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December 15, 2017

To: Central LHIN Health Service Providers

From: Kim Baker, Chief Executive Officer, Central LHIN

Re: Local Health Integration Network Authorities under *the Local Health System Integration Act, 2006*

I am writing to confirm that new Local Health Integration Network (LHIN) directive, investigatory and supervisory authorities ('statutory authorities') under the *Local Health System Integration Act, 2006* (LHSIA) came into force effective September 1, 2017.

The *Patient First Act, 2016* (the "Act") amended LHSIA to give LHINs the tools and authorities they need to become the single point of accountability for local health system planning in their regions and sub-regions.

As managers and integrators of the local health systems, LHINs require appropriate oversight powers to address issues in the system and with Health Service Providers (HSPs). The Act lays out a system of remedies, which include LHIN directive, investigatory and supervisory authorities over HSPs.

To ensure consistency and transparency in the oversight of HSPs performance, the Ministry of Health and Long-Term Care has worked with HSP associations and LHINs to develop guidelines, provide a common framework for the use of the new LHIN statutory authorities, and set out examples of potential graduated LHIN actions and interventions with HSPs. These guidelines and complementary Qs and As are attached for your reference.

At the Central LHIN, we are committed to applying these principles if and as we consider the potential use of any of the new authorities.

On behalf of the Central LHIN, we look forward to continuing to work together to deliver high quality, patient-centred care to patients.

Should you have any questions please do not hesitate to contact Robyn Saccon, Corporate Relations Officer, in the Office of the CEO. Robyn's contact information is as follows: Robyn.Saccon@lhins.on.ca; 905-948-1872 x238.

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Local Health Integration Network Authorities under the *Local Health System Integration Act, 2006*

Purpose

This document outlines principles that guide the potential use of the new Local Health Integration Network (LHIN) directive, investigatory and supervisory authorities ('statutory authorities') under the *Local Health System Integration Act, 2006* (LHSIA).

The Ministry of Health and Long-Term Care ("Ministry") and LHINs are committed to ongoing collaboration and engagement with health service providers (HSPs) to address issues proactively.

In order to ensure consistency and transparency in the oversight of HSP performance, the Ministry has worked with LHINs and HSP associations to develop these guidelines to provide a common framework for the use of the new LHIN statutory authorities and set out examples of potential escalating LHIN actions and interventions with HSPs.

These guidelines are an important part of the Ministry's plan to support a health system that prioritizes patient care and strengthens the quality of care across the province's health care system.

This document also sets out the legal framework for each of the new LHIN authorities. It should be noted that this document is a guideline. Depending on the particular circumstances of a situation, a LHIN may need to take more urgent action to address an issue.

For additional support, please refer to the Questions and Answers document.

Section 1: Background

The Ministry and the LHINs are committed to working with HSPs across the health system to help patients and their families obtain better access to a more local and integrated health care system, improve the patient experience and quality of care.

The *Patient First Act, 2016* (the "Act") amended LHSIA to give LHINs the tools and authorities they need to become the single point of accountability for local health system planning in their regions and sub-regions.

As managers and integrators of the local health systems, LHINs need appropriate oversight powers to address issues in the system and with HSPs. The Act lays out a system of remedies, which include LHIN directive, investigatory and supervisory authorities over HSPs.

These powers enhance the LHINs' ability to hold their Health Service Providers accountable, drive performance improvement, and act decisively where necessary to protect patients in situations where HSPs are not meeting expectations.

Definition of Health Service Providers

Health Service Providers (HSPs) are entities funded by a LHIN under the authority of LHSIA to deliver health care services in Ontario.

The new LHIN authorities apply to HSPs that are funded by, and have a Service Accountability Agreement (SAA) with, a LHIN.

The following are LHIN HSPs under LHSIA:

- Public Hospitals
- Private Hospitals
- Psychiatric Facilities (as defined in the *Mental Health Act*), with certain exceptions
- Non-profit community mental health and addiction services entities

- Approved agencies under the *Home Care and Community Services Act, 1994* (HCCSA) (e.g., providers of community support, homemaking, personal support and professional services as defined in HCCSA)
- Community Health Centres
- Long-Term Care Homes (LTCHs)
- Family Health Teams
- Nurse Practitioner-Led Clinics
- Aboriginal Health Access Centres
- Entities providing primary care nursing services, maternal care or inter-professional primary care programs and services
- Hospices and other non-profit palliative care service providers
- Community Physiotherapy Clinics
- Independent health facilities

The statutory authorities apply to all HSPs with some exceptions (i.e., long-term care homes are not subject to LHIN directive, investigative and supervisory authorities and public hospitals are not subject to LHIN directive and supervisory authorities because separate legislative regimes apply).

The new LHIN authorities do not apply to:

- Home and community care services provided or arranged by the LHINs because these services are provided for the LHINs under applicable legislation. Service Provider Organizations contracted by a LHIN to deliver home and community care services on its behalf are not defined as Health Service Providers.
- Physicians when practicing in a clinical capacity or physician-specific practices because physicians are not health service providers under section 2(3) of LHSIA.

At this time, not all of the listed HSPs under LHSIA have a SAA with the LHIN. The following listed HSPs in LHSIA are funded by, and have contracts with, the Ministry:

- Family Health Teams;
- Nurse Practitioner-Led Clinics;
- Entities providing primary care nursing services, maternal care or inter-professional primary care programs and services;
- Community Physiotherapy Clinics.

As such, the new LHIN authorities do not apply to these listed HSPs. Should the LHINs have a funding relationship with these HSPs in the future, then the new LHIN authorities would apply to these HSPs.

1.1 Guidelines for LHIN Interventions

The Ministry, LHINs and HSPs have a shared responsibility for creating an integrated, efficient and patient-centred health care system for Ontarians. As partners in this endeavor, it is important to ensure that the relationship between LHINs and their HSPs consists of open communication, swift issue resolution and a clear mechanism for ensuring accountability that prioritizes the health care needs of Ontarians.

The LHIN will seek to resolve issues in a proportionate manner, and should use its new authorities after less intrusive means have been unsuccessful. See Appendix 1 for a diagram setting out the progressive responses.

The guidelines provide a framework for LHIN interventions that:

- Assist in the early recognition and identification of concerns or performance factors in the HSPs;
- Prevent or resolve issues at the earliest stages in an effective and consistent manner;

- Support interventions that are at a level appropriate to the nature and scale of the situation and are reflective of the roles of the LHINs and HSPs in the health care system, and within legislative frameworks and authorities;
- Include a staged approach of progressive interventions that escalates in intensity and aligns with the existing performance improvement and remediation process outlined in the service accountability agreements (SAAs).

The proposed framework for LHIN interventions is intended to demonstrate a collaborative and responsive process to effectively resolve performance issues. When a performance issue escalates at the LHIN, it is expected that each level of intervention involve discussions between the LHIN and HSP senior leadership.

1.2 Evaluating HSP Performance

The Ministry is accountable for ensuring that LHINs are meeting expectations and works with the LHIN(s) when these expectations are not being met or are at risk of not being met. The LHINs are evaluated based on obligations outlined in LHSIA, the Memorandum of Understanding between the Ministry and the LHIN and the Ministry-LHIN Accountability Agreement (MLAA).

