Ontario Health Coalition
Analysis of the Mayor's Roundtable Report

February 10, 2020

This is a very quick initial review and analysis of the Mayor's Roundtable Report. This is the report that ostensibly led to the decision to cut 31 crisis and residential treatment beds from the North Bay Regional Health Centre (NBRHC). It is still not clear who made this "decision", whether there are conflicts of interest that involve leaders of community agencies participating in the discussion and vote on cutting funding from the hospital and shifting it to their own agencies, and how this group has the authority to make any decisions of this sort. In fact, the Minister and the government's appointees in the NE LHIN are the decision-makers regarding cuts to and funding of health care services and regardless of what has transpired here, the Minister of Health and the provincial government bear the ultimate responsibility for the final decision. The process is unacceptable and we are calling on MPP Vic Fedeli and the Minister of Health to intervene and stop these cuts before more than half of the existing residential addictions treatment beds in North Bay and the NE region are closed down along with the hospital crisis beds despite clear evidence that there are people already on wait lists for the residential programs and the crisis beds are running at more than 100 per cent occupancy.

Process:

The Mayor invited participants for his roundtable. There is no list of participants included in the report.

We do know that front-line nursing staff working with people with addictions from the hospital were not included. We also know that 'patients' or 'clients' or 'users' of the services were not included. It appears that those included were managers and executive staff, not necessarily people on the front-lines.

Further, the process included the creation of a smaller "Action Team" made up of participants from the roundtable. It is not clear how this group was chosen. This smaller Action Team made the concrete recommendations to cut the hospital services, it appears. There is no list of who was/is on the Action Team included.

The report states that there was a report sent to the Minister of Health from the Mayor's roundtable process. But there is no decision-making process outlined. When we spoke with the NE LHIN on January 17 we were told that the LHIN Board had not voted on the plan to close the hospital program and all the hospital- administered residential treatment and crisis beds. There is no "Mayor's roundtable" in any health care legislation. There is no provision for a hand-picked group to make funding decisions to cut major programs in the magnitude of more than $1.1 million in public money. The LHIN is governed by legislation and has legislative requirements regarding process and transparency. The Minister is also governed by health care legislation and is required to act in a transparent way. The public service, the LHIN, the City have conflict-of-interest requirements, reporting requirements, public access to information, transparency and accountability. How did a mayor's roundtable group, an ad hoc, hand-selected group, apparently operating without any requirements regarding transparency, accountability and conflict-of-interest, become a health care decision-making body? What protections against "empire building" by some at the expense of others, and particularly at the expense of increased risk for patients, were included in the process? It appears none.

Language:

The report reads like the writing of non-profit agencies when looking for grants. It is full of the buzz words that the Ministry uses. There is a "Community Hub" that is referred to as "innovative" and "integrated" though it includes services administered by the hospital and services administered by a future amalgam of community agencies (thus, not integrated). It talks about "wrap around' services though it proposes to cut vital parts of the continuum of care for which there are wait lists. It does not note what it is proposing shutting down to create services that are in reality not as integrated as described here and not as complete as they pretend to be. There is nothing about actual need, current wait lists, no comparative evaluation of outcomes or anything that would support closing the hospital-administered services. There is no explanation as to why they chose to go for a zero-sum approach in which some agencies benefit while major services are cut and closed at the hospital. If the report is truly based on need why not ask for what is actually needed? Why not seek funding for all of the service gaps identified by Dr. Rush? Why not look into why the model and the reality are so different? There is no accurate or objective assessment of what is missing in the continuum of care in the model that they are proposing etc. In fact, this report is not objective in any way. It reads like a funding pitch.

Biased and Incomplete Information:

The summary of Dr. Rush's report on page 6 is extremely limited and biased. It contains incorrect and incomplete information. This is used as the first (and the only) rationale for the scheme to cut the hospital-administered programs and transfer their funding. This section cherry picks two items from Dr. Rush's report without proper explanation and context, and ignores all others. It says that the rationale for the "guiding principles" which begin with a call to realign funding is Dr. Rush's report(s). However, Dr. Rush never recommended the closure of 31 crisis and residential treatment beds from the hospital. To claim or even to imply this is simply incorrect and unfactual.

In fact, the roundtable report is very biased and even patently untrue when laying out the core rationale for their approach on pp. 6. For example, the roundtable says Dr. Rush found:

"…the Nipissing district was over capacity in residential treatment beds and medical withdrawal management services (WMS). The NE LHIN currently provides $1.8 million in funding to NBRHC for these two programs."

