coordinating an efficient and effective diagnostic services system. It will examine how the technical fees component of diagnostic services will be evaluated, compensated and administered. This includes establishing a costing methodology and an ongoing review process to ensure that reimbursement is based on actual costs and current service volumes.[8]

In addition to fees, the DSC will examine the transfer of patients and information between facilities (including hospitals) to see how the process can be streamlined and made more efficient. It will also look at underserviced areas for distribution problems and efficiencies.[9]

Committee Recommendation

The Committee recognizes the complexities of the functions to be performed by the DSC, and the fact that its participants represent various segments of the health care system. Nonetheless, the Committee remains concerned with the length of time it has taken to respond to the Auditor's 1996 recommendation to assess the reasonableness of technical or facility fees by studying the relationship between volume of services and cost, and to the work of the Committee on Technical Fees. This concern was reflected in a letter sent to the Ministry of Health and Long-Term Care by the Committee on March 9, 2005. That letter said that the Committee would likely ask for a further report on this matter.

Supplementary Information
Subsequent to the hearings, the Ministry provided the Committee with an update on the status of the DSC. The Ministry reported that its 2003 're-opener agreement' with the OMA included the creation of a Diagnostic Services Committee Development Team (the Team). The Team was to develop and recommend a framework agreement among principal stakeholders for the structure of the DSC.

The Team submitted its final recommendations in January 2004. Negotiations for a new physician payment agreement began that same month and concluded in March 2005. The OMA's governing council ratified the agreement later in March. Because most OMA/Ministry joint committee work was suspended during negotiations, the DSC had not commenced as of May 19, 2005.

Ratification of the agreement means the DSC is established. The agreement states that

> the Parties agree to activate the Diagnostic Services Committee within three months of the ratification of the 2004 Physician Services Agreement.[10]

The Committee therefore recommends that:

> **1. The Ministry of Health and Long-Term Care report to the Committee on establishing target dates for the completion of the negotiation of facility or technical fees, particularly high volume medical services. The Committee would expect this to be done by June 30, 2006.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

4. DISTRIBUTION OF SERVICES

The *IHFA* allows the Ministry to license new IHFs through a request for proposals (RFP) process after considering the services to be provided, current availability, current and future need, projected cost, and the availability of funding.

Developments Following the Audit

On September 9, 2004, the Minister of Health and Long-Term Care announced the creation of a health results team. A member of the team, Dr. Alan Hudson, was named lead of access to services/wait times (i.e., the wait time strategy).[11]

The First Ministers held a health summit in mid-September 2004. One of the meeting's outcomes was the federal government's creation of a $4.5 billion Wait Times Reduction Fund. In return for this money, the provinces agreed to "achieve meaningful reductions in wait times" in five priority areas (cancer, heart, diagnostic imaging, joint replacements, and sight restoration) by March 31, 2007.[12]

4.1 Diagnostic Services

Since 1990, despite a number of expressions of interest, a minimal number of additional facilities have been licensed to provide the diagnostic services originally licensed under the *IHFA*. However, since the 1996 audit, the Ministry has permitted already-existing licensed facilities to increase the types of services performed if they are located in a region the Ministry considers underserviced.

In a 2002 report, the OMA recommended that it, the Ministry, and the hospital sector establish a Technical Diagnostic Services Management Committee to recommend province-wide, population-based planning methodology and guidelines to determine the capacity, distribution, and choice of appropriate services. The methodology would incorporate criteria relating to population needs, waiting lists, and whether the introduction, expansion or replacement of diagnostic technology demonstrates a cost benefit in the provision of services.

The report also recommended that the committee

- recommend strategies to address service priorities and gaps;
- review requests to introduce new services or expand existing capacity; and
- make recommendations with respect to introducing/expanding services.

While the Ministry supported such a committee, none had been established at the time of the current audit. It was noted that British Columbia has established an Advisory Committee on Diagnostic Services that reviews applications for new facilities.

Ministry-prepared data indicated significant regional variations in service availability. The current audit found no indication that the Ministry had analyzed these differences to determine whether any action was needed to address its commitment to providing universal access where and when services are needed.

There is no limitation on the volume of licensed services that a facility can provide. From 1996/97 to 2002/03, there were significant increases in the utilization of certain procedures. At a number of facilities, utilization had increased by over 100%, and in others, by as much as 700%. The current audit also found no indication that the Ministry had analyzed the reasons for these increases.[13]

4.2 Surgical/Therapeutic Services

The province's ageing population has resulted in an increased demand for cataract surgery and dialysis services.

4.2.1 Cataract Removal Surgeries

Ministry data indicate that the number of cataract surgeries performed grew from approximately 45,000 in 1992/93 to 97,000 in 2002/03. The Ministry assessed the need for these surgeries in 2000/01. It concluded that four regions were under-serviced and that providing surgeries in IHFs would be less expensive than in hospitals. The audit found that only one licensed facility in Ontario (in Toronto) was providing cataract surgery; most surgeries continue to be performed in hospitals. The annual number of surgeries performed by the facility was increased, with Management Board of Cabinet approval, from 300 to 1,300 in 2003/04. Volume provided is now 100% of capacity.[14]

4.2.2 Other Surgical/Therapeutic Services

The need for and availability of licensed surgical/therapeutic services other than cataract surgeries has not been determined since the 1996 audit. Over the same period, there had been no regular review of the number of services provided per unit of population.