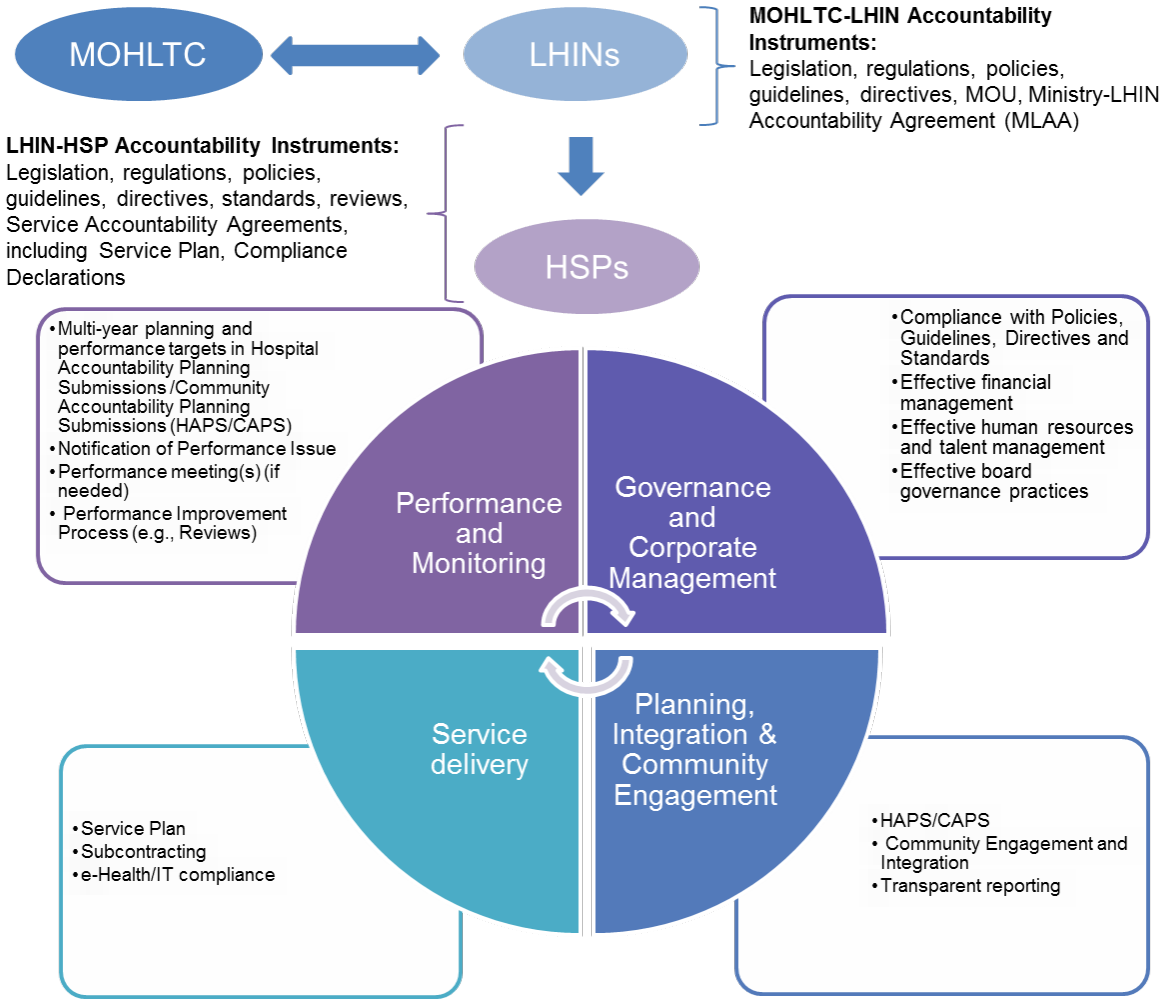
The MLAA establishes key funding and operational expectations of LHINs and the Ministry. LHINs are accountable to the Ministry for improving performance at the LHIN level, as measured against system priorities and targets identified by the Ministry. LHINs are also responsible for preparing reports documenting their performance, on a quarterly basis and are accountable to the Ontario government and the public through public reporting of key indicators.

LHINs subsequently set out requirements with their HSPs through Service Accountability Agreements (SAAs) for the funding and delivery of services. The LHINs negotiate sector specific SAAs with their HSPs that outline accountabilities and performance expectations between the LHIN and HSP. HSPs funded by the LHIN are accountable to the LHIN, for both their own performance and their contributions to shared objectives (e.g. improved collaboration). These SAAs align with the funding and operational expectations set out for the LHINs in the MLAA.

LHINs are accountable for ensuring that their HSPs are meeting performance requirements outlined in their SAAs and the ministry works closely with LHINs to discuss and address issues that arise in their local areas; this collaboration will continue.

The LHINs would address all key areas of focus in the course of negotiating and administering HSP SAAs so that HSPs have clear accountabilities, as outlined in Figure 1 below. This clarity will support the ongoing and successful resolution of issues prior to any consideration of the use of statutory authorities.

Figure 1:



Section 2: Legal Framework

2.1 Range of Statutory and Regulatory Authorities

The LHIN's authorities to issue directives and appoint investigators and supervisors under LHSIA are part of a range of statutory and regulatory powers to which HSPs are subject including, but not limited to, the following:

- The respective integration powers of the Minister and LHINs under LHSIA (ss. 25 - 29);
- The Minister's authority under LHSIA to issue provincial standards for the provision of health services (s. 11.2);
- The LHINs' authority to enter into/amend a SAA with a HSP that it proposes to fund and to set the terms of a SAA subject to the due process requirements in LHSIA (s. 20);
- The LHINs' audit and review powers under LHSIA (s. 21);
- The LHINs' authority to require information and reports (i.e., plans reports, financial statements, and other information (other than personal health information)) from HSPs that they fund (s. 22(1)).

There are a number of other mechanisms that may be engaged to resolve an issue in a HSP, the scope of which should not be duplicated by a LHIN. These mechanisms may include the following:

- An investigation by a regulatory college if the matter involves a concern about the care or treatment received from a health professional;
- An investigation by the HSP through its own internal complaints process;
- A facilitated resolution or investigation by Ontario's Patient Ombudsman in response to a complaint about the care or health care experience of an individual received from a hospital, long-term care home or Community Care Access Centre (CCAC)* after other available complaints resolution mechanisms have been exhausted.
    - *Note: The Patient Ombudsman would have authority over complaints regarding the home and community care and long-term care home placement services that the LHINs assume from the CCACs following the transfers of functions, employees and assets from the fourteen CCACs to the fourteen LHINs and the dissolutions of the CCACs.
- An investigation or review by the Information and Privacy Commissioner of Ontario in response to privacy complaints.

Assuming that there is no duplication in the scope of the various investigations, one investigation would neither take precedence over another nor prevent the existence of another.

Continuous dialogue and communication between the LHIN and HSP is important so that the LHIN can be aware of any parallel processes or other details of material importance in a particular case.

The uses of each of the LHIN's new authorities are subject to the public interest test set out in section 35 of LHSIA:

> 35. In making a decision in the public interest under this Act, the Lieutenant Governor in Council, the Minister or a local health integration network, as the case may be, may consider any matter they regard as relevant including, without limiting the generality of the foregoing,
>
> (a) the quality of the management and administration of the local health integration network or the health service provider, as the case may be;
> (b) the proper management of the health care system in general;
> (c) the availability of financial resources for the management of the health care system and for the delivery of health care services;
> (d) the accessibility to health services in the geographic area or sub-region where the local health integration network or the health service provider, as the case may be, is located; and
> (e) the quality of the care and treatment of patients.

For further information on the potential application of the public interest test, please refer to Appendix 1, "Proposed Intervention Framework".

Under LHSIA, the Minister of Health and Long-Term Care has the authority to direct or investigate a LHIN where the Minister considers it in the public interest to do so. On recommendation of the Minister, the Lieutenant Governor in Council may appoint a supervisor to a LHIN where it is in the public interest to do so.

The LHINs are held accountable to the public and the Ministry through a number of mechanisms. In addition to the MLAA referenced in Section 1.2 above, its quarterly performance reports to the Ministry and public reporting on key indicators, the LHINs also report publicly on their plans and progress through their Annual Business Plan and Annual Report against the Minister's expectations as set out in the Minister's annual mandate letter to the LHINs posted on the LHINs websites.

The *Patients First Act, 2016*, strengthened the LHINs' accountability for local health service planning and performance as well as supported the goal of providing care that is more integrated and responsive to local needs.

