Chapter 1

Summaries of Value-for-Money Audits

Introduction to Mental Health Audits

Sections 3.01, **3.07**, **3.08** and **3.12** in **Chapter 3** deal with mental health:

- 3.01 Child and Youth Mental Health
- 3.07 Housing and Supportive Services for People with Mental Health Issues (Community-Based)
- 3.08 Large Community Hospital Operations
- 3.12 Specialty Psychiatric Hospital Services

What Is Mental Illness?

Ontario's health-care system and the delivery of health-care services are regularly the topics of audits by our Office. Often, these audits focus on physical illnesses and related service delivery, such as palliative care, land ambulances and cancer screening, to name a few. With a recent increase in public awareness of mental illness and an increasing level of resources devoted to its treatment, our Office selected four aspects of mental health services to audit this year.

While people with good mental health live in a state of well-being in which they can cope with the normal stresses of life, function productively and contribute to their community, people suffering from mental illness experience disturbances in their thoughts and/or behaviours that make them unable to cope with life's ordinary demands and routines. Mental illness can be temporary or permanent, and can range from mild illness (such as limited episodes of depression) to more enduring and complex conditions (such as bipolar disorder and schizophrenia). Further, the symptoms experienced by those diagnosed with mental illness can vary greatly—from having little impact on their ordinary life to having crippling effects, resulting in the person's inability to properly function in society and posing a risk of harm to both themselves and others.

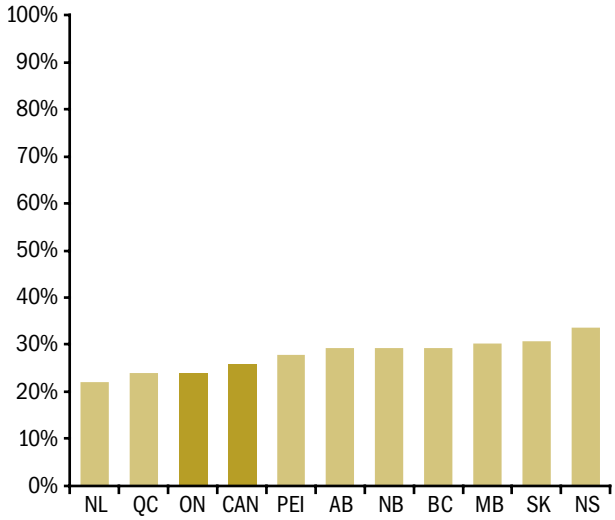
Prevalence of Mental Health Problems in Ontario and Canada

It is estimated that one in five Ontarians (about 2.8 million people) will experience a mental health problem at some point in their lives. According to Statistics Canada, the prevalence of mental illness in 2012 (the latest year for which data is available) was 26% for the whole country. By province, the prevalence of mental illness ranged from a low of 22% in Newfoundland and Labrador to a high of 34% in Nova Scotia, as shown in **Figure 1**. The prevalence in Ontario was 24%.

A 2015 Government of Canada study showed that the number of adult Canadians using health services for a mental illness remained stable between the 1996/97 and 2009/10 fiscal years, but jumped as much as 44% during the same time frame among youth aged 10–14 years. In Ontario specifically, the last five years ending March 31,

Figure 1: Prevalence of Mental Illness for Individuals Aged 15 and Over by Province, 2012

Source of data: Statistics Canada



Note: Includes all categories and levels of mental illness. In contrast, serious mental illness is experienced by about 2.5% of Ontario's population (categorized as a diagnosis of mental illness such as schizophrenia, depression, bipolar disorder or personality disorder; a long duration of illness; and a significant disability in day-to-day functioning).

2016, have seen a 21% increase in the use of emergency departments for mental health conditions.

Scientific understanding of mental illness is improving. Research shows that mental illness is a complex interaction of genetic, biological and personality traits paired with circumstances and social environment. Social conditions such as poverty, inadequate housing, unstable employment and lack of education are some factors that increase the risk of effects on mental health. It is also known that mental health problems affect men and women differently and at different stages in life. We have learned the importance of addressing these conditions early on: 70% of young adults experiencing mental health problems report them as having started in childhood.

Mental Health Care in Ontario

The Ontario Government spends approximately $3.5 billion annually on mental health and addictions services in support of its citizens suffering from mental illness. Of this amount, $3.1 billion is spent by the Ministry of Health and Long-Term Care, and the remainder is spent by the Ministry of Children and Youth Services, which funds a separate community child and youth mental health system. In addition to the $3.5 billion, other ministries of the Ontario Government also allocate resources to mental health services. These services are delivered through a large range of public institutions and groups including schools, hospitals (including psychiatric), community health, child and youth, and other social service agencies, supportive housing agencies, prisons, primary care centres (for example, clinics and doctors' offices) and professionals in private practice. The delivery of these services in Ontario, however, is not centralized or co-ordinated. Rather, the delivery and oversight of mental health services is quite fragmented, with no province-wide integrated network of care, support or oversight.

Recognizing the potential for improvement that greater co-ordination of providers and services might bring, in 2011 the Ontario Government launched *Open Minds, Healthy Minds*, a wide-ranging mental health and addictions strategy. By working with 15 ministries and across government levels, this strategy seeks to improve the quality and co-ordination of mental health services available, and thus the quality of life of Ontarians. A large part of this strategy focuses on early intervention and support for children, in order to identify and intervene in child and youth mental health and addiction issues early in life.

Building on the provincial strategy, in 2012 the Ministry of Children and Youth Services launched *Moving on Mental Health: A System That Makes Sense for Children and Youth*, an action plan to provide a simplified and improved experience for children and youth with mental illnesses and for their families. In particular, it seeks to strengthen community ties so that families will know what mental health services are available and how to access them.

Also in support of *Open Minds, Healthy Minds*, the Mental Health and Addictions Leadership

Advisory Council was struck in 2014 with a three-year mandate to provide advice to the Ministry of Health and Long-Term Care on the implementation of its mental health strategy. Its members represent diverse sectors of the population, including service providers, experts and people with personal experience of mental illness.

Pathways of Access to Care

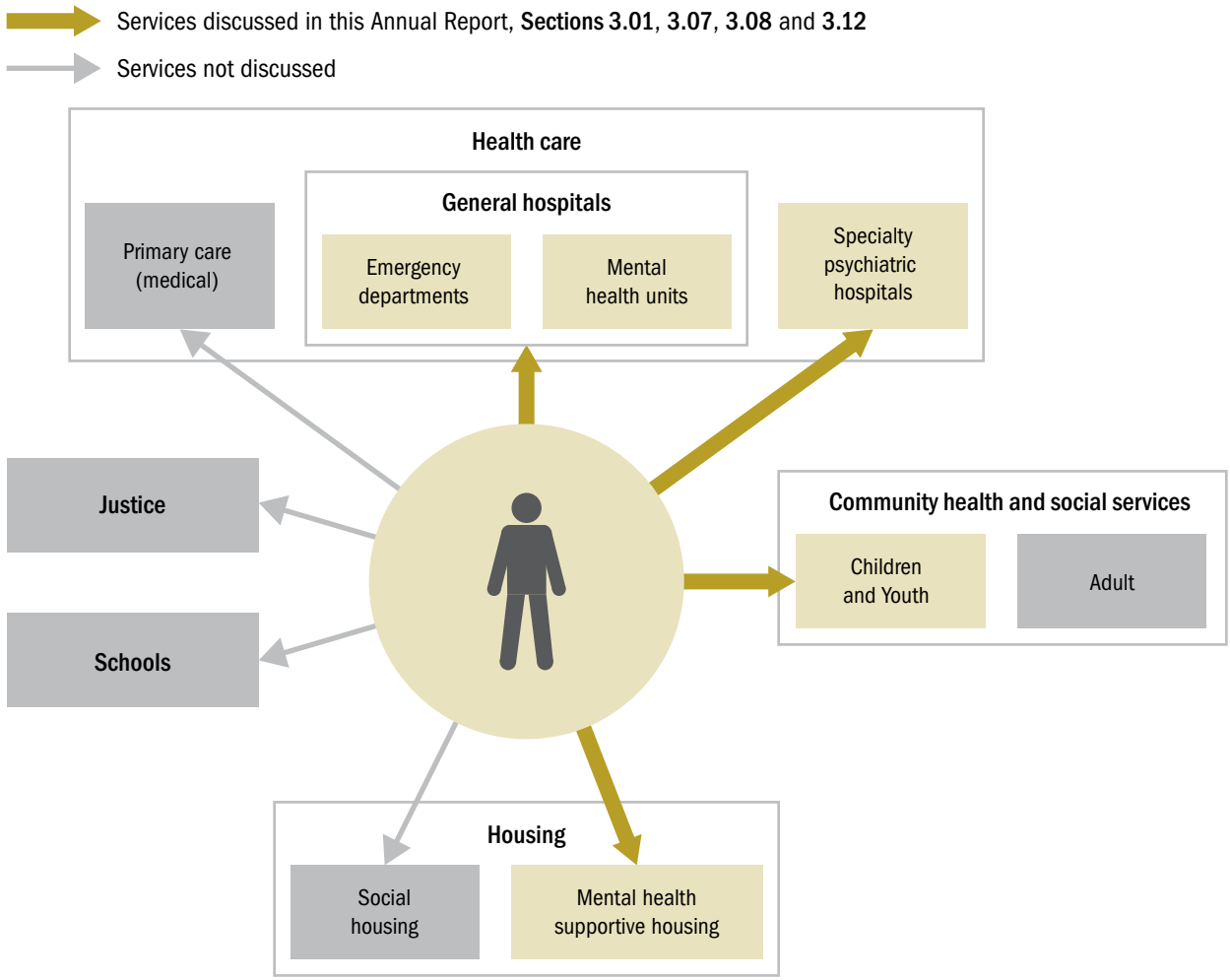
Depending on one's age, location and condition, individuals who are experiencing mental illness have a number of avenues available to get help. Nevertheless, vulnerable individuals have particular difficulty in accessing services. Mental health care services in Ontario are delivered by many different sectors and organizations, as shown in **Figure 2**, and are overseen by multiple provincial ministries.

A person seeking mental health services may access appropriate services in the following ways:

- Primary care, such as one's family doctor, is an option for treatment or referrals to other professionals and services.
- Crisis and emergency care can be accessed through a general hospital emergency department, where one can be treated or stay until further referral to other professionals and services.
- In-patient services are available in 87 of the general hospitals for those with serious mental illnesses.

Figure 2: Services Available to Ontarians Living with Mental Illness

Prepared by the Office of the Auditor General of Ontario



- Specialty psychiatric hospitals treat individuals suffering from the most severe mental illnesses (the four that operate in Ontario are the Centre for Addiction and Mental Health in Toronto, Ontario Shores Centre for Mental Health Sciences in Whitby, the Royal Ottawa Health Group in Ottawa and Brockville, and Waypoint Centre for Mental Health Care in Penetanguishene).
- For children and youth aged 18 and under, services are available through more than 400 community mental health agencies and service providers. These may be accessed directly at the agency or through a referral (from, for example, a school or other health-care professional).
- For adults, support such as crisis intervention, counselling and, if necessary, supportive housing is available through about 300 community-based mental health agencies.

The Four Mental Health Services Audits

In this year's Annual Report, our Office has conducted value-for-money audits of four areas of mental health services in Ontario: housing and supportive services for people with mental health issues, large community hospital operations, specialty psychiatric hospital services, and child and youth mental health.

- In our audit of housing and supportive services for people with mental health issues, we looked at the effectiveness of supportive housing programs delivered by the Ministry of Health and Long-Term Care, in conjunction with the Local Health Integration Networks (LHINs) and service providers. This audit examined the co-ordination of services with other entities, the cost-effectiveness of the program, and the delivery and measurement of the support services.
- In our audit of hospital operations, we assessed whether the systems and procedures in place at large community hospitals could ensure that patients receive timely access to quality, safe, reliable and equitable health-care services, that resources are efficiently used, and that operational effectiveness is measured, assessed and reported. Specifically, this audit looked at three large community hospitals with a focus on patient admissions and movement through the hospital.
- With the specialty psychiatric hospital services, our audit work at the Ministry of Health and Long-Term Care and LHINs focused on their oversight and funding of the four specialty psychiatric hospitals, while our audit work at the hospitals focused on their provision of mental health services and whether the procedures and processes in place ensure that the needs of the patients and the community are met.
- In our audit of child and youth mental health, our objective was to assess whether the Ministry of Children and Youth Services, and child and youth mental health agencies, had effective policies and procedures for ensuring that children in need of mental health services receive appropriate and timely services in accordance with program requirements. We also considered whether funding provided to agencies is commensurate with the value of the services provided.

Summaries of Value-for-Money Audits

3.01 Child and Youth Mental Health

The Ministry of Children and Youth Services (Ministry) provides funding for community-based mental health services in Ontario—such as counselling and therapy, intensive treatment, specialized consultation and assessment, and crisis support—to children and youth (from birth to 18 years of age),

and their families, who are experiencing or at risk of experiencing mental health problems, illnesses or disorders such as depression, anxiety, and attention deficit/hyperactivity disorders.

In 2015/16, the Ministry provided $438 million in transfer payments through its Child and Youth Mental Health (CYMH) program to more than 400 service providers, including agencies that primarily deliver child and youth mental health services and multi-service agencies that deliver a number of other Ministry-funded programs. These agencies reported over 120,000 registered clients.

In our audit this year we noted that many of the issues we highlighted in our 2003 audit of the CYMH program remain significant concerns. Specifically, we found that the Ministry still does not monitor and effectively administer this program to ensure that children and youth in need of mental health services are provided with timely, appropriate and effective mental health services, and to ensure that mental health services are delivered efficiently. While the Ministry has established program delivery requirements, it does not monitor whether agencies comply with these requirements, and its requirements are not always clear, leading to inconsistencies in service delivery across the agencies.

Consistent with our findings in our 2003 audit of community-based child and youth mental health services, the Ministry continues to primarily fund agencies based on historical spending instead of the current mental health needs of the children and youth they serve. We also found that the agencies' cost per client served varies significantly and could be in some respects indicative of funding inequity between agencies, but the Ministry has not assessed these variances to determine their reasonableness. Further, as we noted in our 2003 audit, the Ministry does not measure individual agency performance against targets, and does not effectively monitor client outcomes or overall program performance against measurable and meaningful targets.

Hospital emergency room visits by children and youth and their in-patient hospitalizations for mental health problems have increased more than 50% since 2008/09. Although this trend signals a growing problem, the Ministry has not analyzed the reasons for the increase.

In our audit this year we also found that the four agencies we visited do not always comply with Ministry requirements for the delivery of services. Also, none of these agencies effectively monitor the outcomes of children and youth to help ensure that they are provided with timely, appropriate, and effective mental health services based on their assessed needs.

The following are some of our specific concerns about the delivery of mental health services by agencies:

- **Agencies did not always help in the transition of discharged children and youth to other service providers putting treatment gains already achieved at risk.** None of the four agencies we visited had policies to guide the actions of its staff when discharging clients that require transition to another service provider. Managing transitions is important to maintain continuity of service for clients and minimize disruption to the treatment gains they have already achieved. At one agency, we found cases where clients were discharged to the care of a Children's Aid Society while still requiring service, but were not provided any help to transition to another mental health service provider. At another agency, 50% of the discharged files we reviewed included a recommendation by the agency to transition to another service provider. However, the agency did not work with the service provider it recommended to facilitate the transition, as expected by the Ministry.
- **The mental health needs of children and youth are not assessed consistently, increasing the risk of inconsistent service decisions.** Agencies are required to assess the needs of children and youth using standardized, evidence-informed assessment tools. Standardized, evidence-informed assessment tools are intended to enhance the consistency

and objectivity of assessments. However, we found such tools were either not completed, or it was not evident that results from these assessment tools were used to help develop initial service plans, in about 50% to 100% of the cases we reviewed at three of the four agencies we visited. In addition, at each of the four agencies visited, we also found that in 20% to 100% of the cases we reviewed, the agencies either did not complete evidence-informed assessment tools, or it was not evident that they used the results of these assessment tools to periodically assess the mental health services provided to children and youth to help update service plans, and to inform decisions to discharge children and youth from service.

