Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

RNAO submission on Bill 160: *Strengthening Quality and Accountability for Patients Act, 2017*

Submission to Standing Committee on General Government

November 16, 2017

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Summary of RNAO Recommendations

Schedule 1. Amending the *Ambulance Act*

1. Support the amendment to enable ambulances to go to destinations other than hospitals.
2. Do not permit paramedics to deliver primary care. Refer patients requiring primary care needs to primary care providers.
3. Give the client a choice of where to be delivered by ambulance.
4. Proceed with the ban on fees or co-payments for ambulance services, and extend it to all medically necessary ambulance services.

Schedule 2. Amending the *Excellent Care for All Act, 2010*

5. The legislation must limit the disclosure of personal information to HQO, to non-identifying information required for research purposes only. Require patient consent for the release of any data containing identifying information.
6. Make the Patient Ombudsman an independent officer of the Legislature.

Schedule 3. Amending the *Health Protection and Promotion Act, 1990*

7. Proceed to extend the scope of oversight by public health bodies as written and ensure that public health bodies have the funding to deliver on the expanded responsibilities.

Schedule 4. *Health Sector Payment Transparency Act, 2017*

8. Ban the practice by the medical industry of providing payments and transfers of other value to health-care professionals and to organizations.
9. Until a ban is in place, proceed to require public disclosure of payments and transfers of other value from the medical industry to health-care professionals and to organizations. Ensure that the reporting threshold is very low and that there are few exemptions.

Schedule 5. Amending the *Long-Term Care Homes Act, 2007*

10. Mandate in legislation a minimum of four hours per resident-day of nursing and personal care (nurses and personal support workers) in long-term care. That should be comprised of one attending NP per 120 residents and a staff mix of 20 per cent RNs, 25 per cent RPNs and 55 per cent PSWs.
11. Mandate the following compliance procedure: At the written notice and voluntary plan of correction stages, the inspector should recommend that non-complaint homes use RNAO's Long-Term Care Best Practices Guidelines (LTC BPG) Program to help them achieve

compliance. At a compliance order stage, and for homes that are repeatedly found to be non-compliant, use of the Ministry of Health-funded RNAO LTC BP program should be a mandatory corrective measure. Fines should only be imposed as a last measure.

12. Mandate that LTC inspection reports cover areas of compliance and non-compliance.
13. Proceed with measures to minimize the use of restraints and confinement; however we urge that the word "confinement" be replaced with the term "placement in a protected area" and "confine" with "place in a protected area."
14. Amend Section 6 amending 30.1 (2) 4 of the Act and Section 13 (2.1) (c) to read: "a physician, registered nurse, registered nurse in the extended class or other person," so that both RNs and nurse practitioners are able to recommend placement in protected areas.

Schedule 6. ***Medical Radiation and Imaging Technology Act, 2017***

15. Proceed with updating the regulation of medical radiation and imaging technology, but take measures to ensure RNs and NPs who may perform diagnostic ultrasounds are not obliged to join two regulatory colleges.

Schedule 7. Amending the ***Ontario Drug Benefit Act, 1990***

16. Proceed with the amendment of the *Ontario Drug Benefit Act*, and ensure that NPs and RNs are added to the list of acceptable prescribers and that RNs have access to medications under the EAP, and NPs with palliative care expertise have access to medications under the PCFA program.

Schedule 8. ***Ontario Mental Health Foundation Act, 1990***

17. Ensure significant enhancements in funding for mental health research and services.

Schedule 9. ***Oversight of Health Facilities and Devices Act, 2017***

18. Withdraw Schedule 9. Continue using the names "independent health facilities" and "out of hospital premises." Do not use the name "community health facilities."
19. Do not repeal the *Private Hospitals Act* or the *Independent Health Facilities Act*.
20. Introduce separate legislation to cover health facilities that are not adequately covered under existing legislation.

Schedule 10. Amending the ***Retirement Homes Act, 2010***

21. Proceed with strengthened oversight of retirement homes and with regular audits of the RHRA by the Auditor General, as well as reviews of the RHRA by the Ministry of Seniors Affairs.

22. Do not allow confinement or restraint of residents in retirement homes except under temporary and extraordinary circumstances, until those residents can be placed in more appropriate settings.
23. Replace the word "confinement" with the term "placement in a protected area", and "confine" with the term "place in a protected area."