Under the *Patients First Act, 2016*, each LHIN is required to establish a patient and family advisory committee, which will enhance the voice of patients and families in health care planning.

2.2 Directives by LHINs

Section 20.2 of LHSIA gives a LHIN the power to issue operational or policy directives to a HSP that receives funding from the LHIN, but not for long-term care homes and public hospitals:

- A LHIN may issue operational or policy directives to a health service provider to which it provides funding where the LHIN considers it to be in the public interest to do so (s. 20.2 (1)).
- Before issuing a directive, a LHIN must give notice of a draft directive to the Minister and to each HSP to which it is intended to be issued (s. 20.2(3)).
- Denominational HSPs are protected from a LHIN's directive authority in a manner similar to current protections from LHIN integration authorities (s. 20.2(4)).
- A HSP must comply with every LHIN directive (s. 20.2(5)).
- A LHIN directive may apply to a particular HSP or group of HSPs (s. 20.2(6)).
- In the event of a conflict between a directive and another Act/rule of law, that other Act/rule of law prevails (s. 20.2(7)).
- The LHIN must make every directive available to the public (s. 20.2(9)).

Please see Appendix 2 for an excerpt of the LHSIA provisions.

2.3 HSP Investigators

Section 21.1 of LHSIA gives a LHIN the power to appoint an investigator for a HSP that receives funding from the LHIN, but not for a long-term care home:

- A LHIN may appoint one or more investigators to investigate and report on the quality of the management of a health service provider, the quality of the care and treatment of persons by a health service provider or any other matter relating to a health service provider where the LHIN considers it to be in the public interest to do so (s. 21.1(1)).
- Before appointing an investigator, the LHIN must give notice of its intent to appoint an investigator to the Minister and the HSP (s. 21.1(3)).
- An investigator has certain powers to enter and inspect premises (s. 21.1(4) and (5)).
- An investigator has certain investigation powers with respect to obtaining, reviewing and compelling records relevant to an investigation (s. 21.1(7) and (8)).
- An investigator cannot access personal health information, unless it is with the consent of the individual or in such circumstances as may be prescribed in regulation (s. 21.1(9)).
- An investigator must keep all information from an investigation confidential (s. 21.1(11)).

- An investigator shall make a report to the LHIN upon completion of an investigation and ensure that all personal health information is de-identified from the report (s. 21.1(13) and (14)).
- The LHIN shall provide a copy of the investigator's report to the HSP and make a copy of the report available to the public (s. 21.1(14) and (15)).

Please see Appendix 3 for an excerpt of the LHSIA provisions.

2.4 HSP Supervisor

Section 21.2 of LHSIA gives a LHIN the power to appoint a supervisor over a HSP that receives funding from the LHIN, but not for a hospital (public or private) or a long-term care home:

- A LHIN may appoint a person as a supervisor of a HSP to which it provides funding where the LHIN considers it in the public interest to do so (s. 21.2(1)).
- Before appointing the supervisor, the LHIN must give the Minister and the HSP's governing body at least 14 days notice (s. 21.2(3)) – unless there are not enough members of the governing body to form a quorum (s. 21.2(4)).
- The term of an appointed HSP supervisor is valid until terminated by a LHIN order (s. 21.2(5)).
- A HSP supervisor has the same powers as the governing body of the provider and its directors, officers, member or shareholders, unless the appointment provides otherwise or as specified by the LHIN (s. 21.2(6) and (7)).
- A HSP supervisor has the same rights as the governing body and the chief executive officer of the provider in respect of access to the body's or provider's documents, records and information (s. 21.2(9)).
- A HSP supervisor must not collect, use or disclose personal health information where other information would serve the supervisor's purposes or collect, use or disclose more personal health information than is reasonably necessary for the supervisor's purposes (s.21.2 (10)(a) and (b)).
- A HSP supervisor must make a report to the LHIN as required by the LHIN and ensure that all personal health information is de-identified from the report (s. 21.2(11) and (12)).
- A LHIN may issue directions to a HSP supervisor with regard to any matter within the supervisor's jurisdiction a HSP supervisor must comply with these directions (s. 21.2(13) and (14)).
- The LHIN must make a copy of the HSP supervisor's report available to the public (s. 21.1(15)).

Please see Appendix 4 for an excerpt of the LHSIA provisions.

Section 8(2.3) of LHSIA sets out that the LHIN directive, investigatory and supervisory authorities over HSPs cannot be delegated by the LHIN Board of Directors. This means that only the LHIN Board of Directors may lawfully exercise those powers.

The proposed framework for LHIN interventions set out in Appendix 1 is intended to demonstrate a collaborative and responsive process to effectively resolve HSP performance issues. When a performance issue escalates to the LHIN, each successive level of intervention should involve discussion between the LHIN and HSP senior leadership.

Section 3: General Principles for Use of LHIN Authorities

The processes and principles set out in this guideline are to provide LHINs with guidance only; LHINs are to respond appropriately and based on the seriousness of the situation.

1. *Public interest justification*
    a) Any use of the statutory authorities will be accompanied by a public interest justification setting out what aspect or aspects of the public interest are viewed as warranting the use of the authority.

2. *Proportionate response*
    a) The use of these authorities would not override another applicable law.
    b) Use a proportionate response, where applicable, commensurate with the urgency or severity of the situation. See Appendix 1 for a range of actions that a LHIN could take in response to an issue.
    c) The use of the new directive, investigatory or supervisory authority is not expected to be duplicative of other existing channels available for directing HSPs (e.g., performance obligations as set out in the SAA, including the termination of a contract, provincial standards and other health system complaints resolution mechanisms).
    d) Each new authority is among several available within a progressive range of other authorities available to the LHINs (e.g., operational reviews, audits, information and reports).

3. *Advance consultation*
    a) Prior to issuance of a directive, appointment of an investigator or supervisor, the LHIN is expected to discuss with the HSP or HSPs as appropriate, and the HSP stakeholder association (if applicable) on relevant matters pertaining to the directive or appointment, including any financial or communications implications.
    b) Prior to issuance of a directive, appointment of an investigator or supervisor, the LHIN is expected to consult with the Ministry of Health and Long-Term Care as appropriate.
    c) The LHINs are expected to consider the impacts of any proposed exercise of its authorities on the interests of other funders of the HSP, where applicable.
    d) The LHINs may also discuss any proposed exercise of its authorities with other stakeholders (e.g. other funders, including other non-profit organizations, ministries or levels of government) as appropriate, but will advise the HSP and ensure the discussions are conducted in the public interest.

4. *Advance notification*
    a) Prior to issuance of a directive or appointing an investigator under LHSIA, a LHIN is legally required to provide advance notification to the Minister and the HSP. For HSP supervisors, LHINs are required to provide 14 days notice to the Minister and the governing body of the HSP before the appointment (unless there are not enough members of the governing body to form a quorum) (s. 21.2(3) of LHSIA).
    b) Although a time period is not specified in legislation, best practice is to provide 14 days notice before issuing a directive or appointing an investigator, unless circumstances are deemed by the LHIN to warrant more urgent action.
    c) Notification is expected to be in writing from the LHIN to the HSP with a copy to the Minister of Health and Long-Term Care.
    d) During this notification period, the HSP has an opportunity to respond to the notice (e.g., send a letter to the Minister or LHIN or request a meeting with the Minister or LHIN).

5. *Publication*
    a) It is expected that a LHIN Board's decision to issue a directive, or appoint an investigator or supervisor to a HSP would be made at an open meeting of the Board unless one of the exceptions listed in clauses (a) through (j) under subsection 9(5) of LHSIA apply. Section 9 (3) of LHSIA requires a LHIN to give reasonable notice to the public of the meetings of its board of directors and its committees.
    b) Appropriate information related to each use of a statutory authority is expected to be made available to the public.
        i. Every directive is expected to be provided to the affected HSP(s) and HSP associations (if applicable) and posted on the LHIN website in both official languages.
        ii. Every report of an investigator or supervisor must be made publicly available but the timing of making such a report publicly available may vary depending on the nature and circumstances of the report (e.g., where a person involved in a civil or criminal proceeding may be prejudiced).
        iii. In the normal course, a LHIN is expected to provide an advance copy of the investigator's report to the affected HSP before it is made publicly available.