- **Absent Ministry direction, timelines for reviewing service plans varied between agencies, increasing the risk of delaying children and youth from receiving services most appropriate to their needs.** Although the Ministry requires agencies to regularly review the service plan of each client, it does not prescribe timelines for doing so. We found that the agencies we visited had different timelines for reviewing service plans, ranging from three to six months. As well, at two of the four agencies we visited, we found that in some cases the agencies either did not follow their own timelines or did not review service plans at all as required by the Ministry.
- **There is a risk that the mental health of children and youth can deteriorate while waiting for service, but little is done to monitor wait time trends and their impact.** The agencies we visited do not currently monitor trends in wait times to assess their reasonableness and to identify issues that may require follow-up or corrective action. In addition, although most of the agency caseworkers we spoke to told us that the mental health of at least some, and as many as half, of the children they work with deteriorated while waiting for service, none of the agencies we visited track the impact of wait times on the mental health problems of children and youth waiting for service. We noted that average wait times for some services in 2015/16 exceeded six months at three of the four agencies we visited.
- **Agencies do not monitor and assess client outcomes to determine if clients benefited from the services they received.** The agencies we visited did not consistently determine and record whether clients achieved a positive outcome at the end of their mental health service, as required by the Ministry. As well, all four agencies we visited did not monitor client outcomes to assess their reasonableness and to identify trends that may require follow-up and/or corrective action to help ensure children and youth receive appropriate and effective mental health services.
- **A lack of supervision of key decisions by caseworkers could increase the risk of negative consequences for children and youth.** Neither the Ministry nor the four agencies we visited require supervisors in agencies to review and approve key decisions and documents completed by agency caseworkers.

The following are some of our specific concerns about the Ministry's administration of the Child and Youth Mental Health program:

- **Ministry does not fund agencies based on the current needs of children and youth served.** Similar to when we last audited the program in 2003, the Ministry continues to allocate the vast majority of funding to agencies based on historical allocations instead of the mental health needs of the children and youth they serve. In addition, we found that the Ministry's plan to implement a new needs-based funding model by 2016 has been delayed, and a timeline for its implementation has yet to be determined.
- **Ministry does not provide clear program requirements to agencies and there is**

insufficient Ministry oversight of the services delivered by agencies to help reduce the risk of inconsistent service delivery. Although the Ministry has established minimum expectations for the delivery of services, it has not implemented a process to monitor whether agencies comply with these requirements, and we found many cases where they did not. In addition, we found that the Ministry's expectations are in some respects general, increasing the risk that they will be interpreted and applied inconsistently by agencies. For example, the Ministry requires that clients on waitlists for service be informed at regular intervals about their status, but it has not defined what a regular interval should be. As a result, we found that just one of the agencies we visited had a policy and time frame to update clients about their status while on a waitlist.

- **Ministry does not assess the reasonableness of significant differences between agencies in costs per client and client caseloads per worker to help ensure agencies are effective and efficient.** The Ministry collects information from agencies on the services they provide, their staffing levels and financial data. However, the Ministry does not review this information to identify and assess whether significant differences between agencies in costs per client served and caseloads per agency worker are reasonable. We analyzed this data for 2015/16 for all agencies and found significant variances that warrant Ministry follow-up. For example, we looked at the costs for providing five mental health services, and found that approximately one in five agencies reported average costs per client that were at least 50% higher than the provincial average. As well, between 16% and 24% of agencies reported average caseloads per worker that were at least 50% larger than the provincial average for these same services.
- **Ministry does not monitor the performance of the program or agencies to facilitate corrective action where needed, and does not collect data on all current Ministry performance indicators.** Although the Ministry introduced 13 new performance indicators in the 2014/15 fiscal year, it is still not collecting data on three of them, and has not set targets for any of the indicators against which to measure results. In addition, even though agencies have been reporting their data on the indicators, the Ministry has not analyzed the results to identify if follow-up and corrective action is needed at specific agencies. Our analysis of the Ministry's data identified variances that should be followed up by the Ministry. For example, nearly one in five agencies reported an average wait time for intensive treatment services that was at least 50% longer than the provincial average of 89 days, and nearly one-third of agencies reported that less than 50% of children and youth who ended service with their agency had a positive response to treatment compared to the provincial average of 64%.
- **Better co-ordination with other ministries may help with the delivery of mental health services and improve the outcomes of children and youth.** Although the Ministry led the Ontario Government's Comprehensive Mental Health and Addictions Strategy (Strategy) from 2011/12 to 2013/14, the Ministry has not worked with the other ministries participating in the Strategy to identify whether further opportunities might exist to improve the way the province provides mental health services. In 2014, the responsibility to lead the Strategy transferred to the Ministry of Health and Long-Term Care.

Since 2012, the Ministry has led the implementation of the Moving on Mental Health Plan including taking a number of steps to help improve the program. Some steps taken were as follows:

- Defining core mental health services delivered by agencies.
- Committing to the Development and implementation of an equitable funding model for core mental health services delivered by agencies that reflects community needs.
- Selecting lead agencies in geographic areas that will be responsible for planning and delivering core mental health services. They will also be responsible for creating clear pathways to both core mental health services, and services provided by other sectors such as education and health, so that parents will know where to go for help and know how to get services quickly.

However, we found that while the Moving on Mental Health Plan was expected to be implemented in about three years, it has been delayed and it is unclear when the Plan is expected to be fully implemented.

3.02 Climate Change

Scientific studies indicate increased emissions of greenhouse gases, such as carbon dioxide and methane, from human activities have warmed the Earth's atmosphere and altered climate patterns around the world. Scientists have documented the effects of climate change including the melting of the polar ice caps, rising sea levels, and an increased number of extreme weather events.

The international community has highlighted climate change as an urgent and potentially irreversible threat to humans and the environment, and agreed an international response is required to reduce greenhouse-gas emissions.

Ontario accounts for less than 1% of the world's annual greenhouse-gas emissions, but Ontario's annual average emissions per person is higher than the global average, though lower than the Canadian average.

The Ministry of the Environment and Climate Change (Ministry) has also identified climate change as a critical global environmental and economic challenge that will bring increasingly severe weather to Ontario in coming years.

The Ministry has a mandate to lead Ontario's efforts to reduce greenhouse gases and adapt to the effects of climate change. To do this, it has defined emission-reduction targets and introduced policies and programs, one of the most significant of which is a cap-and-trade system set to commence in 2017. The rules for how cap and trade will operate in Ontario as well as how cap-and-trade revenues are to be spent have been set out in the *Climate Change Mitigation and Low-carbon Economy Act, 2016* and its regulations.

Under cap and trade, businesses that emit greenhouse gases will have to obtain "allowances" equal to their annual emissions—effectively a licence to emit. One allowance would permit the emission of one tonne of carbon dioxide, or its equivalent in other greenhouse gases.

These allowances can be provided free by the government, sold at government auctions, or bought and sold between emitters—the "trade" in cap and trade. "Cap" refers to the limited total number of allowances the government releases into the market annually.

In theory, as the government reduces the supply of allowances each year, the price would rise. Over time, therefore, businesses would find it more economical to develop ways to cut their emissions rather than buy increasingly costly allowances. Also, a business whose emissions are less than its allowances could generate revenues by selling those surplus allowances to other businesses that need them to continue operating.

Instead of an Ontario-only system, the province plans to link its cap-and-trade system to existing ones in Quebec and California, which means that businesses in all three jurisdictions will be able to trade allowances with each other. This would also allow one jurisdiction to claim an emissions reduction that was actually achieved in another.

The Ministry has said Ontario's cap-and-trade program and the revenue it generates for other initiatives will be key to Ontario's fight against

climate change. It has also said that Ontario is on track to achieve its target to reduce 2020 emissions by 15% from 1990 levels. The Ministry has not finalized the design of Ontario's cap-and-trade system beyond 2020 and told us that its estimates and projections related to the impact of cap and trade beyond 2020 are very preliminary.

Our audit indicates that the cap-and-trade system will result in only a small portion of the required greenhouse-gas reductions needed to meet Ontario's 2020 target. Among our findings:

- **It is likely that less than 20% of reductions required to meet the province's 2020 target will be achieved in Ontario:** Of the 18.7 megatonnes (Mt) of greenhouse-gas emissions that will have to be cut to achieve the 2020 target, only 3.8 Mt (20%) are expected to be in Ontario. The remaining 80%—about 14.9 Mt—is actually forecast to be reduced in California and/or Quebec, yet Ontario plans to take credit for both its own 20% (3.8 Mt) reduction and this 80% (14.9 Mt) reduction occurring outside of Ontario. We note that the 2015 Paris Agreement allows one country to claim another's emissions reductions, but only if both federal governments (e.g., Canada and the United States) have formally agreed to such an exchange. At present, no such agreement exists. Further, the final determination of whether Ontario has met a given target is based on the National Inventory Report prepared by the federal government, which also does not count reductions occurring outside Ontario.
- **Small reductions in emissions in Ontario expected to come at significant cost to Ontario businesses and households:** Under the linked cap-and-trade system that the province plans to implement, Ontario businesses are expected to pay up to $466 million by 2020 to Quebec and California for allowances. Based on preliminary estimates by the Ministry in 2015 used to inform program design, that amount could rise to $2.2 billion in 2030—all of it money that will leave the Ontario economy. If initiatives outlined in the Government's Climate Change Action Plan are successful at reducing emissions over the long term, this number may be lower. In addition, Ontario households and businesses are forecast to pay about $8 billion more to the Ontario government over four years beginning in 2017 for fossil fuels such as gasoline and natural gas. The Ministry estimates households are expected to face an average increase in these direct yearly costs of $156 in 2017. Preliminary estimates by the Ministry of Finance indicate that this amount will rise to $210 in 2019 and that households are also expected to face additional yearly indirect costs on goods and services of $75 in 2019.
- **The Ontario Energy Board has ruled not to separately disclose the cost of cap and trade on natural gas bills despite stakeholder groups' interest in disclosure:** The Ontario Energy Board ruled that separate disclosure on natural gas bills is not necessary despite 75 of 80 stakeholder groups indicating a preference for such disclosure. Additionally, our survey of natural gas ratepayers found that 89% of respondents also thought it was important to disclose the impact of cap and trade on natural gas bills.
- **Under the linked system, Ontario's cap does not actually control the amount of greenhouse gases that can be emitted in Ontario:** Because Ontario has chosen to link with California and Quebec, Ontario may exceed its own emissions cap if Ontario emitters decide to purchase allowances from Quebec or California. The cap on emissions set by the Ontario government consequently does not actually control Ontario emissions.
- **Ontario is not expected to help cut significant emissions in Quebec and California in the short term:** The Ontario government has said that this province's involvement

in a linked cap-and-trade system will help reduce emissions in Quebec and California as businesses there become aware of a market in Ontario for their allowances. However, the Ministry has no evidence of this. In fact, allowance-trading information for Quebec and California as of August 2016 indicates there may currently be a surplus of allowances—over 60 Mt of allowances went unsold in the last auction, indicating that well over the 14.9 Mt of allowances that will be needed by Ontario companies are *already* available. This makes it unlikely that, in the short term, there will be any significant decrease in Quebec and California emissions as a result of Ontario businesses buying these allowances.

- **More emissions reductions may be reported than actually achieved:** No formal agreements or rules have been established among the three jurisdictions to prevent a reduction of emissions from being reported in more than one jurisdiction. For example, if an Ontario company buys an allowance from California, that allowance could be reported by the Ontario government as a reduction in Ontario, thereby helping Ontario meet its target. However, California may also count the same reduction toward its target—meaning more reductions overall would be claimed than were actually achieved.

In the four-year period from 2017 to 2020, the Ministry expects to raise about $8 billion in revenues from the sale of cap-and-trade allowances, and it has committed this revenue largely to emission-reduction initiatives.

These initiatives are identified in the Climate Change Action Plan (Action Plan) that the Ministry released in June 2016. The Action Plan estimates that these initiatives will collectively reduce emissions by 9.8 Mt—yet we noted that the Ministry's own environmental consultant estimated cap and trade and the spending of cap-and-trade revenues on these types of initiatives would yield reductions of only 3.8 Mt—slightly more than one-third the Ministry's estimate. Based on our review of the Action Plan, we noted that:

- **Action Plan contains unrealistic or unsubstantiated assumptions:** These include:
  - *Electricity price reductions will have marginal impact:* Cap and trade is expected to bring higher electricity prices, which may lead people to switch to cheaper natural gas—a fossil fuel that also produces greenhouse gases. Between 2017 and 2020, the Ministry plans to spend up to $1.32 billion of cap-and-trade revenues to address this issue. The Action Plan indicates that this will result in 3 Mt of reductions. However, neither the Ministry nor the provincial agency that oversees Ontario's electricity system could show how they arrived at the 3-Mt estimate. In addition, the $1.32 billion is expected to have only a small impact on reducing the expected electricity price increases. In particular, electricity prices are projected to increase by 14% for businesses and 25% for households; after applying the $1.32 billion, businesses will still face a 13% increase and households 23%.
  - *No plan for achieving renewable natural gas goal:* $100 million of cap-and-trade revenues is to be used to help natural gas distributors increase their use of biogas, a "renewable" natural gas made from the decomposition of organic materials. The Action Plan indicates this initiative will reduce emissions by 1 Mt. However, our review of information from the Biogas Association of Canada indicates that the current production capacity for biogas is insufficient to meet this proposed demand. In fact, the required capacity to achieve the 1 Mt is 500 times more than what is currently available. The Action Plan does not indicate how this shortfall will be met.
- **Action Plan commits about $1 billion to previously approved initiatives:** Some initiatives, such as the Regional Express Rail transit

project, were approved years before the Action Plan was created. By including these projects in the Action Plan, the Province has found an alternative way to fund their costs—but will not achieve any additional emissions reductions.

Our other findings include:

- **The Ministry achieved its 2014 emissions reduction target:** The Ministry achieved significant reductions in greenhouse gases by 2014, primarily due to closing all coal-fired power plants. The Ministry has also said that, had it not been for the 2008 economic downturn, Ontario would likely not have met its 2014 emission target.
- **Greenhouse-gas reductions not a priority elsewhere in government:** The reduction of greenhouse gases is not an established priority of many ministries, and there is no government-wide process to ensure climate change is adequately considered in decision-making processes. The mandates and key priorities of some ministries are in conflict with the goal of reducing emissions, and these divergent goals have not been addressed to ensure emissions reduction is considered in decision-making.
- **Many items from the 2011 Adaptation Plan never carried out:** The Ministry has taken little action to identify or follow up on key risks Ontario faces from the anticipated future effects of climate change. Although the Ministry issued an Adaptation Plan in 2011 that was to have been fully implemented by 2014, many of the actions set out in the Plan had not been completed as of August 2016. In addition, the Ministry had not reviewed this Plan to determine whether it should be updated to reflect current information. Areas that require significantly more action include:
  - strengthening winter ice roads to northern communities to protect the communities from increasing isolation caused by climate change; for example, the communities were more reliant on air transport last winter to bring in essential supplies such as food;
  - developing a Growth Plan to support northern community decision-making and monitoring on the impact of climate change, as well as measures to protect and preserve air and water quality;
  - updating provincial building codes to ensure that buildings can resist such effects of climate change as storm water flooding;
  - carrying out a Ministry commitment to review all the different types of buildings owned or controlled by the government to assess them for their resilience to the effects of climate change; instead, the Ministry reviewed only three of the almost 5,000 buildings directly owned or controlled by the Province; and
  - carrying out an assessment of energy infrastructure to ensure it can continue to produce and distribute power during increasingly extreme weather.

Subsequent to our audit, in October 2016, the federal government announced its intention to implement a minimum national carbon price, starting in 2018. The federal proposal is preliminary and, at the time of the completion of our audit, further details were not available to fully assess the impact of this new federal policy on Ontario's projected emissions reductions.

3.03 Electronic Health Records' Implementation Status

The Ministry of Health and Long-Term Care (Ministry) began developing provincial technology infrastructure in 2002 with the creation of the Smart Systems for Health Agency. The functions of this agency, as well as a Ministry branch that previously worked on Electronic Health Record (EHR) application and clinical data management projects, were amalgamated into eHealth Ontario when it was created in 2008.

eHealth Ontario's mandate is to implement a system that, in addition to providing an EHR for every Ontarian, includes a data network that stores EHR data and makes it quickly and securely available to health-care providers.