At the time of the current audit, five licensed IHFs provided therapeutic abortions. According to the Ministry, certain services, such as abortions, "are not available elsewhere in the province to satisfy the current demand and volume."

A recent Ministry document reported that unlicensed facilities are also performing abortions, particularly in one area. Since these facilities are not licensed under the *IHFA*, they are not paid a facility fee for services provided nor are they subject to the same quality assurance process as licensed facilities.

The Auditor recommended that the Ministry assess the need for each service by region and determine what actions are required to meet its commitment to provide services where and when needed. He also recommended assessing the implications – from a financial and waiting list perspective – of licensing more than one IHF to provide cataract surgeries. The Ministry should also determine what legislative or other actions should be taken regarding unlicensed facilities performing surgical and other procedures generally performed in hospitals or licensed IHFs.[15]

Committee Hearings

Assessing Regional Need

The DSC will use a planning-based approach for the diagnostic services system, including making recommendations to address access and health care needs. This will include addressing matters such as access in underserviced areas, new approaches to meet patient needs, and capacity and wait list issues. The DSC will provide advice and recommendations on the funding and structure of the

province-wide diagnostic system, including the use of new funding for diagnostic services. Work is in progress, with an expected completion date of 2008.[16]

Provision of Cataract Surgeries

The Ministry has conducted a needs assessment to identify those areas in greatest need of additional services. It is looking at a range of options to meet community needs, including IHFs.[17]

The government's wait time strategy also includes an ongoing needs assessment process that is looking at the principles of quality, access and efficiency, and will assist in determining the right kind of delivery model for cataract services. Committee members were told that the government had recently announced an additional 2,000 cataract surgeries would be performed in the current fiscal year. The intention is to achieve 9,000 new surgeries in 2005/06.[18]

Supplementary Information

On April 7, 2005, the Minister of Health and Long-Term Care announced that a not-for-profit clinic dedicated to cataract surgeries would open in downtown Toronto later in the year. The new clinic will consolidate services currently provided in four city hospitals and will perform about 5,500 surgeries a year.[19]

Actions Regarding Unlicensed Facilities

The structure of the *IHFA* is such that the definition of an IHF, and the problems and penalties associated with operating an unlicensed facility, all hinge on charging a facility fee as defined in the legislation. Facilities that forgo charging fees do not require licensing under the *IHFA* and are not subject to its quality assurance provisions. The imposition of the quality assurance established under the *IHFA* on unlicensed facilities performing IHF-type services would require significant amendments to the legislation. Committee members were told that the Ministry fully supports consideration of this issue under a policy review of the *IHFA*. Work was in progress with an expected completion date of fall 2006.[20]

4.3 Waiting Lists

The Ministry did not have a system to track and manage waiting times for any services licensed under the *IHFA*. In 2000, it began providing funding to the Ontario Joint Policy and Planning Committee (JPPC) to undertake the Ontario Waiting List Project (OWLP). This project was to develop an understanding of how to manage waiting lists and improve access. The JPPC was to "recommend the methodology that fairly prioritizes patients, enables timely access to services, applies across levels of care and is acceptable to key stakeholders."

The project developed and evaluated priority-rating tools based on work begun by the Western Canada Wait List Project (WCWL), which involved organizations and governments from the four western provinces. The WCWL developed waiting list management tools in five clinical areas. While not specifically established for IHFs, the JPPC reviewed the waiting list tools for MRIs, and

general and cataract surgeries. It made recommendations to further develop and refine each. (Nova Scotia has also started a provincial wait-time monitoring project.)

As of May 2004, audit staff were not aware of any further Ministry initiatives related to the OWLP or of other approaches to obtain information on the waiting time for services provided by IHFs.[21]

The Auditor recommended that the Ministry develop and implement a waiting list management system, and monitor and analyze waiting times.[22]

Committee Hearings

Initial activities of the province's wait time strategy will include the development of a comprehensive information system that will provide the capacity to compile, measure and evaluate wait times in facilities providing key services, including IHFs. This information will be publicly reported so that patients and providers can make informed decisions about their options and feel certain that their needs are being addressed.[23]

In the past, estimations of geographic demand were performed on an individual hospital basis or on current rates of surgery per population and estimates of population growth in those areas. In order to obtain a comprehensive wait time registry, the wait time strategy will look at rates of population growth within a geographic region, as well as the wait times within that same region. Better planning will be facilitated with combining that information. While there is a dearth of information on most services under the strategy, there is good information on cardiac surgery and other cardiac services.[24]

In response to questioning, Ministry staff said that while increasing volumes and capacity were important to the strategy, efficiency has been and will continue to be a major focus. A working group is actually looking at surgical process and diagnostic efficiency.

The Institute for Clinical Evaluative Sciences (ICES) has been asked to look at wait times, as well as the appropriateness and outcome of services. Its first task will be establishing a baseline of wait time data which was expected to be completed in the spring of 2005. Information on the appropriateness and outcome of services may be available next year.

