

3.08—Independent Health Facilities

BACKGROUND

Under the *Independent Health Facilities Act*, the Ministry of Health and Long-Term Care licenses and regulates approximately 1,000 independent health facilities (facilities) in Ontario. Most facilities are “diagnostic,” meaning that they perform services—such as x-rays, ultrasounds, nuclear medicine, pulmonary function studies, and sleep studies—that can be helpful in diagnosing various conditions. At the time of our audit there were also 24 facilities that provided surgical and therapeutic services such as dialysis, abortions, and cataract, vascular, and plastic surgeries. These facilities function in a manner similar to hospital outpatient clinics. The majority of services performed at facilities result from a referral by a physician who has conducted a medical examination of a patient. The facility performs the requested tests and forwards the results to the requesting physician.

The technical fees to be paid to facilities that are licensed under the *Independent Health Facilities Act* are established under the *Health Insurance Act*. The technical fees, also known as “facility fees,” cover the costs of providing services, such as the cost of medical equipment and administrative and occupancy costs. For the 2003/04 fiscal year, technical fee payments to diagnostic facilities and facilities providing surgical and therapeutic services totalled approximately \$257 million and \$16 million, respectively. The total payments are broken down by type of service in the following table.

Technical Fees Paid to Independent Health Facilities, 1999/2000–2003/04
(\$ 000)

Service Provided	1999/00	2000/01	2001/02	2002/03	2003/04
Diagnostic Facilities					
radiology	96,215	96,339	98,303	102,678	106,140
ultrasound	68,941	73,717	79,011	88,730	96,202
nuclear medicine	17,310	18,813	20,513	24,369	29,287
sleep studies	16,911	20,270	25,058	23,449	21,296
pulmonary function	2,229	2,043	1,934	1,978	1,924
MRI/CT*	—	—	—	—	2,282
	201,606	211,182	224,819	241,204	257,131
Surgical/Therapeutic Facilities					
dialysis	7,120	7,305	8,226	8,209	8,154
abortions	4,838	5,093	5,961	6,025	5,341
vascular surgery	803	798	1,111	967	729
plastic surgery	772	718	731	796	898
ophthalmology	458	450	438	434	855
laser surgery	359	359	359	359	359
	14,350	14,723	16,826	16,790	16,336

*First introduced in 2003/04.

Source of data: Ministry of Health and Long-Term Care

The mandate of the Independent Health Facilities program is to: provide a funding mechanism for needed community-based services; ensure patients receive quality health care in independent health facilities; facilitate the establishment of such facilities; and ensure patients are not charged for services covered by the Ontario Health Insurance Plan (OHIP).

AUDIT OBJECTIVES AND SCOPE

The objectives of our audit of the Independent Health Facilities program were to assess whether the Ministry had adequate procedures in place to ensure that:

- the Ministry and the facilities licensed under the *Independent Health Facilities Act* 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.

In conducting our audit, we reviewed relevant documentation and the Ministry's administrative policies and procedures, interviewed ministry staff, researched similar programs in other jurisdictions, and updated the current status of recommendations made in our 1996 audit of the Program. We also obtained additional information from the College of Physicians and Surgeons of Ontario and some of their assessors with regard to the quality assurance process.

Our audit was substantially completed in March 2004 and was conducted in accordance with the standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants and accordingly included such tests and other procedures as we considered necessary in the circumstances. The criteria used to conclude on our audit objectives were discussed with and agreed to by ministry management.

The Ministry's Internal Audit Service had not conducted any recent work on the Independent Health Facilities Program. Accordingly, we could not reduce the scope of our work by relying on its work.

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 independent health facilities. However, if the program is to cost-effectively fulfill its mandate, action is still required to address the following issues, a number of which we had identified in our last audit in 1996:

- The Ministry had still not assessed the relationship between the volume of services provided by individual facilities and the cost of providing services to determine whether the facility fees paid to independent health facilities were reasonable.
- The Ministry had not determined the levels of service that would be required and should be available to meet needs.
- The Ministry had not adequately analyzed the impact nor developed strategies to address the significant regional variations in service levels.
- Although funding to develop a waiting list management system began to be provided in 2000, the program still did not have waiting list information for diagnostic or surgical/therapeutic services.
- The Ministry did not have a process for determining which services should be provided by independent health facilities rather than by hospitals.
- The Ministry had not established time frames for the submission of facility assessment reports by the College of Physicians and Surgeons of Ontario to enable the Ministry to take timely and appropriate action based on assessment results.
- The Ministry had not yet implemented a process to determine which other services provided outside of hospitals and licensed independent health facilities, such as echocardiograms, should be covered by the *Independent Health Facilities Act* to ensure that these services are subject to an appropriate quality assurance process.

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- While 70 sleep study clinics have been allowed to operate since 1998, 18 of them were still not licensed because they had either not yet been inspected or inspections had found that they were not meeting minimum quality standards.