An EHR is defined as a digital lifetime record of an individual's health and health-care history, updated in real time and available electronically to authorized health-care providers. An EHR system allows for the exchange of stored patient health information so that health-care professionals can quickly access patient data, thereby improving quality of care and creating efficiencies.

EHRs will replace physical records (on paper and x-ray film, for example) that are not always up to date or readily accessible to health-care providers, creating a potential for error and duplication.

In 2008, and again in 2010, the Ministry set 2015 as the target year for eHealth Ontario to implement a fully operational EHR system across Ontario. By then, although some EHR projects were up and partially running, a fully operational province-wide EHR system was not in place. The Ministry did not formally extend the 2015 deadline, but eHealth Ontario continued its work and expects to complete the remainder of its project-build work by March 2017. It is unclear when a fully operational EHR system will be available in Ontario.

We found that implementation of EHRs in Ontario has progressed over the last 14 years. For example, the Ontario Laboratories Information System contains a significant number of lab tests done in the province, and many community-based physicians have adopted Electronic Medical Records that replace patients' paper files.

While some individual systems have been developed to collect and provide specific types of patient health information, they do not have complete information and full functionalities, and there is still no provincially integrated system that allows easy and timely access to all this information.

This means that it is still not possible for all authorized health-care professionals to access complete health information (e.g., lab tests, drug information or x-rays) about a patient regardless of where in Ontario the patient received health services. As well, not all physicians who have implemented Electronic Medical Record systems can connect to the provincial databases because of incompatible technology.

A fully operational EHR system depends on the participation of many health-sector organizations, including hospitals, community health agencies, community and hospital medical laboratories, and physicians in community practice, to input the necessary information for sharing. These organizations and professionals would each have invested in their local systems and, while some of these systems would exist even without the EHR initiative, many of these local systems contain health information needed for the provincial EHR systems. Without these local systems and the health information they contain, eHealth Ontario cannot achieve the goal of an EHR initiative.

While the Ministry has a good understanding of the spending on EHR projects managed directly by eHealth Ontario, it has not tracked the total spending on the EHR initiative incurred by other health-care organizations. Spending on projects not managed directly by eHealth Ontario includes, for example, systems used in hospitals and family doctors' offices that contain patient health information.

We used information that the Ministry maintains, along with data we gathered directly from a sample of health-care organizations, to estimate that the cost incurred so far (from 2002/03 to 2015/16) to enable the completion of EHRs across the province is approximately $8 billion.

Because the EHR initiative is still not complete, and lacks an overall strategy and budget (the Ministry only established a budget for eHealth Ontario's portion of the initiative), the Ministry does not know how much more public funding is still needed before the initiative is considered effectively implemented.

Given the continuing importance of having EHRs for the benefit of Ontarians and the health-care system, it is understood that a significant

investment of taxpayer funding is needed to realize benefits to patients and health-care professionals from a provincially integrated EHR system. However, it is equally important that an overall strategy and related budget be in place to ensure that the EHR initiative is appropriately managed and that the intended benefits are achieved in a cost-effective and timely manner.

In addition to the need for a long-term strategy and budget for the remainder of the EHR initiative, it is very important to have full participation of and usage by health-care organizations and professionals because they create clinical information and rely on it to provide quality care to Ontarians. Because most of these organizations and professionals are not accountable to eHealth Ontario, the agency has been unable to fully persuade all parties to contribute clinical information to the EHR systems. As a result, some of the systems that were up and running as of March 2016 contained limited and/or incomplete patient information.

Our specific findings include:

- **More work is needed to enable a functional EHR supported by a province-wide network—**Although approximately $8 billion has been spent so far to enable a functional EHR, parts of the EHRs are still not completely in use and others are only partially functional. This spending covers a 14-year period between 2002/03 and 2015/16, and includes eHealth Ontario's project costs and EHR-related costs incurred in the broader health sector. eHealth Ontario and its predecessor agency spent $3 billion of the total, the Ministry and its funded agencies such as Cancer Care Ontario spent $1 billion, and provincially-funded local health-care organizations such as hospitals and Community Care Access Centres spent about $4 billion. The monies spent covered information technology, the accumulation of information and integrated services required in health-care organizations for sharing through the EHR systems.
- **No overall strategy and budget to guide the implementation of the entire EHR initiative—**In addition to seven eHealth Ontario EHR projects (i.e., Ontario Laboratories Information System; Diagnostic Imaging; Integration Services; Drug Information System; Diabetes Registry; Client, Provider and User Consent Registries; and Client, Provider and User Portals), money is also spent on other projects in the EHR initiative by other health-care organizations through their annual budgets. These publicly funded health-care organizations include hospitals and Community Care Access Centres. The province has not established an overall strategy to guide the work of eHealth Ontario and all other health-sector organizations that must work together to enable a fully functioning EHR system in Ontario. As well, there is also no overall budget for all EHR projects and EHR-related activities undertaken in Ontario.
- **As of March 2016, a year after its deadline passed, seven core projects managed by eHealth Ontario were still within budget but only about 80% complete—**In a June 2010 mandate letter, the government assigned eHealth Ontario 12 EHR projects to be completed by 2015, including seven regarded as core. The government officially approved about $1 billion for the seven core EHR projects under the responsibility of eHealth Ontario, and required the projects to be completed by 2015 (with the exception of the drug information system, which had a 2016 deadline). The actual spending on these seven projects at the time of our audit was within budget. However, in March 2016, eHealth Ontario estimated that it had completed 77% of the seven core assignments. That percentage rises to 81% after taking into account that the scope of some projects changed since 2010 while others were cancelled or reassigned. eHealth Ontario says it expects to fully complete its work

within budget to build the EHR systems by March 2017.

- **eHealth Ontario lacks the authority to require all health-care providers to upload data and the Ministry has not used its authority to require it—**Many factors account for eHealth Ontario's difficulty in completing projects on time. One significant factor is that it has no control over what most health-care organizations do with their own data systems. In effect, eHealth Ontario is mandated to connect these systems, but it has not been given the authority to require organizations to upload necessary clinical information into its EHR systems. As well, the Ministry has not required health-care organizations to participate in the EHR initiative.
- **eHealth Ontario-managed projects contain incomplete data—**Four specific eHealth Ontario projects that we reviewed that were available for use as of March 2016 still lacked some promised features and contained incomplete data. For example:
  - The **Ontario Laboratories Information System**, a database designed to include lab tests done in hospitals, community labs and public health labs, did not have three of the five promised functionalities working at the time of our audit. As a result, health-care professionals were not able to electronically order lab tests for patients, retrieve lab orders, or refer lab tests to other sites or labs if the receiving lab could not conduct the tests. In addition, the database did not contain about 40 million tests, including some conducted either in physician offices or labs in certain hospitals and the community that were not yet contributing to the database, and all those not paid for by the Ontario Health Insurance Plan.
  - The EHR system includes four regional **Diagnostic Imaging databases** across the province to store images such as x-rays and CT scans, and related reports. However, 60% of privately owned imaging clinics do not use digital equipment and so were unable to upload the 5.4 million patient images they create each year. In addition, health-care professionals can only access the imaging database in the region where they practise.
- **$71 million spent on a Diabetes Registry (one of the seven core projects) that was then cancelled—**As part of the EHR project, eHealth Ontario and the Ministry spent $71 million on a province-wide Diabetes Registry, which was to contain information to help treat the growing number of Ontarians with diabetes. However, eHealth Ontario terminated the project in 2012 before it was complete. In our 2012 audit of the Diabetes Management Strategy, we indicated that factors contributing to the cancellation included delays in procuring a vendor and quality issues in the Registry. The $71-million total includes costs associated with an arbitration award to the company developing the Registry after both parties agreed to arbitration.
- **A fully-functional Drug Information System (one of the seven core projects) is not available and is four years away from completion—**The drug information system is used to track dispensed and prescribed medications of all Ontarians. eHealth Ontario was originally responsible for this project, but did not complete it. The Ministry assumed direct responsibility for the project in 2015. By March 2015, the Ministry and eHealth Ontario had spent a combined $50 million on the project. The Ministry has since redesigned the project and expects to complete it by March 2020. It plans to spend an additional $20 million on the first phase, but has given no cost estimate to complete the entire project. As of March 2016, the drug database did not contain information for about 60% of the Ontario population.
- **Utilization of clinical information by health-care professionals below expected**

levels and measurement of system usage was inconsistent—eHealth Ontario reports that many of its systems that have gone online are being actively used, but its definition of "active" was less than stringent. We therefore question whether the utilization rate was actually satisfactory. For example, only 13% of registered users in the Greater Toronto Area accessed lab results and diagnostic images from a web-based viewer in April 2016, compared to a target of 20%. Different systems and databases were subject to different definitions of active use—in some cases, eHealth Ontario reported as "active" someone who used the system once every six months.

Subsequent to our audit, Canada Health Infoway (an organization composed of deputy ministers of health from across Canada) issued a report on October 7, 2016, done at the request of the Ontario Ministry of Health and Long-Term Care, which had asked for an assessment of Ontario's progress on digital health's availability, use and benefits, and how Ontario compares to other provinces and territories.

The report concluded that Ontario is well positioned relative to its peers in terms of availability, use and benefits from investments in digital health solutions. The report also estimated that in 2015, the benefit to Ontario from selected digital health projects was $900 million. The benefits estimate was, for the most part, calculated using a population-based allocation of cross-Canada overall benefits.

Also on October 7, 2016, the Minister of Health and Long-Term Care asked the Premier's business adviser to assess the value of Ontario's digital health program, its assets and all related intellectual property and infrastructure.

3.04 Employment Ontario

Employment Ontario offers a suite of programs designed to provide employment and training services to job seekers and employers, apprenticeship training to students seeking certification and employment in a skilled trade, and literacy and numeracy skills to people who lack basic education necessary for employment. These programs are funded by the Ministry of Advanced Education and Skills Development (Ministry), and the majority are delivered by third-party agencies.

In order to support the Province's economic growth and help ensure Ontarians have long-term sustainable employment, it is important that these programs meet the needs of Ontario's current and future labour market. While Ontario's annual unemployment rate (6.8% in 2015) has generally been in line with the national average, its youth unemployment rate (14.7% in 2015) has been consistently higher than the national average over the last decade by two percentage points.

Our audit found that key programs offered by Employment Ontario are not effective in helping Ontarians find full-time employment. Although the Ministry is redesigning some of its existing programs, more attention is needed to increase their effectiveness and improve efficiency. Specifically, the Ministry needs to take additional steps to increase completion rates for apprentices, and to help people sustain long-term employment in their field of training. We also noted that the Ministry lacks the detailed and timely labour market information necessary to both improve existing programs and develop new ones to meet the current and future labour needs of Ontario. Some of the significant issues we found include:

- **Majority of employment and training program clients unsuccessful in finding full-time employment in their chosen career.** The objective of Employment Ontario's Employment Service program is to find long-term sustainable employment for clients. For 2015/16, at the time of completion of the program, only 38% of clients were employed full-time and only 14% had found employment in either their field of training, a professional occupation or a more suitable job than before the program. Similarly,

in Employment Ontario's Second Career program, which is intended to retrain unemployed and laid-off workers for high-demand jobs, 35% of clients reported being employed when they completed the program, but only 17% were employed full-time, and only 10% were employed in either their field of training, a professional occupation or a more suitable job at time of completion of the program.

- **Overpayments to clients who do not complete programs are not being recovered.** Participants in Employment Ontario's Second Career program who receive funding for retraining but do not regularly attend their program or provide receipts are required to repay the Ministry. In the last three fiscal years, $26.6 million that should have been repaid has been written off as uncollectible.
- **Less than half of the people who begin an apprenticeship program in Ontario complete it.** The average completion rate for apprentices in Ontario (from 2011/12 to 2015/16) was about 47%. Completion rates for voluntary trades were significantly lower than for compulsory trades (35% vs. 59%). Comparable completion results from other jurisdictions were not available because provinces do not follow a single standard method to calculate completion rates for apprentices.
- **Ministry needs to better analyze and address reasons for low apprenticeship completion rates.** The Ministry does not review apprentice completion rates by in-class training provider or employer, and it does not compile and analyze survey results separately (for the majority of questions) for those that completed their apprenticeship program and those that withdrew. Such analyses would enable the Ministry to identify those in-class and on-the-job training providers that may not be preparing apprentices for success, and assess the reasons why apprentices did not complete their apprenticeship. We analyzed apprenticeship completion rates by employer and found that, for employers who have sponsored at least 50 apprentices since the beginning of the program, there were approximately 100 employers that had a low success rate (i.e., less than 20% of their apprentices complete their apprenticeship) but were still actively training almost 4,800 apprentices.
- **Financial incentives to employers may not be encouraging apprentice certification.** In 2015/16, about 60% ($205 million) of all apprenticeship funding was paid to employers through a combination of the Apprenticeship Training Tax Credit, a signing bonus and a completion bonus. The first two financial incentives support apprentices entering the program, but are not tied to employers ensuring apprentices complete the program. The completion bonus, which is more closely aligned with the Ministry's goal of increasing the number of apprentices that get certified, is half the amount of the signing bonus.
- **Number of apprentices at risk of non-completion remains high even after implementation of a monitoring strategy.** The Ministry began monitoring at-risk apprentices in November 2014. At that time, 16,350 apprentices were identified as being at risk of not completing their apprenticeships. About 68% of these cases were resolved by having the apprentice exit the system, in effect cleaning out the Ministry's database. However, by June 2016, the number of apprentices at risk increased to 39,000. Of these, 20,800 were apprentices identified under the same definition as that used in November 2014, and an additional 18,200 apprentices were identified under an expanded definition. Regardless of the definition used, the number of at-risk apprentices has increased during the last 1.5 years since the monitoring strategy was introduced.
- **Ministry's monitoring of apprenticeship training is limited.** Although the Ministry has processes in place to assess an employer's qualifications at the time they submit an

application to train an apprentice, it relies on employers to self-report any changes that may affect their ability to provide sufficient training, such as a change in the number of trainers available to the number of apprentices. Local Ministry offices we visited during our audit confirmed that their involvement with employers is very limited and noted that they visited employers primarily when complaints were received. With regard to in-class training, the Ministry evaluates whether training delivery agents have the tools and resources to deliver courses when they are initially approved for funding, but any monitoring by the Ministry after that point is complaint driven. Ministry staff informed us that they do not directly assess whether instructors are qualified and whether the courses are taught according to the curriculum, nor do they compare the qualification exam pass rates by training delivery agent to identify those with comparatively high failure rates.

- **Ministry lacks necessary data to ensure Employment Ontario programs meet current and future labour needs.** The Ministry does not collect or analyze regional information on labour force skills supply and demand to identify what jobs will have a shortage of skilled workers. According to the Ministry, there are few reliable sector-wide sources of information on employers' anticipated labour needs. The Ministry does publicly report certain labour market information every month (such as unemployment rates by metropolitan areas, and rate of employment growth by highest level of education completed and major occupation groupings); however, this information is not specific to particular jobs or trades to allow for an assessment of the supply or demand for specific occupations. Also, every four years the Ministry reports on the likelihood of people finding employment in various jobs in Ontario. Other provinces, such as British Columbia and Alberta, report projected demand by occupation for a 10 year period that they update annually and biannually respectively.

3.05 Environmental Approvals

Under the *Environmental Protection Act* and the *Ontario Water Resources Act*, anyone who wants to engage in activities in Ontario that release contaminants into the air, land or water—or transport, store or dispose of waste—must obtain an environmental approval from the Ministry of the Environment and Climate Change (Ministry). In this report, anyone releasing a contaminant or pollutant is referred to as an emitter. The *Environmental Protection Act* broadly defines a contaminant to include solids, liquids, gases, odours, heat, sound, vibrations and radiation resulting from human activities that can cause harm to the environment and human health.

In 2010, the Ministry launched its Modernization of Approvals initiative intended to make the environmental approvals program more accessible, flexible and efficient. As part of the initiative, the Ministry:

- introduced the self-registration process for lower-risk activities such as automotive refinishing, non-hazardous waste transportation and commercial printing (prior to this, all emitters had to apply for and receive Ministry approval); and
- implemented an online database of emitters that is intended to allow the public to search for approved emitters within their neighbourhood.