6. *Specificity*

LHIN Directives

i. Every LHIN directive should specify the effective date, to whom it applies, what is directed and whether the directive is time-limited.
ii. Every LHIN directive should specify the outcome expected and, to the extent possible, respect the HSP's decision-making about the means to achieve that outcome.

LHIN Appointment of a HSP Investigator

iii. Once appointed, every LHIN appointment of a HSP investigator should be communicated in writing by the LHIN Board Chair to the HSP.
iv. The LHIN's appointment letter to the HSP investigator should specify the effective date, to whom it applies, the objective and scope of the investigation and the mechanism for terminating the appointment (e.g., upon completion of the investigation and delivery of final report to the LHIN).

LHIN Appointment of HSP Supervisor

v. Once appointed, every LHIN appointment of a HSP supervisor should be communicated in writing by the LHIN Board Chair to the HSP and should include a copy of the appointment letter to the HSP supervisor and the terms of reference, which outlines, among other things, the objective and scope of the supervision.
vi. This communication should specify the effective date, to whom it applies, and the mechanism for terminating the appointment.

7. *Scope of Supervision*
    a) Section 21.2(7) of LHSIA permits a LHIN to specify the powers and duties of a HSP supervisor and the terms and conditions governing those powers and duties.
    b) In appointing a supervisor, the LHIN is expected to consider, on a case-by-case basis, whether it is in the public interest that the powers and duties of the supervisor be specified and that there be terms and conditions governing the powers and duties.

c) A LHIN is expected to consider whether it would be proportionate to appoint a supervisor for one program or part of the HSP's functions. If there is only one program being funded by a LHIN, the LHIN would need to consider whether it could achieve its objectives by terminating the funding and funding another HSP.

Section 4: Examples of Use of LHIN Authorities

4.1 Actions Preceding Use of New LHIN Authorities

Appendix 1 provides a diagram of the range of progressive actions that a LHIN should take in response to an issue.

LHIN statutory authorities would be used after other possible alternative paths have been exercised. Table 1 below provides examples of some of the alternative actions that would be exercised in advance of using the new authorities.

Table 1: **DRAFT** – **Possible Involvement, Triggers and Interventions in Advance of Using New LHIN Authorities**

Stage	Possible Triggers	Possible Interventions

Stage 1 – Identification, Monitoring and Co-resolution of routine issues	• HSP performance issue (one-time or persistent)
	• Failure to meet SAA obligations
	• Failure to demonstrate improving performance on SAA indicators/obligations
	• High-risk performance factors identified (e.g., risk of patient safety and privacy)
	• PIP does not produce desired outcomes
	• Financial management concerns identified
		• Formal and informal resolution processes as outlined in the SAA performance obligations, which may include:
		  • Dialogue between:
		  ▪ LHIN and HSP
		  ▪ LHIN and LHINs
		  • Plan to identify next steps and monitoring (e.g., additional meetings, updates, reports)
		  • Root cause analysis
		  • HSP development and implementation of a PIP (individually or with the LHINs)
		  • Enhanced monitoring (e.g., increased reporting)
		  • Enhanced support and resources if applicable and appropriate for HSP from the LHIN
		  • Coaching of the HSP
		  • Termination of the contract
		• Operational or peer review
		• External/expert reviews and audits

Table 1: **DRAFT** – **Possible Involvement, Triggers and Interventions in Advance of Using New LHIN Authorities**		
Stage	**Possible Triggers**	**Possible Interventions**
Stage 2 – LHIN directives	See Section 4.2 for examples of likely uses of this authority.	
Stage 3 – Formal investigation	See Section 4.2 for examples of likely uses of this authority.	
Stage 4 – Formal supervision	See Section 4.2 for examples of likely uses of this authority.	

4.2 Potential Uses of New LHIN Authorities

- The following are intended to illustrate the **potential uses** of LHIN authorities under LHSIA. The scenarios provided are for illustrative purposes only. These are not definitive or exhaustive lists.

Table 2: **Potential Uses of LHIN Directives to HSPs**	
Regional or Sub-regional	**HSP-specific**
Issues or practices concerning the integration of health care for one or a group of HSPs	Issues or practices concerning organizational management, service delivery, clinical* programs/services, quality of patient care or health care experience that would benefit from improvement in one HSP
Standardization of regional processes to address patient need • e.g., for transition of patients between health service providers and home care in a region	Operational or organizational issue at a specific HSP • e.g., an absence of effective governance on a specific issue
Formalizing a region- or sub-region-wide approach • e.g., Common protocols for referrals	
Enable integrated partnerships to advance patient-centred care among HSPs in a region or sub-region • e.g., rural health hubs, health links, bundled care • e.g., organization of HSP information systems	

*Note: This does not include the authority of the Minister to issue provincial standards, which is set out in section 11.2 of the *Local Health System Integration Act, 2006*.

Table 3: **Potential Uses of LHIN Appointment of Investigators and Supervisors**	
Appointment of Investigator(s)	• Prolonged and repeated financial mismanagement • Pattern of significant patient complaints (e.g., complaints that involve risks to patient care, safety, and privacy). • Concern over appropriate patient care practices and procedures to protect safety and security of patients • Failure to meet obligations in the SAA

Table 3: **Potential Uses of LHIN Appointment of Investigators and Supervisors**	
	• Unstable/ineffective organizational leadership – high rate of senior management or board resignations with a disruptive impact on the organization's effective functioning • Prolonged or disruptive conflict among boards, administration and medical professionals or employees • Emergent issues
Appointment of Supervisor	• HSP is acting in contravention of legislation, directives or policies • Prolonged and repeated financial mismanagement • Pattern of significant patient complaints (e.g., complaints that involve risks to patient care, safety, and privacy). • Mass board resignation • Demonstrated issues related to quality of care • Concerns related to the findings of an investigator or investigators • Serious concerns related to deficits or deficit management, capital projects, etc. • Serious concerns related to governance or administration • Emergent issues

Section 5: Review and Update

These powers under LHSIA came into effect on September 1, 2017.

As the guidelines are used, they will be reviewed annually and updates will be considered on the basis of a sufficient number of reviews to ensure that the guidelines remain timely and relevant.

APPENDIX 1: DRAFT Proposed Intervention Framework

The proposed framework for **LHIN interventions** is intended to demonstrate a collaborative and responsive process to effectively resolve performance issues. When a performance issue escalates to the LHIN, each successive level of intervention should involve discussion between the LHIN and HSP senior leadership.