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP) and nursing students in all settings and roles across Ontario. It is the strong, credible voice leading the nursing profession to influence and promote healthy public policy. RNAO is pleased to offer its submission on Bill 160, *Strengthening Quality and Accountability for Patients Act, 2017.*

Bill 160[1] is an omnibus bill with a common theme of regulating and extending the scope of oversight of the health sector. Introduced by Minister Hoskins on Sept. 27, the ministry's backgrounder says the bill would support *Ontario's Patients First: Action Plan for Health Care.*[2] There are 10schedules, with three creating new pieces of legislation and the other seven amending or repealing other pieces of legislation:

1. amends the *Ambulance Act*
2. amends the *Excellent Care for All Act, 2010*
3. amends the *Health Protection and Promotion Act*
4. creates the *Health Sector Payment Transparency Act, 2017*
5. amends the following legislation: *Long-Term Care Homes Act, 2007*, along with *Health Care Consent Act, 1996*; *Personal Health Information Protection Act, 2004*; and *Substitute Decisions Act, 1992*
6. creates the *Medical Radiation and Imaging Technology Act, 2017*, and repeals *Medical Radiation Technology Act, 1991*
7. amends the *Ontario Drug Benefit Act* (ODBA)
8. repeals the *Ontario Mental Health Foundation Act*
9. creates the *Oversight of Health Facilities and Devices Act, 2017*, and repeals the *Independent Health Facilities Act*, the *Healing Arts Radiation Protection Act* and the *Private Hospitals Act*
10. amends the *Retirement Homes Act, 2010*

For the government explanation of the elements of the bill, please see the appendix.

RNAO supports Bill 160's objectives of strengthening transparency, accountability and quality of care in a person-centred health system. However, we caution against the unintended consequences of a number of the measures in the bill, such as expanding the practice of paramedics to primary care, accelerating privatization of health services, and further compromising safety of residents in long-term care.

Our specific comments are outlined in the following submission.

Schedule 1. Amending the *Ambulance Act*

Under Bill 160, the health minister would be empowered to issue directives to send ambulances to destinations other than hospitals. Done appropriately, this would not only enable patients to be treated in the right setting, but it would also free up capacity in emergency departments and make more efficient use of emergency room staff. For example, patients with urgent mental health issues who go by ambulance to emergency rooms often need to be transferred to mental health facilities. Hospital nurses are often deployed to accompany patients to these services in taxis or private ambulances – which takes up time, wastes resources and reduces access to care. We caution against this schedule being used to shift care from the public acute sector to non-publically funded or to for-profit facilities, which would weaken the system's commitment to public health care.

RNAO is concerned about section 7.0.1 (3) (b). It would allow the health minister to issue a directive to expand the scope of ambulance services to "(iii) other responsibilities to facilitate the adoption of treatment models for persons with lower acuity conditions." Patients with lower acuity conditions should be treated through primary care. RNAO is concerned this provision would further fragment primary care.[3] Moreover, it is not fair to expect paramedics to deliver primary care, as they lack the necessary knowledge and competencies to do so.[4] As recommended by the Ontario Primary Care Council, primary care should be the anchor for health care across the province.[5] Community paramedicine would dilute these efforts by redirecting some patients away from their primary care provider, and fragment care.

The proposed legislation makes changes to fees for ambulance services, such as the extension of the existing ban on fees or co-payments for ambulance services (except for co-payments authorized under legislation) that are redirected elsewhere, other than hospital. RNAO supports this amendment. We suggest that the legislation go even further and completely eliminate ambulance co-payments. At present, medically necessary ambulance co-payments are only waived for persons on social assistance, for transfers between hospital facilities, and for persons living in long-term care, homes for special care or homes for psychiatric patients.[6]

Another important concern regarding ambulance services that should be addressed in this legislation is that patients should be given the choice, when possible, of where to be taken by ambulance. For example, some individuals in the north may be uncomfortable being sent to certain health-care providers due to concerns of racism.[7]

RNAO Recommendations:

1. Support the amendment to enable ambulances to go to destinations other than hospitals.
2. Do not permit paramedics to deliver primary care. Refer patients requiring primary care needs to primary care providers.
3. Give the client a choice of where to be delivered by ambulance.
4. Proceed with the ban on fees or co-payments for ambulance services, and extend it to all medically necessary ambulance services.

Schedule 2. Amending the *Excellent Care for All Act, 2010*

According to the explanatory note in the legislation:

> "*The Excellent Care for All Act, 2010* is amended to,
>
> (a) allow the Ontario Health Quality Council (the "Council") to lease office space reasonably necessary for its purposes without the need to obtain Lieutenant Governor in Council approval;
>
> (b) permit the Council to collect, use and disclose personal health information for purposes to be prescribed by regulation in accordance with any conditions, restrictions or requirements that may also be prescribed;
>
> (c) create an exemption from the application of the *Freedom of Information and Protection of Privacy Act* for records in the custody or control of the Council that were prepared or obtained by the patient ombudsman in the course of conducting an investigation within the meaning of section 13.3 of the *Excellent Care for All Act, 2010*."

Point (b) above would give the Ontario Health Quality Council (now called Health Quality Ontario, or HQO) access to personal health information, subject to regulations presumably made by Cabinet. RNAO is concerned about the open-ended ability for HQO to receive access to personal information based on cabinet- determined regulations. At the minimum, legislation must dictate that any information obtained by HQO should be restricted to that needed for research purposes only and not include identifying information. In addition, patient consent must be required for the release of identifiable information for any purpose.