DETAILED AUDIT OBSERVATIONS

REASONABLENESS OF FACILITY FEES

All diagnostic services offered at independent health facilities are divided into a professional component and a technical component. The physicians performing the services bill the Ministry for the professional component on a fee-for-service basis. This is done through the Ontario Health Insurance Plan in accordance with the Schedule of Benefits under the *Health Insurance Act*.

For most diagnostic facilities, the fees for the technical component (also known as “facility fees”) are listed in the Schedule of Facility Fees for Independent Health Facilities and are also claimed on a fee-for-service basis. The technical component is intended to cover the costs associated with operating the facility, including the cost of premises, equipment, supplies, and personnel used to perform procedures. These fees are not adjusted to address factors that can have an impact on costs, such as the volume of services rendered annually. In contrast, technical fees for facilities offering surgical and therapeutic services and MRIs are funded through negotiated budgets with the Ministry that are based on the actual costs of providing a certain volume of service.

In our *1996 Annual Report*, we recommended that the Ministry assess the reasonableness of facility fees by studying the relationship between the volume of services provided and the costs of providing those services. The Ministry agreed and reported that its staff had been “working to develop 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, which included representatives from the Ministry, the Ontario Medical Association (OMA), and the Ontario Hospital Association, noted that “cost reimbursement should be used as the underlying principle for the funding of technical components of diagnostic services” and that historically, most of the fees had not been set through a rigorous costing process. The Committee also noted that there was a lack of information on the extent to which current fees deviate from real costs, that the fee schedule should be reviewed as soon as possible, and that an appropriate costing methodology would ideally incorporate factors such as economies of scale. The Committee suspected that with the introduction of new technology and equipment, some fees for existing services do not accurately reflect true current costs.

In April 2003, the OMA and the Ministry agreed to form a development team to establish a Diagnostic Services Committee to function as an advisory body to the

Ministry. The committee's responsibilities were to include developing and setting up the process for evaluating and administering technical fees. However, as of April 2004, this committee had not yet been formed.

Recommendation

To help ensure that facility fees paid to independent health facilities are reasonable, the Ministry should:

- **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.**

Ministry Response

In order to address the issue of facility and technical fees, the Ministry of Health and Long-Term Care agreed as part of the 2003 Memorandum of Agreement with the Ontario Medical Association to establish the Diagnostic Services Committee (DSC). The DSC will function as an advisory body to the Minister of Health and Long-Term Care for the purpose of planning and co-ordinating an efficient and effective diagnostic services system in the province of Ontario with accountability among users and providers of diagnostic services. It is also charged with examining how the technical component of diagnostic services (currently described as technical fees) will be evaluated, compensated, and administered, including establishing a costing methodology and an ongoing review process to reflect that reimbursement is based on actual costs and current service volumes.

DISTRIBUTION OF SERVICES

The Act allows the Ministry to license new independent health facilities through a request-for-proposal process after considering the nature of the services to be provided, the extent to which the services are already available, the current and future need for services, the projected cost, and the availability of funding. The Ministry has indicated over a number of years that it is committed to a publicly funded, universally accessible health care system that provides services to all the people of Ontario where they need them and when they need them.

Diagnostic Services

Since 1990, despite a number of expressions of interest for licences, a minimal number of additional facilities have been licensed under the Act to provide the diagnostic services that were originally licensed under the Act. However, since our last audit in 1996, the Ministry has permitted already-existing licensed facilities to increase the types

of services they perform if the facilities are located in a region of the province that is considered to be under-serviced. The Ministry considers a region to be under-serviced if total provided services of a particular type, including services provided in hospitals, are less than 50% of the average number of services provided per capita throughout the province.

In a 2002 report, the Ontario Medical Association (OMA) recommended that the Ministry, the OMA, and the hospital sector establish a Technical Diagnostic Services Management Committee to recommend to the Ministry province-wide, population-based planning methodology and guidelines to determine the capacity, distribution, and choice of appropriate diagnostic services. The proposed methodology was to incorporate criteria relating to: the needs of the population (taking into account factors such as disease prevalence, ease of access, age of the population, and referral patterns); 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:

- be responsible for recommending to the Ministry:
 - strategies to address diagnostic service priorities; and
 - gaps identified through the application of an approved provincial planning framework for diagnostic technology;
- review requests to introduce new services or expand existing capacity; and
- make recommendations with respect to introducing/expanding services.

We understand that while the Ministry supported establishing such a committee, to date, none has been established. We noted that the province of British Columbia has established an Advisory Committee on Diagnostic Services that reviews applications for new diagnostic facilities.

Ministry-prepared data indicated significant regional variations in the availability of services. For example, in the 2002/03 fiscal year:

- For the 62 municipalities with populations greater than 25,000, nine municipalities were under-serviced—according to the Ministry’s criteria of providing less than 50% of the average number of services provided per capita throughout the province—in all four of the main diagnostic specialties (radiology, ultrasound, pulmonary function studies, and nuclear medicine), and another four municipalities were under-serviced in three specialties.
- For the 39 municipalities with populations over 50,000, diagnostic ultrasound services provided varied significantly and ranged from 81 to 659 per 1,000 people.