According to the Ministry, air quality in Ontario has improved significantly over the past 10 years due to measures such as the closing of coal-burning plants that resulted in decreases in air pollutants such as sulphur dioxide, volatile organic compounds and fine particulate matter. These decreases are in line with trends in other provinces in Canada. However, according to Environment Canada, Southern Ontario has the highest level of sulphur

dioxide and second-highest level of fine particulate matter emissions compared to four other large Canadian regions.

In addition, based on the most recently available data from Environment Canada, from 2010 to 2012, water quality in 22% of freshwater rivers in Ontario was rated as being less than fair—that is "marginal" or "poor" quality—worse than the national average of 14%. Also, in 2013, Ontario released the largest amount of mercury and lead into its water compared to other provinces, representing 33% and 28%, respectively, of the total national releases.

Overall, our audit found that the Ministry's environmental approvals program is not effectively managing the risks to the environment and human health from polluting activities. The weaknesses we identify below undermine the objective of the *Environmental Protection Act* and the *Ontario Water Resources Act*, which is to protect and conserve the province's natural environment. Specifically:

- **A significant number of emitters may be operating without proper environmental approvals:** While the Ministry has some processes to identify emitters that are operating without the required environmental approvals, its approach is largely reactive. By the time the emitters are identified and the Ministry takes action, the emitters have often been operating without proper approvals for years. The Ministry has not taken a proactive approach. For example, it has not established information-sharing agreements with other Ontario ministries with information on newly operating emitters that could help the Ministry identify illegal emitting activities at an earlier stage. Our analysis of data we obtained from a leading business directory that collects the names of businesses for each business sector indicates that there may be about 12,000 emitters in the province that are not in the Ministry's emitter database. The Ministry has not performed a similar comparison to identify potential emitters that may be operating without a proper approval.
- **Over 200,000 approvals issued more than 15 years ago have not been updated to meet current environmental standards or to reflect emitters' current operations:** Approvals prior to 2000 did not contain many of the operational requirements that similar current approvals include, such as having properly trained staff and well-maintained equipment. The Ministry largely relies on the emitter to request that its approval be updated when it changes its operations, but emitters do not always do so. The Ministry does not know how many of the emitters that were issued those approvals are still operating.
- **The Ministry's monitoring efforts are not sufficient to prevent and detect emitters that violate regulatory requirements and therefore pose a risk to the environment and human health:** Approximately 80% of the 32,500 emitters that have been issued approvals in the last 15 years have never been inspected—despite the fact that there is a high level of non-compliance by emitters that *have been* inspected. For example, in the last five years, 20% of the 4,147 hazardous-waste-related inspections, 35% of the 4,876 air-related inspections and 47% of the 1,228 sewage-related inspections identified emissions in excess of environmental standards. Also, in 2014/15, 63 inspections of automotive refinishing facilities indicated that 86% did not comply with environmental requirements. For example, facilities were closer than the minimum distance of 120 metres from the places where people live, work and play, or they did not retain records of how much air pollution they had emitted.
- **Penalties levied by the Ministry often did not deter repeat offenders:** One-third of the emitters that were issued penalties from 2009 to 2016 were issued penalties for more than three violations. For example, one emitter was issued penalties for 24 violations in eight of the last nine years, totalling more

than $173,000. Another emitter was issued penalties for 13 violations in seven of the last nine years, totalling more than $192,000. The Ministry had not assessed whether its penalties were effective in discouraging individual companies from repeatedly violating environmental regulations.

We also found that, despite being mandated by the Premier in 2014 to "put greater emphasis on the 'polluter pays' principle," the Ministry bears the brunt of the costs of delivering the environmental approvals program, including costs of future clean-up. Specifically:

- **The Ministry only recovers 20% of its cost of delivering the program:** Application and self-registration fees obtained from emitters do not cover all of the Ministry's costs for administering the environmental approvals program. In 2014/15, such fees covered only about 20% of the program's $23 million costs. The application fees have not been updated since 1998.
- **Financial security is not required for many high-risk activities:** The *Environmental Protection Act* gives the Ministry the authority to require financial security from emitters to cover future clean-up costs. However, we found that the Ministry does not always require financial security from high-risk activities such as hazardous waste transporters, industrial sewage systems and other industrial activities that are likely to result in contaminant spills.
- **Financial security amounts collected are less than estimated future clean-up costs:** The amount required from emitters—and imposed as a condition of the Environmental Compliance Approval—is usually based on the most reasonable estimate for future clean-up. However, our review of a sample of emitters has indicated that the Ministry has collected approximately $10 million less than what it estimated would be required for future clean-up.
- **The Ministry is at risk of paying clean-up costs due to outdated remediation estimates:** Even though our audit work indicated that the estimated remediation costs (the costs to reverse or stop environmental damage) could increase greatly over a period of 10 or more years, in many cases the Ministry does not re-evaluate its long-term remediation cost estimates to determine whether it needs to collect more in financial security from emitters to cover the costs. This exposes the Ministry to the risk of having to pay potentially large clean-up costs if the emitter is unable or unwilling to pay for remediation.

With regard to public involvement in the environmental approvals program, we found the following:

- **Public input is blocked for self-registered emitters:** The public does not have an opportunity to provide input on any of the self-registered activities—which include end-of-life vehicle processing facilities (wrecking yards) as well as commercial printing and others—prior to the emitters starting operations. Given that the Ministry—as part of its modernization initiative—plans to convert many more activities that are currently subject to public input to those that are not, opportunities for meaningful public input will be reduced in the future.
- **Public complaints are not well managed:** The Ministry received approximately 78,000 public complaints and reports of contaminant spills in the last five years, which it tracks in a database. However, the Ministry does not consistently follow up on complaints or reports of contaminant spills on a timely basis or categorize them by their underlying problem. As a result, it is not able to identify and act upon systemic issues to improve the environmental approvals process. For example, at the time of our audit, over 1,800 complaints had not yet been assigned to a Ministry field inspector for follow-up. In addition, about 900 complaints

that the Ministry determined to have warranted a field inspection had not yet been addressed.

- **The publicly accessible emitter database is not functioning as intended:** The publicly accessible emitter database maintained by the Ministry cannot perform the basic searches for which it was designed, such as searching for emitters in a particular neighbourhood.

The Ministry does not know whether its environmental approvals program is effectively regulating polluting activities and how much impact such activities have on human health. In particular, self-registered emitters are not required to provide the Ministry with emissions information. This results in the Ministry not knowing whether levels of pollution from these activities are above approved levels. At the same time, when the Ministry does receive emissions information from higher-risk emitters, it does not assess the environmental and health impacts of those emissions within various regions of the province. Instead, each emitter's data is only reviewed by the Ministry for compliance with its environmental approval limits.

3.06 Environmental Assessments

An environmental assessment is a planning and decision-making process that evaluates the potential "environmental impacts" of a proposed project or plan. This process is required under the *Environmental Assessment Act* (Act), primarily for public-sector projects and plans. The intent of the Act is to establish a process that identifies and resolves potential environmental problems before actual environmental damage occurs, for the betterment of Ontarians. Environmental assessments are intended to identify ways to prevent or mitigate negative effects of projects and plans, and find alternatives and consider public concerns prior to going ahead with the project or plan.

The Ministry of the Environment and Climate Change (Ministry) is responsible for administering the Act. The scope of "environmental impacts" under the Act is broad: in addition to the impact on the natural environment, it includes human life, social, economic and cultural factors that influence a community. The Act also allows for most environmental assessments to be "streamlined"—that is, subject to pre-set and less rigorous processes for projects considered to be routine and to have predictable and manageable environmental impacts.

Overall, our audit found that Ontario's environmental assessment process needs to be modernized and aligned with best practices in Canada and internationally. Because the Act is 40 years old—and is, in fact, the oldest environmental assessment legislation in Canada—it falls short of achieving its intended purpose. For example:

- **Ontario is the only Canadian jurisdiction in which environmental assessments are generally not required for private-sector projects.** These projects—such as mining operations or chemical manufacturing facilities—proceed without an up-front evaluation of the environmental impacts of the project. Such impacts can be extensive and can affect Ontarians for many years. For example, as of March 31, 2015, the government identified that it had a liability of $1.2 billion to clean up 47 contaminated sites that were caused by mining in Ontario over the years. (See **Section 3.10** Management of Contaminated Sites in our *2015 Annual Report*.) With over 4,400 active and abandoned mine sites and 15,000 recorded mine hazards, MiningWatch Canada reports that Ontario ranks first in Canada as having the biggest environmental liability in the mining sector.
- **Environmental assessments are not completed for many significant government plans and programs.** The impact of government plans and programs can have a broader and longer-term impact compared to individual projects, and therefore warrant a thorough assessment beyond that which is possible for individual projects. Although the Act applies to government proposals, plans

and programs, only streamlined assessments have been conducted, and only for forest-management plans. No other environmental assessments have been completed for any government plan or program in the last two decades. This is because:

- **The Act is not specific about the types of plans and programs that must be assessed.** This means that determining whether a government plan—for example, the province's Long-Term Energy Plan and the Ministry's cap-and-trade program—requires an environmental assessment is open to interpretation by the provincial ministries and agencies that propose the plan.
- **Other legislation undermines the role of environmental assessments by exempting certain plans and programs from requiring them.** For example, the Climate Change Action Plan, transportation plans, and the government's renewable energy program are exempt from requiring an environmental assessment. In reaction to this, 92 municipalities have passed resolutions as "unwilling hosts" to wind farm developments. These resolutions do not have the authority to stop any wind farm development projects.

Public consultation is one of the cornerstones of the environmental assessment process. Prior to passing the Act in 1976, the government emphasized the important role the public can play in identifying potential impacts, assessing their significance, and evaluating the advantages and disadvantages of a project or plan. However, the benefits of public input have not been realized because:

- **Decisions regarding whether to grant public requests for more extensive consultation are at the Minister's discretion, with no clear criteria or an independent body to ensure objectivity.** In the last five-and-a-half years, the Minister has denied all but one of the public requests to have 177 streamlined assessments "bumped up" to comprehensive assessments. Also, the Minister has denied all 190 public hearing requests related to four projects (Durham and York Energy Centre, Hanover/Walkerton Landfill Expansion, West Carleton Environmental Centre, and Highway 407 East Extension). Clear communication about why requests were rejected would instill more public confidence in the environmental assessment process.
- **The public is not informed about most projects.** The majority of projects undergo the less rigorous streamlined environmental assessment process that includes about 30 days of public consultation. The Ministry's website only has information about projects undergoing comprehensive environmental assessments. Neither the project owners nor the Ministry provide the public with information about streamlined assessments beyond this brief consultation period.

Neither the comprehensive nor the streamlined process is effectively or efficiently overseen by the Ministry. As a result, the public obtains minimal assurance that these processes are effective in preventing and/or mitigating the negative environmental impacts of projects.

Other significant observations include the following:

- **The type of assessment required for a particular project is often not based on the project's potential environmental impact.** For example, the basis for determining whether a comprehensive or a streamlined assessment is required for a particular project often depends on its size, scale and cost rather than its potential impact.
- **The Ministry has no assurance that streamlined assessments are conducted properly because of its limited involvement.** Many streamlined assessments are completed without the Ministry's knowledge—including, for example, 80% of those conducted by

the Ministry of Transportation in the last five years. Without knowledge of these assessments, Ministry staff cannot provide input into these assessments. In cases where the Ministry was aware of the projects and had reviewed the assessments, deficiencies were identified in more than half the assessments, indicating that project owners were not always conducting them properly.

- **Lengthy Ministry reviews of public requests to bump up streamlined assessments to comprehensive assessments cause unnecessary project delays.** Multiple layers of reviews—including four levels of sign-off by the Director, Assistant Deputy Minister, Deputy Minister and the Minister— resulted in an average of seven months of delays, but did not substantively change the outcome of the review. The additional reviews generally only resulted in grammatical wording changes or merely restated existing commitments in the environmental assessments. Projects were delayed until all reviews were completed, which often resulted in financial and non-financial costs to project owners.
- **The cumulative effects of multiple projects are usually not assessed.** Despite international best practices, project owners are not required to consider the cumulative effects of other relevant activities such as known future projects and those that are already occurring in the project area; this can result in projects going ahead in areas that are already subject to significant environmental stresses.
- **The Ministry does not have effective processes to ensure that projects are implemented as planned.** Such processes could include field inspections during project implementation or requesting data, after projects are implemented, that shows their environmental impact.

3.07 Housing and Supportive Services for People with Mental Health Issues (Community-Based)

The shift from institutional to community mental health services and supports that began in the late 1990s and continued in the decade that followed has increased the need for mental health supportive housing in Ontario. Under four supportive housing programs funded by the Ministry of Health and Long-Term Care (Ministry), the Ontario government subsidizes over 12,300 housing units and funds support services to individuals with serious mental illness who have housing needs. Mental health supportive housing is especially important to those who are homeless or staying in places that may not be promoting their recovery, or who have just been discharged from hospitals. The programs are delivered by mental health housing and support services agencies that contract with the Ministry and/or the Local Health Integration Networks (LHINs) that have a mandate to plan, fund and integrate health services, including mental health services, in 14 geographic areas within Ontario.

Supportive housing includes two components—housing and support services. The Ministry funds and monitors housing, while the LHINs fund and monitor support services. Support services are provided to help housing clients cope with their mental illness and stay housed. They may include case management, counselling and vocational supports. Housing agencies deliver these services to their clients either on their own or in partnership with other mental health agencies.

In 2014, the Ministry created the Mental Health and Addictions Leadership Advisory Council (Council) to help the government move forward with its mental health and addictions strategy, *Open Minds, Healthy Minds*, which was launched in 2011. The Council considers supportive housing a priority area, and will be making recommendations to the Ministry by 2017 on actions needed to meet the objectives of the strategy.

Providing supportive housing for people with mental health challenges who require housing makes economic sense. With the right housing and supports, people recovering from mental illness gain a renewed sense of dignity and hope, and can reintegrate into the community more successfully. Research shows that providing a home to people with mental health challenges can help save money in the long run in hospital, prison and shelter stays, and in other ways as well. One study found that for every $10 invested in housing and supporting a client, an average saving of $15.05 for a high-needs client and $2.90 for a moderate-needs client can be realized.

Our audit found that the Ministry, the LHINs and service providers do not have adequate information, systems and procedures in place to cost-effectively oversee, co-ordinate and deliver housing with support services to people with mental illness. They also do not sufficiently measure and publicly report on the effectiveness of Ontario's mental health supportive housing programs. Consistent with concerns our Office raised in previous audits of community mental health in 2002 and 2008, and our subsequent follow-up on the latter audit in 2010, we continue to find that the Ministry does not have consolidated information on the demand for mental health supportive housing in the province, does not assess the cost-effectiveness of the four mental health housing programs (as described in **Chapter 3**, **Section 3.07**, **Appendix 1**), and does not measure the outcomes of individuals housed. Similarly, LHINs do not know what types of support services are provided to housing clients on an annual basis, how effective they are, and whether clients are satisfied with supportive housing. The lack of a housing policy framework to guide the provision of mental health supportive housing contributes to the Ministry's and the LHINs' difficulty in sufficiently overseeing and co-ordinating the delivery of supportive housing services to Ontarians.

We also found that clients living in ministry-funded housing may not be receiving similar services across the province. As well, without information on the demand for mental health housing the Ministry cannot set and has not set any goals for how many mental health supportive housing units are to be made available to those in need, and has not developed a housing policy, despite having identified this as an area of need in its own 1999 mental health policy framework. We also found that without standards and expectations, the Ministry cannot reasonably ensure that its funding is contributing to good-quality supportive housing services that meet the needs of clients. Similarly, LHINs have not prescribed the types and duration of support services that should be available to housing clients at different points in their recovery path, and do not require agencies to report aggregate client assessment information to determine areas of unmet needs.

Providing mental health housing with support services can help reduce inequities and allow people living with mental illness to reach their full potential. With limited resources available, the province needs to make careful choices to provide mental health supportive housing to those who would benefit most from it. This could mean some who are currently receiving mental health supportive housing might need to transition to other forms of housing, such as those that are not tied to support. Doing so would help the Ministry focus on providing the available housing and supports to those who have nowhere else to go and have the greatest need for mental health supportive housing, so they can have a better chance to move on with their lives. But it is important that governments have plans in place to connect clients who could live independently to community support services should they need them over the course of their lives, regardless of where they live. This approach has been in place in parts of the United States and has resulted in people continuing to live independently for years after they initially received mental health supportive housing.

