

Independent Health Facilities

Background

Independent health facilities are located in communities throughout Ontario and provide certain health services at no charge to patients insured under the provincially funded Ontario Health Insurance Plan (OHIP). About 800 facilities provide primarily diagnostic services (such as x-rays, ultrasounds and sleep studies), and about 25 provide surgery (such as cataract and plastic surgery) or dialysis. Patients generally require a requisition signed by their physician in order to receive the services, and test results, where applicable, are sent to this physician. Under the *Independent Health Facilities Act*, the Ministry of Health and Long-Term Care (Ministry) is responsible for licensing, funding and co-ordinating quality assurance assessments of these facilities.

The facilities are independently owned and operated, with most being for-profit corporations; less than 3% are non-profit organizations. The Ministry estimates that about half are fully owned or controlled by physicians, many of whom are radiologists who interpret, for example, x-rays and ultrasounds. The Ministry pays facility owners a “facility fee”—an amount for each type of service provided and/or a contracted amount—for

overhead costs, such as rent, staffing, supplies and equipment.

In the 2010/11 fiscal year, the Ministry paid \$408 million in facility fees. Total facility-fee payments increased by about 4% per year between the 2006/07 and 2010/11 fiscal years, primarily because of increased volume of services (because the fees paid to facilities for each type of service remained largely unchanged). The total facility-fee payments are broken down by type of service in Figure 1.

As well, the Ministry pays physicians working in these facilities—often radiologists—a standard fee for each service provided, known as a “professional fee.” The Ministry does not track the total professional fees paid to physicians for the specific services they provide in independent health facilities.

The Ministry contracts with the College of Physicians and Surgeons of Ontario (the professional oversight organization for physicians in Ontario) to obtain assurance on the quality of the services provided by facilities licensed under the *Independent Health Facilities Act*. As well, the Ministry conducts inspections of facilities with x-ray equipment, including independent health facilities, under the *Healing Arts Radiation Protection Act*.

Figure 1: Total Facility Fees Paid, by Type of Service, 2006/07–2010/11 (\$ million)

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

	2006/07	2007/08	2008/09	2009/10	2010/11
Diagnostic Services					
Ultrasound	129.9	138.0	150.7	166.2	173.0
Radiology (includes x-rays)	116.1	114.6	110.7	113.6	111.0
Nuclear medicine ¹	39.5	41.6	44.0	42.5	40.8
Sleep studies	29.3	32.8	36.5	39.1	39.6
MRI/CT	5.7	5.7	8.4	8.9	10.0
Pulmonary function studies ²	2.1	2.0	2.1	2.3	2.4
Subtotal	322.6	334.7	352.4	372.6	376.8
Surgical/Therapeutic Services					
Dialysis	9.9	9.8	10.2	11.0	15.2
Abortion	6.4	6.2	6.5	7.0	7.1
Ophthalmology	6.4	6.5	6.4	6.4	6.4
Plastic	1.0	1.0	1.0	1.0	1.1
Vascular ³	0.9	0.7	0.7	0.8	0.8
Laser ⁴	0.4	0.3	0.4	0.5	0.4
Subtotal	25.0	24.5	25.2	26.7	31.0
Total	347.6	359.2	377.6	399.3	407.8

1. Patient tests using radioactive material (e.g., a small amount is administered and images are taken of where it goes in the body to observe blood flow through the heart or lungs).

2. A test to measure a patient's lung function.

3. Surgery for patients who have problems with their arteries or veins.

4. Surgery using a laser beam to cut tissue or remove a surface abnormality or lesion.

Audit Objective and Scope

Our audit objective was to assess whether the Ministry had implemented systems and processes to determine whether independent health facilities were providing Ontarians with insured services in a timely and cost-effective manner, in accordance with legislated requirements. Ministry senior management reviewed and agreed to our objectives and associated audit criteria.

Our audit work was primarily conducted at the Kingston offices of the Ministry's Independent Health Facilities Program. As well, we obtained information from the Toronto offices of the Ministry's X-ray Inspection Services Unit. In conducting our audit, we reviewed relevant documents,

analyzed information, interviewed appropriate ministry staff, and reviewed relevant research from Ontario and other jurisdictions. As well, we surveyed independent health facilities to determine whether certain services were available. We also had discussions with the College of Physicians and Surgeons of Ontario and the Canadian Nuclear Safety Commission related to the operation of independent health facilities in Ontario. Further, we obtained information and had discussions with senior management about similar facilities in other Canadian jurisdictions.

We did not rely on the Ministry's internal audit service team to reduce the extent of our audit work, because it had not recently conducted any audit work on independent health facilities.

Summary

Our last audit in 2004 found that the Ministry generally had adequate procedures in place for ensuring that independent health facilities complied with legislation and ministry policies but noted a number of areas requiring ministry action. These included determining the service levels necessary to meet patient demand, the reasonableness of fees paid for facilities' overhead costs, the wait times for services and which community-based services should be subject to a quality assurance process. Since our 2004 audit, the Ministry has taken action to enhance the oversight of services offered in independent health facilities. For example, it has arranged for the College of Physicians and Surgeons of Ontario (College) to conduct more frequent assessments of facilities with previously identified issues; it has also amended the *Medicine Act, 1991* to enable the College to conduct service-quality inspections of community health clinics that use anaesthesia (such as those providing plastic surgery and colonoscopies) but are not covered by the *Independent Health Facilities Act*.

Nevertheless, in several other areas the concerns we raised in 2004 still remain. For example, ministry data indicates that patients in about 50% of Ontario municipalities continue to be underserved for certain diagnostic services (including radiology, ultrasound and pulmonary function studies). As well, even though the Ministry has not increased the rates paid to facilities for overhead costs since 2006 (in fact, it decreased the rates by 2.5% in spring 2012), the Ministry has not researched the current actual overhead costs of providing the services. These costs may have changed significantly because new technology allowing certain tests to be performed much faster often results in lower overhead and staffing expenses.

Ensuring timely availability of services and reasonable facility fees are both especially important because the Ministry's 2012 Action Plan for Health Care indicated that a number of less complex

medical procedures may be moved from hospitals into community clinics, such as independent health facilities. Some of our other more significant observations include the following:

- Every facility is paid the same amount for each type of service provided, regardless of the total number of services the facility provides. Consequently, larger facilities in urban areas often benefit from economies of scale, because certain costs (such as rent and salaries for reception staff) generally do not increase proportionately with the number of services performed. Paying slightly higher fees in locations with smaller populations and lower fees in high-density locations, for example, might encourage more facilities to service areas that are currently underserved without affecting the Ministry's total facility-fee payments.
- The Ministry generally does not allow facilities to easily relocate to more underserved areas.
- The Ministry estimated that certain services—such as MRIs, dialysis and colonoscopies—were about 20% to 40% less expensive if delivered in community clinics, including independent health facilities, rather than in hospitals.
- Although the Ministry has some information on facility ownership and estimates that about 50% of facilities are owned or controlled by physicians, many of whom are radiologists, it has not analyzed the patterns of physicians referring patients to their own facilities or related persons' facilities. Further, many patients assume they must go to a facility listed on their physician's referral form, when in fact they can choose a hospital or any facility that offers the required service. In 2009, the Canadian Association of Radiologists noted that as many as 30% of CT scans and other imaging procedures across Canada contribute no useful information or are inappropriate. The Ministry estimated that about 20% of facility-fee tests are likely inappropriate.