That is false. The residential treatment beds listed in the Rush report include both those administered by the hospital and those administered by North Bay Recovery Home (see pp 13 of the 2018 report footnote #8). There is no distinction between them in Dr. Rush's charts.[1] Thus the statement in the report (paragraph 3 under the rationale page 6) that the NE LHIN provides the funding for these services to the hospital is factually untrue. The NE LHIN provides *some* of the funding for these services to the hospital. In addition to the hospital funded care, there is funding for 22 beds at the North Bay Recovery Home that were not mentioned. If they were mentioned it would be very evident that they too should have been considered in the pool of funding that could be reallocated if one was going to cut residential treatment beds (if one was to follow the line of reasoning given in the roundtable report which we do

[1] Though we understand this to be a weakness in Dr. Rush's report since the two programs are very different. However, Dr. Rush did call for a more thorough review of the residential programs and this does not appear to have been done.

not agree with). The beds at both the hospital and the North Bay Recovery home should have been assessed and considered if one was going to have to cut. But it is clear on pp. 19 that the only consideration was given to cutting the hospital's funding.

Paragraph 4 states: "[Dr. Rush's] report also found the Nipissing district was lacking any capacity in key addiction services such as: Community WMS, Telephone WMS, Mobile WMS, Addictions Day/Evening Treatment programs and Addictions Case Management." Inexplicably missing from this list are other services Dr. Rush found to be missing in his projection model: acute intoxication, hospital complexity-enhanced residential and several other types of service. What is notable is that they only looked at one set of services and ignored the others, ignoring all of those that would have required enhanced hospital services.

The evidence also suggests that there should be more, not less, hospital-administered crisis beds as those beds are running at more than 100 per cent capacity. There is no assessment of these beds, need, or any other evidence in the roundtable report. By cutting them from the hospital and funding only beds in the so-called community hub, a vital part of the continuum of care at the hospital has been removed. It is not clear what the admission criteria for those beds will be and how this will work for people presenting at the emergency department (as they will do) in need of this level of service. There is apparently a methadone nurse position that Dr. Rush made special mention of as a strength as the hospital WMS/residential treatment services. The roundtable report does not recognize this at all. (In fact, it does not recognize anything "hospital" as a strength.)

Moreover, Dr. Rush's report gives the results of using his model, based on Canada-wide projections of need. Dr. Rush himself cautioned that his report understates the level of need of people in the region because it does not include Indigenous Peoples and homeless people. In North Bay and the NE region, there are four problems with the projections:

1. Indigenous people make up 13.4 per cent of the population of the NE region according to the report. Their level of need is under-estimated according to Dr. Rush (pp. 10 – 11, 2018 report). That would significantly impact any projections. It is inexplicable that this is not noted in the Mayor's Roundtable report.
2. The Mayor's Roundtable was ostensibly centred on homelessness. Yet there is no actual assessment of homeless people's needs in the Rush report. In fact, Dr. Rush cautions again that his report understates the level need because it does not include the homeless population (ibid). This is not noted in the Mayor's roundtable report.
3. The Rush report (2016) finds that a significant proportion of the population seeking substance abuse treatment were from outside the NE region (pp. 31, 2016 report) and almost 30 percent of admissions to the North Bay Regional Health Centre's addictions programs are from outsider the NE region (pp. 34, 2016 report) which brings into question whether the correct population data was used to project need. If the real catchment area for the NBRHC programs is bigger than the NE LHIN region, that should have been taken into account. The LHINs were expressly not supposed to hinder Ontarians being able to seek care outside their arbitrary LHIN region and hospital services bordering the NE LHIN have been dramatically cut (eg. in North Muskoka and Muskoka). We cannot be sure, but this, in addition to points 1 and 2, may explain why the projection model does not fit the reality on the ground.

The fact that there are wait lists for both the North Bay Recovery Home's 90-day residential program and the hospital's 21-day residential program is contrary to the projections in the Rush report. There has been no actual study of why this is. Yet the plan coming out of the Mayor's Roundtable makes the radical and risky recommendation to close down *more than half* of the residential treatment beds for the region in the context of existing waitlists without looking at the actual need vs. the theoretical need and seeing what might be causing the difference. There have been value-laden assumptions and statements made by the LHIN clinical staff without any evidence to support their antipathy towards the hospital-administered program. But it has become abundantly clear as we have researched this that no one has any actual data and no one has actually bothered to find out what the needs are of these three populations that are not included in the Rush report.