Following are some of our significant observations:

- **The Ministry identified the need to develop a policy on housing as early as 1999, but no**

such policy has been developed since then. The Ministry and three other ministries (the Ministry of Housing, the Ministry of Children and Youth Services, and the Ministry of Community and Social Services) together operate 14 housing programs in Ontario. Some of these serve seniors, victims of violence and people with chronic illnesses. In 2014, the four ministries together began to transform this fragmented housing system in the long term. At the time of our audit, the four ministries were working on a supportive housing framework to guide better alignment of existing and/or planned housing initiatives; they intended to release it publicly by early 2017. Since the ministries expect to implement the framework in 10 years, changes in the housing system may not be completely realized until almost three decades since the Ministry first identified the need for a housing policy.

- **The Ministry does not have consolidated regional or agency wait-list information.** Not all LHINs have regional wait lists, and the Ministry does not require housing agencies to maintain wait lists. Without a clear picture of the need for mental health supportive housing in each LHIN region, the Ministry cannot effectively plan for the allocation of housing stock in the province. In any event, the Ministry does not set goals with timelines on how many mental health supportive housing units it needs to fund in the long run.
- **People usually move from the wait list into available housing in the order in which they applied.** People who are ready to be discharged from hospitals but have nowhere to go do not get priority over others in accessing mental health supportive housing, even though the cost of a hospital bed can be as much as nine times the cost of providing supportive housing. Also, those with a higher level of needs, such as 24/7 care including meal preparation or medication management, have difficulty getting into the first available housing because not all units are structured to allow for such levels of care. Individuals who have mobility issues also tend to have longer waits because some units are not outfitted with accommodation that would meet their needs. Meanwhile, shared units remain vacant for up to 39 months because clients usually prefer not to share a unit. The Ministry does not know how many shared units it funds in Ontario.
- **The Ministry considers mental health supportive housing as long term and permanent.** Clients living in Ministry-funded supportive housing consider their house or unit their permanent home. But some supportive housing clients no longer need or want support services. This practice contradicts the principle of supportive housing, which includes an element of support services. One housing agency we visited proposed to the Ministry that there be a continuum of housing, so individuals whose level of support needs changes over the course of tenancy can step up to higher-support housing if necessary, or transition to other settings, such as the private market or social housing, once they stabilize. However, at the time of our audit, the Ministry had not provided any direction to agencies to guide transitioning efforts.
- **The Ministry's approach to mental health supportive housing by default creates a backlog in accessing available housing.** There is no certainty on when occupied units will next become available since supportive housing is permanent housing. Wait times to access mental health supportive housing can be up to seven years in the regions we visited.
- **The Ministry is starting to make progress in updating two older housing programs (Homes for Special Care and Habitat Services) that no longer follow best practices.** Eighty percent of the units in Ontario's mental health supportive housing are provided to individuals living with mental illness under two of the four ministry-funded mental

health supportive housing programs, where not-for-profit agencies either own the units, purchased with government funding, or rent from the private market with subsidies from the Ministry. The remaining 20% of the units are in these two older programs that were created decades ago and do not follow current best practices, as they primarily provide room and board only but no significant rehabilitative support services. At the time of our audit, the Ministry was beginning to review one program, and has allowed changes to the other. We are encouraged to see the Ministry go in this direction, having previously noted in our 1987 audit that residential care homes (which primarily provide room and board) for the mentally ill were not the best housing choice given that they were not required to provide support services.

- **The Ministry's subsidy payments to agencies may not be appropriately geared to tenants' ability to pay their rent.** The Ministry paid just over $100 million in 2015/16 to housing agencies to operate over 12,300 housing units in Ontario, but did not appropriately monitor whether agencies verified tenants' income levels. We found that income was not verified at the required intervals at six of the seven housing agencies we visited. As well, the Ministry did not require housing agencies that own properties containing housing units to conduct building-condition audits, which would have informed both the agency and the Ministry if the capital reserve is in an unfunded liability position (meaning that the agencies lack the reserve funds to pay for needed major repairs and renovations). This could potentially raise issues of safety for clients living in these buildings, and financial exposure for the Ministry, which funds the capital reserve.
- **LHINs do not confirm whether appropriate support services are delivered to housed tenants.** LHINs do not know whether agencies provide these various support services, whether all housing clients receive support services, and whether clients living in one area of the province receive comparable service hours to clients with similar needs living in another area. LHINs give agencies full discretion to deliver to their housing clients whatever support services they deem proper and at whatever frequency and level of service.
- **The Ministry does not collect outcome information on housing clients to determine whether clients live independently and achieve recovery.** The Ministry collects output-based information, such as how many units are occupied but does not collect outcome data, such as if clients' visits to hospitals or encounters with the justice system have decreased, or whether their ability to function has improved. The need to collect outcome data has been identified in many public reports, including the 1999 government implementation plan for mental health reform, and the 2010 report by the Ontario Legislature Select Committee on Mental Health and Addictions. The Mental Health and Addictions Leadership Advisory Council noted in 2015 that it will work on creating a common data set. In other words, the issue of not having outcome data is still not resolved almost two decades after the government itself acknowledged this concern.

In the last three years, the Ministry has been moving in the right direction—it established a cross-ministry working group and a leadership advisory council to address specific issues with mental health supportive housing. But these issues, in areas such as the types of support services, outcome data, housing model and best practices sharing, have already been identified in many provincial reports on mental health in the last three decades. The Ministry and the LHINs can take guidance from these reports to implement changes in the way they plan, oversee and fund mental health supportive

housing to ensure housing and support services providers deliver the program to clients requiring such services in a purposeful way.

3.08 Large Community Hospital Operations

Ontario's network of 147 public hospitals includes 57 large community hospitals, along with small community hospitals, teaching hospitals, chronic-care and rehabilitation hospitals, and speciality psychiatric hospitals.

Large community hospitals are distinguished from the others by the high number of patients they treat. The Ministry of Health and Long-Term Care (Ministry) defines large community hospitals as those with 2,700 or more acute and day-surgery weighted cases in any two of the prior three years.

The 57 large community hospitals account for about 14,990 of Ontario's 31,000 hospital beds—or 48%.

This audit examines operations at three large community hospitals, each governed by a different regional authority (called a Local Health Integration Network, or LHIN).

Each of the three hospitals treats acute patients at two different sites and, together, the three hospitals accounted for $1.3 billion in Ministry funding, or 16% of the $7.89 billion total funding to large community hospitals in 2015/16.

Our audit was primarily based on data we collected at the hospitals we visited. However, to better understand all large community hospitals, we also did a survey of the 54 other hospitals in this category, and reviewed available aggregated data for all 57 large community hospitals.

In certain areas—those related to surgical-safety performance and infection rate, for example—we reviewed provincial data that covers all 147 public hospitals, because the data was not broken down by hospital type (such as large versus small community hospitals).

Typically, nine out of every 10 patients who go to a hospital leave the hospital after being diagnosed and treated in the emergency room. At the three large community hospitals we visited, we found that half of these patients are treated and are able to leave the hospital within three hours. However, we also found that the one in 10 patients whose conditions were serious enough to warrant admission to hospital for further treatment waited too long in the emergency room.

Our audit also found various key factors that are hindering patient care in hospitals. These include scheduling operating rooms and surgeon time in a way that makes it difficult for hospitals to respond to unexpected emergency surgical cases in a timely manner; letting surgeons book elective surgeries when they have on-call emergency duties; the lack of a centralized system to book patients on long wait lists for surgeries within the same region; rigid scheduling practices that limit the availability of physicians, operating rooms and beds; funding uncertainties; and certain faulty quality-of-care practices that can lead to health problems and risks in hospitalized patients.

Among our findings:

- **Patients waiting too long in emergency rooms**: Many patients with conditions serious enough to require hospital admission wait excessive periods in emergency rooms—much longer than the Ministry-set target of no more than eight hours from triage (prioritizing patients according to the urgency of their conditions) to being transferred to intensive-care units or other acute-care wards. (The Ministry target is set for the 90th percentile. This means that 90% of patients should be transferred within eight hours, and no more than 10% should wait any longer.) In 2014/15, at the three hospitals we visited, only 52% of patients were transferred to intensive care in eight hours, not 90%; the 90th percentile wait time (after the 10% of patients with the longest wait times are removed) was 23 hours, not eight hours. The same year, only 30% of patients at the three hospitals we visited were transferred to other acute-care wards in eight

hours, not 90%; the 90th percentile wait time was 37 hours, not eight hours.

- **Operating rooms not fully utilized**: Although most hospital sites we visited have nine to 12 operating rooms, only one at each site remained open evenings, weekends and statutory holidays for emergency surgery only. Our survey also found that most hospitals have planned operating-room closures over March break and for two to 10 weeks during the summer. This was despite the fact that many patients had been waiting a long time for elective surgery.
- **Long surgical wait times put patients at risk**: At the three hospitals we visited, one in four patients with critical or life-threatening conditions had to wait four hours on average for surgeries that should have started within two hours. We also noted that 47% of patients who should have undergone emergency surgery within two to eight hours had to wait on average more than 10 hours longer. For example, we noted that one patient who had suffered a traumatic brain injury waited 21.5 hours to receive a surgery. This patient had been assessed by a surgeon upon arrival at the emergency room and subsequently reassessed, by the same surgeon and another surgeon, to be clinically stable. However, two elective surgeries were prioritized to be completed before this case. During the waiting period, the patient's condition deteriorated rapidly and they went into a coma. The patient did not recover from the emergency surgery and died four days later.
- **Emergency surgical patients not always given priority**: Emergency surgeries have to compete with elective surgeries for operating-room time, resulting in long wait times for patients requiring emergency surgeries. All three hospitals we visited have policies that allow the most critical emergency surgeries to bump all others. However, other types of emergency surgeries typically have to wait until after hours, when that day's elective surgeries have been completed, or for a weekend slot. For example, a patient suffering from abdominal pain waited 25 hours before receiving surgery. The patient was diagnosed with acute appendicitis after a 7.5-hour investigation in the emergency room and waited another 17.5 hours from the time a decision was made that surgery was necessary to the time a surgery was performed. The patient's appendix ruptured during the waiting period, and had to stay in the hospital twice as long as expected due to a surgical complication.
- **Patients waiting too long for some urgent elective surgeries**: We reviewed wait times for elective surgeries at all 57 large community hospitals, and noted that they had not improved in the five years leading up to 2015/16. We also noted that some large community hospitals are struggling to meet the Ministry's wait-time targets for the most urgent elective surgeries—for example, only 33%, not 90%, of urgent neurosurgeries were completed within the Ministry's 28-day target. In addition, patients in a certain part of the province waited almost a year for cataract surgery without being given the option of having it done earlier elsewhere, because there is no centralized referral and assessment system for each type of surgery in each region.
- **Year-end funding confirmation for cancer surgeries not timely**: The Ministry provides funding for cancer surgeries based on projections submitted by hospitals. At one hospital we visited, the hospital spent over $3.7 million on cancer surgeries, which was about $321,000 more than its mid-year projection. However, the Ministry did not confirm with this hospital that it would receive additional funding for the shortfall until six months after the March 31, 2016, year end due to the timing of the hospital data reporting and reconciliation process. This delay has created funding uncertainty and made it difficult for

the hospital to plan and forecast in the current fiscal year and in the development of the future year's operating budget.

Another area of concern in our audit was patients developing new health problems as a result of their hospital stay. For example:

- **Patients discharged from Ontario hospitals had a relatively high incidence of sepsis**: Sepsis occurs when the body's fight against infection actually harms the patient, and can result in death. Canadian Institute for Health Information data for March 2015 shows Ontario hospital patients had the second-highest rate of sepsis in Canada (after the Yukon): 4.6 cases per 1,000 patients discharged, compared to an average of 4.1 for the rest of Canada. Bed occupancy rates of 85% or higher contribute to the likelihood of infection while in hospital. During 2015/16, 60% of all medicine wards in Ontario's large community hospitals has occupancy rates higher than 85%.
- **Alternate-level-of-care patients suffer from relatively high incidences of falls and overmedication**: At one of the hospitals we audited, senior alternate-level-of-care patients (that is, patients who no longer require hospital care but must remain there until a bed becomes available in another care setting) fell 2½ times more often than residents of long-term-care homes in the same LHIN area between January 2014 and March 2016. We also found that 37% of these patients were given anti-psychotic drugs in 2014/15, compared to 31% at the long-term-care homes in the area and 27% at long-term-care homes province-wide. (The other two hospitals did not track, on an aggregate level, falls and anti-psychotic drug therapy for their alternate-level-of-care patients.)
- **Ontario patients have relatively high incidences of health problems and risks that could be better managed with better quality-of-care practices**: We identified three health problems that Ontario hospitals do not manage or prevent as well as hospitals outside Ontario:
  - *Post-operative pulmonary embolism:* A pulmonary embolism is a blockage in the lung, often caused by a blood clot, that can damage the lung and other organs, and even lead to death. Leg or hip surgery is one of the risk factors for blood-clot blockage, as is having to stay in bed after surgery. There are ways to predict its likelihood and prevent clots after surgery, including medication and making the patient active as soon as possible after surgery. Ontario hospital patients aged 15 or over have a relatively high incidence of post-operative pulmonary embolism after hip- and knee-replacement surgeries: 679 cases per 100,000 patients discharged, compared with 660 Canada-wide and 362 for the 34 other Organisation for Economic Co-operation and Development (OECD) countries.
  - *Objects left inside surgical patients:* Objects such as sponges or pieces of other medical tools that are inadvertently left in a patient after surgery can cause internal bleeding, infections, other complications or death. Ontario surgical patients aged 15 or over experienced a higher rate of errors: 7.5 per 100,000 discharges, compared with 4 for the 34 other OECD countries (the Canada-wide rate is 8.6).
  - *Vital life-saving medical equipment not adequately maintained:* Medical equipment such as ventilators, anesthesia units and defibrillators are used to keep patients alive. Like any complex machinery, they need to be regularly maintained or serviced to work properly; otherwise, they can fail, putting patients at risk. We found that at one hospital we visited, 20% of the equipment was not being maintained according to schedule; for some equipment, the last required maintenance was two years overdue. At another,

only 53% of the equipment was being maintained according to schedule; 30% of the equipment received maintenance late, and 17% had received no maintenance.

Among our other findings:

- Hospital decision-making on patient care has been negatively impacted by the physician appointment and appeal process. We noted some instances where hospitals were not able to resolve human resources issues with physicians quickly because of the comprehensive legal process that the hospitals are required to follow under the *Public Hospital Act*. In some cases, longstanding disputes over physicians' hospital privileges have consumed considerable hospital administration and board time that could be better spent on patient care issues.
- As of March 2016, about 4,110 alternate-level-of-care patients were occupying hospital beds even though they no longer needed them. About half are waiting for long-term-care-home beds because there are not enough available in the community. We calculated that hospitals could have treated about 37,550 more patients if these alternate-level-of-care patients were not waiting in the hospital. Hospital beds are also more expensive than long-term-care beds. We estimated the additional cost to be $376 million in 2015/16.
- The three hospitals we audited do not have adequate access controls over private patient information. We found computer accounts still active for people no longer employed, computers without automatic logout function and unencrypted portable devices.
- None of the hospitals we visited had a centralized scheduling system to efficiently track and manage scheduling for all nursing units. As a result, nurses worked significant amounts of overtime, with a correspondingly significant number of sick days. We found that two of three hospitals do not conduct a thorough analysis to evaluate the costs and benefits of using agency nurses versus hiring additional full and/or part-time nursing staff. Although the third hospital has conducted a cost-benefit analysis on the use of agency nurses, the agency costs at this hospital had more than tripled in the last four years.

3.09 Metrolinx—Public Transit Construction Contract Awarding and Oversight

Metrolinx is an agency of the Ministry of Transportation responsible for operating a network of train and bus routes across more than 11,000 square kilometres (km) in the Greater Toronto and Hamilton Area. Currently valued at $11 billion, Metrolinx uses about 680 km of railway track on seven train lines, 66 train stations and 15 bus terminals. In total, about 69 million passenger boardings occur annually on Metrolinx vehicles.