Once the Ministry has a fully comprehensive wait time registry, its initial focus will be the strategy's five priority areas. (The system will have the capability to expand to other procedures in the future.) Doctors will then be able to give their patients a choice of wait times. This choice will depend on which facility is performing the procedure.

With time, the strategy will be able to provide a sense of what a reasonable wait time for a procedure should be. The Committee also learned that Ontario's wait time strategy was not as advanced as those in many other jurisdictions.[25]

Supplementary Information
The Institute for Clinical Evaluative Sciences (ICES) released a report identifying the volume and associated wait time for each element of the wait time strategy on April 6, 2005.[26]

Committee Recommendation

The Committee recommends that:

> **2. The Ministry of Health and Long-Term Care provide the Committee with an update on and the expected completion date of the work of the wait time strategy as it relates to services provided under the *Independent Health Facilities Act*. Reference should be made to the work of the Institute for Clinical Evaluative Sciences.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

4.4 Service Planning

No evidence was found to indicate that the Ministry had established a process or criteria for assessing whether a particular service should be provided in hospitals or in licensed facilities. For certain surgical procedures, such an assessment may indicate that providing the procedure at licensed facilities would enable hospitals to address other needs that can only be met in a hospital. The assessment could vary among regions due to factors such as hospital capacity and the availability of trained medical practitioners.[27]

The Auditor recommended that the Ministry implement a process for determining whether particular services should be provided by hospitals or by licensed IHFs.[28]

Committee Hearings

The introduction of any service, either in a hospital or in an IHF, should consider the best mechanism for delivering the service for the benefit of the patient. Senior officials at the Ministry assess the best possible options and venues for providing patient care and optimizing available human and financial resources.

The process for the creation of new IHFs requires the Minister to authorize the issuance of an RFP. In deciding whether to issue an RFP, the Minister must consider the items set out in s. 5 of the *IHFA*, including current and future need. Consideration must also be given to the extent to which the service is already available, and the projected cost and availability of public funds.

The IHF program includes an assessment and rationale for establishing an IHF-based service, as opposed to a hospital-based service, as part of that material for the Minister's consideration. This generally includes a cost comparison and an assessment of the complexity of the service. It also includes quality assurance issues associated with providing the service in a non-hospital setting.[29]

The RFP process is more or less the same as set out in the *IHFA* at proclamation in 1990. It has been used in a few instances (e.g., dialysis proposals and MRIs/CTs). The process was the same in each case in terms of following government procurement guidelines and a competitive process. The *Savings and Restructuring Act, 1996* amended the *IHFA* to allow for directed RFPs to enable the Minister to request a proposal from a specific facility. It has been used in two instances - 1999 and the fall of 2004.[30]

Committee members were reminded that IHF licences are also provided through a change in the Schedule of Benefits which brings services under the *IHFA*. This is what was done in the case of sleep studies.[31] (Sleep studies are discussed in section 7 of this report.)

Committee Recommendation

The Committee recommends that:

> **3. The Ministry of Health and Long-Term Care report to the Committee on the criteria used to determine whether a service should be provided in a hospital or in an independent health facility.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

5. ASSESSMENTS AND INSPECTIONS

To ensure that appropriate standards are met, the *IHFA* provides for assessments of the quality of services provided by licensed facilities. The College of Physicians and Surgeons (the College) is responsible for conducting these assessments, and develops and publishes clinical parameters and facility standards. Assessments determine facility compliance with the parameters and standards. In 2003/04, the Ministry paid the College $1.3 million to conduct assessments, and to develop and publish parameters and standards.

In addition to the assessors, the Ministry and the College may appoint inspectors. Ministry inspectors may inspect a facility to ensure that it complies with the *IHFA*'s provisions and regulations, and licence terms and conditions. Inspectors may be appointed by the College to inspect a facility prior to its being licensed. Inspections may also be conducted when the Director of Independent Health Facilities (the Director) has reasonable grounds to believe that unlicensed facilities are charging a facility fee for insured services.

The Ministry's expectations of the College regarding the assessment process were last delineated in a 1992/93 memorandum of understanding (MOU).[32]

5.1 The Assessment Process

Facilities to be assessed are selected by the Ministry at the beginning of each fiscal year. Selection is based on various risk factors. The 1996 audit report noted that assessments had not been performed on two-thirds of licensed facilities and that only 47 of the 336 facilities whose licences had been renewed had been assessed. The current audit noted that over 85% of facilities were being assessed at least once within the five-year period of a licence.

When the *IHFA* was amended in 1996, it permitted unannounced assessments. As of March 2004, no unannounced assessments had been conducted. To help provide assurance that IHF services comply with clinical practice parameters and facility standards, the Auditor felt some assessments should be performed without advance notice.

After the College completes its assessment, a report is forwarded to the Director. The Director reviews the report and may request additional information or authorize College representatives to obtain a plan of corrective action from the facility. Where an assessment has identified a risk to patient health and safety, the Director may suspend the licence or restrict the services that can be provided. When the facility has demonstrated that problems resulting in the suspension have been fixed and recommendations have been implemented, the College informs the Director, who may then reinstate the licence or remove restrictions on the services that can be provided.[33]

5.2 Time Frames for Submitting Assessment Information

The Ministry has not established time frames for the College's forwarding of completed assessment reports to the Director. The 1996 report recommended that the Ministry establish time frames. The Ministry agreed.