In addition to the above comments regarding HQO, RNAO has previously expressed its concern about the Patient Ombudsman being placed under HQO in a September 3, 2014 letter to the Premier,[8] and reiterated that concern in a letter to Minister Hoskins on August 25, 2015.[9] Bill 160 would be an opportunity to make the Patient Ombudsman an independent officer of the Legislature.

RNAO Recommendations:

5. The legislation must limit the disclosure of personal information to HQO to non-identifying information required for research purposes only. Require patient consent for the release of any data containing identifying information.
6. Make the Patient Ombudsman an independent officer of the Legislature.

Schedule 3. Amending the *Health Protection and Promotion Act, 1990*

The proposed amendments would extend the scope of oversight by public health bodies over recreational water facilities and personal service settings. So long as the public health bodies are sufficiently resourced to handle the expanded responsibilities, these are welcome changes.

RNAO Recommendation:

7. Proceed to extend the scope of oversight by public health bodies as written and ensure that public health bodies have the funding to deliver on the expanded responsibilities.

Schedule 4. *Health Sector Payment Transparency Act, 2017*

The proposed act would require the medical industry to disclose payments and transfers of other value to health-care professionals and to organizations. Pharmaceutical firms are known to transfer tens of millions of dollars to Ontario health professionals annually.[10] Evidence shows that there is a correlation between receipt of drug money and health-care providers prescribing more brand-name drugs.[11] [12] [13] [14] [15] Disclosing and posting these payments will make the system more transparent, and it will alert the public to the practitioners who are being rewarded by the medical industry.

We are concerned that most of the details in this act will be implemented through regulations set by Cabinet and we prefer that they appear in legislation for greater certainty. For example, regulations could create high or low reporting thresholds and/or exemptions could be extensive. Standardized reporting guidelines should be mandated in legislation for all transfers of value and for all real or perceived conflicts of interest.

RNAO prefers to ban the practice entirely. In the case of pharmaceuticals, a fully functioning universal pharmacare program would not only provide free medication to all Ontarians without user fees, it should also be accompanied by an evidence-based formulary supported by guidance on prescribing, which would supplant the drug company promotion. RNAO looks to the government of Ontario to provide leadership for a pan-Canadian standardized, publicly funded and publicly controlled pharmacare program,[16] [17] [18] and welcomes the introduction of an Ontario pharmacare plan as an important first step.

RNAO Recommendations:

8. Ban the practice by the medical industry of providing payments and transfers of other value to health-care professionals and to organizations.
9. Until a ban is in place, proceed to require public disclosure of payments and transfers of other value from the medical industry to health-care professionals and to organizations. Ensure that that the reporting threshold is very low and that there are few exemptions.

Schedule 5. Amending the *Long-Term Care Homes Act, 2007*

From Explanatory Note to Bill:

> "A number of Acts related to long-term care homes are amended.
>
> *Long-Term Care Homes Act, 2007*
>
> A number of amendments are made to this Act including:
>
> The provisions of the Act dealing with "secure units" are repealed. Instead, a system is enacted to deal with both the restraining and confining of residents.
>
> A system of administrative penalties is provided for.
>
> *Health Care Consent Act, 1996*
>
> This Act is amended to provide for rules with respect to confining ["confining" to be defined in the LTC Homes Act regulations; the Act speaks about restraining and

confining, whereas before, it was restraining only] in a care facility, including rules for who may give consent to confining on behalf of an incapable person, and respecting reviews by the Consent and Capacity Board.

Related amendments are made to the *Personal Health Information Protection Act, 2004* and the Substitute Decisions Act, 1992."

The Ontario government has recently made a series of important commitments in its *Action Plan for Seniors*,[19] which RNAO was quick to applaud as important steps forward.[20] Improvements include enhancing long-term care staffing to a provincial average of four hours of direct care per resident-day and the creation of 5,000 new long-term care (LTC) beds by 2022 and 30,000 "over the next decade." Depending upon how quickly these commitments are delivered, this will materially improve care in long-term care, and support measures in Schedule 5 of Bill 160.

RNAO has been calling for four hours of nursing and personal care per resident day, [21] which would deliver more nursing and personal care than the government undertaking of four hours of direct care, as the latter would include other classes of support worker. RNAO calls for putting the four-hour standard into legislation.

In the above referenced report, RNAO noted, "Resident clinical and social outcomes are maximized with a staff mix of: (1) one NP per LTC home, with no less than one NP per 120 residents, (2) at least 20 per cent RNs, (3) 25 per cent RPNs and (4) 55 per cent personal support workers (PSWs), subject to increases that align with greater acuity. Two RNs working 24/7 per 100 beds are the recommended minimum to allow for surge capacity as it becomes necessary."[22]

RNAO has a number of recommendations and comments on Schedule 5.