- Unlike hospitals, facilities are assessed by the College to help ensure, among other things, that diagnostic images are correctly “read” by the physician, who is often a radiologist. However, as of March 2012, about 12% of facilities had not been assessed within the last five years. Even for the assessed facilities, the College assessors did not review the work of all physicians working at each assessed facility.
- As of March 2012, the Ministry’s X-ray Inspection Services Unit (Unit) had not inspected almost 60% of facilities as frequently as required to ensure that radiation-producing equipment—for example, x-ray equipment—was appropriately shielded to prevent staff and patients from being exposed to excessive radiation levels.
- The Unit and the Independent Health Facilities Program (Program) areas did not regularly share information. For example, the Unit did not have the current location of 12 facilities that had moved, so the Unit had not inspected whether the radiation-producing equipment at the new locations for these facilities was safely installed. Further, the Unit’s inspection reports on facilities were not routinely forwarded to the Program.
- Although the Ministry has attempted to improve patient service by introducing two websites listing, among other things, certain locations where patients can obtain diagnostic services such as x-rays and ultrasounds, neither site lists all locations offering these services. One of the websites, which lists all independent health facility locations and services, could be made more user friendly:
 - if it had search capability (for example, by postal code or service) to help patients locate facilities; and
 - if it included information on facility wait times for those services that historically do not have same-day access (such as MRIs and CTs) to help patients who want their tests as soon as possible.

Detailed Audit Observations

ACTIONS SINCE OUR 2004 AUDIT

Since our last audit in 2004, the Ministry has undertaken several initiatives related to independent health facilities, including the following:

- In 2006, the Ministry, in conjunction with the College of Physicians and Surgeons of Ontario (College), initiated unannounced reassessments of some facilities and in 2009 initiated more frequent facility assessments for facilities with previously identified significant issues.
- In 2008, the Ministry began receiving from the College the names of suspended physicians who had worked in facilities.
- In 2011, the Ministry commenced a review of independent health facility billings to identify questionable billing practices. This review was ongoing at the time of our audit.

ACCESS TO SERVICES

Distribution of Facility Services

Before the introduction of the *Independent Health Facilities Act* (Act) in 1990, organizations could offer health services outside of hospitals and charge patients a fee to cover their overhead costs. When the Act became effective, any organizations that were already providing the health services covered under the Act were “grandparented” if they sent a facility application to the Ministry and passed a quality assurance assessment by the College. As a result, these organizations were permitted to be licensed for the services they were providing, in the location where they were providing them at that time. Once licensed, they could bill the Ministry for their facility-fee costs, but were no longer permitted to bill patients for their overhead costs.

Assessing Service Levels

Since grandparenting those facilities in existence at the time the Act became applicable to them, the Ministry has approved only six new licences for facilities that bill the Ministry on a fee-for-service basis. However, facilities with licences may apply at any time to provide services they are not currently licensed to provide, in five service categories (radiology, nuclear medicine, ultrasound, pulmonary function studies and sleep studies) or their subspecialties, including mammography (a radiology subspecialty) and obstetrical and gynecological ultrasound (an ultrasound subspecialty). The Ministry will approve the request only if the area where the facility is currently operating is determined to be underserved for those diagnostic tests or procedures. The Ministry has divided the province into a total of 105 areas, primarily municipalities of varying sizes.

In response to a recommendation in our *2004 Annual Report*, the Ministry indicated that its Diagnostic Services Committee (with members from the Ministry, the Ontario Medical Association and the Ontario Hospital Association) was expected, among other things, to make recommendations concerning patient access to diagnostic services in underserved areas. This Committee was discontinued in 2008, and according to the Ministry, no such recommendations were ever made.

To assist in determining whether an area is underserved or overserved, the Ministry calculates the total number of services billed per capita by hospitals for outpatients and by independent health facilities in the Ministry-defined areas, and compares these to the provincial average. This calculation is performed for the five services as well as for more than 15 subspecialties within those services. As shown in Figure 2, both hospitals and independent health facilities perform a significant number of these services.

The Ministry does not have a benchmark for what constitutes a reasonable level of per capita diagnostic services. Therefore, the Ministry has defined an underserved area as any area providing less than 70% of the provincial average per capita service level. An overserved area is defined as any area providing over 150% of the average per capita service level. The Ministry determines all other areas (that is, those providing between 70% and 150% of the average per capita service level) to be adequately served. The Ministry indicated that, based on its analysis, overall there is an adequate supply of the five main services, with about 1,300 services per 1,000 people in Ontario.

But the Ministry has not, for the most part, analyzed the distribution of underserved and overserved areas across the province or over time. We analyzed the Ministry's data and noted that,

Figure 2: Number of Selected Diagnostic Services Performed by Hospitals and Facilities, 2010/11

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

Type of Service	Hospital		Total
	Outpatient Services	Facility Services	
Radiology (includes x-rays)	4,515,000	3,878,000	8,393,000
Ultrasound	2,152,000	4,267,000	6,419,000
Nuclear medicine ¹	752,000	432,000	1,184,000
Pulmonary function studies ²	593,000	152,000	745,000
Sleep studies	43,000	106,000	149,000
Total	8,055,000	8,835,000	16,890,000

1. Patient tests using radioactive material (e.g., a small amount is administered and images are taken of where it goes in the body to observe blood flow through the heart or lungs).
2. A test to measure a patient's lung function.

according to the Ministry's definition, about 50% of Ontario municipalities (both rural and urban areas) had been consistently underserved and about 7% had been consistently overserved from the 2007/08 fiscal year to the 2010/11 fiscal year. We also noted that in some cases, an underserved area was next to an overserved one. For example, one underserved area with 632 services per 1,000 people in the 2010/11 fiscal year was next to an overserved area in which 3,299 services per 1,000 people were provided. The Ministry had not analyzed which areas it defined as underserved might in fact have adequate access to services that could be as close as a few kilometres away in neighbouring areas. Furthermore, the Ministry's most recent analysis of service availability per Local Health Integration Network (LHIN, the corporation mandated to work with local health providers to determine the health service priorities for its region, with the province being divided into 14 LHIN regions) was conducted in 2007. At that time, the number of services ranged from about 1,100 services per 1,000 people in one LHIN to almost 3,400 services per 1,000 people in another LHIN. Currently LHINs are responsible for planning and funding diagnostic services only in hospitals, but the Ministry indicated that it is considering the extent to which LHINs should be involved with planning and funding diagnostic services at independent health facilities in the future.

Furthermore, the Ministry does not age- or gender-adjust the population statistics used for its per capita analyses. Because diagnostic procedures tend to be required more frequently as individuals age, and some services are more likely to be provided to women rather than men, factoring in these demographics would result in more meaningful results. For example, obstetrical and gynecological ultrasounds are performed only on women, and bone mineral analysis is much more commonly performed on older adults, because bones become less dense with age. However, all per capita analyses conducted by the Ministry were based on total populations, and did not consider whether an area's

population had, for example, a higher percentage of women or older adults.

The Ministry does not encourage facility owners to relocate to areas within the province that are underserved. Consequently, even though populations in certain areas of the province may have longer wait times for access to these diagnostic services, the Ministry's current method of approving new services to be offered by existing facilities may not be addressing the underservicing issue. The Ministry believes that community hospitals may be better able to meet local service demands in sparsely populated areas.

The Ministry indicated that, because independent health facilities provide only a small portion of other services such as Magnetic Resonance Imaging (MRI) and Computed Tomography (CT), its analysis of the per capita levels of these other services by LHIN generally excludes those provided by facilities. However, we noted that the per capita counts of CT and MRI machines would rise by at least 10% to 50% if machines performing the services at the facilities were included.