There were also no time frames with respect to taking corrective action when a facility has been assessed to be non-compliant or deficient. The 1996 report noted that facility and College staff were required to meet within two months, or as soon as practicable, after the assessment to discuss the report. These meetings have been discontinued. Facilities now forward information to the College, which provides assurance that they have taken the necessary corrective action. There is no required time frame for forwarding this information.

The current audit reviewed assessment reports for facilities that had significant concerns, but were not suspended, between April 1, 2000 and March 31, 2003. It found that, in most cases, the College did not receive information on actions taken until four to six months after the assessment. While the Ministry indicated that such a time frame was reasonable, audit staff could not determine the basis for this conclusion.[34]

To help improve the effectiveness of the assessment process, the Auditor recommended the establishment of time frames for the submission of assessment reports by the College to the Director, and the forwarding of information from

IHFs to the College that provides assurance that any required corrective action has been taken on a timely basis. He also recommended that the Ministry regularly update its agreement with the College in a signed MOU.[35]

Committee Hearings

Updating Agreement with College in MOU

Work on implementing this recommendation is in progress. The need for the MOU was discussed with the College at a December 2004 meeting. However, significant discussion is required to resolve issues on program objectives, scope of activities and deliverables. Nonetheless, the MOU is to be developed and implemented in 2005/06.[36]

When asked if another body could be made responsible for conducting assessments, Ministry staff replied that the *IHFA* specifies that the College is to do them. Any change would require a legislative amendment.[37]

Unannounced Assessments

The Ministry has initiated discussion with the College and hopes that together they will develop policies and procedures defining the circumstances under which unannounced assessments will be conducted. Work is expected to be completed by this year or next. Policy will be implemented upon receipt of the necessary approvals.[38]

Because unannounced inspections have been allowed since 1996 and since none had been conducted as of March 2004, Ministry staff were asked to explain this significant lack of activity. The Committee was told of concerns about teams of professionals travelling some distance only to find a facility closed or without scheduled patients. Facilities licensed for multiple modalities might not be able to provide a complete picture of their operations if assessments were conducted on an unannounced basis.

However, major roadblocks seem to have been the need to develop a process for conducting an unannounced assessment and to provide appropriate training, over and above the standard training program supplied by the College.[39]

Supplementary Information

According to correspondence from the Ministry following the hearings, a proposal for implementing a process for unannounced assessments of IHFs had been finalized in March 2005. The proposal calls for targeting unannounced assessments on a subset of the assessment plan. It would see approximately 50 of the 200 assessments in 2005/06 conducted without prior notice.

The proposal was sent to the College in April 2005. A meeting of the Coordinating Committee of the IHF Program will be scheduled to discuss implementation issues and develop implementation timelines. When implementation issues and costs are resolved, the proposal will go to Ministry

senior management for approval. A process for unannounced assessments is expected to be implemented in 2005/06.[40]

Time Frames for Submitting Reports

Work on establishing time frames is in progress, with an expected completion date of this year or early next year. The College has committed to a turnaround time under a new process of within 10 business days of receipt of the report for facilities determined to be operating in a manner prejudicial to health and safety. The turnaround time will be 72 hours for immediate health and safety risks. This will allow the Ministry to respond in a more timely fashion.

Current letters to licensees say they must contact the College within 15 days of receiving the report, if recommendations are of an administrative nature only. For more serious concerns not requiring licensing action, the licensee is instructed to contact the College within 15 days and submit a written plan addressing the recommendations within 30 days of receipt of the report.[41]

Committee Recommendations

The Committee recommends that:

4. The Ministry of Health and Long-Term Care ensure that a process for conducting approximately 50 of 200 assessments without prior notice is implemented in 2005/06.

5. The Ministry of Health and Long-Term Care report to the Committee on its progress in developing and implementing a Memorandum of Understanding (MOU) with the College of Physicians and Surgeons of Ontario establishing protocols for

(i) conducting unannounced assessments; and
(ii) providing the appropriate training to staff carrying out those assessments.

The Committee requests that the Ministry provide the Committee Clerk with a written response to these recommendations within 120 days of the tabling of this report in the Legislature.

5.3 Licence Suspensions and Reassessments

Under the *IHFA*, the Director may immediately suspend a licence when there are reasonable grounds to believe that the facility poses a threat to a person's health or safety. Generally, such action is based on the results of an assessment report from the College. As previously discussed, there are no time frames for when the Director is to receive assessment reports once the assessment has been completed. The current audit found that, where assessments led to a licence suspension or the removal of services from the licence, an average of approximately three months

had elapsed from the date of initial assessment to the date of suspension or service removal.

The 1996 report noted that the Ministry had no documented policies on following up on or reassessing facilities with unfavourable assessments. In over 60% of the reassessments, significant problems continued to exist. The current audit noted that for about 20% of the reassessments conducted since April 1, 2000, significant problems continued to be identified. Despite the reduction in the persistence of significant problems, the Ministry still did not have a formal policy on the appropriate action to be taken where facilities continued to have quality assurance issues. Such actions could include revoking a licence.