We found no indication that the Ministry had analyzed these differences to determine whether any action was needed to address the Ministry’s commitment to providing universal access where and when services are needed.

Notwithstanding the conditions placed on increasing the *types* of diagnostic services performed, there is no limitation on the *volume* of licensed services that an individual diagnostic facility can provide. From the 1996/97 to the 2002/03 fiscal year, there had been significant increases in the utilization of certain diagnostic procedures. For example, based on our analysis of ministry data, the facility fee claims for one ultrasound technical fee procedure showed that utilization had increased from approximately 72,000 services to 159,000 services annually. At a number of facilities, utilization of this and other services had increased by over 100% and in some instances by as much as 700%. We found no indication that the Ministry had analyzed the reasons for such dramatic increases in the number of procedures at these facilities.

Surgical/Therapeutic Services

As previously noted, facilities offering licensed surgical and therapeutic services are funded through negotiated budgets, based primarily on the number of services that the Ministry will pay a facility to perform. The Ministry has noted that, with an aging population, there is increased demand for cataract surgery and dialysis services.

CATARACT REMOVAL SURGERIES

According to ministry data, the number of cataract surgeries performed in Ontario has steadily increased, from approximately 45,000 annually in the 1992/93 fiscal year to 97,000 in 2002/03. In 2000/01, the Ministry assessed the need for cataract removal surgeries and concluded that four regions of the province were under-serviced relative to the province as a whole. The Ministry also concluded that providing cataract surgeries in an independent health facility should be less expensive to the Ministry than providing them in a hospital. At the time of this year's audit, only one licensed facility, located in Toronto, was providing cataract surgery in Ontario. The majority of cataract surgeries in Ontario were being performed in hospitals. In 2003/04, with Management Board of Cabinet approval, the Ministry increased the number of cataract surgeries performed by the licensed facility from 300 to 1,300 annually. According to the Ministry, this brought the volume of services provided by this facility to 100% of its capacity.

Recent information on the need for cataract surgeries included the results of a September 2003 needs assessment performed by the Ministry that indicated that other regions in Ontario with large populations were providing significantly fewer cataract surgeries per capita than was Toronto—the region where the only licensed facility performing the surgeries is located. The Ministry also noted that in 2001/02, while the provincial average was 2,595 services provided per 100,000 people over 50 years of age, cataract surgeries actually provided in communities with populations over 100,000 ranged from 1,837 to 3,286 annually per 100,000 people. The Ministry estimated that an additional 9,000 annual cataract surgeries were required to address the annual increase in the number of individuals needing surgery and to address, over

the next five years, the 33,000 individuals already waiting for surgery. According to a 2003 Fraser Institute Study, Ontario's median patient waiting time between meeting with a specialist and cataract surgery was 19 weeks, as compared with: Ontario physicians' indication in the report of eight weeks as a reasonable waiting time; and waiting times of 7.5 and 12 weeks, respectively, in Alberta and British Columbia, which also provide cataract removal surgeries outside of hospitals.

OTHER SURGICAL/THERAPEUTIC SERVICES

Since our *1996 Annual Report*, the need for and availability of licensed surgical/therapeutic services other than cataract removal surgeries—such as abortions, vascular surgeries, and dialysis—has not been determined. Neither have there been regular reviews of the level of service provided (that is, the number of services provided per unit of population) throughout the province.

With respect to abortions, at the time of our audit there were five licensed independent health facilities—located in two major cities in Ontario—that were providing 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.”

We noted from a recent document prepared by the Ministry that unlicensed facilities are also performing abortions, particularly in one area of the province. Since these facilities are not licensed under the *Independent Health Facilities Act*, they are not paid a facility fee for the services they provide. However, this also means that they are not subject to the same quality assurance process as licensed facilities. We question whether excluding these facilities from the quality assurance process meets the spirit and intent of the Act and the Independent Health Facilities Program with respect to quality assurance.

Recommendation

To help ensure that the services provided under the *Independent Health Facilities Act* are reasonably accessible to all Ontarians, the Ministry should:

- **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; and**
- **assess the implications—from a financial and waiting-list perspective—of licensing more than one independent health facility to provide cataract surgeries.**

The Ministry should also determine what legislative or other actions should be taken regarding unlicensed facilities that are performing surgical and other procedures that are generally performed in hospitals or licensed independent health facilities.

Ministry Response

The Diagnostic Services Committee (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 issues such as access in under-serviced 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.

The Ministry supports evaluating the impact of licensing additional cataract surgery centres under the Independent Health Facilities Act. The Ministry has conducted a needs assessment to identify areas of the province in greatest need for additional cataract surgery services and is in the process of seeking approval to issue request for proposals to establish additional cataract surgery facilities under the Act.