Administrative penalties

RNAO has strong concerns about imposing fines on a sector that is already under-resourced. One of the challenges that LTC homes face with achieving compliance is adequacy of funding. Compliance may be even more difficult with the imposition of fines. As a result, RNAO recommends the intermediate step of compulsory correction plans that incorporate RNAO Best Practice Guidelines (BPGs), with six-month follow-ups to verify compliance. Fines should be used only as a last resort.

RNAO points to Recommendation 6 from the 2015 Auditor General's report on the LTC home inspection process:[23]

- "To ensure that long-term-care homes are not repeatedly in non-compliance … the Ministry of Health and Long-Term Care should:
- strengthen its enforcement processes to promptly address homes with repeated non-compliance issues including when to escalate homes for further actions and the evaluation of the use of other enforcement measures (e.g., fines, penalty); and help homes achieve compliance with the Act by providing additional information and support on how to rectify issues, and by sharing best practice between long-term-care homes."

The first part of the recommendation is reflected in the administrative penalty component of Schedule 5. However, Schedule 5 amendments don't include the second piece of this

recommendation, that MOHLTC should help homes to achieve compliance. This portion of the recommendation should be included as well. The Ministry of Health and Long-Term Care's response to Recommendation 6 references RNAO's Long-Term Care Best Practices Program (LTC BPP),[24] supporting our recommendation on referencing RNAO Best Practices Guidelines in the legislation. RNAO urges that the compliance inspector be directed to assist LTC homes to achieve compliance with RNAO's LTC BPP as a means of correction in the inspection report.

RNAO has strong concerns that the proposed legislative change could result in widespread application of administrative penalties due to the current high rates of non-compliance in this highly regulated sector, particularly since the proposed legislation is vague – "if the inspector or Director *is of the opinion* that the licensee *has not complied with a requirement*" (emphasis added). In 2016, the average number of written notices of non-compliance was 7.43 / RQI (Resident Quality Inspection). Of 627 RQIs completed, only 37 homes had 0 written notices (i.e., 0 areas of non-compliance).[25]

To support homes to achieve and maintain compliance, we recommend that RNAO's LTC Best Practices Program be used throughout the stages of non-compliance, as follows:

1. When issued a written notification of non-compliance, inspectors should recommend that the home work with RNAO's LTC BP Program and Coordinator to achieve compliance.
2. When issued a voluntary plan of correction, inspectors should recommend that the home work with RNAO's LTC BP Program and Coordinator as part of the home's voluntary plan to achieve compliance.
3. When issued a compliance order, inspectors should mandate that the home use RNAO's LTC BP Program and Coordinator to assist in preparing and executing a plan to achieve compliance.

Inspection reports

LTC homes are overall compliant on most aspects of the inspections, and some are doing exemplary work around some indicators. This is not reflected in the inspection reports. We recommend that inspection reports identify both areas of compliance and non-compliance in a high-level aggregate way.

Confinement

RNAO is concerned about the use of the term "confinement" in the legislation, which we interpret to mean placement in a secure unit. The term has punitive connotations and sounds like incarceration. We prefer the term "placement in a protected area."

Measures to minimize use of restraints and confinement are welcome. In Section 5, when LTC home licensees are writing policy on minimization of restraining and confining residents, it is important to ensure that governing regulations are guided by RNAO's Best Practice Guidelines such as *Promoting Safety: Alternative Approaches to the Use of Restraints.*[26] RNAO's elder abuse BPG identifies inappropriate restraining or confining as abuse.[27] It is important that there is adequate staffing in order to minimize restraining and confining residents, and the province's November 7, 2017 announcements will support this legislation, if the additional resources are deployed quickly enough.

There appears to be an inconsistency in who can recommend confining. In Section 6 amending 30.1 (2) 4, it is "A physician, registered nurse or other person provided for in the regulations" while in 13 (2.1) (c), it is "a physician, registered nurse in the extended class or other person." RNAO recommends using "a physician, registered nurse in the extended class registered nurse, or other person" in both instances.

RNAO Recommendations:

10. Mandate in legislation a minimum of four hours per resident-day of nursing and personal care (nurses and personal support workers) in long-term care. That should be comprised of one attending NP per 120 residents and a staff mix of 20 per cent RNs, 25 per cent RPNs and 55 per cent PSWs.
11. Mandate the following compliance procedure: At the written notice and voluntary plan of correction stages, the inspector should recommend that non-complaint homes use RNAO's Long-Term Care Best Practices Guidelines (LTC BPG) Program to help them achieve compliance. At a compliance order stage, and for homes that are repeatedly found to be non-compliant, use of the Ministry of Health-funded RNAO LTC BP program should be a mandatory corrective measure. Fines should only be imposed as a last measure.
12. Mandate that LTC that inspection reports cover both areas of compliance and non-compliance.
13. Proceed with measures to minimize the use of restraints and confinement; however we urge that the word "confinement" be replaced with the term "placement in a protected area" and "confine" with "place in a protected area."
14. Amend Section 6 amending 30.1 (2) 4 of the Act and Section 13 (2.1) (c) to read: "a physician, registered nurse, registered nurse in the extended class or other person," so that both RNs and nurse practitioners are able to recommend placement in protected areas.