Since 1996, the *IHFA* has permitted the Minister to make regulations prescribing circumstances under which facility owners would be required to pay for an assessment. This would enable the Ministry to charge for reassessments due to problems noted in the initial assessment. At the time of the current audit, facility owners were still not required to pay for reassessments.

The current audit also noted that the Ministry does not publicize quality assurance issues. Although facilities whose licences have been suspended or restricted due to quality assurance problems cannot bill for facility fees during suspension or restriction, potential patients and referring physicians may not be aware of these issues.

The Auditor recommended that the Ministry have a formal policy on suspending facilities with serious quality assurance issues, especially when the same issues arise on reassessment, and consider charging facilities for reassessments. He also suggested consideration should be given to appropriate public disclosure of serious quality assurance problems at IHFs.[42]

Committee Hearings

Development of Formal Policy and Charging Fees

The Ministry will develop a policy establishing circumstances under which licensing action will be taken for repeat quality assurance problems where the deficiency does not constitute a health and safety risk or an immediate threat. It also supports consideration of charges for reassessments. It will develop an options paper setting out the process for implementing this change, and the advantages and disadvantages of charging licensees costs for reassessments. Work on these issues is in progress with an expected completion date in 2005/06.[43]

IHFs are assessed once during their five-year licence term. Approximately 200 assessments are conducted each year. Implementing charges for reassessments would require a regulation change under the *IHFA* and involve six to 10 facilities a year. While they would be an incentive to operators to take corrective action, charges would require a certain amount of administrative work (i.e., preparing a proposal, going through the regulatory process, implementation) for a fairly small return.[44]

Disclosure of Quality Assurance Problems

The Ministry will develop an options paper on this matter. A number of issues need to be considered in the development of a system for public disclosure. They include the retention period for information, the posting of proposed suspensions while under appeal, the impact of changes in ownership, and timing for the posting of information. Work is in progress and is expected to be completed this year or in early 2006.[45]

The Ministry routinely suspends around 10 to 15 licences each year. In the last year, all suspended facilities took corrective action and have been reinstated. Because this information is not publicly reported, Ministry staff were asked if it would be available through a freedom of information (FOI) request. Committee members were told that an FOI case had gone to appeal.[46]

Supplementary Information

Following the hearings, correspondence from the Ministry told the Committee that a request for disclosure of assessment reports involving serious deficiencies identified through IHF assessments was received under the *Freedom of Information and Protection of Privacy Act* (*FIPPA*) in February 2002. The Ministry was of the opinion that much of the information in the reports should be severed as it was corporate information covered under s. 17 of the *FIPPA*. It asked that affected third parties (licensees) be allowed input with respect to disclosure. The decision to disclose with severances was appealed by the requestor and 20 affected parties.

In February 2003, the Information and Privacy Commissioner issued a notice of inquiry related to the disclosure. The Commissioner ruled in October 2003 that s. 17 of the *FIPPA* did not apply; there was no evidence of harm associated with the disclosure. The assessment reports were ruled releasable, subject to minor severances of personal information.

The Ministry said the Commissioner's decision clarified the disclosure of information related to problem assessments. It also eliminates the *FIPPA* issue respecting the Auditor's recommendation.[47]

Committee Recommendation

The Committee recommends that:

> **6. The Ministry of Health and Long-Term Care disclose suspensions related to quality assurance problems in a timely manner and report to the Committee on how it will implement this recommendation.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

5.4 Assessment Methodology

Assessors receive and analyse information relating to patient care maintained by facilities. The methodology for selecting samples of records to be reviewed has been delegated to the College. It provides assessors with guidelines for performing the assessment. The 1996 report recommended that the Ministry ensure that guidelines consider the time period covered, the volume of services provided, and the number of specialities practised. It also recommended that assessors who do not follow the guidelines document their justification. The Ministry agreed and indicated that it would request that the College review and refine its sampling guidelines.

During the current audit, Ministry staff reported that the policy for sample selection is a review of a minimum of 10 services per specialty. Audit staff reviewed a sample of completed reports. In some cases assessors did not select 10 items from each speciality and did not document the reasons for not completing the minimum sample. Some assessors had facility staff select file samples.[48]

The Auditor recommended that the Ministry work with the College to ensure that the sample of services to be assessed is sufficient to reach a conclusion and is selected from a complete listing of all services rendered to patients, and the sample is selected independently by the College or by the Ministry.[49]

Committee Hearings

The Ministry will discuss the Auditor's recommendation with the College. Requirements for the review of files and sample selection will be included in the MOU with the College. Work is in progress, with an expected completion date of 2005 or 2006. The matter was discussed with the College at a December 2004 meeting. Requirements for sample size and selection process were scheduled for discussion at a February 2005 meeting.[50]

Committee Recommendation

The Committee recommends that:

> **7. The Ministry of Health and Long-Term Care ensure the Memorandum of Understanding (MOU) currently being negotiated with the College of Physicians and Surgeons of Ontario includes criteria addressing the review of files and the sample of services to be assessed.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

5.5 Clarity of Assessment Conclusion

The *IHFA* requires that facilities' services conform to generally accepted quality standards. The 1996 report recommended that the Ministry work with the College

to ensure assessment reports contain clear conclusions on whether clinical practice parameters and facility standards have been met. The Ministry agreed and said it was working with the College "to help improve the quality and content of the reports." During the current audit, audit staff found that the College's reports and other communications still did not consistently state whether parameters and standards had been met. Where it is unclear whether standards have been met, the Ministry needs to obtain clarification from the College, which contributes to the delays in the Ministry acting on reports.