Changing Facility Locations

In order to ensure service availability across Ontario, especially in areas that the Ministry has determined are underserved, independent health facilities are required to obtain ministry approval before relocating their operations. The Ministry permits facilities to relocate only within their current Ministry-defined area, or to within five kilometres of the current location if crossing into another area. Further, the Ministry will deny any move if a hospital within one kilometre of the proposed new location objects. As well, the Ministry will not approve moves from an overserved area to an underserved area if the move violates any of these rules. In 2011, the Ministry approved 47 facility moves.

We noted that some Ministry-defined areas are quite large, whereas other areas are small. For example, facilities within the city of Ottawa,

which is almost 2,800 square kilometres, have many more options for where to deliver services as compared to facilities located within the city of St. Thomas, which is about 40 square kilometres. Facilities located in the city of Toronto can move anywhere within it. We also noted that there were several donut-shaped areas (generally made up of the areas surrounding a city) that facilities could move around in, but they generally could not move to the city within the centre of the area, and facilities in the centre generally could not move to the donut-shaped area.

The Ministry indicated that many facility owners would like to relocate from less populated areas to more population-dense locations. Consequently, certain owners have attempted to “leapfrog” from their current location to a more populated location. For example, in one case, over a four-year period, a facility applied to move seven times, two of which were approved and five of which were denied due to exceeding both the five-kilometre rule and crossing an area boundary. While these relocation controls are undoubtedly necessary, we expected that the Ministry would have considered what changes could be made to encourage facilities to move from overserved to underserved areas.

Future Independent Health Facility Services

The Ministry has analyzed the cost of providing certain services conducted in hospitals compared with the cost of providing those services in the community and has determined that money could be saved by moving various services, particularly less medically complex ones, out of hospitals and into community-based clinics, such as independent health facilities. Specifically, the Ministry estimated that MRIs and dialysis, as well as colonoscopies and echocardiograms (ultrasounds of the heart), are less expensive—by a range of about 20% to 40%—if delivered by a community provider rather than in a hospital. At the time of our audit, most of these services were more frequently delivered in a hospital setting than in the community.

Ontario’s Action Plan for Health Care (Plan), released by the Ministry in January 2012, notes that more routine procedures may be moved in the future out of hospitals and into community-based clinics, such as independent health facilities. The Plan specifically notes that more cataract procedures will be conducted by an existing independent health facility because the facility can do them at a lower cost than a hospital can. Although not mentioned in the Plan, the Ministry indicated to us that, in the 2013/14 fiscal year, it expects to increase the number of MRIs offered in one existing independent health facility, also at a lower cost than in hospitals. At the time of our audit, the Ministry had no other specific plans to move any other services to community facilities.

RECOMMENDATION 1

To help ensure that Ontarians have timely and convenient access to required tests and procedures, the Ministry of Health and Long-Term Care should:

- better identify areas within the province where the combined levels of services offered by hospitals and independent health facilities indicate that the area is underserved (for example, by analyzing population and gender distribution within each area and determining the resulting needs for services); and
- develop ways to help address patient needs in regions identified as underserved, such as offering incentives to encourage facilities to provide services in underserved areas or reviewing policies that restrict a facility’s ability to move into underserved areas.

MINISTRY RESPONSE

The Ministry is pleased that the Auditor has referenced the Minister’s Action Plan for Health Care, which communicates our commitment to ensuring access for all Ontario residents to appropriate health-care services, including

timely and convenient access to required tests and procedures. Through the Action Plan, more services will be provided in the community and under a variety of service delivery models suited to the service type and community health-care needs. The Independent Health Facility (IHF) model of service delivery provides a strong foundation for moving more diagnostic tests and procedures into the community.

To support the move of more services into the community and to ensure that services are planned and delivered in accordance with local and regional population needs, the Ministry is:

- actively exploring opportunities for joint planning between the Local Health Integration Networks and IHFs to ensure the right mix and distribution of diagnostic tests and procedures to meet local health needs and to better identify areas within the province where the combined levels of services offered by hospitals and IHFs indicate that the area is underserved; and
- enhancing the planning relating to the volume of services delivered in the community and closer to home for patients, with consideration to incentive options to attract IHF service providers to underserved areas, as well as reviewing its IHF relocation policies to better facilitate the movement of diagnostic tests and procedures to underserved areas.

BILLINGS

Funding Arrangements

Fee-for-service Facilities

Fee-for-service independent health facilities (for example, x-ray and ultrasound facilities) are paid a standard facility fee for each type of service performed. These fees were negotiated between the Ministry and the Ontario Medical Association (OMA, the bargaining organization that represents

physicians in Ontario) and are intended to reflect the approximate overhead cost (including rent, staffing, supplies and equipment) of performing each service. The rates are set out in the Schedule of Facility Fees for Independent Health Facilities. Each facility fee has a corresponding professional fee that the physician can charge for performing the test or interpreting the test results. Professional fees, which are also negotiated between the Ministry and the OMA, are set out in the Ontario Health Insurance Plan's Schedule of Benefits. Figure 3 lists the top five facility fees billed, the volume of each service, and the corresponding professional and facility fees per service. The Ministry did not have information available on the total professional fees billed for these services.

Between 1992 and 2005, the Ministry made some across-the-board decreases and one increase to the Schedule of Facility Fees for Independent Health Facilities. From 2005 on, no changes were made until May 2012, when the Ministry implemented a 2.5% across-the-board reduction in facility fees and a 5% reduction in their associated professional fees "in recognition of the latest evidence, improvements in technology, and changes in standards of care." Reductions were also implemented for certain other service fees, such as those for colonoscopies.

All facilities are paid the same amount for each service, no matter where the facility is located or how many services it provides. Consequently, larger facilities can benefit from economies of scale because certain costs, such as rent and the salaries of reception staff, do not increase proportionately with the number of services performed.

A 2000 report produced by the Committee on Technical Fees (members of which included the Ministry, the 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 acknowledged that most of the facility fees had not been set through a rigorous costing process. The Committee suspected that with the introduction of

Figure 3: Top Five Total Facility Fees Paid, 2010/11, and Associated Fee Levels

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

Type of Service	2010/11		As of April 1, 2011 (\$)	
	Total Facility Fees Paid (\$ million)	Volume	Facility Fee Paid per Service	Professional Fee Paid per Service
Chest radiology (x-rays—2 views)	20.0	826,000	24.18	11.30
Pelvic ultrasound—complete (physician present at time of service)	17.7	355,000	50.00	32.30
Pelvic ultrasound—complete (physician not present at time of service)	16.4	328,000	50.00	24.20
Sleep study (initial diagnostic)	15.5	41,000	380.25	128.30
Ultrasound of vagina or rectum	14.6	291,000	50.00	24.20

new technology and equipment (which make some services less time-consuming to perform), some fees did not accurately reflect the costs, and noted that there was a lack of information on the extent to which fees deviated from actual costs. Therefore, the Committee recommended that the fee schedule be reviewed as soon as possible, and suggested that an appropriate costing methodology would ideally incorporate factors such as the economies of scale available to high-volume facilities.

In our *2004 Annual Report*, we 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.” At that time, the Ministry indicated that the Diagnostic Services Committee would be reviewing this area. But this Committee was discontinued in 2008, without completing any such analyses, making any related changes to the fee schedule or doing any work to assess the current overhead costs of running a facility.