The structure of the Act is such that the definition of an independent health facility and the prohibitions and penalties associated with operating an unlicensed facility all hinge on the charging of a facility fee as defined in the legislation. Facilities that forego the charging of facility fees do not require licensing under the Act and are not subject to the quality assurance provisions of the Act.

The imposition of the quality assurance process established under the Act on facilities performing independent health facility-type services but not licensed under the Act would require significant amendments to the Act. The Ministry supports the consideration of this issue under a policy review of the Act and the inclusion of amendments, subject to policy approval, if/when the Act is open for amendment.

Waiting Lists

One method of determining whether access to services may need to be addressed is through maintaining and monitoring the waiting lists for those services. At the time of this year's audit, the Ministry did not have a waiting-list system to track and manage waiting times for any of the services that are licensed under the *Independent Health Facilities Act*. In 2000, the Ministry began providing funding to the Ontario Joint Policy and Planning Committee (JPPC) to undertake the Ontario Waiting List Project. This project was to develop an understanding of how to effectively manage waiting lists and improve access to health care services. As part of its mandate with respect to the project, 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 that were based on work begun by the Western Canada Wait List Project (WCWL), a collaborative undertaking by medical associations, ministries of health, regional health authorities, and health research centres involving British Columbia, Alberta, Manitoba, and Saskatchewan. The WCWL developed waiting list management tools in five clinical areas. While the tools were not specifically established for independent health facilities, the JPPC reviewed the waiting list tools for MRIs, general surgeries, and cataract surgeries (as noted earlier, the Ministry has estimated the number of individuals waiting for cataract surgeries). We understand that, as a result, recommendations were made to further develop and refine each of the tools. We noted that the province of Nova Scotia has also started a provincial wait time monitoring project.

As of May 2004, we were not aware of any further initiatives undertaken by the Ministry relating to the Ontario Waiting List Project or of other approaches to obtain information on the waiting time for services provided by independent health facilities.

Recommendation

To help determine the severity of regional service-level fluctuations, the Ministry should:

- **develop and implement a waiting list management system; and**
- **monitor and analyze waiting times.**

Ministry Response

As an effort to manage wait lists in Ontario, the government has committed to provide timely and appropriate access to key services, including cataract surgery, hip and knee total joint replacements, selected cancer and cardiac services, and MRIs.

Initial activities to address wait times, as part of Ontario's Wait Time Strategy, will include the development of a comprehensive information system so that the province has the capacity to compile, measure, and evaluate wait times in all facilities providing key services, including independent health facilities. This information will be publicly reported so that patients and their providers can make informed decisions about their options and feel certain that their needs are being addressed.

Thus far, the government has invested in the following initiatives to address wait times by increasing volumes in the following targeted areas:

- ***fund nine additional MRI services, seven of them expected to be up and running by next year;***
- ***fund 9,000 additional cataract surgeries annually by 2005/06;***
- ***deliver 2,300 more hip and knee replacements annually by 2007/08; and***
- ***increase cardiac procedures by more than 36,000 annually by 2007/08.***

Service Planning

As noted previously in this report, all services provided at licensed independent health facilities are also provided in hospitals. During our audit, we found no evidence 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 different regions of the province. Regional factors that could affect the assessment would include hospital capacity (such as the availability of operating rooms in the immediate area) and the availability of trained medical practitioners to staff a licensed facility.

Recommendation

To help ensure that independent health facilities are being appropriately used to meet the health care needs of the public, the Ministry should implement a process for determining whether particular services should be provided by hospitals or by licensed independent health facilities.

Ministry Response

The Ministry supports this recommendation. The introduction and/or expansion of any service, either in hospital or independent health facility, should consider the best mechanism for delivering the service for the benefit of the patient. Senior ministry officials assess the best possible options and venues for providing patient care, optimizing available human and financial resources.

The process for the creation of new independent health facilities requires the Minister to authorize the issuance of a request for proposals. In deciding whether to issue a request for proposals, the Minister must consider the items set out in Section 5 of the Independent Health Facilities Act, including need and future need for the service, the extent to which the service is already available, and the projected cost and availability of public funds. The Independent Health Facilities Program currently includes an assessment and/or rationale for establishing an independent health facility-based service as opposed to a hospital-based service as part of the briefing material for the Minister. This generally includes a cost comparison between hospital-based and independent health facility-based services, an assessment of the complexity of the service, and quality assurance issues associated with providing the service in a non-hospital setting.

ASSESSMENTS AND INSPECTIONS

To ensure that appropriate medical standards are met, the Act provides for assessors to be appointed to assess the quality of services provided by licensed facilities. The College of Physicians and Surgeons of Ontario (College) is responsible for conducting these assessments and develops and publishes clinical practice parameters and facility standards for facilities. Assessments specifically determine whether a facility has complied with the clinical practice parameters and facility standards. For example, according to the parameters and standards, diagnostic equipment should operate properly and be properly maintained and facility staff should have the appropriate qualifications and training. In the 2003/04 fiscal year, the Ministry paid the College \$1.3 million to conduct assessments and to develop and publish clinical practice parameters and standards for facilities.