Schedule 6. ***Medical Radiation and Imaging Technology Act, 2017***

RNAO welcomes the updating of regulation of medical radiation and imaging technology to include diagnostic ultrasounds, so long as provisions are made to allow RNs and NPs to continue to perform sonography without being required to join the College of Medical Radiation and Imaging Technologists of Ontario.

RNAO Recommendation:

15. Proceed with updating the regulation of medical radiation and imaging technology, but take measures to ensure that RNs and NPs who may perform diagnostic ultrasound are not obliged to belong to two regulatory colleges.

Schedule 7. Amending the ***Ontario Drug Benefit Act, 1990***

This amendment updates the reimbursement criteria in the *Ontario Drug Benefit Act* (ODBA). Formerly, a physician had to prescribe a drug before the Ontario Health Insurance Plan would pay for it. This expands the list of acceptable prescribers beyond physicians. The list of

acceptable prescribers is determined by the executive officer of the Ontario public drug programs, who is appointed by Cabinet under section 1.1. of the ODBA. This is a welcome change that supports provisions under the *Protecting Patients Act, 2017 (Bill 87)* that allowed prescriptions written by nurse practitioners (NPs) to be reimbursed under the Ontario Drug Benefit (ODB) program including those previously restricted under the Exception Access Program (EAP). NPs continue to have barriers in accessing medications that fall under the EAP Palliative Care Facilitated Access Program. It is hoped that this amendment will allow NPs with expertise in palliative care to prescribe medications under the Palliative Care Facilitated Access Program (PCFA). This change would also support RN prescribing, provided that the executive officer adds them to the list of acceptable prescribers.

RNAO Recommendation:

16. Proceed with the amendment, and ensure that NPs and RNs are added to the list of acceptable prescribers and that RNs have access to medications under the EAP, and NPs with palliative care expertise have access to medications under the PCFA program.

Schedule 8. *Ontario Mental Health Foundation Act, 1990*

According to the government backgrounder:

> "The province is proposing to repeal the *Ontario Mental Health Foundation Act* (OMHF) to complete the dissolution of the foundation. The decision to dissolve the OMHF has been made based on the results of a review that found the bulk of OMHF's original mandate (diagnosis and treatment) is currently delivered by community-based organizations. Its research mandate will be managed through Ontario's existing Health System Research Fund."

Mental health services and research on mental health have been underfunded in Ontario. The resulting cost to society is very high. RNAO does not oppose reallocation of funding for mental health research, but it is important to ensure that more resources flow to the sector. Reallocation of funding within the sector will not deal with the funding shortfall.

RNAO Recommendation:

17. Ensure significant enhancements in funding for mental health research and services.

Schedule 9. *Oversight of Health Facilities and Devices Act, 2017*

Under this proposed legislation, private hospitals and independent health facilities would become "*community health facilities"* (CHFs). They are currently governed by the *Private Hospitals Act* and the *Independent Health Facilities Act* respectively. The bill extends beyond those facilities to include non-hospital clinics, which would be specified in the regulations. The law firm Weir Foulds notes this leaves the scope of facilities covered by the legislation unclear (e.g., would dentist offices be covered?).[28] An executive officer would oversee both CHFs and "energy applying and detecting medical devices." That officer could renew, refuse to renew, revoke or suspend licenses for both.

The bill has a ban on facility fees (Section 17 (1)), and we support the ban as it addresses one financial barrier to access. However, that merely continues a ban that was present in the *Independent Health Facilities Act*. Even if the government is able to prevent all monetary barriers to access through bans on various user fees, there remain other concerns. A review of four decades of experience with privatization in the United States with a combination of public funding and private health care management and delivery found that "for-profit health institutions provide inferior care at inflated prices."[29] For-profit provision leads to cherry-picking of profitable services and clients, leaving the public sector to deal with high-cost clients. [30] [31] An abundance of literature points to poorer outcomes from for-profit health care[32] [33] [34] [35] [36] [37] [38] [39] [40] and at higher cost.[41]

Schedule 9 is problematic as it creates "community health facilities" which, despite the name, are overwhelmingly for-profit entities. It is confusing, because Ontario also has not-for-profit community health centres which are community governed and deliver primary care, as the Association of Ontario Health Centres (AOHC) has pointed out in a letter to the Standing Committee.[42] RNAO supports AOHC's call for the government to continue using the names "independent health facilities" and "out of hospital premises," and not to create the name "community health facilities."