In September 2003, the Ministry established a Facility Review Panel to provide additional support to the Director in making enforcement decisions. The panel was to advise as to whether the concerns identified by assessors reflected a failure to meet minimum standards of practice and to clarify the seriousness of any deficiencies. However, the Auditor noted that the conclusion of the audit was still too early to assess the success of this initiative.[51]

5.6 Assessment Tracking Systems

The Ministry maintains an assessment database containing information on the types of services provided by a facility, its status (active or suspended), and any dates on which action was taken with regard to problems at a facility.

The 1996 report recommended verifying data integrity, reviewing the feasibility of filing assessment information by licence number, and developing a system for tracking the completion of assessments. The current audit noted that activity was being tracked by licence number and that efforts had been made to increase data integrity. However, some data entry errors still needed to be corrected and the Ministry was not using the database to monitor the timeliness of the process. In addition, the database was not ideally structured for monitoring overall timeliness. Because reassessments and assessments are not linked, it is not easy to determine the time that has elapsed from the date of the first assessment to when significant assessment concerns have been resolved.[52]

The Auditor recommended that the Ministry ensure that its management information system is structured to link all data relating to a specific facility.

In its initial response, the Ministry said the current management information system met the IHF program's need for data with respect to tracking quality assurance assessments under the *IHFA*. Proposed changes would enhance the reporting capability of the system. At the same time, the Ministry had to balance the value of the enhancements against available resources to program and implement the changes. Other systems projects took priority over proposed changes to the quality assurance management information system which would be implemented if/when resources were available.[53]

6. UNLICENSED TECHNICAL SERVICES

The 1996 audit report noted that when the *IHFA* was introduced, many OHIP insured services that had a technical component were not covered by this legislation. The Schedule of Benefits contained 65 technical procedures that were not included under the *IHFA*. The 1996 report recommended the development of criteria for determining which of these services and procedures should be licensed. In its response, the Ministry noted that the number that could be covered was so substantial that a rigorous process would be required to prioritize areas for expanded coverage.

In 1997, a joint committee of the Ministry and the College developed criteria for expanding coverage to other services provided outside of hospitals. Criteria included quality assurance and utilization.[54] As a result of applying the utilization criteria, the *IHFA* was extended in 1998 to include sleep studies. However, while the joint committee recommended evaluating other procedures for inclusion under the *IHFA*, audit staff understood that no further evaluations had been conducted.

Studies and reports have reinforced the importance of the quality assurance process for technical services. For instance, in a 2000 report, a joint committee of the Ministry, the OHA and the OMA noted that the *IHFA*'s requirement for quality assurance was more comprehensive than any comparable requirements. That report also noted that the lack of an external quality assurance program for technical services provided in physicians' offices and medical clinics made the offices and clinics vulnerable to criticism for having inconsistent standards and quality. In a 2002 report, the OMA noted that the quality management program for IHFs was widely regarded as a major asset and that the challenge is to have a quality management system for technical diagnostic services that works across all sectors.

When a service that is not covered under the *IHFA* is performed outside a public hospital, the service is not subject to the *IHFA*'s quality assurance process. Under the *Health Insurance Act*, facilities performing these procedures are paid a technical fee.

Other procedures (e.g., allergy testing, colonoscopies) may be performed outside hospitals without requiring that the facility be licensed, but only the professional component of these procedures is paid for. In 2000/01, 19,260 colonscopies, approximately 12% of all such procedures, were performed outside of public hospitals. Since these procedures are not covered by the *IHFA*, they were not subject to its quality assurance provisions.

Audit staff found no indication that the Ministry had analyzed whether any additional services being performed outside of hospitals and licensed facilities should be licensed under the *IHFA* and subject to its quality assurance process, since 1987.[55]

The Auditor recommended that the Ministry assess which diagnostic and surgical services performed outside of hospitals and licensed IHFs should be covered by the *IHFA*.[56]

Committee Hearings

Any decision to expand the IHF program must balance the cost of implementing a licensing and quality assurance program against the need for enhanced quality assurance of services performed in community-based settings, and planning and utilization controls on the service achieved through the IHF licensing scheme.

The Ministry developed criteria in 1997 to evaluate proposals for expansion of the *IHFA*. These criteria were used to regulate sleep medicine facilities and led to their licensing through changes to the Schedule of Benefits in 1998. They should continue to be used to evaluate any proposals for expansion of the *IHFA*. Evaluation of proposals for new and/or expanded services will be conducted on a case-by-case basis.[57]

Committee Recommendation

The Committee recommends that:

> **8. The Ministry of Health and Long-Term Care report to the Committee on the number of requests to increase licensed independent health facilities services received in 2004/05 and the types of services involved.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

7. SLEEP STUDIES

Most sleep studies are overnight procedures where a patient is observed and monitored continuously for factors like oxygen saturation and sleep staging. The 1996 audit report noted that technical fees paid to facilities performing these procedures, which did not then require a licence, had increased by 135% over a four-year period. Sleep study clinics are now covered by the *IHFA*. The Physician Services Committee recommended that they be added primarily to limit the number of facilities permitted to bill for performing these services. In 1998, approximately 70 clinics came under the *IHFA* and were allowed to operate while their licences were pending. Between 1998/99 and 2002/03, sleep study technical-fee billings increased from $14.9 million to $23.4 million, a 57% increase.