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

The Ministry's expectations of the College regarding the assessment process were originally delineated in a 1992/93 Memorandum of Understanding (MOU) between the Ministry and the College. While the Ministry and the College annually agree on objectives and deliverables, there has been no updated MOU.

The Assessment Process

The facilities to be assessed are selected by the Ministry at the beginning of each fiscal year. The Ministry bases its selection on various risk factors that identify facilities with the highest potential for problems. In our *1996 Annual Report*, we noted that assessments of the quality of services provided had not been performed on two-thirds of the facilities licensed under the Act and that only 47 of the 336 facilities whose licences had been renewed had been assessed. During our current audit, we were pleased to note that significant improvement has been made, as the Ministry was assessing over 85% of facilities at least once within the period of a licence, which is generally five years.

We also noted that when the Act was amended in 1996, it permitted unannounced assessments to be conducted. This would enable assessors to directly observe on a surprise basis the quality of the services provided and to ascertain whether procedures are being performed by qualified staff. However, as of March 2004, no unannounced assessments of facilities had been conducted.

After the College completes its assessment of a selected facility, it forwards a report to the Director of the Independent Health Facilities Program. The Director reviews the report and may request additional information on the College's recommendations or authorize College representatives to obtain a plan of corrective action from the assessed facility. Where an assessment has identified a risk to patient health and safety, the Director may suspend that facility's licence or restrict the services that the facility can provide. When the facility has provided the College with sufficient documentation to demonstrate that problems resulting in the suspension have been fixed and that the recommendations have been implemented, the College informs the Director, who may then reinstate the facility's licence or remove restrictions on the services that can be provided.

Time Frames for Submitting Assessment Information

The Ministry has not established time frames for the College's forwarding of its completed assessment reports to the Director of the Program. In 1996, we recommended that the Ministry establish such time frames. The Ministry agreed with our recommendation at that time.

Time frames were also lacking with respect to the taking of corrective action when a facility has been assessed to be non-compliant or deficient in certain areas. In this regard, in our *1996 Annual Report* we noted that facility and College staff were required to meet within two months, or as soon as practicable, after the assessment to discuss the assessment report. These meetings have been discontinued. Instead, facilities are to forward information to the College, which provides assurance that they have taken the necessary corrective action with regard to deficiencies noted in the assessment. There is no required time frame for the forwarding of this information. We reviewed assessment reports for facilities that the Ministry had concluded had significant concerns but that were not suspended—for the period between April 1, 2000 and March 31, 2003—and found that, in most cases, the College did not receive the information on what action had been taken until four to six months after the assessment date. While the Ministry indicated to us that a four-to-six-month time frame for receiving information about action taken in response to non-life-threatening problems was reasonable, we could not determine the basis for this conclusion.

Recommendation

To help ensure that the College of Physicians and Surgeons is meeting the Ministry's expectations regarding the assessment process and the development of clinical practice parameters and facility standards, the Ministry should regularly update its agreement with the College in a signed Memorandum of Understanding.

To help provide assurance that independent health facility services comply with clinical practice parameters and facility standards, some assessments should be performed without advance notice.

To help improve the effectiveness of the assessment process, the Ministry should establish time frames for:

- the submission of assessment reports by the College of Physicians and Surgeons of Ontario to the Director of the Independent Health Facilities Program; and
- the forwarding of information from independent health facilities to the College that provides assurance that any required corrective action has been taken on a timely basis.

Ministry Response

The Ministry supports this recommendation and will ensure that its expectations of the College of Physicians and Surgeons of Ontario regarding the assessment process and the development of clinical practice parameters and facility standards are regularly updated in a signed Memorandum of Understanding (MOU).

Discussions have been initiated with the College of Physicians and Surgeons of Ontario to develop policies and procedures defining circumstances under which unannounced assessments will be conducted.

The College of Physicians and Surgeons has committed to a turnaround time under the new panel review 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 and within 72 hours for immediate health and safety risks. This will allow the Ministry to respond to health and safety issues in a more timely fashion. Details of the proposed timelines will be discussed with the College of Physicians and Surgeons of Ontario and included in the MOU.

Current letters to the licensee include the following time frame for response to the recommendations in the report:

- *Where the report includes only recommendations of an administrative nature, the licensee is instructed to contact and discuss the recommendation with the College of Physicians and Surgeons of Ontario within 15 days of receipt of the report.*
- *Where the report includes more serious concerns, but they are not of a degree of severity requiring licensing action, the licensee is instructed to contact and discuss the recommendations with the College of Physicians and Surgeons of Ontario within 15 days of receipt of the report and to submit a written plan to the CPSO addressing the recommendations within 30 days of receipt of the report.*

Although part of the template letters for response, these time frames are not presently documented in a written policy. This policy will be prepared and included in the program's policy binder.