The biggest concern with Schedule 9 is that its repeal of the *Private Hospitals Act* removes the ban on issuing of licenses for new private hospitals.[43] [44] There is no equivalent ban introduced in Schedule 9. This may be unintentional, but the effect would be that a future government could start approving requests to open private hospitals. This would be devastating to Ontario's health system because it would greatly expand the scope for two-tier health care and cherry-picking of potentially profitable activities that normally take place in hospitals. For example, private hospitals could focus on less complicated procedures and healthier clients, leaving the public system to deal with the more costly cases. RNAO cautions that Schedule 9 would occasion the normalization or expansion of for-profit provision of health care.

RNAO opposes repeal of the *Private Hospitals Act* and the *Independent Health Facilities Act*. If the province wants to extend regulation to other facilities, it should create separate legislation to do so, without weakening existing regulation of for-profit health entities. This is a sizeable piece of the sector, and should be subject to proper oversight and regulation. There are now over 935 for-profit independent health facilities alone in Ontario.[45] We are concerned that existing regulations are not strong enough to address the already known weaknesses with infection control and reporting in some facilities.[46] [47] There is a pressing need for broader and stronger regulation, but this schedule is not the right way to go.

RNAO Recommendations:

18. Withdraw Schedule 9. Continue using the names "independent health facilities" and "out of hospital premises." Do not use the name "community health facilities."
19. Do not repeal the *Private Hospitals Act* or the *Independent Health Facilities Act*.
20. Introduce separate legislation to cover health facilities that are not adequately covered under existing legislation.

Schedule 10. Amending the *Retirement Homes Act, 2010*

On the face of it, the schedule is about strengthening oversight powers of the Retirement Homes Regulatory Authority (RHRA), along with enhancing transparency and accountability via audits of the RHRA by the Auditor General and reviews of the RHRA by the Ministry of Seniors Affairs.

Regulation of confinement and restraint of residents is also clarified. It would remain possible to restrain or confine residents under the new legislation.

RNAO supports more oversight and regulation when it comes to protecting vulnerable people in retirement homes.[48] [49] [50]

RNAO believes that confinement and restraints are rarely appropriate in retirement homes, where staffing and resources are limited. As with Schedule 5, RNAO strongly recommends replacing the punitive-sounding "confinement" with the term "placement in a protected area."

RNAO Recommendations:

21. Proceed with strengthened oversight of retirement homes and with regular audits of the RHRA by the Auditor General, as well as reviews of the RHRA by the Ministry of Seniors Affairs.
22. Do not allow confinement or restraint of residents in retirement homes except under temporary and extraordinary circumstances, until those residents can be placed in more appropriate settings.
23. Replace the word "confinement" with the term "placement in a protected area", and "confine" with the term "place in a protected area."

Appendix: Bill 160, as Explained by the Government

Schedule 1. *Ambulance Act*

Government backgrounder: "Ontario is proposing to change the *Ambulance Act* to provide paramedics with increased flexibility to deliver alternative care options on-scene to patients, avoiding unnecessary visits to the emergency department.

Currently, paramedics are bound by law to transport patients to hospital facilities only. The proposed changes, if passed, would help reduce overcrowding in emergency departments by allowing paramedics to redirect low acuity patients who call 911 to non-hospital facilities (e.g. mental health facility or other home and community care resource)."

Explanatory Note to Bill: "Amendments are made to the *Ambulance Act* in respect of directives by the Minister, the appointment of Directors, the powers of inspectors and investigators, who may make disclosures to whom, who can hold themselves as a paramedic and rules regarding fees. Other amendments are made to definitions and regulation-making authority."

Schedule 2. *Excellent Care for All Act, 2010*

Government backgrounder: "The proposed amendments to the *Excellent Care for All Act, 2010* include:

- Enabling the Patient Ombudsman to conduct investigations in private by excluding their investigation records from the *Freedom of Information and Protection of Privacy Act*
- Allowing government to make regulations specifying purposes for which Health Quality Ontario (HQO) may collect, use, and disclose personal health information which may be included, in its yearly reports." This is concerning.

Explanatory Note to Bill: "*The Excellent Care for All Act, 2010* is amended to,

(a) allow the Ontario Health Quality Council (the "Council") to lease office space reasonably necessary for its purposes without the need to obtain Lieutenant Governor in Council approval;

(b) permit the Council to collect, use and disclose personal health information for purposes to be prescribed by regulation in accordance with any conditions, restrictions or requirements that may also be prescribed; and this is concerning

(c) create an exemption from the application of the *Freedom of Information and Protection of Privacy Act* for records in the custody or control of the Council that were prepared or obtained by the patient ombudsman in the course of conducting an investigation within the meaning of section 13.3 of the *Excellent Care for All Act, 2010*."

Schedule 3. *Health Protection and Promotion Act, 1990*

Government backgrounder: "Ontario is amending the *Health Protection and Promotion Act* to, if passed, permit the regulation of recreational water facilities like splash pads and wading pools to protect the health and safety of infants and young children. These changes would also permit

the regulation of personal service settings like barber shops, nail salons, tattoo parlours and their aesthetic practices to better prevent infection in these settings.