Actions preceding the use of new LHIN authorities

Severity of Risk/ Issue

STAGE 1: IDENTIFICATION, MONITORING AND CO-RESOLUTION OF ROUTINE ISSUES

POSSIBLE TRIGGERS:

- HSP performance issue (one-time or persistent)
- Failure to meet SAA obligations
- Failure to demonstrate improving performance on SAA indicators/obligations
- High-risk performance factors identified (e.g., risk to patient safety and privacy)
- Performance Improvement Plan (PIP) does not produce desired outcomes
- Financial management concerns identified

INTERVENTIONS MAY INCLUDE:

- Formal and informal resolution processes as outlined in the SAA performance obligations, which may include:
  - Dialogue between:
    - LHIN and HSP
    - LHIN and LHINs
  - Plan to identify next steps and monitoring (e.g., additional meetings, updates, reports)
  - Root cause analysis
  - HSP development and implementation of a PIP (individually or with the LHINs)
  - Enhanced monitoring (e.g., increased reporting)
  - Enhanced support and resources if applicable and appropriate for the HSP from the LHIN
  - Coaching of the HSP
  - Termination of the contract
- Operational/peer review
- External/expert reviews or audit

STAGE 2: LHIN DIRECTIVE

(may not be HSP performance-related)

POSSIBLE TRIGGERS:

- Issues or practices concerning organizational management, service delivery, clinical programs/services, quality of patient care or health care experience that would benefit from improvement in one HSP
- Issues or practices concerning the integration of health care for one or a group of HSPs

EXAMPLES MAY INCLUDE:

- Operational or organizational issue at a specific HSP
- Standardization of regional processes to address patient need
- Formalizing a region- or sub-region-wide approach
- Enable integrated partnerships to advance patient-centred care among HSPs in a region or sub-region

STAGE 3: LHIN APPOINTMENT OF INVESTIGATOR

POTENTIAL USES

- Prolonged and repeated financial mismanagement
- Pattern of significant patient complaints (e.g., complaints that involve risks to patient care, safety and privacy)
- Concern over appropriate patient care practices and procedures to protect safety and security of patients
- Failure to meet obligations in the SAA
- Unstable/ineffective organizational leadership – high rate of senior management or board resignations with a disruptive impact on the organization's effective functioning
- Prolonged or disruptive conflict among boards, administration and medical professionals or employees
- Emergent issues

STAGE 4: LHIN APPOINTMENT OF SUPERVISOR

POTENTIAL USES

- Contravention of legislation, directives or policies
- Prolonged and repeated financial mismanagement
- Pattern of significant patient complaints (e.g., complaints that involve risks to patient care, safety and privacy)
- Review demonstrates quality of care issues
- Mass board resignation
- Concerns related to the findings of (an) investigator(s)
- Serious concerns related to deficits or deficit management, capital projects, etc.
- Serious concerns related to governance or administration
- Emergent issues

Level of Intervention

Notes: The framework is presented in a sequential order but the interventions applied may not occur in a linear fashion. The amount of time available to resolve issues is limited, therefore a finite period of time should be spent on each level of intervention. If the issue cannot be resolved within a set time, then the level of intervention should be escalated.

APPENDIX 2: LHSIA SECTION 20.2 – DIRECTIVES BY LHINs

Directives by local health integration networks

20.2 (1) A local health integration network may issue operational or policy directives to a health service provider to which it provides funding where the network considers it to be in the public interest to do so. 2016, c. 30, s. 19.

Exception

(2) Subsection (1) does not apply to a licensee within the meaning of the *Long-Term Care Homes Act, 2007*, a person or entity that operates a public hospital within the meaning of the *Public Hospitals Act*, or the University of Ottawa Heart Institute/Institut de cardiologie de l'Université d'Ottawa. 2016, c. 30, s. 19.

Notice

(3) Before issuing a directive, a local health integration network shall give notice of a draft directive to the Minister and to each health service provider to which it is intended to be issued. 2016, c. 30, s. 19.

Restriction

(4) A directive shall not unjustifiably as determined under section 1 of the *Canadian Charter of Rights and Freedoms* require a health service provider that is a religious organization to provide a service that is contrary to the religion related to the organization. 2016, c. 30, s. 19.

Binding

(5) A health service provider shall comply with every directive of a local health integration network. 2016, c. 30, s. 19.

General or particular

(6) An operational or policy directive of a local health integration network may be general or particular in its application. 2016, c. 30, s. 19.

Law prevails

(7) For greater certainty, in the event of a conflict between a directive issued under this section and a provision of any applicable Act or rule of any applicable law, the Act or rule prevails. 2016, c. 30, s. 19.

Non-application of *Legislation Act, 2006*

(8) Part III (Regulations) of the *Legislation Act, 2006* does not apply to the operational or policy directives. 2016, c. 30, s. 19.

Public availability

(9) A local health integration network shall make every directive under this section available to the public. 2016, c. 30, s. 19.

APPENDIX 3: LHSIA SECTION 21.1 – INVESTIGATORS

Investigators

21.1 (1) A local health integration network may appoint one or more investigators to investigate and report on the quality of the management of a health service provider, the quality of the care and treatment of persons by a health service provider or any other matter relating to a health service provider where the local health integration network considers it to be in the public interest to do so. 2016, c. 30, s. 21.

Application

(2) Subsection (1) applies to health service providers that receive funding from the local health integration network but does not apply to a licensee within the meaning of the *Long-Term Care Homes Act, 2007*. 2016, c. 30, s. 21.

Notice of appointment

(3) Before appointing an investigator, the local health integration network shall give notice of its intention to appoint an investigator to the Minister and the health service provider. 2016, c. 30, s. 21.

Powers

(4) An investigator may, without a warrant and at reasonable times,

(a) enter the premises of a health service provider that may be investigated under this section;

(b) subject to subsection (5), enter any premises where a health service provider provides services; and

(c) inspect the premises, the services provided on the premises and the records relevant to the investigation. 2016, c. 30, s. 21.

Dwellings

(5) No investigator shall enter a place that is being used as a dwelling, except with the consent of the occupier. 2016, c. 30, s. 21.

Identification

(6) An investigator conducting an investigation shall produce, on request, evidence of his or her appointment. 2016, c. 30, s. 21.

Powers of investigator conducting investigation

(7) An investigator conducting an investigation may,

(a) require the production of records or anything else that is relevant to the investigation, including books of account, documents, bank accounts, vouchers, correspondence and payroll records, records of staff hours worked and records of personal health information;

(b) examine and copy any record or thing required under clause (a);

(c) upon giving a receipt and showing the evidence of appointment, remove a record or anything else that is relevant to the investigation for review or copying, as long as the review or copying is carried out with reasonable dispatch and the record or thing is promptly returned to the local health integration network;

(d) in order to produce a record in readable form, use data storage, information processing or retrieval devices or systems that are normally used in carrying on business in the place; and

(e) question a person on matters relevant to the investigation. 2016, c. 30, s. 21.

Obligation to produce and assist

(8) If an investigator requires the production of a record or anything else that is relevant to the investigation under this section, any of the following who has custody of the record or thing shall produce it and, in the case of a record, shall on request provide any assistance that is reasonably necessary to interpret the record or to produce it in a readable form:

1. The health service provider.

2. Any person employed by the provider.

3. Any person performing services for the provider. 2016, c. 30, s. 21.

Restriction

(9) An investigator shall not exercise the investigator's powers under subsections (7) and (8) to access personal health information except,

(a) with the consent of the individual who is the subject of the personal health information; or

(b) in such circumstances as may be prescribed. 2016, c. 30, s. 21.

Same

(10) If an investigator accesses personal health information under subsection (9), the investigator shall not,

(a) collect, use or disclose the personal health information if other information will serve the purpose of the investigation; or

(b) collect, use or disclose more personal health information than is reasonably necessary for the purpose of the investigation. 2016, c. 30, s. 21.

Confidentiality

(11) An investigator and his or her agents shall keep confidential all information that comes to the investigator's knowledge in the course of an investigation under this Act and shall not communicate any information to any other person except as required by law or except where the communication is to the local health integration network or a person employed in or performing services for the local health integration network. 2016, c. 30, s. 21.

Report of investigator

(12) The investigator shall, upon completion of an investigation, make a report in writing to the local health integration network. 2016, c. 30, s. 21.

De-identification of personal health information

(13) Before providing a report to the local health integration network under subsection (12), the investigator shall ensure that all personal health information is de-identified. 2016, c. 30, s. 21.

Same

(14) The local health integration network shall cause a copy of the report of an investigation, with all personal health information de-identified, to be delivered to the health service provider. 2016, c. 30, s. 21.

Public availability

(15) The local health integration network shall make every report of an investigation available to the public. 2016, c. 30, s. 21.

APPENDIX 4: LHSIA SECTION 21.2 – SUPERVISORS

Health service provider supervisor

21.2 (1) A local health integration network may appoint a person as a health service provider supervisor of a health service provider to which it provides funding where the network considers it in the public interest to do so. 2016, c. 30, s. 21.