Metrolinx was established in 2006 as a planning agency, and then merged in 2009 with GO Transit (GO), which had been operating the regional transit system since 1967. With this merger, Metrolinx became responsible for operating, maintaining and expanding GO's network of trains and buses. Expanding public transit capacity is a high priority for Metrolinx: under the government's 25-year "Big Move" plan, announced in 2008, about $27 billion is earmarked for new public transit infrastructure over the next 10 years.

In the past five years, Metrolinx has completed about 520 construction projects costing a total of about $4.1 billion. The average cost of these projects was about $8 million. These projects included building new parking lots, expanding GO railway tracks, building tunnels and bridges for trains, and upgrading existing GO stations.

Metrolinx's construction projects proceed differently depending on the contractor Metrolinx works with. Of the $4.1 billion Metrolinx spent over the past five years, about $3.4 billion (82%) was on projects where Metrolinx contracted out all of the work. That is, external firms designed the project,

constructed it and oversaw it. For almost all of these projects, Metrolinx contracted with a separate company to design the project and a different company to construct it (this is the traditional model for delivery of construction projects).

The other $725 million (18%) of construction dollars Metrolinx spent in the past five years was paid to Canada's two major railway companies—the Canadian National Railway (CN) and the Canadian Pacific Railway (CP). When GO was first established, it used existing CN and CP track. As demand for GO train service increased, GO bought as much CN and CP track and surrounding land that it could. When CN and CP would not sell land to GO, GO paid them to construct more track lines on their land and paid them, as per the terms of their agreement, to use the lines. This continued after Metrolinx assumed responsibility for GO. Thus, Metrolinx has had to hire either CN or CP as the sole contractor for these projects on CN and CP land.

Our audit found that Metrolinx does not have adequate processes in place to consistently ensure value for money in its delivery of construction projects. Because of deficiencies noted in its oversight processes around construction contracts, and because of deficiencies we confirmed in a sample of contracts, there is a risk that it is spending more than what is required, and there remains a significant risk that this will continue to happen.

Metrolinx continues to award contracts to poorly performing contractors that submit the lowest bids—it does not track contractors' past performance and does not consider contractors' ability to deliver completed projects on time, which has resulted in Metrolinx incurring additional costs. Metrolinx has had many years to implement a contractor performance-management system but still has not done so.

For contracts with CN and CP, Metrolinx does not do work to know that it is getting what it pays for: it does not verify charged costs; it does not ensure that charged costs are reasonable; when it requests that the parts on a project be new, and pays the cost of new parts (as opposed to less expensive recycled ones), it does not require that parts be checked to ensure that they are new. It has also been paying excessively high mark-up rates charged by CN for building new rails for Metrolinx (CN's mark-up rates are specified on its invoices, while CP's are not as clear).

Our specific observations are as follows:

Metrolinx Rarely Holds Design Consultants and Construction Contractors Accountable When They Deliver Work That Is of Poor Quality and/or Late—and It Continues to Award Them More Work.

- **Design consultants' errors and delays result in additional costs to Metrolinx, yet Metrolinx takes little action to recover costs and prevent this from reoccurring.** Metrolinx allows design consultants to produce designs that are not feasible to construct, contain errors, misestimate the quantity of materials required, or omit specifications—all with no repercussions. Because designs created by consultants are used by the contractor to calculate bid prices, they need to be free of error; otherwise, there can be considerable cost overruns during construction. Also, since construction cannot begin until the design is finalized, design delays can significantly impact the overall project time frame and cost. In our review of a sample of Metrolinx project documents from the past five years, we noted that consultants made frequent errors in their designs. In one project alone, errors made by the consultant caused a project to be over budget by 35%, or $13.6 million, a cost that Metrolinx had to pay as a result of the design not including all final requirements. In a sample of six projects whose total initial construction costs were over $178 million, $22.5 million *more* had to be spent just because of the design consultants' errors and omissions. There were no repercussions in

these cases, and Metrolinx did not factor in this poor performance when selecting these design consultants for future projects.

- **With the exception of two contractors, Metrolinx does not appear to be addressing problems caused by construction contractors that have a history of poor performance on Metrolinx projects.** A contractor might repeatedly be late in delivering work, not construct the project according to the approved design, not follow safety regulations and/or not fix deficiencies on time—yet Metrolinx will hire the contractor for future projects, provided it is the lowest bidder. Only in the cases of two contractors did Metrolinx take past unacceptable performance into consideration. For example:
  - **One contractor was awarded 22 more projects after performing poorly for Metrolinx.** We noted that Metrolinx issued a letter of default to a contractor in 2009 because construction workers had not even shown up on the project site for several weeks. Despite this, since then, Metrolinx has awarded this contractor 22 more projects worth a total of $90 million. We reviewed the contractors' performance on a few of these 22 projects and noted that project staff continued to rate its performance as poor. For example, on a project in 2012, this contractor installed several pieces of substituted equipment and building materials that were not approved in the contract (the substitutions were caught by Metrolinx only after-the-fact). On another project in 2013, this contractor took six months, after it had already completed the project, to fix its deficiencies—one significant deficiency was the absence of a functioning camera and surveillance system that posed a safety risk to commuters using the station.
  - **Metrolinx terminated a contract with another poorly performing contractor, paid it almost the full amount, and then re-hired it for another contract.** Metrolinx hired the same contractor for Phase 2 of a project to install external cladding (cover) for a pedestrian bridge over Highway 401 even though the contractor had performed extremely poorly on Phase 1. The contractor again had performance issues on Phase 2: it significantly damaged glass covering the bridge, and Metrolinx estimates it will cost $1 million to replace the glass. Metrolinx terminated the contract with the contractor because of performance issues, even though the construction had not been completed, and paid the contractor almost the full $8 million of its contract. We noted that, after performing poorly on both Phase 1 and Phase 2, Metrolinx still awarded this contractor another major project valued at $39 million (to build a new platform at a GO station).
- **Late construction projects have resulted in additional costs, yet Metrolinx rarely takes action against contractors for not delivering on time.** Even though Metrolinx incurs significant costs because of contractors completing projects late (anywhere from four months to 25 months), it seldom takes action against contractors that do not deliver on schedule. For example, on one project alone, Metrolinx paid consultants over $350,000—or 160%—more than budgeted to oversee this project because the contractor was 25 months late in completing the project. In a sample of eight projects whose total initial budget for oversight services was $1.35 million, over $2 million *more* had to be spent because of how late contractors were in completing their projects. That is 150% more than the initial oversight budget total. Although Metrolinx could charge contractors "liquidated damages"—a pre-determined amount included in contracts to cover additional oversight costs if a project is late—it has

not always included them in its contracts to allow it to charge liquidated damages. As well, based on information provided to us by Metrolinx, Metrolinx has rarely sought action against contractors for the recovery of additional costs.

- **Metrolinx does not take action against contractors that breach safety regulations during construction.** Metrolinx rarely takes into account whether contractors breached safety regulations that resulted in unsafe site and working conditions when awarding future contracts. We found that even when a contractor has caused safety issues to the public as well as construction workers, Metrolinx has taken no action against it, and has continued to award it future contracts. We noted that in *all* of Metrolinx's audits of compliance with safety regulations at construction sites over the past three years, contractors breached regulations. Instances were found where contractors frequently erected unsafe scaffolds, or improperly labelled and stored flammable materials. Metrolinx informed us that the contractor, upon Metrolinx's request, had stopped the unsafe behaviour right away; however, we noted that there were no follow-up audits to determine whether the contractor continued to breach safety regulations, nor any repercussions for the contractor for its unsafe actions.
- **Metrolinx is not diligent in ensuring that contractors fix deficiencies in their work in a timely manner.** In three-quarters of the projects we reviewed, we noted that contractors took much longer than the industry standard of two months to fix all deficiencies. On average, these contractors took almost eight months to fix outstanding deficiencies.
- **Metrolinx has not addressed the risk of poorly performing sub-trades being selected by the contractor.** Metrolinx allows contractors to subcontract up to 100% of the work on their projects. Metrolinx has experienced significant issues with sub-trades—to the extent that its staff have requested that Metrolinx pre-screen sub-trades to ensure that those with a poor work history do not jeopardize project timelines.

Metrolinx's Accounting System Allows Payments to Exceed Projects' Approved Budgets.

- **Metrolinx does not have, in its enterprise management system, a control in place to ensure that payments exceeding approved budgets have been approved for over-expenditure.** As a result, project staff must manually keep track of project expenditures to ensure that they are within the budget. However, we found that they are not always properly doing this. In one instance, in March 2013, Metrolinx issued a contractor two payments totalling $1.2 million over the project's approved $17 million budget without having authorization to exceed the budget. Three years later, on the same project, the same problem occurred again: Metrolinx made three payments totalling $3.2 million over the approved budget without prior authorization.

Metrolinx Has Not Managed Its Relationship with CN and CP in a Way that Ensures Value-for-Money for Ontarians.

- **Metrolinx pays CN and CP without verifying most costs.** Metrolinx's projects with CN and CP are costed in one of two ways. With some CN projects, CN provides an estimate of the total costs, and that estimate becomes the lump-sum amount Metrolinx ultimately must pay for the project. With other CN projects and almost all CP projects, CN or CP invoices Metrolinx based on the project's time and materials. In all cases, Metrolinx pays CN and CP without verifying most costs:
  - We found that Metrolinx does not do sufficient work to determine if the estimated lump-sum costs on CN projects are reasonable. We also noted instances where

Metrolinx paid for costs unrelated to its projects, such as costs for maintaining CN railway track.

- We similarly found that Metrolinx does not verify whether invoices billed by CN and CP actually relate to work done on Metrolinx projects. For example, we found several CN charges to Metrolinx for work CN had done on track that it owned that GO Trains never use. Metrolinx does not have a site inspector at CN or CP to ensure work done by the railways, and, although it has the ability to audit invoices under its agreement with CN, it does not do so.
- Compared to other rail companies that work for Metrolinx, CN charged Metrolinx significantly higher materials and labour costs. Specifically, materials costs were about 60% higher and labour costs were 130% higher. Information on CP's costs were not detailed enough to allow us to perform the same comparison.

- **CN Railway installed recycled parts; Metrolinx paid for new.** Metrolinx informed us that it may sometimes visually inspect railways once they are built, but inspections are not mandatory, and the results of any inspections that are done are not documented. We noted one instance where recycled parts were being used when only new parts were purchased. Without inspecting the parts used in railway construction, Metrolinx cannot know if it pays for new parts but receives recycled parts instead.
- **Metrolinx pays CN and CP excessive mark-up rates on projects.** All contracts with CN and CP are sole-sourced. CN's mark-up rates on labour and parts are set in a long-term agreement with Metrolinx. These rates are as much as 74% higher than industry benchmarks. Metrolinx has not negotiated any mark-up rates with CP, and they are usually not transparent. We found that CP disclosed their mark-up rates in only one of the projects we sampled, and they were about 30% higher than industry benchmarks.

3.10 Ministry of Transportation—Road Infrastructure Construction Contract Awarding and Oversight

The Ministry of Transportation (Ministry) is responsible for the construction and maintenance of provincial highway and bridge infrastructure, which is currently valued at $82 billion. It consists of about 40,000 km of highway lanes covering a distance of about 17,000 km, and almost 5,000 bridges and culverts.

The Ministry enters into construction contracts for work either to rehabilitate existing infrastructure in order to continue using it or to create new infrastructure to expand capacity. The road network, most of which was originally built by the 1990s, requires considerable ongoing maintenance. The Ministry expects to spend about $14 billion over the next 10 years for road and bridge rehabilitation and about $4 billion for road and bridge expansion.

In the past five years, the Ministry has awarded about 600 large construction contracts (greater than $1 million each) totalling about $5.5 billion. These contracts are for projects such as re-paving sections of highways, expanding highways, building new bridges or rehabilitating existing bridges. The average contract was valued at $9.1 million. The Ministry also awarded about 1,450 minor construction contracts totalling about $580 million. Minor work usually involves less significant repairs on existing structures. The average value of these contracts was about $400,000.

The road construction industry in Ontario is mainly represented by two groups: the Ontario Road Builders' Association (ORBA) and the Ontario Hot Mix Producers Association (OHMPA). They consult with the Ministry on technical matters and lobby on behalf of their members' interests.

Our audit found that, in 2000, the Ministry began identifying significant problems throughout

the province with pavement cracking years before it is expected to, resulting in increased cost to taxpayers for highways having to be repaired or repaved sooner than expected, and increased inconvenience and time lost for drivers due to more frequent road work. In 2004, the Ministry confirmed that poor quality asphalt cement was the primary cause of premature cracking. In 2007, two tests for assessing the quality of asphalt and the likelihood of it cracking prematurely were developed; however, at the time of our audit, the Ministry had fully implemented only one of them—five years after it was developed—and was using the second on only a limited number of projects. This is the case because over the years, the Ministry decided not to implement all the tests due to multiple requests from the asphalt industry to not implement them.

Similarly, in response to requests from construction contractors who belong to ORBA, the Ministry made significant policy changes that benefit the contractors over taxpayers' best interests.

The Ministry has also paid bonuses to contractors after it became aware that contractors may have tampered with samples, substituting good samples for testing in place of the actual asphalt used. As well, the Ministry has paid for costs to repair roads that should have been covered under contractors' warranties. Although the Ministry works with contractors to change their behaviour through discussions and improvement plans, it rarely penalizes poorly performing contractors, including contractors that breach safety regulations, and allows them to continue to bid on and be awarded future contracts.

We also noted that it is the contractors, not the Ministry, that hire the professional engineers responsible for certifying that construction of structures (such as bridges) adheres to required standards. A few of these engineers have certified that construction, that was subsequently found to be unsafe, was in compliance with the standards.

Some specific observations in this audit include:

- **Premature cracks in highways have significantly increased Ministry's highway-repair costs.** We identified highway projects in all regions of the province where pavements had to be fixed for cracks much earlier than their expected life of 15 years—and some as early as only one year after the highway was open to the public. Sufficient documentation is not available for us to determine the full extent of this issue and the total additional cost paid by the Ministry to repair pavement because of premature cracking. However, we were able to examine five highway projects where all repair costs incurred because of premature cracking were tracked; we noted that the Ministry paid $23 million to repair these highways on top of the $143 million originally paid to pave them. The highways had to be repaired just one to three years after the pavement was laid.
- **Ministry delayed implementing tests to identify asphalt likely to crack prematurely.** The Ministry extensively studied two tests that would allow it to detect, before asphalt was laid, whether pavement is likely to crack early—both tests are required in combination to understand if pavement will in fact crack early. But rather than implementing these new tests as soon as they were validated in 2007, the Ministry waited five years to implement one of them—and still has not implemented the other one across all contracts nine years later. When we asked why action was not taken sooner, the Ministry informed us that instead of a traditional client/supplier relationship between the Ministry and its contractors and suppliers, its approach is to work "collaboratively" with the industry. Thus, decisions such as implementing these tests were discussed and determined through a Joint Pavement Committee made up of OHMPA and Ministry staff and, in essence, allowed the Ministry's suppliers to determine the quality of materials they would supply, even though premature cracking would result in additional revenue for the industry as a whole and incur additional costs for taxpayers.

- **Ministry pays contractors bonuses for meeting the requirements of the contract, something contractors are always expected to do.** In 2012, the Ministry paid contactors about $8.8 million in bonuses for providing the quality of asphalt specified in contracts. It has continued to pay roughly the same amount of bonuses since then (although in 2013 it stopped tracking the amounts paid). However:
  - The Ministry has been aware since 2000 of quality issues surrounding asphalt, and had neither addressed its concerns about premature cracking in a timely manner, nor changed its bonus-payment practices.
  - Contractors have the opportunity to tamper with asphalt samples to obtain bonuses. The Ministry was aware of sample-switching but has neither investigated it to impose fines nor implemented controls to ensure that sample-switching does not occur.
- **Ministry policies changed to benefit the Ontario Road Builders' Association (contractors' association).** Although it is rare throughout the provincial government for ministries' internal audit reports to be shared with outside parties (unless a request is made through the *Freedom of Information and Protection of Privacy Act*), the Ministry shared with ORBA an internal audit report of a review of its construction contracts program. ORBA requested to review the report's recommendations with the Ministry, so the Ministry established a joint policy committee of ORBA and Ministry representatives to review the report. Ministry staff had concerns with the establishment of this committee because it would allow ORBA to strongly influence how the report's recommendations should be implemented, which was an internal operational matter. The Ministry decided against staff's recommendations and created a joint policy committee comprised of six ORBA members (five of which are contractors) and six government representatives (only three from the Ministry of Transportation, with one other from the Ministry of Infrastructure, one from Infrastructure Ontario, and one from the Ministry of Finance). Moreover, the Ministry decided that rather than working on implementing recommendations made by Internal Audit, the joint policy committee would focus on addressing an action plan document created by ORBA and its recommendations. We noted that ORBA's action plan, not unexpectedly, was in the best interests of its members.