These changes would bring Ontario in line with several other jurisdictions in Canada."

Explanatory Note to Bill: "The Schedule amends the *Health Protection and Promotion Act*. The principal amendments include:

1. Replacing the term "guideline" with "public health standard" and the term "reportable disease" with "disease of public health significance".
2. Adding the Ontario Agency for Health Protection and Promotion as a recipient of reports regarding diseases and events.
3. Extending the dismissal notice and attendant rights of medical officers of health to associate medical officers of health.
4. Removing approval requirements for an acting medical officer of health appointed by a board of health.
5. Providing that the Minister may, in certain circumstances and subject to limitations, issue orders relating to new or emerging diseases and provisions related to such orders.
6. Amending matters subject to Lieutenant Governor in Council and Minister regulations.
7. Removing transition provisions."

Schedule 4. *Health Sector Payment Transparency Act, 2017*

Government backgrounder: "Ontario is introducing new legislation that would, if passed, make it mandatory for the medical industry, including pharmaceutical and medical device manufacturers, to disclose payments made to health care professionals and organizations, as well as other recipients. This legislation would strengthen transparency by providing information about financial relationships within the health-care system and help patients make better informed decisions about their own health care.

The medical industry would be required to report all information about all other transfers of value, including meals and hospitality, travel associated expenses, and financial grants. The public would be able to search this information in an online database."

Explanatory Note to Bill: "The Schedule enacts the *Health Sector Payment Transparency Act, 2017.*

The purpose of the Act, as set out in section 1, is to require the reporting of information about financial relationships that exist within Ontario's health care system, including within health care research and education, and to enable the collection, analysis and publication of that information in order to, among other things, strengthen transparency. The Act requires that certain transactions be reported to the Minister who shall analyse and publish the information. The Act establishes a framework for inspections and other compliance mechanisms. The Act provides for periodic review by the Minister."

Schedule 5. ***Long-Term Care Homes Act, 2007***

Government backgrounder: "While the vast majority of long-term care homes are in compliance with provincial rules and regulations, the legislation proposes new enforcement tools, including financial penalties, and new provincial offences to ensure long-term care home operators are addressing concerns promptly.

The legislation also proposes a consent-based framework to protect residents who need to be secured in a long-term care home for safety reasons."

Explanatory Note to Bill: "A number of Acts related to long-term care homes are amended.

Long-Term Care Homes Act, 2007

A number of amendments are made to this Act. Some of them are set out below.

The provisions of the Act dealing with "secure units" are repealed. Instead, a system is enacted to deal with both the restraining and confining of residents.

A system of administrative penalties is provided for.

The Director is given the power to suspend a licence, in addition to the existing power to revoke one. Provisions are also added permitting the Minister to suspend a licence, and to make operational and policy directives in respect of long-term care homes.

Courts are given additional authority in making probation orders in prosecutions under the Act. The Crown is given the ability to require a trial to be conducted by a judge rather than a justice of the peace.

A number of amendments of a technical nature are made, as well as amendments respecting the French version of the Act.

Health Care Consent Act, 1996

This Act is amended to provide for rules with respect to confining [confining to be defined in the LTC Homes Act regulations; the Act speaks about restraining and confining, whereas before, it was restraining only] in a care facility, including rules for who may give consent to confining on behalf of an incapable person, and respecting reviews by the Consent and Capacity Board.

Related amendments are made to the *Personal Health Information Protection Act, 2004* and the Substitute Decisions Act, 1992."

Schedule 6. ***Medical Radiation and Imaging Technology Act, 2017***

Government backgrounder: "Ontario is proposing changes to strengthen transparency of the oversight of diagnostic medical sonographers (those who use ultrasound) by replacing the *Medical Radiation Technology Act* with new legislation to cover the entirety of the medical radiation and imaging technology profession.

Key changes proposed under the new *Medical Radiation and Imaging Technology Act* include:

- Updating the name of the profession and of the health regulatory college overseeing the profession to accurately reflect the entirety of its membership

- Changing the scope of practice statement to include the "application of soundwaves" to capture diagnostic sonographers

Appropriately identifying all radiation and imaging professionals that are members of the college."

Explanatory Note to Bill: "The *Medical Radiation Technology Act, 1991* is repealed and replaced.

The *Medical Radiation and Imaging Technology Act, 2017* governs the practice of medical radiation and imaging technology, which is defined as the use of ionizing radiation, electromagnetism, soundwaves and other prescribed forms of energy for the purposes of diagnostic or therapeutic procedures, the evaluation of images and data relating to the procedures and the assessment of an individual before, during and after the procedures.

The College to govern the profession and its Council are provided for, as are restricted titles."

Schedule 7. *Ontario Drug Benefit Act, 1990*

Government backgrounder: "This proposed new amendment would remove the last outdated reference to physicians in the *Ontario Drug Benefit Act* to reflect that other health-care professionals (such as nurse practitioners) can prescribe drug products in Ontario.