Certain providers excepted

(2) This section does not apply with respect to a health service provider that is,

(a) a person or entity that operates a hospital within the meaning of the *Public Hospitals Act* or a private hospital within the meaning of the *Private Hospitals Act*; or

(b) a licensee within the meaning of the *Long-Term Care Homes Act, 2007*. 2016, c. 30, s. 21.

Notice of appointment

(3) The local health integration network shall give the Minister and the governing body of the health service provider at least 14 days notice before appointing the supervisor. 2016, c. 30, s. 21.

Immediate appointment

(4) Subsection (3) does not apply if there are not enough members of the governing body to form a quorum. 2016, c. 30, s. 21.

Term of office

(5) The appointment of a health service provider supervisor is valid until terminated by order of the network. 2016, c. 30, s. 21.

Powers of supervisor

(6) Unless the appointment provides otherwise, a health service provider supervisor has the exclusive right to exercise all of the powers of the governing body of the provider and its directors, officers, members or shareholders as the case may be. 2016, c. 30, s. 21.

Same

(7) The local health integration network may specify the powers and duties of a health service provider supervisor appointed under this section and the terms and conditions governing those powers and duties. 2016, c. 30, s. 21.

Additional powers of supervisor

(8) If, under the order of the network, the governing body continues to have the right to act with regard to any matters, any such act of the body is valid only if approved in writing by the health service provider supervisor. 2016, c. 30, s. 21.

Right of access

(9) A health service provider supervisor appointed for a health service provider has the same rights as the governing body and the chief executive officer of the provider in respect of the documents, records and information of the body and the provider. 2016, c. 30, s. 21.

Restriction

(10) A health service provider supervisor shall not,

(a) collect, use or disclose personal health information if other information will serve the purposes of the supervisor; or

(b) collect, use or disclose more personal health information than is reasonably necessary for the purposes of the supervisor. 2016, c. 30, s. 21.

Reports

(11) A health service provider supervisor shall make a report to the network as required by the network. 2016, c. 30, s. 21.

De-identification of personal health information

(12) Before providing a report to the network under subsection (11), the health service provider supervisor shall ensure that all personal health information is de-identified. 2016, c. 30, s. 21.

Network's directions

(13) The local health integration network may issue directions to a health service provider supervisor with regard to any matter within the jurisdiction of the supervisor. 2016, c. 30, s. 21.

Directions to be followed

(14) A health service provider supervisor shall carry out every direction of the network. 2016, c. 30, s. 21.

Public availability

(15) The network shall make every report of a supervisor available to the public. 2016, c. 30, s. 21.

Key Messages on Guidelines for LHIN Use of Statutory Authorities

- As part of the *Patients First Act, 2016* and to support LHINs to fulfill their expanded mandates as the single point of accountability for local health system planning in their regions and sub-regions, the *Local Health System Integration Act, 2006* (LHSIA) was amended to provide the LHINs with additional tools and authorities in the form of new directive, investigatory and supervisory powers over the Health Service Providers they fund, with certain exceptions.
- These new authorities strengthen a larger framework of accountability and oversight under LHSIA and build on LHINs' existing authorities to arrange integrations and conduct audits and reviews of their Health Service Providers.
- These new LHIN authorities are also complemented by new Ministerial authorities to issue directives to appoint investigators and supervisors over LHINs under LHSIA and to issue directives to public hospitals under the *Public Hospitals Act*.
- The Minister also has directive, investigatory and supervisory authorities over LHINs.
- The Ministry and the LHINs are committed to working with HSPs across the health system to help patients and their families obtain better access to a more integrated health care system, improve the patient experience and deliver high-quality care.
- The ministry engaged a number of Health Service Provider associations/organizations to gather feedback on guidelines for the use of the LHIN statutory authorities, and has incorporated their advice where appropriate.
- The guidelines emphasize the importance of open communication, early issue resolution and graduated response.
- The new LHIN authorities are intended for use after other available interventions for resolving an issue have been exercised or considered.
- These new authorities mirror the approach that has demonstrated success in hospitals.
- The ministry is committed to monitor the use of the new LHIN authorities and review the guidelines in one year.

Statutory Authorities under the *Local Health System Integration Act, 2006*

Questions and Answers

Consultation Process

1. What did the Ministry of Health and Long-Term Care consult on?

A. The Ministry of Health and Long-Term Care ("Ministry") consulted with key internal and external stakeholders on the development of policy guidelines to support implementation of new Ministerial and Local Health Integration Network (LHIN) statutory authorities under the *Local Health System Integration Act, 2006* (LHSIA). In Spring 2017, the Ministry consulted on the development of guidelines that are intended to clarify the principles and potential uses of:

- Minister's authorities to issue directives to, and appoint investigators and supervisors over LHINs; and
- LHIN authorities to issue directives to, and appoint investigators and supervisors over Health Service Providers.

2. Why were guidelines developed on these statutory authorities under LHSIA?

A. In response to feedback the Ministry received during the Legislative Standing Committee hearings on Bill 41, *Patients First Act, 2016* and to enable implementation of the new LHIN authorities with our health system partners in a manner that is aligned with the goals of a more local and integrated health care system, the Ministry committed to developing clear and consistent guidelines for the application of the new Ministerial and LHIN directive, investigatory and supervisory authorities. The Ministry conducted consultations with internal and external stakeholders on the development of policy guidelines for each set of authorities.

These consultations were modeled after the consultation process that the Ministry undertook with the Ontario Hospital Association over the course of Fall/Winter 2016 to develop a framework that outlines the principles that will guide the potential use of the new Ministerial directive authority over public hospitals under the *Public Hospitals Act*.

3. Who did the Ministry consult with on the development of these guidelines?

A. The Ministry consulted with the LHINs and internal Ministry stakeholders that manage relationships with LHINs on the development of guidelines for the Ministerial authorities to direct, investigate and supervise LHINs under LHSIA.

To develop guidelines for the LHIN authorities to direct, investigate and supervise Health Service Providers under LHSIA, the Ministry consulted with internal Ministry stakeholders that manage relationships with Health Service Providers and external organizations and associations that represent Health Service Providers. The Ministry invited a group of diverse external stakeholders with representation from the LHINs, inter-professional primary

care organizations and the hospital, long-term care, community support services and physiotherapy sectors to participate in these consultations.

4. What were the consultation timeframes?

A. The Ministry conducted consultations with internal and external stakeholders in Spring 2017.

5. What issues were raised by HSP associations during the consultations?

A. Consultation participants raised a number of concerns that were addressed during the consultation process:

- Some HSPs possess corporate and governance structures that span multiple jurisdictions (e.g., Salvation Army). It is expected that LHINs note any unique aspects of the governance structure and consider any potential unintended consequences of appointing a supervisor when contemplating potential use of these new authorities.
- HSPs raised concerns about bearing the cost for the appointment or an investigator. The Ministry has clarified in the guidelines that, in the normal course, it is expected that that the LHINs would bear the cost.
- HSPs raised concerns about having an opportunity to be consulted on the report and findings of an investigator or supervisor before it is made publically available by the LHIN. The Ministry has clarified in the guidelines that, in the normal course, a LHIN is expected to provide an advance copy of the investigator's report to the affected HSP before it is publically released.

Proclamations under the *Patients First Act, 2016*

6. When did the LHIN authorities over Health Service Providers come into effect?

A. The LHSIA provisions for LHIN directive, investigatory and supervisory authorities over Health Service Providers came into effect on September 1, 2017.

As you may know, the Minister's authorities over LHINs came into effect upon Royal Assent of the *Patients First Act, 2016,* on December 8, 2016.

Applicability of New Authorities

7. To whom do the new LHIN authorities under LHSIA apply?

A. The new LHIN authorities apply to Health Service Providers (HSPs) that are funded by, and have a Service Accountability Agreement (SAA) with, a LHIN. HSPs are entities funded by a LHIN under the authority of LHSIA to deliver health care services in Ontario.