Licence Suspensions and Reassessments

Under the Act, the Director may immediately suspend a facility's licence when there are reasonable grounds to believe that the facility poses a threat to any person's health or safety (as a result of, for example, a lack of qualified staff or equipment not operating properly). Generally, such action is based on the results of an assessment report from the College. As discussed in the previous section, there are no time frames for when the Director of the Program is to receive assessment reports once the assessment has been completed. During this year's audit we found that, where assessments led to the suspension of a facility's licence or to some of the services being removed 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.

We noted in our 1996 audit that the Ministry had no documented policies on following up on or reassessing facilities with unfavourable assessments. We also found then that, in over 60% of the instances where facilities were reassessed, significant problems continued to exist. During our current audit, we 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, we were concerned that the Ministry still did not have a formal policy on the appropriate action to be taken where facilities continue to have quality assurance issues. Such actions could include revoking a facility's licence.

Since 1996, the Act has permitted the Minister to make regulations prescribing circumstances under which facility owners would be required to pay for the cost of an assessment. In 1996, the Ministry indicated that this would enable it to charge for reassessments that were necessary due to problems noted in the initial assessment. However, at the time of this year's audit, facility owners were still not required to pay for reassessments. Such a requirement could provide an additional incentive for facility owners to comply with quality standards.

We also noted that the Ministry does not publicize information regarding facilities where quality assurance issues have been raised. Although facilities whose licences have been suspended or restricted due to quality assurance problems cannot bill for facility fees during the period of suspension or restriction, potential patients and physicians who refer patients to the facilities may not be aware that quality assurance issues have been identified.

Recommendation

To help improve the effectiveness of the process for assessing independent health facilities and to help ensure that quality standards are met, the Ministry should:

- 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.

To help protect the public, the Ministry should consider appropriate public disclosure of serious quality assurance problems at independent health facilities.

Ministry Response

The Ministry supports this recommendation. The program area will develop a policy establishing circumstances under which licensing action will be taken for repeat quality assurance problems, where the deficiency, in itself, does not constitute a health and safety risk or an immediate threat to health and safety.

The Ministry supports that charges for reassessments be considered. The program area will develop an options paper setting out the process for implementing this change (regulation change under the Independent Health Facilities Act) and the advantages and disadvantages of charging the licensees for costs associated with conducting reassessments under the independent health facilities quality assurance program.

The Ministry supports the recommendation that public disclosure of licensing action resulting from quality assessments be considered. The program area will develop an options paper on this issue. A number of issues need to be considered in the development of a system of public disclosure of quality assurance problems in independent health facilities, including the retention period for the information, the posting of proposed suspensions while under appeal, the impact of changes in ownership on posted information, the timing for the posting of information and maintenance of information, et cetera.

While the Provincial Auditor makes the point that perhaps disclosure of quality assurance problems would be beneficial, it is the Director of independent health facilities who regulates independent health facilities. Disclosure of such information relating to an independent health facility might require an amendment under the Independent Health Facilities Act and might require an amendment to the agreement between the Ministry and the College with respect to the use, collection, and disclosure of information.

Assessment Methodology

Assessors receive and analyze information from medical records and notes, charts, and other material relating to patient care maintained by independent health facilities. The Ministry has delegated the methodology for selecting samples of records to be reviewed at the facilities to the College of Physicians and Surgeons. To assist the assessors, the College provides them with guidelines for performing the assessments. In our *1996 Annual Report*, we recommended that, to minimize the risk of not detecting potentially serious health and safety issues, the Ministry should ensure that the sampling guidelines of the College consider the time period covered by the assessment, the volume of services provided by the facility, and the number of specialties practised at the facility. We also recommended that assessors who do not follow the guidelines document their justification. The Ministry agreed with our recommendation and indicated that it would request that the College review and refine its sampling guidelines.

During our current audit, ministry staff informed us that the College's policy for sample selection is for the assessor to review a minimum of 10 services per specialty. We reviewed a sample of completed assessment reports and found that in some cases the assessors did not select 10 items from each specialty. The reasons for not completing the minimum sample size were not documented. We also found that some assessors we contacted were having facility staff select the samples of files that would be assessed rather than selecting a random sample themselves. As a result, there is a risk that the facility will select only those files that it has ensured meet the required standards.

Recommendation

To help ensure effective assessment of the quality of services provided by independent health facilities, the Ministry should work with the College of Physicians and Surgeons of Ontario 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.**

Ministry Response

The Ministry supports this recommendation. This issue will be discussed with the College of Physicians and Surgeons of Ontario and requirements for review of files and sample selection will be included in the Memorandum of Understanding between the College and the Ministry.

