

ONTARIO NURSES' ASSOCIATION

Submission on Bill 160
Strengthening Quality and Accountability for Patients Act, 2017

Standing Committee on General Government

Room 151
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The Ontario Nurses' Association (ONA) is the union representing 65,000 registered nurses and health-care professionals, as well as 16,000 nursing student affiliates, providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

While we make substantive comments below, we are expressing our disappointment at the outset that the Ministry of Health and Long-Term Care (MOHLTC) did not consult with ONA during the policy work prior to tabling the proposed amendments contained in the ten schedules that comprise the omnibus Bill 160. Because we represent frontline health professionals providing patient care in the sectors related to these proposed amendments, our advice and guidance could have been beneficial to the Ministry before tabling this legislation. This flawed process has resulted in flawed legislation. While ONA was able to arrange a one-hour briefing from the Ministry on Bill 160 last Friday, our initial reservations have not been resolved.

Below we raise questions and concerns around many of the proposed amendments as we believe these policies could lead to lower quality care for our patients. While Health Minister Hoskins has been a champion of public health care in Ontario, the proposed amendments that we address not only reduce the regulation of the existing private delivery in Ontario, but appear designed to facilitate further privatized health care rather than constrain. This will lead to lower quality outcomes for patients as has been demonstrated consistently in the research literature. Our recommendations below relate to six of the ten schedules, as follows: Schedule 1 (Ambulance Act), Schedule 3 (Health Protection and Promotion Act), Schedule 4 (Health Sector Payment Transparency Act), Schedule 5 (Long-Term Care Homes Act), Schedule 9 (Oversight of Health Facilities and Devices Act), and Schedule 10 (Retirement Homes Act).

SCHEDULE 1 – AMBULANCE ACT

Section 7.0.1 allows the Minister to issue operational or policy directives to the operator of a land ambulance service where the Minister considers it in the public interest to do so. ONA is of the view that this broad discretion, combined with the proposed amendments contained in Schedule 9, may not be in the public interest as currently written.

The Minister's operational or policy directive may include conveyance of patients by ambulance to destinations other than hospitals. No definition is provided for the term "destinations other than hospitals." As a result, destinations other than hospitals could refer to any non-hospital facility, whether or not such a facility is a private, for-profit facility. This understanding has been confirmed by Ministry representatives.

The decision to transfer a patient to a non-hospital destination appears to rest with the paramedics. The treatment required during this transfer by paramedics is to be done in accordance with the prescribed standard of care but is not specified in the proposed amendments. Similarly, "other responsibilities" to facilitate the adoption of treatment models for persons with low acuity conditions are not specified in the proposed amendments. No definition is provided.

All of this raises serious issues of liability for paramedics that we understand the Ministry is aware of and will be hosting additional consultations to review the protocols for the transfer to non-hospital designations. ONA believes this policy change raises significant concerns around quality and safety for our patients.

These amendments will allow the Minister to direct ambulance services to transfer patients to locations such as private for-profit clinics that the Minister proposes under amendments in Schedule 9. We not believe that these provisions are in the public interest. We will have more to say under Schedule 9 related to the evidence on poor outcomes in private clinic settings.

At this point, we believe that these proposed amendments facilitate moving additional services out of non-profit hospitals into for-profit clinics. Patient choice of destination is not considered. The Ministry will be consulting further on scenarios where patients may be transferred to hospital emergency the first time and then protocols potentially developed for this patient. We are concerned about acute changes that may take place, even with an initial assessment respecting a certain treatment. As well, any fees do not appear to be prohibited and potentially may be charged patients at the non-hospital destination.

None of the above amendments are in the public interest. Rather, these proposed amendments appear to be a further step to facilitate moving service out of public hospitals and facilitating further privatization of our health care services in Ontario.

If there are specific destinations, other than hospitals, that this power is intended to cover that do appear to be in the public interest, then the Minister should specify these destinations upfront and name them in legislation so everyone is clear. We also understand that the Minister's directives will be available to the public but only after the directives have been issued.

Similarly, we oppose the blanket regulation-making authority under the proposed amendment to Subsection 22(1)(f), which permits the Minister to exempt any and all from the provisions of the Ambulance Act, including exemptions for pilot projects. Any exemptions must have public consultation and be specified in legislation. Consultations on regulations do not have the same legislative process as applies to legislation.