The following are LHIN HSPs under LHSIA:

- Public Hospitals

- Private Hospitals
- Psychiatric Facilities (as defined in the *Mental Health Act*), with certain exceptions
- Non-profit community mental health and addiction services entities
- Approved agencies under the *Home Care and Community Services Act, 1994* (HCCSA) (e.g., providers of community support, homemaking, personal support and professional services as defined in HCCSA)
- Community Health Centres
- Long-Term Care Homes
- Family Health Teams
- Nurse Practitioner-Led Clinics
- Aboriginal Health Access Centres
- Entities providing primary care nursing services, maternal care or inter-professional primary care programs and services
- Hospices and other non-profit palliative care service providers
- Community Physiotherapy Clinics
- Independent health facilities

The statutory authorities apply to all HSPs with some exceptions (i.e., long-term care homes are not subject to LHIN directive, investigative and supervisory authorities and public hospitals are not subject to LHIN directive and supervisory authorities because separate legislative regimes apply).

The new LHIN authorities do not apply to:

- Home and community care services provided or arranged by the LHINs because these services are provided for the LHINs under applicable legislation. Service Provider Organizations contracted by a LHIN to deliver home and community care services on its behalf are not defined as Health Service Providers.
- Physicians when practising in a clinical capacity or physician-specific practices because physicians are not health service providers under section 2(3) of LHSIA.

At this time, not all of the listed HSPs under LHSIA have a SAA with the LHIN. The following listed HSPs in LHSIA are funded by, and have contracts with, the Ministry:

- Family Health Teams;
- Nurse Practitioner-Led Clinics;

- Entities providing primary care nursing services, maternal care or inter-professional primary care programs and services;
- Community Physiotherapy Clinics.

As such, the new LHIN authorities would not apply to these listed HSPs. Should the LHINs have a funding relationship with these HSPs in the future, then the new LHIN authorities would apply to these HSPs.

Other Considerations

8. Is a LHIN legally authorized to remove a board and appoint a supervisor to a Health Service Provider that is independently-governed and receives its funding from multiple sources?

A. Yes. Section 21.2 of LHSIA provides LHINs with the authority to appoint a person as a supervisor of a Health Service Provider to which it provides funding when it considers it to be appropriate to do so in the public interest. A LHIN is legally authorized to remove a board of a Health Service Provider defined under LHSIA when it is in the public interest to do so, without limitation on the basis of the percentage of LHIN funding.

The LHIN's supervisory authority under LHSIA is modelled after existing precedents in law that have been used successfully for many years. For example, the supervision provision under the *Public Hospitals Act* has been applied to public hospitals, which are legally incorporated institutions governed by voluntary boards, funded by multiple sources and many have charitable status. Although not exactly the same, public hospitals and community health service provider organizations share these features.

During the Legislative Standing Committee hearings for Bill 41: *Patients First Act, 2016*, concerns were raised about whether a LHIN can legally remove a board and appoint a supervisor when LHIN funding accounts for less than fifty per cent of the Health Service Provider's funding.

The LHIN supervisory authority to appoint a supervisor is constrained by criteria set out in a definition of 'public interest' under LHSIA, rather than a threshold of LHIN funding to a Health Service Provider. These criteria include:

- the quality of the management and administration of the health service provider;
- the proper management of the health care system in general;
- the availability of financial resources for the management of the health care system and for the delivery of health care services;
- the accessibility to health services in the geographic area or sub-region where the health service provider is located; and
- the quality of the care and treatment of patients.

When proposing to appoint a supervisor, a LHIN could consider:

- **Source of funding**: While a certain proportion of funding may come directly from a LHIN, it is likely that other sources of funding would be from public sources (e.g., other provincial ministries, federal or municipal governments) that may warrant greater public accountability measures. Other sources may be private, although this may be a small proportion of a Health Service Provider's total funding.
- **Nature of the funding (operational base or one-time)**: If a Health Service Provider, such as a community health centre or an Aboriginal Health Access Centre, receives a percentage of funding that is base funding critical to the organization's ongoing operations year-over-year, this may warrant greater public accountability measures.
- **Threshold**: It is not clear what an appropriate threshold level would be or how to measure it (i.e., the proportion of funding received from a LHIN may change from year to year based on other revenue the Health Service Provider receives).
- **Purpose of supervisor role**: The focus of the LHIN's decision to appoint a supervisor would be based on the Health Service Provider's role in the health care system. Identifying a threshold of revenue received from a LHIN focuses on the Health Service Provider's revenue, rather than its role in the system, or the nature of the services it provides.

The Ministry reviewed the Ontario Healthcare Financial and Statistical (OHFS) 2015-16 year end data in order to assess the potential impact of a LHIN's use of its supervisory authority on Health Service Providers (i.e., community and primary health care agencies) that are less than 50% funded by the LHINs.

Based on this analysis, the Ministry identified that out of the 996 community and primary health care agencies reviewed, an approximate **41 (4%)** receive less than or equal to 50% of total revenues from the LHIN and the Ministry.

9. Can there be a situation in which an HSP supervisor is appointed by the LHIN to exercise less than a full supervision over the HSP? For example, can a supervisor be appointed to oversee only one program or a part of the organization's functions?

A. The legislation does contemplate situations where the appointment of an HSP supervisor could be scoped based on the specific circumstances of a situation. Section 21.2(6) of the *Local Health System Integration Act, 2006* (LHSIA) provides an HSP supervisor with the exclusive right to exercise all of the powers of the governing body of the provider, its directors, officers, members or shareholders unless the appointment provides otherwise. Section 21.2(7) of LHSIA permits a LHIN to specify the powers and duties of an HSP supervisor and the terms and conditions governing those powers and duties. These provisions are modeled after the government's supervision authority over hospitals under the *Public Hospitals Act*.

It is anticipated that most situations warranting the appointment of a supervisor would warrant a full-scope of supervision. Any scoping of a supervisor's appointment would have

to be made in the public interest and on a case-by-case basis. Circumstances warranting supervision are likely to be situations where there are multiple performance factors. Consideration will need to be given to whether it would be sufficient to appoint a supervisor for one program or part of the organization's functions. If there is only one program being funded by a LHIN, the LHIN would need to consider whether it could achieve its objectives by terminating the funding and funding another HSP.

10. How does the LHIN authority to appoint a supervisor apply when an HSP operates with federal funding (e.g., Aboriginal Health Access Centres (AHACs)?

A. If an HSP is named under LHSIA and has a funding agreement with the LHIN, then the LHIN may exercise its new authorities to issue directives or appoint an investigator or supervisor to that HSP. A LHIN's use of these new authorities is not limited by the percentage of funding that the HSP receives from the LHIN. As set out in the guidelines, it is expected that any LHIN use of its new authorities would, where possible, consider the impacts on the interests of other funders of the HSP and follow consultation with the Ministry and discussion with the affected HSP and funders.

11. How does the LHIN authority to appoint a supervisor apply when an HSP is a federally incorporated organization?

A. The incorporation of an HSP under federal statute raises additional considerations for the application of the LHIN's supervisory authority.

The legislation sets out that a LHIN appointment of a supervisor must be on notice to the Minister and clarifies that the scope of a LHIN-appointed supervisor can be specified by a LHIN. In these circumstances, the Ministry could clarify how it expects the LHINs to limit any supervision in respect of a federally incorporated organization. This can be done through a policy guideline, instruction or Minister's directive to the LHINs. Under the legislation, a Minister's directive is binding upon the LHINs.

12. Are HSP officers and directors provided immunity from the exercise of any of the LHIN authorities?

A. No. There is no provision under LHSIA or in its regulations that holds the director and officers of an HSP harmless for implementing a LHIN directive. Indeed, directors and officers are required to comply with the law, which would include complying with a LHIN directive.