Clarity of Assessment Conclusions

The *Independent Health Facilities Act* requires that services provided by independent health facilities conform to generally accepted quality standards. In our *1996 Annual Report*, we recommended that the Ministry work with the College of Physicians and Surgeons of Ontario to ensure assessment reports contain clear conclusions on whether clinical practice parameters and facility standards developed by the College and other experts have been met. The Ministry agreed with our recommendation and stated that it was working with the College “to help improve the quality and content of the reports.” However, during this year’s audit, we found that the College’s reports and other communications still did not consistently state whether clinical practice parameters and facility 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 assessment reports.

In September 2003, the Ministry established a Facility Review Panel to provide additional support to the Director of the Independent Health Facilities Program in making enforcement decisions. The panel was to advise the Director 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, at the end of our audit it was too early to assess the success of this initiative.

Assessment Tracking Systems

The Ministry maintains an assessment database that contains information on the types of services provided by each facility, the facility’s status (active or suspended), and any dates on which the Ministry and/or the College took action with regard to the problems at a facility.

In our *1996 Annual Report*, we recommended that the Ministry: take steps to verify the integrity of data in the assessment database; review the feasibility of filing all assessment information by licence number (to facilitate tracking facility information); and develop a system for tracking the completion of facility assessments. During this year’s audit we noted that the Ministry was tracking assessment activity by licence number and that efforts had been made to increase data integrity. However, we noted that some data entry errors still needed to be corrected and that the Ministry was not using the database to monitor the overall timeliness of the assessment process. In addition, the Ministry’s database was not ideally structured for the monitoring of overall assessment timeliness. For instance, in certain circumstances, more than one reassessment is required to resolve all of the significant deficiencies identified in the original assessment. However, because reassessments and assessments are not linked within the database, determining the time that has elapsed from the date of the first assessment to when significant assessment concerns have been satisfactorily resolved is not readily determinable.

Recommendation

To help ensure that decision-makers have access to all relevant information when assessing independent health facilities, the Ministry should ensure that its management information system is structured to link all data relating to a specific facility.

Ministry Response

As noted in the report, a number of changes to the database were implemented as a result of the last audit in 1996. The current management information system meets the program's needs for data with respect to tracking quality assurance assessments under the Independent Health Facilities Act. The proposed changes to the system would enhance the reporting capability of the system, but the Ministry must balance the value of these enhancements against available resources to program the changes and staff resources to implement any systems changes. Other systems projects would currently take priority over changes proposed to the quality assurance management information system. Changes will be implemented if/when resources are available.

UNLICENSED TECHNICAL SERVICES

In our *1996 Annual Report* we noted that when the *Independent Health Facilities Act* was introduced in 1990, many OHIP insured services that had a technical component were not covered by the Act. The *Health Insurance Act's* Schedule of Benefits contained 65 technical procedures that were not included under the *Independent Health Facilities Act*, such as electrocardiograms (recordings of the electrical activity of the heart), electroencephalograms (recordings of the electrical activity generated by neurons in the brain), and echocardiograms (electronic plottings of the echoes of sound pulses sent into the chest to map the heart). We recommended that the Ministry develop specific criteria for determining which technical services and procedures should be licensed under the *Independent Health Facilities Act*. In its response to our 1996 audit, the Ministry noted that the number of services that could theoretically be covered by the Act were so substantial that a rigorous process would be required to prioritize the areas for expanded coverage.

In 1997, a joint committee of the Ministry and the College developed criteria to be used for expanding the Act's coverage to other services that were being provided outside of hospitals that were not covered by the Act. The criteria included quality assurance criteria (for example, consideration of the risk to the patient from the performance of the service) and utilization criteria (for example, consideration of any increased costs to the government). In its *1996–97 Annual Report*, the Standing Committee on Public Accounts recommended that these criteria be used for any expansion of the technical services and procedures licensed under the Act. We

understand that as a result of applying the utilization criteria, the Act was extended in 1998 to include sleep studies. However, while the joint committee had also recommended evaluating other procedures—such as echocardiography services—for inclusion under the *Independent Health Facilities Act*, we understand that no further evaluations have been conducted to determine additional services that should be included.

Various studies and reports have reinforced the importance of the Ministry's quality assurance process for technical services for ensuring the protection of the public. For instance, in a 2000 report, a joint committee of the Ministry, the Ontario Hospital Association, and the Ontario Medical Association (OMA) noted that the Act's requirement for quality assurance—mandating quality standard development, inspections, and regular assessments and providing for remedial actions—was more comprehensive than any comparable medical quality assurance requirements. That report also noted that the lack of an external quality assurance program for technical services provided in individual 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 also noted that the quality management program for independent health facilities has been 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 not covered under the Act is performed outside a public hospital, the service is not subject to the Act's quality assurance process. Examples of such services are, as mentioned earlier, echocardiograms and electroencephalograms. Under the *Health Insurance Act*, the facilities performing these procedures are paid a technical fee. Ministry data indicate that technical fee payments for echocardiography services between the 1995/96 and the 2002/03 fiscal years increased by 53%—from \$30 million to \$46 million.