Recommendations for Schedule 1:

- Specify under Subsection 7.0.1(3)(a) that any operational or policy directives to the operator of a land ambulance the Minister considers to be in the public interest must only permit transfer to a public hospital for initial assessment of patients.
- Specify under Subsection 7.0.1(3)(b) the particular expansion of responsibilities and treatment models of patients that can safely be undertaken by paramedics.
- Delete the regulation-making exemption from the Act in Section 22(1)(f) or alternatively specify which parts apply to the exemption.

SCHEDULE 3 – HEALTH PROTECTION AND PROMOTION ACT

ONA is concerned with the proposed amendment in Section 7(2) to amend the list of specified regulated health professionals – physicians, nurses, pharmacists – who have a duty to report reactions related to the administration of an immunizing agent by adding “or a prescribed person.”

Regulated health professionals are listed as having a duty to report a reaction to ensure the safety of the public because they are able to make the assessment regarding a reaction to an immunizing agent. If there is an additional regulated health professional that the Ministry is considering to prescribe this duty, then the regulated health professional should be specified in legislation.

In the alternative, if the Minister is uncertain of the regulated health professional that might be prescribed this duty as some point in the future, the legislation should be amended to say “or a prescribed regulated health professional.”

Recommendations for Schedule 3:

- Specify in legislation any additional regulated health professional that has a duty to report reactions related to the administration of an immunization agent, as is currently the practice in this legislation. Alternatively, amend Section 7(2) to say “or a prescribed regulated health professional.”

SCHEDULE 4 – HEALTH SECTOR PAYMENT TRANSPARENCY ACT

While ONA supports the intention of the new Act, we have a number of questions for clarity as regulated nurses will be covered by the legislation.

The question of threshold under Section 2(2) to trigger the reporting of a transaction of value is not specified but is left to be prescribed in regulation. We believe this should be specified. We understand from Ministry representatives that there will be consultations regarding the threshold, which is as low as ten dollars in the U.S.

Our concern with the threshold relates primarily to the context that surrounds the payment and whether that will be applied to regulate the threshold. For example, in the case of nurses, transactions of value may accompany training with respect to a certain medical device or equipment. Such as a lunch session, for example. If these sessions are the only learning or educational opportunities available to nurses, then we are concerned about how such activities will be characterized. If the learning sessions are included in the threshold, then we understand that nurses will be required to consent that their information be disclosed in the reporting of the transaction of value. We would not want to see this consent lead to nurses being wary about participating and choosing to avoid the educational opportunity.

As well, without a dollar value being specified, it remains unclear whether certain transactions of a minor nature are considered to be reportable. If the figure of ten dollars is used as an example, then the threshold appears to apply to almost any transaction whatsoever, except for a coffee. A coffee and a muffin might be included.

Similarly, the legislation is silent with respect to the processes around how (the manner) and when the reporting is conducted, except that the manner and frequency of reporting is to be prescribed in regulation. We understand the reporting is likely to be done on an annual basis. It is also stated that the payor is to report to the Minister the information set out in Section 4(5), including the name of the parties to the transaction and other personal information. It is not clear when and if the recipient of the transaction of value is notified of the report. We believe this should be specified. It appears that the recipient will be asked to consent to disclosure if they attend an event with a transaction of value above the threshold. We believe the process should be set out in legislation, rather than awaiting regulation.

Recommendations for Schedule 4:

- Specify in legislation the threshold to trigger reporting of a transaction of value or alternatively, specify in legislation the policy intent that the context of the transaction may mitigate the reporting of the value.
- Specify the manner and frequency of reporting in legislation.
- Specify in legislation that the recipient is notified of their information will be included in the report to the Minister. The precise process for notifying the recipient could be set out in regulation if it is to be done through a consent process or otherwise following further consultations.

SCHEDULE 5 – LONG-TERM CARE HOMES ACT

The new definition of “confine” being added in Section 2(1) to the Act, but which will only be defined in regulation, raises a number of concerns for ONA and our members who provide care in the long-term care (LTC) sector.

While ONA supports limitations on confining residents and supports the rights of residents related to confinement, we are concerned that the appropriate levels of staffing to care for the high-needs of residents is not in place. At the same time, the definition of a “secure unit” in Section 2(1) is repealed, although we understand that secure units may still remain and specialized units are under policy development and consideration.

What we know is that most residents have two or more chronic conditions and take multiple medications. Over 90% have cognitive impairment, and for 30%, the impairment is severe.