Before a facility can become licensed, the College must perform a pre-licensing inspection. Facilities may continue to operate until the Ministry licenses them. If the College identifies serious quality assurance problems, the Director can prohibit the operator from billing for technical fees. The latter action would generally be taken only if an operator refuses to correct identified deficiencies.

Audit staff noted that quality concerns raised in many pre-licensing inspections required more than one inspection to resolve. On average, it took 16 months from the initial inspection to license a clinic. At the end of the audit fieldwork, 18 of the sleep study clinics in operation still had not been licensed because they had not yet rectified deficiencies or had not yet been inspected.

To ensure that quality standards are met, the Auditor recommended that all facilities be inspected on a timely basis. He also recommended that the Ministry follow up on problems identified on a timely basis to verify that corrective action has been taken.[58]

Committee Hearings

To ensure that any future grandfathering situation is resolved in a timely manner, the Ministry recognizes the need to ensure that sufficient dedicated resources, both within the IHF program and the College, are assigned to the inspection and licensing processes. Ministry staff reported that they had commenced working on the Auditor's recommendation.[59]

8. OTHER MATTER

8.1 Magnetic Resonance Imaging

Magnetic resonance imaging (MRI) produces high quality images of body structures. These images can be an extremely effective method of detecting such things as brain abnormalities, tumours or aneurysms. They can often provide critical information before surgery.

The government announced the expansion of diagnostic services to include MRI services in the summer of 2003. Access had previously been available in hospitals only. MRI services provided at IHFs would be less expensive than those in hospitals, but would be subject to *IHFA* provisions.

After evaluating submitted bids, the Ministry selected operators to provide services at five locations licensed between July and September 2003. Unlike other diagnostic services, funding for MRI services was limited to the amount of the bid price. It was also contingent on the provision of minimum levels of insured services.

Like other IHFs, operators can receive income for those services not covered by OHIP. However, contracts with MRI facilities limit the extent to which uninsured services can be performed. Facilities are also required to report on the volume of uninsured services provided.

At the conclusion of the audit, the Auditor's staff were told that the government was reviewing these facilities and other options for providing MRI services.

Developments Following the Audit

In July 2004, the press reported that the province was preparing to buy seven private MRI and computer tomography (CT) clinics. A spokesperson for the Premier confirmed that negotiations were taking place.[60]

Three for-profit MRI clinics in Kitchener, Kingston and Richmond Hill were "repatriated" by late September 2004. Early in October, a Ministry of Health and Long-Term Care spokesperson said the three facilities were operated by private non-profit corporations.[61]

Committee Hearings

The previous government issued an RFP in the fall of 2002 for seven MRI/CT services and clinics. The current government then proceeded with a conversion process for those clinics. The Committee heard that four clinics in four centres were now non-profits. Discussions and negotiations regarding the conversion of three remaining clinics were ongoing.

Ministry staff were asked to describe the process behind the 2002 RFP. Under the *IHFA*, the Minister can direct the Director to issue a competitive RFP. In this instance, as in others, the Minister was provided with information on present and future service needs, and the availability of funds.

Based upon that information, the RFP was directed at specific geographic areas. It followed the normal procurement processes: bidders' meetings and answers to written questions. These were followed by a formal evaluation process which resulted in the awarding of the licences to the contractors and operators. There was one area where an award was not made, Brantford, because the results of the proposal request indicated that it would be more cost-efficient to provide the services in a hospital than in an IHF. In that case, the Minister decided to cancel the RFP.[62]

9. COMMITTEE RECOMMENDATIONS

The Committee requests that the Ministry provide the Committee Clerk with a written response to these recommendations within 120 days of the tabling of this report in the Legislature.

1. The Ministry of Health and Long-Term Care report to the Committee on establishing target dates for the completion of the negotiation of facility or technical fees, particularly high volume medical services. The Committee would expect this to be done by June 30, 2006.

2. The Ministry of Health and Long-Term Care provide the Committee with an update on and the expected completion date of the work of the wait time strategy as it relates to services provided under the *Independent Health Facilities Act*. Reference should be made to the work of the Institute for Clinical Evaluative Sciences.

3. The Ministry of Health and Long-Term Care report to the Committee on the criteria used to determine whether a service should be provided in a hospital or in an independent health facility.

4. The Ministry of Health and Long-Term Care ensure that a process for conducting approximately 50 of 200 assessments without prior notice is implemented in 2005/06.

5. The Ministry of Health and Long-Term Care report to the Committee on its progress in developing and implementing a Memorandum of Understanding (MOU) with the College of Physicians and Surgeons of Ontario establishing protocols for

(i) conducting unannounced assessments; and
(ii) providing the appropriate training to staff carrying out those assessments.