Other procedures may also be performed outside of hospitals without requiring that the facility be licensed, but these procedures do not have a separate technical fee—only the professional component of these procedures is paid for. Examples of such services are allergy testing and colonoscopies, which are used to diagnose colon and bowel disease. Ministry data indicate that, in the 2000/01 fiscal year, 19,260 colonoscopies—or approximately 12% of all such procedures performed in the province—were performed outside of public hospitals. Since these procedures were not covered by the Act, they were not subject to the quality assurance provisions of the Act.

We found no indication that the Ministry had analyzed, since 1997, whether any additional services that are being performed outside of hospitals and licensed facilities should be licensed under the Act and therefore be subject to the Act's quality assurance process.

Recommendation

To help ensure the consistent quality of medical services in Ontario and to help minimize the risk to patients, the Ministry should assess which diagnostic and surgical services performed outside of hospitals and licensed independent health facilities should be covered by the *Independent Health Facilities Act*.

Ministry Response

Any decision to expand the Independent Health Facilities Program to include additional services 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 independent health facilities licensing scheme.**

The Ministry developed criteria in 1997 to evaluate proposals for expansion of the Independent Health Facilities Act to include additional services. This criteria was used to evaluate the proposal to regulate sleep medicine facilities under the Act, and led to the licensing of sleep medicine facilities through changes to the Schedule of Benefits in 1998. These criteria should continue to be used to evaluate any proposals for expansion of the Act to include additional services.

To date, evaluation of the potential for independent health facilities expansion has only occurred in response to specific proposals from the OMA or the Ministry or to unsolicited proposals from individuals interested in establishing a facility.

SLEEP STUDIES

Most sleep studies are overnight procedures where a patient is observed and monitored continuously for factors such as oxygen saturation (to assess whether the patient's red blood cells are carrying sufficient oxygen through the arteries) and sleep staging (to assess sleep disorders such as apnea). In our *1996 Annual Report*, we noted that technical fee billings from facilities performing sleep study procedures, which at that time did not require a licence under the Act, had increased by 135% over a four-year period. Since then, sleep study clinics have been added to the services covered by the *Independent Health Facilities Act*. The Physician Services Committee recommended that sleep study clinics be added primarily in order to limit the number of facilities permitted to bill for performing sleep study services. In 1998, approximately 70 sleep study clinics were brought in under the Act and were allowed to operate while their licences were pending. Between the 1998/99 and 2002/03 fiscal years, sleep study

technical-fee billings increased from \$14.9 million to \$23.4 million, representing a 57% increase.

Before a facility can become licensed, the College of Physicians and Surgeons must perform a pre-licensing inspection to determine if the facility is complying with established clinical practice parameters and facility standards. 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.

We noted that quality concerns raised in the pre-licensing inspections of many sleep study clinics required more than one inspection to resolve them. On average, it took 16 months from the date of initial pre-licensing inspection to license an individual sleep study clinic. At the end of our fieldwork, 18 of the sleep study clinics that were in operation had still not been licensed because they had not yet rectified deficiencies or had not yet been inspected. Deficiencies noted in facilities that were inspected included staff not adequately monitoring patients during sleep studies.

Recommendation

To help ensure that new facilities that are brought under the *Independent Health Facilities Act* in future meet quality standards, the Ministry should:

- inspect all such facilities on a timely basis; and
- follow up on problems identified on a timely basis to verify that corrective action has been taken.

Ministry Response

The Ministry supports this recommendation. 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 Independent Health Facility Program and in the College of Physicians and Surgeons of Ontario, are assigned to the inspection and licensing processes.

OTHER MATTER

Magnetic Resonance Imaging

Magnetic Resonance Imaging (MRI) produces high-quality images of body structures that can be used as an extremely effective method of detecting, for example: brain abnormalities, tumours or inflammation of the spine, aneurysms or tears of the heart or aorta, problems with organs within the abdomen, and damage to the structure of

joints, soft tissues, and bones. MRI scans often provide crucial information before surgery. In the summer of 2002, the provincial government announced that diagnostic services in independent health facilities would be expanded to include MRI services and that access to MRI services in Ontario was to be improved as a result, since the services had previously been available only at hospitals. Moreover, the MRI services provided at facilities were to be less expensive to the Ministry than those provided at hospitals. The facilities would be subject to all the provisions of the Act, including its quality assurance requirements.

After evaluating the bids submitted by potential suppliers, the Ministry selected operators to provide MRI services at five locations. Between July and September 2003, these facilities were licensed for the services. However, the funding for the MRI services, unlike that for other diagnostic services, was limited to the amount of each operator's bid price and was contingent on the operator providing minimum levels of insured services.

The operators can also receive income by charging patients for services not covered by the Ontario Health Insurance Plan (this is the case at all independent health facilities). However, it is important to note that the contracts with the MRI facilities limited the extent to which uninsured services could be performed, and facilities were required to report to the Ministry on the volume of uninsured services provided.

At the end of our audit, we understood that the provincial government was reviewing the future of these facilities and other options for providing MRI services.