The Ministry did, however, provide us with a 2008 Jurisdictional Comparison of Medical Imaging Systems prepared by another province involving five Canadian jurisdictions, using data from the 2006/07 fiscal year. The comparison found that, at that time, Ontario’s facility fees were often lower than fees paid by other provinces. However, the Ministry has not investigated whether this is still the case, using updated data on the other jurisdic-

tions’ fee levels. We noted that both British Columbia and Alberta provided a range of services, both surgical and diagnostic, in community clinics but they did not have separate professional and facility-cost fees; rather, the entire payment was combined in one fee. We compared the combined facility and professional fees paid in Ontario for three services to the fees paid for the same services in British Columbia and noted that the Ontario fees were within 6%, more or less, of the fees paid there.

In April 2011, the Ministry requested that the OMA (representing physicians), the Ontario Hospital Association (representing hospitals) and the Coalition of Independent Health Facilities (representing facilities) submit facility-fee funding options to it by October 2011. The Coalition’s response did not suggest any funding options; it focused on structuring future funding discussions. Neither the OMA nor the Ontario Hospital Association submitted options, although both were given an extension until March 2012 to do so. The Ministry indicated that it did not expect any further submissions relating to facility fees from the OMA or the Ontario Hospital Association, because the renegotiation of the Physicians Services Agreement, which sets out compensation for physicians, was the key priority in 2012.

As previously noted, the Ministry will not approve new services for a facility if the area is overserved for the services in question. But facilities can increase the number of services they currently

provide at their existing locations by purchasing, without ministry approval, additional diagnostic equipment—the Ministry’s licence with facilities requires only that they inform the Ministry within 30 days of new equipment being purchased. More equipment leading to more services being provided results in the Ministry paying more facility and professional fees. But if the facilities providing the services are in an underserved area, the area benefits from the increased service availability.

In contrast to the unlimited number of services that facilities can receive payment for, laboratories, which are also funded on a fee-for-service basis, are subject to a provincial maximum funding level for all labs across the province as well as a maximum that applies to each laboratory.

Negotiated Contract Facilities

The Ministry funds 35 facilities, including facilities performing MRIs and cataract surgery, through negotiated contracts for providing an established volume or number of hours of services. If a facility performs fewer services than the contracted amount, the Ministry reduces the facility’s funding. Facilities performing more than the contract amount do not receive additional ministry funding.

The contracted dollar amount (based on volume and hours) for facilities that were “grandparented” when the legislation was introduced was determined through negotiations between the Ministry and the facilities. Subsequently, in seven cases, the Ministry approved MRI and CT services, which had not previously been covered under the Act, through a competitive process. For other new services, such as cataract surgeries, the Ministry negotiated directly with known providers, as permitted under the *Independent Health Facilities Act*. In all cases, subsequent contracts are negotiated between the Ministry and each facility.

In 2004, the Ministry established an Expert Panel to help improve, among other things, access to, and the quality and efficiency of, MRI and CT services in hospitals and independent health

facilities. The Panel’s 2005 report indicated that these services were not being delivered efficiently. In the case of MRIs, this was primarily due to the Ministry’s having allocated a longer-than-necessary time for certain types of MRI procedures and paying facilities for rerunning MRIs when the facility made an error. In the case of CT scans, the report indicated that the tests should take 20 minutes regardless of which body part is being scanned, whereas the contract rates were based on estimated times per service that were, on average, more than 60% longer. The Ministry told us that it did not at that time consider the rate reductions for CT scans suggested by the Panel to be appropriate for facilities, although it had no analysis supporting its conclusions. When renegotiating five-year contracts between 2007 and 2009 for the five independent health facilities performing MRIs, the Ministry again did not consider the Panel’s recommendations. On the other hand, a couple of years after these contracts were negotiated, the Ministry did approach these MRI facilities regarding a rate reduction. While some of them agreed to reduced rates, the others refused. The Ministry continued to pay these facilities at the 2007 contract rate while paying the other facilities the reduced rate. The Ministry indicated that it expected to negotiate a reduced rate with the other facilities when the contract is renewed in 2012.

With most negotiated contracts, the Ministry does not periodically confirm that the rates paid are reasonable. Although it might not be practical to always conduct a competitive process, the Ministry could, for example, periodically obtain information from other jurisdictions or otherwise periodically review costs to help obtain assurance on the reasonableness of the rates. Because facility fees are not being periodically reviewed, there is a risk that some services are increasingly expensive to provide, but more of a risk that technological improvements have resulted in facility fees significantly exceeding the actual cost of performing the services.

Referrals for Service

Patients generally require a physician's referral in order to obtain services from an independent health facility. The Health Council of Canada indicated in its 2010 report *Decisions, Decisions: Family Doctors as Gatekeepers to Prescription Drugs and Diagnostic Imaging in Canada* that increased access to diagnostic imaging has "allowed for increased use of diagnostic imaging, some of which may be considered over-use." The report noted research indicating the overuse of diagnostic imaging, but concluded that it is difficult to say why and by how much. In this regard, the Canadian Association of Radiologists' website notes that as many as 30% of CT scans and other imaging procedures across Canada contribute no useful information or are inappropriate. Studies from other jurisdictions also indicate the incidence of potentially inappropriate imaging. On the basis of studies in two other jurisdictions, the Ministry estimated that about 20% of facility-fee billings in Ontario are likely inappropriate—for example, due to unnecessary testing.

In some cases, the physician referring the patient is the physician who performs the service, or otherwise works at or owns the facility to which the patient is being referred. This is called "self-referral," because the physician is referring the patient to him- or herself. Physician self-referrals can improve patient care in certain situations: for example, ultrasounds of the eye may be ordered and completed by an ophthalmologist to help diagnose and treat suspected eye disease earlier. However, various studies, including a *Journal of the American Medical Association* article published in 2012, have indicated that "evidence continues to mount showing that physicians with ownership stakes in imaging equipment are more likely to refer their patients for imaging tests than physicians who send their patients to radiologists for independent imaging." The article further noted that "when physicians can refer to scanners they own, [and] there is no third-party oversight, they might be making subconscious decisions to image."

One condition for maintaining a licence for a fee-for-service facility is ministry approval of any changes in the facility's controlling ownership; in the calendar years 2008 through 2011, more than 175 such changes were approved. Facilities are required to confirm ownership every five years as part of their licence renewal. In addition, some owners forward documents indicating the date on which changes were made in share ownership. However, the Ministry does not otherwise periodically ask facilities to confirm ownership by, for example, having owners tick a box on a form and sign if ownership has not changed or state changes in writing and sign. As a result, the Ministry spends extensive administrative effort in tracking ownership structures.

Although the Ministry estimates that about half of Ontario's facilities are fully owned or controlled by physicians, it has not analyzed patterns of referrals by these physicians to their own facilities. The Ministry also does not have information on whether the physicians who refer patients to a given facility have a spouse or other direct relative who owns part or all of the facility. The Ministry could use a form confirming ownership to also periodically confirm whether the owner(s) or any of their immediate family are physicians.

In May 2012, the Ministry proposed to pay only 50% of the facility and professional fees for services where a physician referred a patient to the clinic the physician worked at. The Ministry had not, however, estimated the impact of this 50% reduction on independent health facilities, although ministry documents indicate that some facilities might be forced to close operations and that there was a potential reduction in the quality and safety of imaging or testing services because clinics might use "shortcuts" to reduce costs in order to remain viable. Furthermore, the Ministry generally did not have any information on what might be a reasonable proportion of self-referral tests and what proportion appeared excessive and thereby warranted follow-up. In June 2012, in response to concerns raised by the Ontario Medical Association, the Ministry

announced that it was establishing a panel to review physician self-referrals and would wait for the panel's recommendations before changing the fees related to self-referrals.