We also know that skilled care professionals have a significant impact on resident well-being, but many long-term care facilities have only one Registered Nurse on staff. Our seniors deserve better levels of skilled care.

There’s also the question of the number of hours of care that residents should be receiving. We know that seniors in nursing homes have more complex conditions now than they did before. To meet these needs, research indicates that residents should get 4 hours of direct care each day, and that 20 percent of that care should be delivered by skilled registered nurses. This standard of care won’t happen without regulation and adequate funding, and will be the minimum necessary to provide adequate care under the amendments being proposed.

We understand the Ministry will be undertaking consultations related to the recent announcement to move toward four hours of care in long-term care homes. ONA raises the issue of skilled care now in the context of limitations on confining of residents and in the context of rising acuity levels.

In this context, it is certainly worthwhile revisiting the recommendations from the 2005 inquest into the deaths of two residents at Toronto’s Case Verde nursing home in 2001.

It is important to remember that much of the evidence at the Case Verde inquest related to questions about the need for assessment and provision of care for potentially aggressive residents in long-term care homes.

The inquest heard repeatedly that specialized units or facilities were required for aggressive residents, but they were generally non-existent in Ontario. The inquest also received evidence about the requirements of higher staff to resident ratios in specialized units/facilities to meet the more intense needs of these residents.

It was clear in the evidence before the inquest that the specialized services required by the specified residents could not be provided based upon the funding provided at that time, and that increased funding had to be made available to ensure that these difficult to care for residents receive the care they need (see recommendations 22 to 25 in the inquest).

In fact, the inquest specifically noted in a recommendation to the Ministry of Health and Long-Term Care that “due to health care restructuring LTC facilities have become the “new Mental Health institutions” in Ontario, without the funding and resource necessary nor a recognition of the anticipated needs given demographics in Ontario related to the increased aging population with cognitive impairments” (see recommendation 4 in the inquest).

We raise these issues of appropriate funding and staffing in the context of the move to revise the requirements related to confining and restraining residents in long-term care homes as proposed in Schedule 5. Every long-term care home is to have a written policy to minimize the restraining and confining of residents.

However, the proposed amendments do not address the essential requirement of appropriate staffing levels to provide the needed care to existing residents and to ensure the safety of residents and staff, and to be in compliance with the Resident’s Bill of Rights. There will certainly be further work expected of staff around forms and processes, in addition to care work, related to the rules around confining residents. The appropriate staffing must be in place and not be expected to be undertaken with existing staffing complements. Otherwise, resident care will suffer.

A policy shift to minimize restraining and confining of residents, therefore, must consider the staff resources available to address the additional workload concerns that will arise in order to meet the higher-care needs and rights of residents. It should also be noted that where a Placement Coordinator recommends confining of an applicant, homes are authorized to approve the admission of residents based on the amended criteria in Section 13(2): the home lacks the physical facilities; the home lacks the nursing expertise; other circumstances to be provided in regulation. This consideration only applies to the admission of new residents, not to existing residents, and will impact current lengthy waiting lists for entry to long-term care homes if homes are not staffed and set up to accept high-needs residents.

Recommendations for Schedule 5:

- A definition of “confining’ must be provided in legislation rather than left to regulation. The policy intent must be specified in legislation.
- A minimum standard of 4.0 hours of daily worked care for residents, including 20% RN care, must be funded to ensure the care needs of residents are met. The policy intent of appropriate nursing staffing must be acknowledged in legislation for the safe care of residents.

SCHEDULE 9 – OVERSIGHT OF HEALTH FACILITIES AND DEVICES ACT

ONA finds that the proposed amendments in Schedule 9 are extremely problematic. If the intent of the Ministry with these amendments was to provide better, safer inspection and regulation of primarily for-profit independent health facilities and out-of-hospital clinics, then the Ministry has not attained the necessary standard of safety and quality. The repeal of the *Private Hospitals Act* and the *Independent Health Facilities Act*, combined with the proposed new act, facilitates the expansion of for-profit clinics, and does not provide an enhanced inspection regime to regulate safe, quality patient care.

First, no public consultation has taken place regarding this significant transformation in the ownership of Ontario health facilities.

Second, the repeal of the *Private Hospitals Act* means that the ban on granting further licences for private hospitals is now eliminated and the Minister's powers to regulate licences for private hospitals has been removed. The Ministry has informed us that the repeal of the *Private Hospitals Act* will not proceed until a safety and quality regime is in place. However, the legislative amendments as proposed do not specify this policy intent.