  Through this process, and because of multiple requests made by ORBA prior to it, ORBA influenced internal Ministry policy in its favour, including the following:
  - **A Ministry policy changed to allow contractors to delay paying fines; some fines are now uncollectible.** Prior to 2011, contractors had to pay liquidated damages (late fines) right away when they were late delivering on projects. However, the Ministry agreed to a change in its policy to allow contractors to delay paying fines if the contractor wanted to contest the fine. We noted that other provinces such as Alberta, British Columbia and Quebec collect fines immediately, then issue a refund if the dispute is resolved in the contractors' favour. With this change in policy, contractors have been able to postpone paying a total of about $6 million in fines for up to four years. During these four years, two contractors went bankrupt; the Ministry will never be able to collect the $660,000 in late fines they owed.
  - **New policy no longer discourages litigious contractors from repeatedly suing the Ministry.** Prior to 2015, the Ministry could prohibit contractors that filed multiple lawsuits that it deemed to be frivolous from bidding on future contracts. Lawsuits considerably add to the workload of Ministry staff and to legal costs for the

Ministry. Upon the industry's requests, the Ministry removed a contract clause in 2015 that had given the Ministry the ability to exclude litigious contractors from bidding on future contracts. Ministry records show that between 2007 and 2015, contractors filed 12 lawsuits. Prior to 2007, lawsuits were virtually non-existent. The new policy change may contribute to even more lawsuits.

- **The Ministry changed its dispute-resolution policy, providing incentive for contractors to dispute more often.** In the Ministry's original dispute-resolution process, a contractor wishing to make a claim against the Ministry had to escalate the claim through three levels within the Ministry before launching legal action. This process worked well given that about 95% of disputes were successfully resolved through this process. However, upon the industry's request, the Ministry agreed in 2016 to change the process, allowing contractors to ask for a third-party referee to be involved at any level of the dispute process. There is a risk that referees may make middle-ground decisions instead of strictly applying the terms of the contract. This may create an incentive for contractors to file more claims and go directly to a referee.

- **Engineers who certify structures are built correctly are hired by the contractor, and have provided false certifications.** One of the most important quality-control measures in building public infrastructure is to have sufficient oversight by a professional engineer to verify and provide certification that key construction activities are performed to the appropriate standards. Given the nature and importance of their work, the Quality Verification Engineers (QVEs) who perform this work should be independent from the contractors whose work they are reviewing—but, in fact, we found that they are hired by, work for and report directly to the contractors. We noted that Ministry regional staff had identified instances across the province where QVEs provided erroneous or misleading conformance reports to the Ministry. The Ministry also relies on its contract administrators and quality assurance staff to provide oversight, but a sign-off by the QVE provides assurance to the Ministry that a structure will be safe for public use and that specifications have been met.

- **The Ministry is lenient in managing poorly performing contractors.** The Ministry does not effectively penalize contractors that have serious performance issues, and allows them to bid on future contracts. Contractors that have received unsatisfactory ratings are allowed to continue to bid on and have been awarded significant amounts of work for the Ministry. For instance, three contractors that have consistently received an unsatisfactory rating for several years because of their poor performance were awarded construction contracts worth about $45 million each over the last five years—for a total of about $135 million. As well, the Ministry has paid to repair the contractors' substandard work even when the work was to be covered by the contractor's warranty.

- **The Ministry awards new projects to contractors that have breached safety regulations.** The Ministry can penalize contractors that perform unsafe work; in practice, this rarely happens. Rather than imposing monetary fines for unsafe work, the Ministry's penalty process is intended to reduce the amount of future work a contractor can bid on. However, we noted that in seven such infractions we examined, none of the penalties were large enough to prevent contractors from bidding on Ministry projects. This is because the ceiling amount (the maximum amount a contractor can bid on for a contract) is not reduced enough by the penalty to impact any future bids by the contractor. Also, a smaller

contractor that had breached safety regulations was banned from bidding on future contracts in one of the Ministry's regions but was still awarded work in other regions. In addition to these penalties, the Ministry also works with contractors to change their behaviour through discussions and improvement plans.

3.11 Physician Billing

As of March 31, 2016, Ontario had about 30,200 physicians (16,100 specialists and 14,100 family physicians) providing health services to more than 13 million residents at a cost for the year then ended of $11.59 billion. This is 20% higher than the $9.64 billion paid to physicians in 2009/10.

Physicians operate as independent service providers and are not government employees. They bill their services to the province under the Ontario Health Insurance Plan (OHIP) as established under the *Health Insurance Act*.

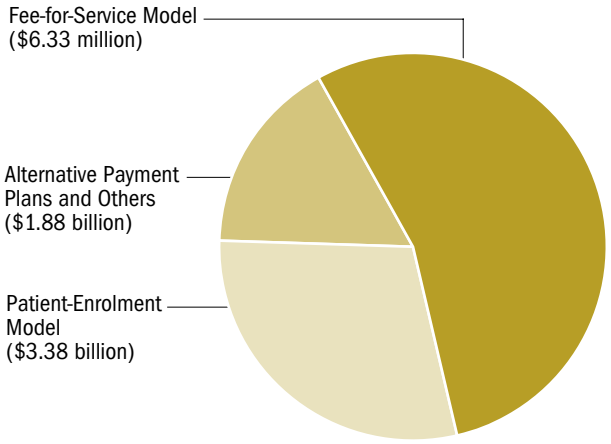
Under the December 2012 Ontario Medical Association Representation Rights and Joint Negotiation and Dispute Resolution Agreement (OMA Representation Rights Agreement), the Ministry of Health and Long-Term Care (Ministry) recognized the OMA as the exclusive bargaining agent of physicians, and both parties agreed, among other things, to consult and negotiate in good faith on physician compensation and related accountability.

The Ministry is responsible for establishing policies and payment models to fairly compensate physicians, while at the same time ensuring that taxpayer funds are spent effectively. Through various divisions with an annual budget of about $27.9 million and 260 staff, the Ministry administers payments to physicians and ensures billings are appropriate. Its Negotiations and Accountability Management Division has the main role in overseeing this billing process.

Physicians in Ontario can bill under three major models:

- The first is a **fee-for-service model** (fiscal year 2015/16—$6.33 billion) under which physicians are compensated based on a standard fee for each service they perform. They bill using fee codes in OHIP's Schedule of Benefits. This model has been the principal way that physicians bill since 1972. It is widely used today, mainly by specialists.
- The second is a **patient-enrolment model** (fiscal year 2015/16—$3.38 billion) under which physicians form group practices (such as Family Health Organizations and Family Health Groups) and are paid for the number of patients enrolled with them, and for a predetermined basket of services the group provides to those patients. The objective is for family physicians to offer their patients more comprehensive and continuous care. Remunerations might also include a combination of bonuses, incentives and other payments for additional work including fee-for-service payments for services outside the basket of services. Family physicians could opt into one of the patient-enrolment models or continue with fee-for-service. This type of model generally allows family physicians to earn more than under the fee-for-service model. As of March 31, 2016, 8,800 out of 14,100 family physicians had opted for one of the patient-enrolment models (Family Health Organizations and Family Health Groups accounted for 92% of the total number of enrolled patients). The remaining family physicians mainly bill fee-for-service or are paid through alternative payment plans.
- The third is **alternative payment plans** (fiscal year 2015/16—$1.88 billion) and other contracts with hospitals and physician groups to provide specific services. In addition to the $1.88 billion, approximately $1.2 billion was paid to alternative-payment-plan physicians as fee-for-service, which is included in the $6.33 billion paid under the fee-for-service model mentioned above. **Figure 1** provides a breakdown of payments.

Figure 1: Payments to Ontario Physicians, 2015/16
Source of data: Ministry of Health and Long-Term Care



Over the last five years, Ontario physicians have been among the highest paid in Canada. While one reason for this is that Ontario has the third-highest population-per-physician ratio, it also compensates more physicians than other provinces with models such as the patient-enrolment model—a more expensive model than fee-for-service. Over the years, physicians were paid additional incentives even after reviews concluded that some of these payments likely did not improve the quality of patient care. For example, in 2014/15, each family physician in patient-enrolment models received $3 per patient each month, which cost $364 million on top of base capitation payments (the fixed amount paid for each enrolled patient, regardless of patient visits or services actually performed).

However, use of patient-enrolment models has still not translated into increased access to care as measured by wait times—57% of Ontarians waited two days or more to see their family physician in 2015/16 as compared to 51% in 2006/07. Ministry survey data for the period October 2014 to September 2015 showed that approximately 52% of Ontarians found it difficult to obtain medical care in the evening, on a weekend or on a public holiday without going to a hospital emergency department.

Our review of Ministry data noted that in 2014/15, each physician in a group practice called a Family Health Organization worked an average of 3.4 days per week, while each physician in a group practice called a Family Health Group worked an average of four days per week. In 2014/15, 60% of Family Health Organizations and 36% of Family Health Groups did not work the number of weeknight or weekend hours required by the Ministry. As well, many patients are visiting walk-in clinics for care that could normally be provided by family physicians. The Ministry's survey data for October 2014 to September 2015 showed that approximately 30% of Ontarians had visited a walk-in-clinic in the last 12 months.

The Ministry is also having challenges managing and controlling the use of services billed under the fee-for-service model. One way to achieve some cost savings here is by encouraging physicians, based on clinical research, to reduce medically unnecessary services. However, the Ministry has had limited success with this and in 2015 implemented across-the-board cuts to physician payments, which is not a sustainable way to contain costs.

Another way to manage costs is to adjust fee-for-service rates based on new clinical practices—an area where Ministry attention is still needed. Further, the Ministry's oversight and recovery of inappropriate fee-for-service payments is weak and is hindered by its lack of an inspection function and ineffective enforcement of payment recovery mechanisms.

Some of our more detailed findings are as follows:

- **Patient-enrolment models for compensation of family physicians are not meeting original objectives and pose management issues for the Ministry**. There were four objectives when Ontario decided to implement the more expensive patient-enrolment model: to increase patient and physician satisfaction, cost-effectiveness, access to care, and quality and continuity of care.
  - The objective of increasing patient satisfaction with family physicians has been achieved, but at a cost: the Ministry estimates that for the year ended

March 31, 2015, physicians were paid for base capitation under Family Health Organizations approximately $522 million that would not have been paid under a fee-for-service model, in part because physicians were compensated for approximately 1.78 million patients that they had enrolled, but did not treat.

- Although the number of Ontarians who have a family physician has risen by 43% since 2006/07 (from 7.4 million to 10.6 million in 2015/16), it has not translated into increased access to care as measured by wait times, as previously noted.
- The Ministry is not able to demonstrate whether patient-enrolment models have improved quality and continuity of care, and its cost-effectiveness evaluations are inconclusive. The Ministry's billing system indicated that 40% of enrolled patients went to walk-in clinics or other family physicians outside the group in which they were enrolled. As well, an estimated 27% of enrolled patients have chronic health conditions and regularly seek primary care outside their physician group, contrary to best practices. This resulted in duplicate payments of $76.3 million cumulatively over the five years up to fiscal 2014/15. The Ministry does not recover these payments.
- High use is being made of emergency-department services for non-urgent care that could be provided by family physicians. During 2014/15, about 243,000 visits were made to emergency departments for conditions that could have been treated in a primary care setting. The Ministry estimated these visits cost $62 million, of which $33 million was incurred by patients enrolled in Family Health Organizations that are compensated using the patient-enrolment model. The Ministry does not recover this money from these patients' family physicians.
- In 2014/15, 1.78 million (or 33%) of the 5.4 million patients enrolled with a Family Health Organization did not visit their family physician at all, yet these physicians still received a total of $243 million for having them enrolled. Most of the patients who did not visit their physicians were males between the age of 20 and 29.

- **Ministry faces challenges controlling costs under the fee-for-service model.**
  - **Under the 2012 OMA Representation Rights Agreement, the Ministry and the OMA must consult and negotiate in good faith to establish physician compensation.** Fee-for-service claims have been growing at an annual rate of 3.3%, despite the Ministry's targeted rate of 1.25%. In a taxpayer-funded system, the decision to provide a service should be based on whether it is medically necessary—a professional judgment that should also be informed by medical research studies. The Ministry has not been successful in achieving a reduction of medically unnecessary services. It initiated an across-the-board payment reduction because it did not reach an agreement on future billing amounts and rules with physicians.
  - **Ministry does not have the information it needs to assess whether the large variances in gross fee-for-service payments to the same type of specialists are reasonable.** We noted that large variances exist in gross payment per physician (before deduction of office expenses and overhead) within certain specialties. For example, in 2014/15, ophthalmologists at the higher end of the pay range received an average of about $1.27 million each—close to 130%, or over $710,000, higher than the approximately $553,000 received by ophthalmologists in the middle of the pay range. However, the Ministry does not have complete information on physicians'

practices and profit margins to help it analyze the disparities.

- **There is a high disparity of gross payment per physician between specialists.** The fee-for-service model in Ontario favours procedural specialists (those who perform procedures such as diagnostic testing or surgery), who also generate a high volume of services. For example, vascular surgeons, who perform on average 12,230 services per year, would be paid an average of $43 per service, whereas pediatricians average 6,810 services and would be paid an average of $31 per service. To assess reasonableness, and the impact of technology on service levels, the Ministry needs to obtain more information on physicians' practices, including operating costs and profit margins.

- **Ministry lacks a cost-effective enforcement mechanism to recover inappropriate payments from physicians.** The Ministry has had no inspector function since 2005. Its current recovery process on inappropriate billings is lengthy and resource-intensive: the onus is on the Ministry to prove that the physicians who bill on the honour system are in the wrong, not on the physicians to prove they are entitled to the billing. Unless a physician repays amounts voluntarily, it is very difficult for the Ministry to recover inappropriate payments. Legislative changes in 2005 established a Physician Payment Review Board. Alberta and British Columbia can order a physician to repay overpayments without an order from a similar board.

- **Ministry does not investigate many anomalous physician billings.** The Ministry did not investigate many instances where physician billings exceed the standard number of working days and expected number of services. We noted that, for example, nine specialists each worked over 360 days in 2015/16; six of these worked 366 days (2016 was a leap year). A further example includes one respirologist who worked 361 days in 2015/16 and billed the province $1.3 million, close to five times higher than the upper expected limit and billed for close to 12,400 services that year, about four times the upper expected range for the same billing category. Other examples of anomalies:
  - One cardiologist worked 354 days in 2015/16 and billed the province $1.8 million, which is three times higher than the upper expected limit for physicians in the same billing category (procedural specialists). This specialist provided over 13,200 services that year, 2.4 times the upper range of expected services for physicians in the same billing category.
  - One diagnostic radiologist worked 313 days in 2015/16 and billed the province $1.7 million, which is 2.8 times the upper expected limit for physicians in the same billing category (diagnostic specialists). This specialist provided over 57,400 services that year, 5.6 times the upper range of expected services for physicians in the same billing category.

While the Ministry had initiated some investigations on its own, the investigations were not done in a timely manner. For example, one cardiologist billed $2.5 million during 2014/15 for performing over 68,000 services, more than six times the number of services rendered by the average cardiologist. However, the Ministry had not concluded its investigation at the time of our audit.

- **Ministry does not follow up on many cases of possible inappropriate billings by physicians.** Since the beginning of 2013, the Ministry has not actively pursued recovery of overpayments in proactive reviews; it was recovering approximately $19,700 in 2014 and nothing in 2013 and 2015. In prior years, recoveries were well over a million dollars. As well, the Ministry no longer follows up on all physicians who have billed inappropriately in

the past. This is a concern since in our analysis of 34 physicians who billed inappropriately, 21 had previous instances of inappropriate billing. In addition, the Ministry acknowledged that some specialists are systematically billing one particular code inappropriately. We identified about 370 specialists who were billing this code inappropriately and estimated that between April 1, 2012, and March 31, 2016, the overpayment amounted to approximately $2.44 million.