Verifying Billings

As shown earlier in Figure 1, total payments to facilities have increased by about 4% a year, from \$348 million in the 2006/07 fiscal year to \$408 million in 2010/11. In particular, facility-fee payments for diagnostic services increased by about 4% a year, from \$323 million to \$377 million. However, ultrasound services increased by 7% a year, from \$130 million to \$173 million, over this time period. More specifically, with 12 ultrasound services, both numbers of services performed and payments increased by more than 50% between 2006/07 and 2010/11. For example, the number of ultrasound billings under the code “miscellaneous extremities charge per limb” increased 130% from 2006/07 to 2010/11 or over 20% per year on average, from a total of \$2.9 million to \$7.5 million. Facility fees have changed very little, so most of this change was due to increases in the volume of services provided. Total payments for contracted services (such as dialysis and abortions) increased from \$31 million in 2006/07 to \$41 million in 2010/11. The biggest increase was due to the Ministry providing one-time funding in 2010/11 for the replacement of about 70 dialysis machines at the facilities offering dialysis services. Although the Ministry reviews service volumes and their effect on total costs to some extent for contracted services, it has not reviewed the reasons for changes in the volume of fee-for-service payments.

The Ministry indicated that historically it has informally identified (for example, through complaints and assessments of facility expansion applications) questionable facility billing practices a few times a year, resulting in about one referral a year to the Ontario Provincial Police. In November 2011, the Ministry began a claims integrity project, which involved reviewing the data on facility-fee claims for the 2010/11 fiscal year. This review identified

that about 25% of operating facilities had some unusual billing patterns. For example, five facilities were billing more than 500 and up to 2,200 combined head and pelvis ultrasounds on the same visit for patients, whereas most facilities billed fewer than 50 of this ultrasound combination. According to the Ministry, this diagnostic combination is expected to occur only rarely, because few patient conditions can be diagnosed by using it. Despite this being a good analysis, the Ministry believed that many of the unusual billings could be resolved through educating facilities on appropriate billing practices and indicated that it was developing educational materials that would be shared with facilities starting in fall 2012. In addition, although the Ministry provided us with a list of potential additional data analyses that might identify other inappropriate billing practices, no plans were in place to conduct such analyses.

The Ministry provides the College of Physicians and Surgeons of Ontario with detailed information on the services billed by each facility. However, the College informed us that although it does receive patient-care data from the Ministry, this information is not provided to assessors and that the assessors' role does not include any claims verification processes. Rather, the College indicated that assessors are provided with only the number of patients who received a particular service within a particular time—for example, the previous few months. The College's assessors select a sample of procedures performed on patients based on information provided by the facility visited to ensure, among other things, that each has an appropriately authorized requisition from a physician. However, the assessors do not test whether the procedures billed to the Ministry were actually performed. We also noted that the Memorandum of Understanding between the Ministry and College did not state that assessors were expected to check facility billings to the Ministry, either by using data from the Ministry or by any other method.

Facilities are to send the Ministry information on when physicians start or stop working at the facility.

The Ministry indicated that it will pay only those billings from a facility that relate to physicians who are listed as working at that facility. Physicians sign the form that facilities submit that states the physician's start date, but when facilities submit the form that states a physician has left, the physician generally does not sign the form, nor is a departure date indicated. As well, every facility fee billed to the Ministry generally should have a corresponding professional fee billed by the facility physician who interpreted the diagnostic test or, in the case of surgery, performed the procedure. The Ministry indicated that it does not periodically reconcile or spot-check the facility fees and the professional fees billed by facility owners and physicians, respectively, to identify discrepancies.

RECOMMENDATION 2

To enhance the cost-effective management of the Independent Health Facilities Program, the Ministry of Health and Long-Term Care should:

- periodically review the fee it pays to independent health facilities (to cover staffing, equipment and other overhead costs) by assessing the actual costs of the services and by making periodic comparisons to other jurisdictions;
- consider alternatives for better managing the volume of fees chargeable by facilities in overserved areas, such as requiring these facilities to obtain ministry approval before increasing capacity by buying more equipment;
- consider requiring facility owners to declare all potential conflicts of interest to the Ministry, and periodically review billing data to identify facilities with unusual billing patterns, including billings resulting from unexpectedly high levels of self-referrals of patients by physicians who own or work at that facility, or who are related to someone who owns the facility—and follow up with these facilities; and

- for selected services, periodically verify that facilities have billed the Ministry only for services provided to patients—for example, through matching facility billings to physician requisitions or to the associated physician's professional fees for the same service.

MINISTRY RESPONSE

The Ministry will consider the feasibility of conducting an inter-jurisdictional review and a relative-value-to-cost analysis of the technical fees that it pays to Independent Health Facilities (IHF).

The Ministry agrees that information about equipment that is purchased by IHF operators is of interest. In this regard, the Ministry established a grant program in the 2011/12 fiscal year to assist IHFs in the purchase of digital equipment and is considering a second year of grant funding for this purpose. Furthermore, the Ministry is considering capacity planning at the local level involving the Local Health Integration Networks, as well as possibly requiring approval prior to capacity expansion by IHFs operating in overserved areas.

The Ministry is concerned about self-referral and ensuring appropriate utilization of diagnostic and imaging services in Ontario, including services rendered in physician-owned facilities. The Ministry's Expert Panel on Appropriate Utilization of Diagnostic and Imaging Studies is expected to make recommendations in fall 2012 regarding the appropriate utilization of diagnostic and imaging services rendered in various professional settings, including IHFs. The recommendations, when received, will be fully reviewed with the Ontario Medical Association and actions will be formulated to address issues relating to self-referral and appropriate utilization in Ontario, including in the IHF sector. As well, the Ministry agrees that the level of physician ownership or material interest in an IHF business operation is of interest and is actively

exploring mechanisms to require that physicians report this information.

In addition, the Ministry is taking further action to implement processes to monitor and manage utilization through proactive claims-data analyses, provider outreach and education, clinic audits, and payment recovery processes. The clinic audit process would include verification processes to ensure that facilities have billed the Ministry only for services they have provided to patients.

PERFORMANCE MONITORING

College of Physicians and Surgeons of Ontario Quality Assurance Assessments

To help ensure the quality of services, all facilities are required under the Act to have a quality adviser, who is responsible for advising the owner about the facility's quality and standards of services. Facility owners who are physicians may appoint themselves as the facility's quality adviser. To obtain independent assurance on the quality of the services provided by facilities, the Ministry has entered into a Memorandum of Understanding (MOU) with the College of Physicians and Surgeons of Ontario (College), the professional oversight organization for physicians in Ontario. Under this agreement, the College is to conduct quality assurance assessments of the services provided by facilities using "Clinical Practice Parameters and Facility Standards" (Standards) developed by the College.

The assessments are conducted by College-appointed assessors—usually a team of one physician and one technologist who have experience in the facility service(s) being assessed. Assessors generally spend about a day at a facility and then submit a report to the College. This report indicates whether the facility met the Standards and provides detailed observations to support the conclusion, as well as recommendations for improvement if needed. Once reviewed by the College, the report is forwarded by the College to the Ministry.

If the facility does not meet the Standards, the report is reviewed by the Ministry's medical consultant, who advises the Ministry on any additional actions that should be taken. When requested to do so by the Ministry, the College will conduct a reassessment, and occasionally focused assessments to follow up on certain issues. The Ministry may act to suspend or revoke licences based on the assessment report's recommendations.

The Ministry paid the College about \$1.5 million for conducting the quality assurance processes at facilities, which included more than 200 facility assessments in the 2010/11 fiscal year. At the time of our audit, the Ministry and the College were negotiating a revised MOU, which was expected to require the facilities to pay the College for conducting assessments, rather than the Ministry paying the College.