Third, independent health facilities, renamed as 'community health facilities' under the new Act, are not defined in legislation but will be prescribed in regulation. The Ministry has told us that 'community' is meant to signal location but we believe it is confusing for the public since we already have non-profit community health centres in Ontario.

Under Section 4(1), any person may apply for a licence to operate a 'community health facility,' (with any conditions or prohibitions to be prescribed by regulation), whether or not the executive officer appointed to oversee the process has requested applications. This is where we believe the actual timing of the repeal of the *Private Hospitals Act* is critical since grandfathered private hospitals will then be subsumed under the rules set out for a "community health facility."

This new appointed, unelected executive office position will now have the authority for the regulation of private health facilities (including grandfathered private hospitals) that previously rested with the Minister. New provisions also allow for an appeal of the executive officer's decisions to grant new licences to the Health Services Appeal and Review Board.

Under the *Independent Health Facilities Act*, Section 3(3.1) prohibits the charging of facility fees to patients, but that specific provision is **not** included in the new proposed *Oversight of Health Facilities and Devices Act*. We hope this is an oversight that will be corrected.

Specific provisions regarding safety and quality standards, complaint process, inspection bodies and enforcement discretion are to be provided for, if any, in regulations. In fact, the inspecting bodies to be designated in regulations are also charged with developing safety and quality standards.

This raises concerns for us. The 2012 Annual Report of Ontario's Auditor General (p. 149) indicates that most (97%) of the existing 800 plus Independent Health Facilities (IHF) are independently owned and operated as for-profit corporations. Less than 3% are non-profit organizations.

In addition, given the quality and patient safety issues highlighted in media reports in recent times on issues regarding proper sterilization procedures in private clinics, for example, we question whether the government's plan to open the door to move even more services from public hospitals into private clinics is in the best interests of our patients. We will have more to say about quality and safety issues below.

There is an extensive body of literature that raises quality concerns when services are delivered in for-profit settings. A Canadian study in the 2011 Canadian Journal of Gastroenterology, comparing the experiences of patients receiving colonoscopy in hospital and nonhospital settings, for example, found that nonhospital clinics were far less likely to adhere to guidelines regarding follow-up intervals for low-risk patients, and 31.7% of patients reported paying a fee in nonhospital clinics.

The government has made quality a defining feature of care under the *Excellent Care for All Act*. This is why quality care in hospitals has become a key factor in accountability structures and processes. Moving procedures out of hospitals, however, means moving away from a focus on quality that has become institutionalized in hospital accountability agreements and reporting processes under the *Public Hospitals Act*.

We are continuing to raise concerns about how a framework of quality and safety for patients will be implemented within private, predominantly for-profit independent health facilities that are now proposed to be renamed as 'community health facilities.'

The proposed framework for quality assurance programs for the private clinics, we understand, will likely continue to be managed by the assessments and inspections conducted by the professional college such as the College of Physician and Surgeons. We note again that there have been a number of documented challenges reported in the media with this quality assessment framework.

The 2012 annual Report of the Ontario Auditor General notes that 12% of diagnostic imaging IHFs had not been assessed for quality within the last five years (p. 152) and 60% of x-ray IHFs had not been inspected as frequently as required to check for excessive radiation levels (p. 152). Again, the new proposed inspection regime is left to be prescribed in regulation under the new Act.

The 2012 annual report of the Ontario Auditor General notes that about 50% of Ontario municipalities had been underserved by IHFs (p. 154) and notes that the Ministry believes "community hospitals may be better able to meet local service demands in sparsely populated areas."

Finally, if the government policy intent is to find cost reductions through ramping up the volume of procedures in private, for-profit clinics, and moving these procedures out of community hospitals, then this will have an impact on the viability of public community hospitals that lose those procedures to continue to be able to provide a range of services in their community.

Recommendations for Schedule 9:

- Because of the lack of specificity in the proposed new Act related to this significant private, for-profit health sector expansion, we ask that Schedule 9 be repealed.
- Full public consultations on any proposed changes to the Private Hospitals Act and the regulation of existing private, for-profit clinics, including a safe, quality inspection regime, must be undertaken on a priority basis.