- **Ministry has had minimal success in controlling excessive preoperative cardiac testing.** The Ministry targeted savings of $43.7 million for 2013/14 by reducing the number of unnecessary preoperative cardiac tests, but actual savings were only $700,000. The Ministry later calculated that for fiscal year 2014/15 alone, approximately $35 million was paid to physicians for up to 1.15 million preoperative cardiac tests, which may not have been medically necessary, for low-risk surgeries.
- **Concerns of the Ontario Association of Cardiologists (Cardiologists Association) about cardiac-care spending published in an open letter to the Auditor General were reasonable.** The results of our review of the concerns are detailed in this report. In October 2014, the Ministry became aware of fee-for-service claims for two cardiac rhythm monitoring tests that were inappropriately claimed and paid to physicians. The Ministry determined that approximately 70 physicians were overpaid by at least $3.2 million between April 2012 and May 2015. However, at the time of our audit, the Ministry was not planning to recover any of this amount. In October 2015, the Ministry made the fee for cardiac-ultrasound services the same regardless of whether or not a cardiologist was physically on site. Prior to this, although a cardiologist could have supervised services via telephone or video-conference off site, a cardiologist physically present for the services would have been paid more by being on site. Our review of the Ministry's data for the period October 2015 to March 2016 in comparison to the same prior-year period found that the increase in amount paid by the Ministry and the volume of services conducted was minimal—less than 0.1%. However, we believe that the Ministry should continue to monitor the volume of these services provided to ensure that only necessary services are being conducted with proper supervision.
- **Taxpayers continue to pay significant amounts for the rising cost of physician medical liability protection.** A joint effort between the Ministry, the OMA and the Canadian Medical Protective Association to review the legal context surrounding the dramatic increase in medical malpractice trends is long overdue.

3.12 Specialty Psychiatric Hospital Services

There are about 2,760 long-term psychiatric beds in 35 facilities (primarily hospitals) across Ontario. These beds are for children, adults and seniors who need treatment for the most severe or complex forms of mental illness. The beds are also for forensic patients—people who have, or are suspected of having, mental illness and who have been charged with a criminal offence.

About half (1,389) of these beds are located in four hospitals, called specialty psychiatric hospitals, that primarily provide mental health care. Our audit focused on these four hospitals, which are:

- Centre for Addiction and Mental Health (CAMH) in Toronto;
- Ontario Shores Centre for Mental Health Sciences (Ontario Shores) in Whitby;
- The Royal Ottawa Health Group (The Royal) with sites in Ottawa and Brockville; and
- Waypoint Centre for Mental Health Care (Waypoint) in Penetanguishene.

In 2015/16, these four specialty psychiatric hospitals treated about 7,200 patients and handled about 280,000 visits from out-patients (people who can manage their mental illness without needing to stay overnight at a hospital).

A referral is generally required for a person to be admitted to a specialty psychiatric hospital. Most patients are referred by general hospitals, family doctors, psychiatrists, or mental health community organizations.

When patients are ready to be discharged from a specialty psychiatric hospital but are not able to return home, or do not have a home to return to, the hospitals must co-ordinate with other care providers, such as supportive housing and long-term-care homes, to ensure that the patient's care needs will continue to be met.

The Ministry of Health and Long-Term Care (Ministry) is responsible for providing overall direction, funding and leadership for mental health care in Ontario. The Ministry provides funding to 14 regional Local Health Integration Networks (LHINs) responsible for planning and integrating health services in their respective region. LHINs enter into an accountability agreement with specialty psychiatric hospitals and provide funding to them. In 2015/16, specialty psychiatric hospitals received $673 million, which represents over 20% of the $3.3 billion the Ministry spent in total on mental health care.

Our audit found that for the past five years, specialty psychiatric hospital funding did not keep up with inflation or the increased demand for mental health services. To deal with this, these hospitals have had to close beds, which has resulted in patients now waiting longer to access specialty psychiatric hospital services.

These hospitals have also changed their employee mix to include more part-time staff. It is not clear that current resources, including staffing, allow enough activities like group therapy, or therapy involving the use of facilities available at the hospitals (such as swimming pools) to occur. These are important to a patient's treatment and patients feel there are not enough of them.

Specialty psychiatric hospitals have not been able to deal with safety concerns to the degree that staff have requested. We also found that important patient file documentation, such as inclusion of patient risks in patient care plans or updates on the status of a patient's treatment, was missing from patient files.

The Ministry and LHINs have focused less on specialty psychiatric hospitals compared to other areas of health care, such as general hospitals. The Ministry has not created mental health standards to ensure that specialty psychiatric hospitals are consistent regarding which patients they admit, how they treat those patients and how those patients are discharged. While the Ministry collects wait time information and funds general hospitals based on the demand for their services, it does not do this for specialty psychiatric hospitals. Specialty psychiatric hospitals have to regularly complete and submit the same template of information that LHINs collect from general hospitals, however this template contains very little information that is specific to mental health care or specialty psychiatric hospitals. It asks many details that specialty psychiatric hospitals return blank because they are unrelated to them, such as the number of MRIs and breast screenings they perform to detect cancer. As a result, the Ministry and LHINs are not collecting the appropriate type of information to know how successful specialty psychiatric hospitals are in treating their patients.

The following are some of our significant observations:

- **Wait times for patients to receive treatment are long and getting longer:** In 2015/16, children had to wait more than three months to receive help for severe eating disorders at Ontario Shores. At Waypoint, the wait list for one of the main out-patient programs was so long that in 2015/16, the hospital temporarily stopped adding new people to the wait list, even though they required the treatment.

Patients with borderline personality disorders (instability in mood and behaviour) waited about a month and a half in 2011/12 for a program at Ontario Shores. In 2015/16, they had to wait seven months. Our audit of hospital records over the past five years found evidence of two people who died by suicide while waiting for help.

- **More people could have been treated if patients were not staying in the hospitals longer than necessary as a result of a shortage of beds in supportive housing and long-term-care homes:** In the last five years, approximately one in 10 beds in specialty psychiatric hospitals was occupied by patients who no longer needed to be treated in the hospital but could not be discharged due to the lack of available beds in supportive housing or at long-term-care homes. The cost of care there is less than one-fifth of what it is at specialty psychiatric hospitals. In 2015/16, if the four specialty psychiatric hospitals had been able to find a place to discharge their patients as soon as required, the cost of caring for these people in supportive housing or long-term-care homes would have been $45 million less, and the hospitals would have been able to treat about 1,400 more people.
- **There is a lack of long-term psychiatric beds in some regions:** In 1988, the Ministry commissioned a report that recommended the Ministry ensure all residents have access to mental health services in their own communities or as close to them as possible. Almost 30 years later that is still not the case. In the North Simcoe Muskoka LHIN, there are no beds for children with mental illnesses. Beds dedicated for individuals with addictions are only available in six of the 14 LHINs. The lack of needed care resulted in the Ministry spending almost $10 million between 2011/12 and 2015/16 to send 127 youths to the United States so that they could receive needed treatment.
- **Long-term psychiatric beds have closed across the province:** Between 2011/12 and 2015/16, there was a net reduction of 134 long-term psychiatric beds across the province. Thirty-two of those long-term beds that were closed were at specialty psychiatric hospitals. Bed reductions stemmed from the limited increase in funding specialty psychiatric hospitals got for their ongoing operations.
- **The Ministry and LHINs are not collecting relevant information for funding decisions:** During our audit, the Ministry increased funding for specialty psychiatric hospitals by 2%. This increase was not supported by actual demand for specialty psychiatric services; nor did it target programs that had the biggest need (wait lists) for treatment. Without mental health targets and relevant information, the Ministry or LHINs cannot make effective funding decisions.
- **Some patient files are being completed late and are missing required information, which could impact the patient's care:** Patient files we reviewed at CAMH and Ontario Shores were updated late or missing important information. During a patient's admission, key patient health and behavioural risks are identified. These risks should be documented in a patient's care plan. Some care plans we reviewed were missing this information. About 40% of the care plans were prepared late and were missing timelines for patients' treatment goals. We also found that hospital discharge plans were completed later than they should have been, which could increase wait times for beds.
- **The hospitals are increasing their use of part-time staff:** Over the past five years hospitals shifted toward hiring more part-time staff. The Registered Nurses Association of Ontario (RNAO) recommends that 70% of all nursing staff should be full-time to achieve best quality care results. In 2011/12, three specialty psychiatric hospitals employed at

least 70% of their staff who provide direct patient care on a full-time basis. Five years later, one of the hospitals had a full-time staff level above 70% and all had fewer full-time staff overall. The mix of full-time and part-time staff varies between the hospitals, and none have a target for this mix.

- **The hospitals are spending less money on direct patient care than other comparator hospitals and their spending has decreased:** Since 2011/12 specialty psychiatric hospitals' spending on direct patient care has decreased by 2 cents, from 64 cents to 62 cents in 2015/16, out of every dollar that they receive from the Ministry. This is 5% less (3 cents) than the average of 65 cents that other comparator hospitals in Ontario spend on direct patient care. During this time period, specialty psychiatric hospitals had to deal with increasing costs without much additional funding from the Ministry for their ongoing operations.
- **There are not enough mental health emergency departments in the province:** CAMH has the only emergency department in Ontario that is exclusively for people experiencing mental health issues. This emergency department was first established in the 1960s. Although Ontario's population has doubled since then, no additional mental health emergency departments currently exist in the province. The Ministry has no plans to create additional ones.
- **Waypoint's new forensic building has had deficiencies since it opened in 2014 that have seriously impacted the safety of patients and staff:** In 2014, Waypoint opened a new building to house its high-security forensic program. Since then, 90 deficiencies impacting staff and patient safety were identified. These deficiencies, including a poorly constructed fence and a broken electronic door-closing mechanism, contributed to over 800 reported safety hazards between 2014/15 and 2015/16 (related to staff assaults, property damage, vandalism and a patient climbing over a fence to leave without authorization). As a result of several hospital staff being assaulted and injured, including one who was stabbed by a patient, the Ministry of Labour was called in and issued seven compliance orders to address safety issues that occurred in the new building.
- **Without provincial mental health standards, the hospitals have each created their own standards for admission, treatment and discharge, resulting in patients being treated differently:** Ontario does not have provincial mental health standards and currently there is no set timetable to create them. In Ontario, each of the four specialty psychiatric hospitals develops their own standards pertaining to patient admission, treatment and discharge. These standards can sometimes differ resulting in differences of how patients with the same diagnosis are regarded by each hospital. One general hospital reported to us that it referred the same patient to two of the specialty psychiatric hospitals, and the patient met admission standards at one hospital, but was rejected at the other.
- **Specialty psychiatric hospitals have developed new treatment methods that show improved patient care outcomes:** Specialty psychiatric hospitals are implementing new treatment methods to better treat certain mental illnesses. For instance, Ontario Shores developed a new approach to treat certain schizophrenia patients that led to a decrease in the number of patients who were prescribed multiple anti-psychotic medications. Such medications have strong side effects. However, we found that there is no process for hospitals to share new treatment methods developed by their peers.
- **The Ministry has not done any analysis to learn why general hospital emergency room visits in Ontario related to mental health are increasing:** In the past five years,

there has been a 21% increase in general hospital emergency department visits by people with mental illness. During that time, the percentage of repeat emergency visits within 30 days for substance abuse grew by 18% and for mental health by 9%. The Ministry has not conducted any analysis to determine why emergency department visits for mental health or substance abuse have increased.

- **Mental health information is not shared among the LHINs or with the police:** Only one LHIN has a database whereby all providers of mental health services can look up patients' information to identify all the care and services that patients are receiving. This ensures patients receive the care that they require and prevents duplication of care. A similar problem exists with the sharing of patients' information with the police. Police told us that some hospitals are not willing to share patient information. Without this information, the police have to assume patients who leave without authorization from specialty psychiatric hospitals pose a high risk of danger to the public, which can lead to a greater use of force.

3.13 Supply Chain Ontario and Procurement Practices

The process of procuring goods and services by the Government of Ontario is intended to be open, fair and transparent. The Government spends an average of $3.5 billion annually on procuring goods and services. (This does not include spending on the construction of capital assets, such as highways and buildings.)

The individual government ministries across the Province independently make decisions on what goods and services they require. The Treasury Board Secretariat (Secretariat) is responsible for updating and maintaining the rules and best practices for procurements that are laid out in the Ontario Public Service Procurement Directive (Directive). The ministries are required to follow these procurement requirements.

According to these requirements, ministries must first source goods and services from arrangements of preferred suppliers. These suppliers have been selected through a competitive process by Supply Chain Ontario (SCO) to ensure that the ministries are receiving the best price for quality goods and services. The ministries select preferred suppliers to bid on their procurement contracts, and the winning supplier(s) provides the goods, services or consultants. For some goods and services, such as office supplies and courier services, SCO selects a single preferred supplier for all the ministries to use in order to get the lowest price through bulk purchasing.

The largest preferred supplier arrangement is IT Consulting Services. This service allocates, based on need, either internal IT staff or external IT consultants to ministries. It is managed by the Secretariat. The ministries make a request to the Secretariat for their IT staffing, which the Secretariat first tries to fill with internal employees. If none are available, it will help ministries find external IT consultants with the required expertise.

Overall, we found that ministries are following the procurement requirements and that procurement of goods and services is mostly competitive, fair and cost-effective. For example, based on our testing we found that most ministries properly planned and acquired their procurements competitively. In addition, ministries mostly received goods and services at the contract price. However, we did find examples where the procurement requirements were not followed. Non-compliance can increase ministries' risk of not receiving value for money from awarded contracts. We also noted that the government is not taking full advantage of bulk buying opportunities and may be forgoing associated price discounts. In addition, we noted that a shortage of internal IT staff is resulting in an overreliance on more costly external IT consultants. We further noted some weaknesses in how

ministries procure IT consultants that leave the process vulnerable to fraud.

Some of our specific findings are as follows:

- **Supply Chain Ontario (SCO) manages preferred supplier arrangements effectively.** We found that preferred supplier arrangement files were complete, awards were justifiable and the process was fair and done competitively according to the procurement requirements.
- **SCO lacks information to identify bulk buying opportunities.** SCO does not have ready access to ministries' procurement information because there is no centralized electronic database. For example, it can tell whether a supplier received a payment of $500,000, but does not know if the payment is for one contract or 10 contracts, the duration of the contract, or what good or service was purchased. Without this information, SCO cannot proactively identify new bulk buying opportunities that could potentially reduce future costs.
- **A shortage of internal IT staff has led to an overreliance on costly consultants.** Over the past two years, the ministries' approximately 3,200 requests for IT staff have been filled about 90% of the time by external consultants. The Secretariat, which oversees IT staffing, estimates that a consultant costs $40,000 more annually than a permanent employee. Part of the extra costs of using consultants is the middleman fee paid by the ministries to the preferred supplier for placing a consultant.
- **Best practices over the procurement of IT consultants are not always followed.** We found weaknesses in how ministries procure IT consultants. Consultants are hired without in-person interviews, payments to consultants can be authorized by the same person who hires them, and the Secretariat that processes these payments does not perform any additional review to ensure payments are legitimate. Because of these control weaknesses, the risk exists that the ministries may not always be selecting the most qualified candidate. For example, a senior manager at a ministry created and hired a phantom consultant. Over a period of several months, the senior manager approved the phantom consultant's invoices and pocketed $150,000 for himself. The Secretariat has still not implemented internal controls to prevent this situation from recurring.
- **The new online procurement system is not widely used due to design concerns.** In 2014, SCO implemented a new online procurement system intended to make the bid process more efficient and paperless. It was designed to conduct tenders online. However, concerns with the system, such as limiting the number of characters in data fields where suppliers input their bids, impact the bidding process. As a result, suppliers continue to submit paper bids that are assessed manually. In 2015/16 only about 146, or 32%, of 458 total tenders were conducted using the system. About 100 of the 146 were for complex tenders. Bids for another 145 complex tenders were still handled in paper form and reviewed manually. SCO intends to make use of the system mandatory by January 2017.
- **Suppliers are charged higher fees under the new online procurement system.** New system user fees charged to suppliers are two-and-a-half times higher than those charged before the new system was implemented. The increase in fees has raised the concern that small businesses could be discouraged from bidding on government contracts.