Determining Assessor Independence

Because assessors must have experience in the area that they are reviewing, most of the physicians and technologists who perform facility assessments for the College regularly work in hospitals and/or independent health facilities. To help prevent potential conflicts of interest between an assessor and the facility that he or she is assessing, the College verbally asks assessors if they have any potential conflicts (after providing examples of what would constitute a conflict, such as being related to someone or having previously worked with someone at the facility to be assessed). Assessors are generally not permitted to assess a facility with which they have a conflict. However, the College does not require assessors to sign a document declaring that they have no conflicts.

Although the College is responsible for appointing facility assessors, because of the competitiveness of certain facilities, facilities have the option to reject an assessor and have an alternate appointed in certain situations (such as potential conflicts of interest). The College informed us that facilities exercise this option about 2% of the time.

Scheduling Assessments

The Ministry uses its database, which includes the dates of all facility assessments and reassessments, to identify which facilities it will request the College to assess during the next year. The Ministry's general policy is to have each facility assessed every five years. It provides that year's list to the College, which is responsible for scheduling assessments with each facility.

We found that, as of January 2012, the College had not assessed within the previous five years about 12% of the facilities that should have been assessed. The Ministry indicated that assessments could be delayed for various reasons, including a lack of assessors with service-specific knowledge (for example, the College indicated that assessors for sleep study clinics are difficult to find because fewer people specialize in this area) and facilities postponing assessments because of proposed moves to other locations.

In our 2004 Annual Report, we recommended that the Ministry consider having the College perform at least some assessments without advance notice. At the time of our current audit, facilities were always provided with at least six to eight weeks' notice so that they could prepare for the visit. (Reassessments may be unannounced, as discussed further under *Following Up on Assessments*.)

Conducting Assessments and Reporting Assessment Results

The College's assessors use a checklist based on the College's "Clinical Practice Parameters and Facility Standards" (Standards) to conduct their assessments. The Ministry has a copy of the Standards but generally does not receive a copy of the checklists used. To complete the checklist, assessors select and review a sample of test images (in the case of diagnostic facilities) and/or patient charts, surgical notes, and so on (in the case of dialysis and surgical clinics); where possible, they also observe tests being performed on patients. We noted that the College's sampling guideline recommended using

the same minimum sample sizes (between 10 and 15 per type of service provided, depending on the type of facility) for all facilities providing a particular service, regardless of the number of procedures provided by the facility. We also noted that the assessors' approach to choosing this sample did not ensure that they reviewed the work of all professionals at the facility.

After it receives the assessors' report, the College is to report assessment results to the Ministry within three to 20 business days, depending on the seriousness of the assessment results (these time frames were implemented in 2005). We noted that the College generally met these deadlines in the 2010/11 fiscal year. But there is no established deadline by which assessors must report results to the College. We noted that the time between the assessment date and the date that the Ministry received the assessment results from the College was a median of 47 days in the 2010/11 fiscal year, with 90% of reports being received within 84 days. Most of this longer time frame was the time between the assessment date and the College's receipt of the report from the assessor.

The assessment results provided to the Ministry rate facilities on a scale of one (the highest rating: the facility is following the required standards, and there are no recommendations) to five (the lowest rating: patient care is at risk, and recommendations may include the immediate closure of the facility). Between January 2007 and January 2012, more than 80% of the approximately 1,100 facilities that were assessed were rated as meeting the standards with few or no significant recommendations (that is, the facilities received one of the top two ratings).

Following Up on Assessments

The College generally determines whether facilities require any additional follow-up after an assessment, based on feedback from its assessors. Follow-up can range from requiring the facility to forward documents, such as an action plan detailing how it will address identified deficiencies, to the Ministry requesting the College to conduct a reassessment.

Reassessments are generally conducted three months to a year after the original assessment, based on the College's judgment. Six facilities were reassessed in the 2010/11 fiscal year.

In our 1996 and 2004 Annual Reports, we noted that the Ministry and the College had not agreed on timeframes for the College's follow-up activities, and recommended that the Ministry update its Memorandum of Understanding with the College to incorporate such timeframes. However, no timeframes were in place at the time of our current audit.

The Ministry can ask the College to conduct its planned reassessments on an unannounced basis. In these cases, the College either sends assessors in completely unannounced or notifies the facility that an assessment will be conducted within the next month, without providing a specific date. We noted one case where the facility denied the assessors entry on two "unannounced" occasions in 2010 before providing access in March 2011, even though the *Independent Health Facilities Act* states that all facility owners are required to co-operate fully with assessors. However, the Act has limited penalties for refusal to co-operate, and the College told us that it does not have any authority to impose penalties in this situation.

In the 2009/10 fiscal year, to obtain more assurance that facilities with previously identified and rectified problems were continuing to meet standards, the Ministry asked the College to assess certain facilities every two to three years, rather than the standard five years. In the 2010/11 fiscal year, the College conducted 26 of these mid-cycle assessments.

Inspections Conducted by the X-ray Inspection Services Unit

While the College's standards require facilities to check radiation-producing equipment every six months, the Ministry is responsible under the *Healing Arts Radiation Protection Act* (HARP Act) for periodically inspecting a facility's radiation-

producing equipment, including primarily the equipment used to perform x-rays but also the equipment used for CT scans and fluoroscopy (which involves a series of x-rays that produce a continuous moving image on a monitor, giving, for example, a picture of the movement of contrast dye through a patient's body). The Ministry's X-ray Inspection Services Unit (Unit) is responsible for these inspections, as well as for ensuring the appropriate initial installation of radiation-producing equipment (for example, sufficient lead in the walls for shielding). The Unit also ensures that x-ray equipment does not produce radiation in excess of standards set out in the HARP Act. Radiation produced by CT equipment is not reviewed by the Unit because there are no similar standards for CT equipment.

The Unit is responsible for inspecting just over 7,600 locations—including hospitals, dental sites and more than 450 independent health facilities—with radiation-producing equipment. In the 2011/12 fiscal year, the Unit inspected a total of nearly 1,700 locations, including about 70 independent health facilities.

The Unit has four inspectors who perform announced visits that are scheduled using risk-rankings for the various types of facilities. For example, independent health facilities are required to be assessed within one year of opening a new location and every two to three years after that, unless they receive a ranking of "bad" as a result of an inspection, in which case they are inspected annually until the situation is rectified. Ministry policy is to inspect all radiation-producing equipment at new locations and about 25% of the equipment at established locations. The Unit cannot easily determine the percentage of facility equipment tested because it did not document all equipment in use at the inspected facilities. We also noted that ministry policy does not indicate that inspectors should ensure that all equipment is tested over time; rather, the policy indicates that higher-risk equipment, such as fluoroscopy equipment, should be tested.

We reviewed the data from the Unit's inspection database and found that as of March 2012, almost 60% of the independent health facilities had not been assessed within the Unit's prescribed time frames. Furthermore, the Ministry could not determine how many of these facilities were new or how many had been rated as "bad" in their last inspection.

The Unit does not rely on the work of other oversight entities, including the Canadian Association of Radiologists, the Ontario Association of Radiologists and the Ontario Breast Screening Program, all of which review certain types of radiation-producing diagnostic imaging equipment, including equipment in independent health facilities. The work of these organizations might enable the Unit to reduce its time at some facilities and focus its efforts on facilities and/or equipment that are not otherwise being tested.