The proposed change in scope for nurse practitioners was first addressed under the Protecting Patients Act, 2017, and would increase patients' access to the medications they need."

Explanatory Note to Bill: "The *Ontario Drug Benefit Act* (ODBA) is amended to specify that regulations are not required in order for the Minister and the executive officer to disclose personal information.

Clause 23 (3) (b) of the ODBA is repealed and replaced to make a change relating to establishing reimbursement criteria for certain drug benefits listed on the Ontario Drug Benefit Formulary. Currently, section 23 of the ODBA indicates that the reimbursement criteria for these benefits could include a requirement that the use of a drug be prescribed by a physician or member of a class of physicians specified by the executive officer [the "executive officer" of the Ontario public drug programs is appointed by Cabinet under section 1.1.] The amendment provides that the executive officer may establish reimbursement criteria relating to any prescriber or class of prescribers, and not only physicians."

Schedule 8. *Ontario Mental Health Foundation Act, 1990*

Government backgrounder: "The province is proposing to repeal the *Ontario Mental Health Foundation Act* (OMHF) to complete the dissolution of the foundation. The decision to dissolve the OMHF has been made based on the results of a review that found the bulk of OMHF's original mandate (diagnosis and treatment) is currently delivered by community-based organizations. Its research mandate will be managed through Ontario's existing Health System Research Fund."

Explanatory Note to Bill: "The *Ontario Mental Health Foundation Act* is repealed. Consequential amendments are made to other Acts."

Schedule 9. *Oversight of Health Facilities and Devices Act, 2017*

Government backgrounder: "Ontario is proposing to strengthen the safety and oversight of services delivered in community health facilities and with medical radiation devices like X-ray machines, CT scanners, ultrasound machines and MRIs.

The province's legislation would, if passed:

- Modernize and expand the regulation of medical radiation devices in all facilities to ensure safety and quality when using these devices
- Strengthen accountability in the system for providing high quality care
- Ensure patients and their caregivers have access to critical information about the quality of care provided through public reporting

This proposal would also allow private hospitals or other health facilities to be designated as community health facilities at a later date, so there is consistent quality oversight through detailed reporting and an enhanced inspection regime. This legislation would also allow the *Private Hospitals Act* to be repealed at a later date."

Explanatory Note to Bill: "A regulatory system is established for community health facilities and energy applying and detecting medical devices.

The position of executive officer for community health facilities and energy applying and detecting medical devices is created and the functions and responsibilities of the executive officer are provided for.

Provision is made for inspecting bodies to carry out functions with respect to community health facilities.

A wide range of enforcement tools, including compliance orders, cessation orders and administrative monetary penalties are provided for.

Provision is made for the Minister of Health and Long-Term Care to provide funding for some community health facilities and inspecting bodies and to take action where payment should not have been made.

The *Independent Health Facilities Act*, the *Healing Arts Radiation Protection Act* and the *Private Hospitals Act* are repealed.

A range of consequential amendments are made to other Acts. In addition, the existing provision in the *Independent Health Facilities Act* providing for disclosure of personal information by the Minister is amended to establish that regulations are not required to be made imposing conditions on the release."

Schedule 10. ***Retirement Homes Act, 2010***

Government backgrounder: "Ontario has a robust oversight system enforced by the Retirement Homes Regulatory Authority (RHRA) and recently consulted on ways to continue to improve the system in place.

The proposed changes would:

- Strengthen the oversight powers of the RHRA

Increase transparency, accountability and governance through changes that include permitting the Auditor General to conduct value-for-money audits of the RHRA and by giving the minister authority to require reviews of the RHRA"

Explanatory Note to Bill: "The Schedule amends the *Retirement Homes Act, 2010*. The amendments include the following:

If the Minister considers it reasonable to do so in the public interest, the Minister may unilaterally amend the memorandum of understanding between the Minister and the Retirement Homes Regulatory Authority after giving the Authority the notice that the Minister considers reasonable in the circumstances.

The Minister may require the Authority to establish advisory committees. The Minister may require that policy, legislative or regulatory reviews related to the Authority be carried out.

The Minister may require the Authority to make available to the public certain information relating to the compensation for members of its board of directors or officers or employees of the Authority.

The Auditor General may conduct an audit of the Authority.

Section 70 of the Act, on the permitted confinement of residents of a retirement home, is made more specific, for example, in the explanation that is required to be given to a resident before confinement is done. A licensee of a retirement home must ensure that no device prohibited for use in any applicable regulations is used to restrain or confine a resident of the home.

The powers of an investigator under section 80 of the Act to conduct an investigation under a warrant are expanded.

The Registrar may apply to the Superior Court of Justice for an order directing a person to comply with a provision of the Act or the regulations made under it or with an order made under the Act. Upon the application, the court may make any order that the court thinks fit."

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