6. The Ministry of Health and Long-Term Care disclose suspensions related to quality assurance problems in a timely manner and report to the Committee on how it will implement this recommendation.

7. The Ministry of Health and Long-Term Care ensure the Memorandum of Understanding (MOU) currently being negotiated with the College of Physicians and Surgeons of Ontario includes criteria addressing the review of files and the sample of services to be assessed.

8. The Ministry of Health and Long-Term Care report to the Committee on the number of requests to increase licensed independent health facilities services received in 2004/05 and the types of services involved.

NOTES

[1] Ontario, Office of the Provincial Auditor, *2004 Annual Report* (Toronto: The Office, 2004), p. 215; and Ontario, Legislative Assembly, Standing Committee on Public Accounts, *Official Report of Debates (Hansard)* (24 February 2005): P291.
[2] Office of the Provincial Auditor, *2004 Annual Report*, pp. 216-217.
[3] Ibid., p. 217.
[4] The Schedule of Facility Fees is part of the Schedule of Benefits.
[5] Office of the Provincial Auditor, *2004 Annual Report*, pp. 218-219.
[6] Ibid., p. 219.
[7] Standing Committee on Public Accounts, *Official Report of Debates*, p. P295.
[8] Ibid., pp. P291-P292.
[9] Ibid., pp. P295 and P304.
[10] Letter from Deputy Minister, Ministry of Health and Long-Term Care, Toronto, to Clerk, Standing Committee on Public Accounts, 19 May 2005.
[11] Ontario, Ministry of Health and Long-Term Care, "McGuinty government transforming health care to better meet patient needs," *Canada NewsWire*, 9 September 2004.
[12] Mary Gordon, "Ottawa 'developing' health bill," *Toronto Star*, 24 September 2004, p. A6.
[13] Office of the Provincial Auditor, *2004 Annual Report*, pp. 219-221.
[14] Ibid., pp. 221-222.
[15] Ibid., p. 222.
[16] Standing Committee on Public Accounts, *Official Report of Debates*, p. P292.
[17] Ibid., p. P292.
[18] Ibid., p. P298.
[19] Rob Ferguson, "Plans under way to open cataract surgery clinic," *Toronto Star*, 8 April 2005, p. A13.
[20] Standing Committee on Public Accounts, *Official Report of Debates,* p. P292.
[21] Office of the Provincial Auditor, *2004 Annual Report*, pp. 223-224.
[22] Ibid., p. 224.
[23] Standing Committee on Public Accounts, *Official Report of Debates,* p. P292.
[24] Ibid., p. P299.
[25] Ibid., pp. P300-P301.
[26] Ontario, Ministry of Health and Long-Term Care, "ICES landmark report identifies how long Ontarians are waiting for key health services," *Canada NewsWire*, 6 April 2005.
[27] Office of the Provincial Auditor, *2004 Annual Report*, p. 225.
[28] Ibid., p. 225.
[29] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P292–P293.
[30] Ibid., pp. P299-P300.
[31] Ibid., p. P300.
[32] Office of the Provincial Auditor, *2004 Annual Report*, p. 226.
[33] Ibid., pp. 226-227.
[34] Ibid., p. 227.
[35] Ibid., pp. 227-228.
[36] Standing Committee on Public Accounts, *Official Report of Debates*, p. P293.
[37] Ibid., p. P301.
[38] Ibid., p. P293.
[39] Ibid., pp. P302 and P304-P305.
[40] Letter from Deputy Minister, Ministry of Health and Long-Term Care, Toronto, to Clerk, Standing Committee on Public Accounts, 19 May 2005.
[41] Ibid., p. P293; and Office of the Provincial Auditor, *2004 Annual Report*, p. 228.
[42] Office of the Provincial Auditor, *2004 Annual Report*, p. 230.
[43] Standing Committee on Public Accounts, *Official Report of Debates*, p. P293.
[44] Ibid., p. P302.
[45] Ibid., p. P293.
[46] Ibid., p. P299.

[47] Letter from Deputy Minister, Ministry of Health and Long-Term Care, Toronto, to Clerk, Standing Committee on Public Accounts, 19 May 2005.
[48] Office of the Provincial Auditor, *2004 Annual Report*, p. 231.
[49] Ibid.
[50] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P293–P294.
[51] Office of the Provincial Auditor, *2004 Annual Report*, p. 232.
[52] Ibid.
[53] Ibid, p. 233.
[54] The Standing Committee on Public Accounts recommended the use of these criteria in the expansion of licensed technical services and procedures in its *Annual Report 1996-1997*.
[55] Office of the Provincial Auditor, *2004 Annual Report*, pp. 233-234.
[56] Ibid., p. 235.
[57] Standing Committee on Public Accounts, *Official Report of Debates*, p. P294.
[58] Office of the Provincial Auditor, *2004 Annual Report*, p. 236.
[59] Standing Committee on Public Accounts, *Official Report of Debates*, p. P294.
[60] Dennis Bueckert, "Province to buy private health clinics, make them public," *Globe and Mail*, 17 July 2004, p. A7.
[61] Ann Lukits, "Repatriation of MRIs just 'smoke and mirrors': Critic," *Kingston Whig-Standard*, 1 October 2004, p. 1.
[62] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P294-P295.