The Ministry had no policies or procedures on what type of information should be exchanged between the Unit and the Ministry's Independent Health Facilities Program; rather, communications occur at the discretion of staff in each ministry area. We noted that minimal communication or exchange of information took place between the Unit and the Program. For instance, the Unit's inspection system and the Program's database were not linked, and although the Ministry indicated that data comparisons to identify discrepancies could be conducted manually, this has not been done. As a result, for example, the Unit incorrectly categorized almost 40 independent health facilities as dental offices, which are generally inspected every five years rather than every three years for independent health facilities. The Unit also had two facilities that were actually open incorrectly listed as "closed" and did not have current information on 12 facilities that had moved more than a year previously. Furthermore, the Unit's inspection reports were not forwarded to the Program—although the inspection staff told us that they would inform the Program of any significant issues.

Ministry Monitoring

Suspensions and Revocations of Licences

The *Independent Health Facilities Act* (Act) states that the Ministry can revoke, suspend or refuse to renew a facility's licence for a variety of reasons. Problems can include quality assurance issues (such as equipment requiring maintenance) and operational issues (such as facilities operating out of unapproved locations; ceasing to operate for at least six months without taking reasonable steps to prepare to reopen; or transferring over 50% of a facility's ownership without obtaining ministry approval).

The Act allows the Ministry to immediately suspend a facility's licence if there is an immediate risk to a patient's health or safety. We noted that the last suspension occurred in 2011. The Ministry indicated that in most cases, there is no immediate risk to patients. In these cases, under the Act, the Ministry issues a "proposal to suspend" a facility's licence, an approach that provides the facility with time to correct any identified quality assurance problems in order to avert a licence suspension. Between January 2007 and January 2012, the Ministry issued such notices to 32 facilities. The Ministry ultimately suspended seven for not taking the required corrective action on a timely basis.

The Ministry can revoke the licence of suspended facilities that do not correct identified problems, as well as facilities with operational issues. The Ministry's records indicated that six licences were revoked from January 2007 through January 2012. Most of these revocations occurred because the facility had ceased operations for more than six months and did not make sufficient efforts to reopen.

When the Ministry proposes to suspend or revoke a licence, the Act allows the facility owner 15 days to request a hearing with the Health Services Appeal and Review Board. Facilities that request a hearing can continue to provide services to patients and bill the Ministry until the Board makes a decision. We noted that between January

2007 and January 2012, facilities requested hearings regarding seven proposals to revoke. Of the 21 hearing requests that were resolved between January 2007 and January 2012, 17 were settled between the Ministry and the facility owner before the Board reached a decision, three were not pursued by the facility owner, and the Board made a decision on the remaining one. Most of the 17 that were settled involved three facility owners. We also noted that the average time from request for hearing until resolution was about five years for quality assurance issues and two years for operational issues.

Even though the Act gives the Ministry significant discretion regarding whether or not to license facilities if it has reasonable grounds to believe that a facility is not being operated in accordance with the law or with honesty and integrity, this provision is rarely used. For example, the Ministry licensed an owner to provide a new service even though ministry staff had identified significant concerns about this owner's billings the year before (a full investigation of the billings irregularities was still under way when the owner was licensed for the new service).

Other Monitoring Activities

The Ministry is made aware of activities or circumstances that constitute a contravention of the Act in a number of ways, including complaints by the public and other facility owners. However, the Ministry has no information about complaints made directly to facilities. The Ministry tracks the complaints it receives (mostly from the public) that indicate quality-of-care deficiencies or other violations of the Act. About 35 such complaints were tracked in 2011, with over half pertaining to quality assurance issues such as equipment not being disinfected between patients and facility staff not behaving professionally. The Ministry's complaint follow-up activities varied depending on the nature of the complaint. For example, in two cases the Ministry asked the College of Physicians and Surgeons to

conduct a focused facility assessment to review the issues.

The Ministry also conducts other administrative activities to ensure compliance with the Act, some of which may involve time-consuming processes. For example, as previously noted, ministry staff make extensive efforts to track information on facility owners. And every month, ministry staff manually review a report on facility billings, track which facilities have not billed in the previous six months and send a letter to those facilities. The letter asks the facility to either confirm that it has ceased operations or provide the steps it is taking to reopen. A follow-up letter is issued after an additional six months if necessary, and if billings do not begin again, more progressive actions, such as a proposal to revoke the facility's licence, are undertaken. Between January 2007 and January 2012, the Ministry sent about 200 letters regarding 100 facilities that did not bill for at least six months.

While these may be worthwhile efforts, we expected that the Ministry would have assessed whether its time might be more effectively used following up on those facilities with unusual or possibly inappropriate billing practices, as discussed previously.

RECOMMENDATION 3

To better ensure that independent health facilities are providing services according to quality medical standards established by the College of Physicians and Surgeons of Ontario (College) and are meeting other legislated requirements, the Ministry should:

- work with the College to ensure that every facility is inspected at least once between each five-year licence renewal for that facility;
- consider including additional expectations in its Memorandum of Understanding with the College, such as:
 - requiring assessors to review the quality of each physician's work at the facility; and
 - requiring that assessment results for facilities with significant issues be more

promptly reported to the Ministry after the assessment;

- consider, when next reviewing the *Independent Health Facilities Act*, adding penalties for facility owners who refuse access to the College’s assessors when they arrive unannounced;
- develop policies and procedures to improve information-sharing between the Ministry’s Independent Health Facilities Program and its X-ray Inspection Services Unit, including information on the location of facilities offering x-ray services as well as information on inspection results, so that each has the most current information available on the facilities they oversee; and
- consider options for streamlining the monitoring of facilities’ activities, including determining whether the Ministry’s X-ray Inspection Services Unit can rely on the work of other professional or federal oversight entities to enable it to focus its activities on the newer or higher-risk facilities.

MINISTRY RESPONSE

The Ministry is working with the College to ensure that every independent health facility is inspected at least once within the five-year renewal cycle. Although there may be exceptional circumstances (for example, where services are not currently being provided or when a facility is in the process of relocating, changing owners or expanding the scope of services being provided), the Ministry will work closely with the College to minimize such exceptions.

The Ministry agrees with the recommendation with respect to requiring assessors to review the quality of each physician’s work. At this time, the College is in the process of aligning the quality assurance assessment program for independent health facilities with its peer review program for physicians, to ensure that radiologists are peer-reviewed at the same

frequency as other physician specialties. As well, with respect to the College’s prompt reporting of facilities with significant issues to the Ministry, a working group has been established to review reporting policies and to suggest appropriate standards for the turnaround time from the date of assessment to notifying the Director of significant issues.

The Ministry will consider implementing penalties or other appropriate provisions in situations where facility operators deny access to the College’s assessors.

Patient safety is a ministry priority. The X-ray Inspection Unit is embarking on a review of its inspection delivery model and is collaborating with other branches of the Ministry in a broader review of the *Healing Arts Radiation Protection Act* (HARP Act) to identify options to enhance the oversight of x-ray machines in Ontario. The Ministry has made a specific commitment to review the current HARP Act to identify opportunities that would help promote continuous improvement in the safe use of radiation-emitting medical imaging devices.

COMMUNITY HEALTH-CARE CLINICS NOT COVERED BY THE ACT

Community health-care clinics fall into two categories:

- those that are covered by the *Independent Health Facilities Act* (Act), which we refer to throughout this report as “independent health facilities” (facilities), and
- those that are not covered by the Act, which we refer to as “community health-care clinics” (or community clinics).

In our 2004 audit of independent health facilities, we noted that some diagnostic procedures, such as colonoscopies, were not licensed services under the Act and were therefore performed at community health-care clinics not covered by this legislation. We also observed that a licensed

service, abortion, was being performed both in independent health facilities and in community clinics. At that time, neither community clinics providing colonoscopies nor community clinics providing abortions were subject to the College's quality assurance assessments.