SCHEDULE 10 – RETIREMENT HOMES ACT

The proposed amendments to the *Retirement Homes Act* mirror the amendments to the *Long-Term Care Homes Act* related to the repeal of secure units and the definition of ‘confine’ to be prescribed in regulations. Note that the provisions in Section 70 in the *Retirement Homes Act* concerning confinement in retirement homes were never proclaimed. We continue to advocate that they not be enacted.

Retirement homes are not health care facilities. They are supportive housing for seniors. They do not have the regulated nursing staff required to deliver the level of care that would be needed for high-care seniors. They are not substitutes for long-term care homes.

We oppose any move by the government to enact the provisions of Section 70 and for that reason, we oppose the proposed amendments related to ‘confining’ in Schedule 10.

Recommendations for Schedule 10:

- We ask that the proposed amendments related to ‘confining’ in Schedule 10 be repealed. Confinement in Retirement Homes is not appropriate in any circumstance and must not be permitted.

CONCLUSION

ONA takes the position that moving additional procedures out of hospitals and into private for-profit clinics is not in the best interests of safe, quality care for our patients. For that reason alone, such clinics must be limited and must be highly regulated. The amendments proposed in Schedule 9 do not limit and do not sufficiently regulate in legislation the proliferation of private, for-profit clinics. We are opposed to the repeal of the *Private Hospitals Act*. We are opposed to the renaming of independent health facilities as ‘community health facilities’ and appropriate quality and safety standards must be set out in legislation.

We continue to maintain that the use of public hospital outpatient clinics is the best approach for safe, efficient and integrated quality patient care in a non-profit clinic setting. Moving services out of hospitals is fragmenting care, not integrating care.

Moving services out of hospitals into private, for-profit clinics also raises issues regarding the proposed amendments to transfer patients by ambulance to non-hospital designations. We oppose such transfers unless specifically defined, which have significant implications for our patients, including the expansion of unspecified treatment models by paramedics.

Transferring patients by ambulance to non-hospital destinations is potentially moving patients into an unspecified regulatory framework for clinics that are predominately for-profit and have a long-standing record of quality issues for their patients.

We strongly urge the government to revisit the proposed amendments in Schedule 1 regarding the *Ambulance Act* and to repeal Schedule 9.

With respect to Schedule 5, we believe the proposed amendments regarding confinement in long-term care homes presupposes a level of skilled RN care that is not yet in place or funded. Such proposals are not in line with previous recommendations from coroner inquests and we believe the proposed amendments should be postponed until the Public Inquiry into Long-Term Care completes its recommendations.

We ask that Schedule 10 be repealed as retirement homes are the wrong location to confine seniors as they do not have the staffing that we are recommending for long-term care homes.

Finally, we make some recommendations for clarity related to Schedules 3 and 4.

We end with our call for full public consultations on any changes to the way private hospitals and clinics are regulated, including any expansion of the private health sector. Prior consultation on the proposals in Bill 160 with groups like ONA who represent frontline care providers would have been a wise choice by the government. This should be a top of mind consideration for any future health system legislative proposals.

Summary of ONA Recommendations for Bill 160

Recommendations for Schedule 1:

- Specify under Subsection 7.0.1(3)(a) that any operational or policy directives to the operator of a land ambulance the Minister considers to be in the public interest must only permit transfer to a public hospital for initial assessment of patients.
- Specify under Subsection 7.0.1(3)(b) the particular expansion of responsibilities and treatment models of patients that can safely be undertaken by paramedics.
- Delete the regulation-making exemption from the Act in Section 22(1)(f) or alternatively specify which parts apply to the exemption.

Recommendations for Schedule 3:

- Specify in legislation any additional regulated health professional that has a duty to report reactions related to the administration of an immunization agent, as is currently the practice in this legislation. Alternatively, amend Section 7(2) to say “or a prescribed regulated health professional.”

Recommendations for Schedule 4:

- Specify in legislation the threshold to trigger reporting of a transaction of value or alternatively, specify in legislation the policy intent that the context of the transaction may mitigate the reporting of the value.
- Specify the manner and frequency of reporting in legislation.
- Specify in legislation that the recipient is notified of their information will be included in the report to the Minister. The precise process for notifying the recipient could be set out in regulation if it is to be done through a consent process or otherwise following further consultations.

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Recommendations for Schedule 9:

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- Full public consultations on any proposed changes to the Private Hospitals Act and the regulation of existing private, for-profit clinics, including a safe, quality inspection regime, must be undertaken on a priority basis.

Recommendations for Schedule 10:

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