In 2007, the Ministry licensed one independent health facility in Northern Ontario to provide, among other things, colonoscopies. The Ministry had no documented rationale for why only this community clinic was licensed as a facility to provide colonoscopies. At the time of our current audit, the Ministry had no information on the number of non-facility community clinics operating in Ontario that were performing colonoscopies. However, information at the Ministry indicated that in the 2010/11 fiscal year, about 36% of all colonoscopies were performed in community clinics.

In 2010, legislative changes to the *Medicine Act, 1991* made the College of Physicians and Surgeons of Ontario (College) responsible for inspecting all community clinics that use anaesthesia to provide insured services (such as cosmetic surgery and colonoscopies) and uninsured services (such as hair transplants). However, the Ministry does not obtain information on the frequency or outcome of these inspections. We contacted the College, which informed us that since commencing such inspections in fall 2010, it had inspected about 50 community clinics performing colonoscopies and four community clinics performing abortions. The College indicated that most of the community colonoscopy clinics had passed their inspections with some conditions. No information was provided by the College regarding the community abortion clinics.

We also noted that about 50 of the x-ray sites inspected by the Ministry's X-ray Inspection Services Unit were community clinics, not independent health facilities. These clinics cannot bill the Ministry or their patients for facility fees for insured services, but physicians working in these clinics can bill the Ministry for the related professional

fees. The Ministry's Independent Health Facility Program was not aware of these community x-ray clinics, and, unlike the case with independent health facilities, the x-rays read by radiologists in these clinics are not periodically reviewed by the College.

RECOMMENDATION 4

To ensure that all community clinics providing insured services—even those that do not use anaesthesia—offer quality medical services, the Ministry of Health and Long-Term Care should consider engaging the College of Physicians and Surgeons to oversee those clinics that offer services that would be subject to College oversight if they were classified as independent health facilities.

MINISTRY RESPONSE

The Ministry agrees that the provision of quality health care that includes quality medical services is a priority and established Health Quality Ontario (HQP) to lead the Ministry's quality and evidence-based agenda. Among other things, HQP makes recommendations to the Ministry regarding the quality of health- and medical-care services provided to patients, including services provided by community and specialized clinics, and also provides guidance and makes recommendations to health-care providers and relevant organizations on standards for patient care based on evidence, and clinical best practice guidelines and protocols.

Furthermore, Cancer Care Ontario and the College are working in partnership to plan and implement a model for quality improvement focused on selected health services that are delivered in settings other than an independent health facility, including pathology, colonoscopy and colposcopy. The Ministry expects to receive an implementation plan by March 2013.

PUBLIC INFORMATION

Patients have the right to choose which independent health facility they go to. To make these choices, patients need information on which facilities provide the service(s) they require and where these facilities are located.

Referral Forms

Patients requiring services provided by an independent health facility often get a referral form from their physician that provides contact information for one facility or for several facilities owned by the same owners. Many patients assume that they must go to a facility on the referral form; but in fact they are free to choose a hospital or any facility that offers the required service(s), including a facility that may be closer to home. As noted earlier, some physicians have a financial interest in certain facilities, which, as several studies have indicated, may influence both the rate at which they prescribe certain tests and which facilities they refer patients to. In contrast, referral forms for laboratory services (such as blood tests) are standardized and do not readily lend themselves to listing specific laboratories. At the time of our audit, the Ministry did not have any plans to develop a standardized referral form for services provided by independent health facilities.

Ministry Website

The Ministry has a website (the Health Care Options Directory) that allows the public to search for locations providing services such as x-rays and ultrasounds. But this site does not list all of the independent health facilities and hospitals providing these services. Rather, it is primarily a listing of these services provided outside of facilities and hospitals, such as in after-hours clinics. In 2010, the Ministry introduced another website that lists only the independent health facilities in Ontario. The list includes each facility's address and telephone

number, as well as all the services each facility is licensed to provide. The Ministry told us that this list is updated monthly and that patients interested in identifying alternative facilities can review this list.

However, we noted that the list was not as helpful as it could be. For example, unlike the Health Care Options Directory website, this website had no tools allowing users to search by postal code or by service area. More significantly, the list did not always offer an accurate description of the services offered at a given facility: a clinic listed as licensed to offer a specific service might not actually offer that service. When we contacted a sample of facilities that the website indicated were licensed to provide fluoroscopy services, 35% said that they did not provide such services at all, and another 20% said that they had temporarily suspended the service because of machine-maintenance or other issues. One facility's phone number was no longer in service, and a staff person at another directed us to a different location, which we noted was not licensed to provide the service. (The Ministry was following up with this facility.) The website also did not list the specific services provided at a given facility. For example, not all facilities offering ultrasound services perform knee ultrasounds.

We noted that as of January 2012, the list included addresses for almost 950 facilities; however, information at the Ministry indicated that there were about 800 unique facility locations. We were informed that some facility owners operate with multiple licences out of one location. As well, we noted that more than 20 listed facilities had not been open for at least five years.

In our *2004 Annual Report*, we recommended that the Ministry consider publicly disclosing any serious quality assurance problems at independent health facilities. We noted during our current audit that the Ministry's website included the dates and results of each facility's last quality assurance assessment. However, it did not indicate which facilities had been suspended for failing to meet required standards; instead, suspended facilities

were just removed from the online list. Because suspended facilities may continue to offer patient services (they cannot bill facility fees, but can still bill professional fees), the Ministry requires suspended facilities to remove their licences from their walls so that patients know that they are suspended. But the Ministry has not analyzed whether this is an effective way of informing patients that the facility's licence is suspended.

The website also provides no information about the process for filing a complaint about an independent health facility.

Wait Times

The Ministry's Wait Time Strategy website reports wait times for MRI and CT examinations at hospitals, and for cataract surgeries at hospitals and at one of the two independent health facilities providing these surgeries. The Ministry does not report the wait times for an MRI or CT at the seven independent health facilities offering these services. As a result, patients cannot "shop" for the shortest wait time for these services. As well, the Ministry does not collect or report wait times for other diagnostic services provided by independent health facilities, such as x-rays and ultrasounds, because the Ministry does not expect significant waits for these services. Although we would not expect the Ministry to track services with same-day access (such as many types of x-rays), public information on wait times for services that have historically involved a significant wait (such as MRIs, CTs and cataract surgeries) might be beneficial.

RECOMMENDATION 5

To ensure that patients have access to relevant information about independent health facilities that can help them obtain required services, the Ministry of Health and Long-Term Care should:

- consider the costs and benefits of introducing a standardized referral form, similar to that used in the laboratory program, that restricts physicians from recommending a preferred facility and that contains information about how to locate an independent health facility using the Ministry's website;
- combine existing website information into one website with search functionality that specifies all locations where patients can access community services, such as x-rays and ultrasounds, as well as available services and wait times for services that do not have same-day access (for example, MRIs and CT scans); and
- provide information on its website regarding how to register a complaint about an independent health facility.

MINISTRY RESPONSE

The Ministry agrees that public information-sharing accomplished through accessible and user-friendly formats, tools and mechanisms is important. In this regard, the Ministry will:

- explore options for standardizing diagnostic referral forms, including the potential for electronic referral formats;
- explore options to combine existing website information to ensure patients have access to comprehensive information (the Ministry is in the process of having independent-health-facility MRI and CT service wait times reported through the Provincial Wait Times Strategy); and
- include information on its website on how to register a complaint about an independent health facility.