Existing protections already found in normal corporate mechanisms for operating a health service provider organization (e.g., corporate indemnity) are sufficient to protect HSP directors and officers from any potential liability arising from the implementation of a LHIN directive.

In the case where an HSP supervisor is appointed by the LHIN to exercise full supervision over an HSP, the supervisor would replace the HSP's board of directors (unless otherwise specified by the LHIN) and would assume the board's responsibilities and liabilities.

13. What would happen if a LHIN directive is in conflict or deemed to be in conflict with an HSP's officers' and directors' fiduciary duties?

A. The HSP must comply with the directive and by doing so, would be complying with the law and in turn, fulfilling the fiduciary duties of the corporation's officers and directors. If a corporation's officers and directors breach a directive, they would be putting their organization's administration at risk.

14. Who pays for the LHIN-appointed investigator or supervisor to an HSP?

A. In the normal course, it is expected that a LHIN would bear the costs for an appointment of an investigator or supervisor to an HSP. The HSP would not be expected to pay for a LHIN-appointed investigator or supervisor. However, the financial implications of each LHIN appointment would be assessed on a case-by-case basis. It is expected that as part of the 'advanced consultation' principle set out in the guidelines, the LHINs would have a discussion with the HSP about the implications (e.g., financial, communications, etc.) of the appointment of an investigator or supervisor.

15. Does the LHIN's supervisory authority extend to assets (e.g., land, houses) held by an HSP?

A. Yes. Unless the appointment provides otherwise, a LHIN-appointed supervisor could exercise all of the powers of the governing body of the HSP and its directors, officers, members or shareholders as the case may be. In general, it is not anticipated that the supervisor's role would be that of a receiver or trustee charged with a collection function or the disposal of an organization's assets. Those functions are governed by separate legislation (i.e., the federal *Bankruptcy and Insolvency Act*). It is more likely that the supervisor's role would be to stabilize the organization so that a board of directors could be re-engaged.

16. Will an HSP be consulted on the report and findings of an investigator or supervisor before it is made publicly available by the LHINs?

A. In the normal course, a LHIN is expected to provide an advance copy of the investigator's report to the affected HSP before it is publicly released. This expectation is contained in the 'publication' principle set out in the guidelines.

This is not likely to arise in the case of an HSP supervisor because a full-scope supervision is likely to be in place and the supervisor would replace the HSP's board of directors and assume the board's responsibilities and liabilities.

17. There seems to be a conflict in LHSIA between the requirement that a LHIN investigator keep all information that comes to his/her knowledge during the course of the investigation confidential and the requirement for a LHIN to make an investigator's report to the LHIN available to the public. How is this reconciled?

A. The requirements to keep information confidential and make reports publicly available are found in other legislation such as the *Auditor General Act, 1990*.

The collection of information by an investigator during the course of an investigation will be kept confidential. However, the investigator also has an obligation to produce a report to the LHIN, which must be made publicly available. This report may include any information the investigator deems to be in the public interest to report. No personal health information will be included in the investigator's report.

18. How do the directive, investigatory and supervisory authorities under the *Public Hospitals Act* relate to the LHIN directive, investigatory and supervisory authorities over Health Service Providers under LHSIA?

A. The Minister's directive authority and Lieutenant Governor in Council (LGIC) authority over hospitals under the *Public Hospitals Act* are separate authorities that do not overlap with the LHIN directive and supervisory authorities over Health Services Providers under LHSIA. The LHIN directive authority does not apply to public hospitals and the LHIN supervisory authorities do not apply to hospitals (public and private) because separate legislative regimes apply (*Public Hospitals Act* and *Private Hospitals Act)*.

Both the LGIC under the authority of the *Public Hospitals Act* and the LHIN under LHSIA, may appoint one or more investigators to investigate and report on the quality of the management of a hospital, the quality of the care and treatment of persons by the hospital or any other matter relating to the hospital when it is in the public interest to do so.

In considering when this authority would be used and by whom, it is expected the principles outlined in the LHIN Authorities guidelines would be applied and the proposed intervention framework used to guide any decisions by the LGIC and the LHIN. The Ministry and the LHIN would consult with each other prior to the use of the respective investigatory authorities to ensure there is no duplication. Efforts would be made by the Ministry and the LHIN to identify, monitor and co-resolve any routine issues that may arise in a hospital. Any further response taken would be proportionate to the urgency or severity of the situation.

19. When do integration authorities apply and when do directive authorities apply?

A. LHIN integration authorities are set out in sections 25, 26 and 27 of LHSIA. These authorities are not new and have been available for use by the LHINs for over a decade. Integration authorities are likely to be used by the LHIN to address the questions of "what services" should be combined to advance integrated patient care and "by whom". Any use of the LHIN's integration authorities would be done in the public interest. For example,

where there are two different HSPs providing the same services, a LHIN may choose to use its integration authorities to combine services in a community or region.

It is anticipated that the new LHIN directive authority would not duplicate the LHIN integration authorities. The directive authority is likely to be used by the LHIN to address the question of "how services should be delivered" to advance integrated patient care in a region. For example, a directive may be used to formalize a region- or sub-region-wide approach through a common protocol for referrals.

20. What is the distinction and interaction between Minister's provincial standards and LHIN directives?

A. Under section 11.2 of LHSIA, the Minister may issue a provincial standard for the provision of health care services that are provided or arranged by a LHIN or an HSP where the Minister considers it in the public interest to do so. This is a new Minister's authority under LHSIA. LHIN directives are not meant to be duplicative of the Minister's authority to issue provincial standards and would not address the identification of provincial clinical standards to be adopted by a LHIN or HSP. However, a LHIN directive could be used to supplement a Minister's provincial standard by requiring that all HSPs adopt the standard in their delivery of care.

21. Can a LHIN sub-region exercise the LHIN directive, investigatory and supervisory authorities?

A. No. A LHIN sub-region is not a legal entity. Only a LHIN may exercise the LHIN directive, investigatory and supervisory authorities under LHSIA.

22. The public interest test is so broad. How would the public interest test criteria be applied?

A. Section 35 of LHSIA sets out key criteria to be considered in the application of the public interest test:

(a) the quality of the management and administration of the local health integration network or the health service provider, as the case may be;
(b) the proper management of the health care system in general;
(c) the availability of financial resources for the management of the health care system and for the delivery of health care services;
(d) the accessibility to health services in the geographic area or sub-region where the local health integration network or the health service provider, as the case may be, is located; and
(e) the quality of the care and treatment of patients.

The public interest test in LHSIA is modeled after the public interest test in the *Public Hospitals Act.* The test is a statement of factors that can be considered before the exercise of an authority but is not meant to provide an exhaustive list of criteria. The application of

the test will depend on the facts of a situation, on a case-by-case basis. The new LHIN directive, investigatory and supervisory authorities cannot be delegated by the LHIN Board of Directors and any decision to exercise these authorities must be made at an open meeting of the Board unless one of the exceptions outlined in the legislation applies.

23. If a LHIN is concerned about the performance of an HSP, why wouldn't it simply terminate the funding contract/Service Accountability Agreement with that provider? Why would the LHIN resort to appointing a supervisor over that HSP?

A. A funder always reserves the right to terminate a funding contract with a provider as per the terms and conditions of that funding contract. In the case of a funding contract between a LHIN and an HSP, a LHIN could decide to exercise its right to terminate a Service Accountability Agreement with an HSP where the HSP's performance is not meeting expectations.

The LHIN also has a legislated mandate to plan, fund and integrate the local health system and would have to consider a number of factors related to the needs in a community and the services available to address these needs. In the case where an HSP provides a service that can be readily delivered by another HSP in the same area, it may make sense for a LHIN to terminate a funding contract. Where an HSP provides a service that cannot be readily delivered by another HSP, the LHIN may consider the use of other available authorities to address the situation.

24. How are the LHINs held accountable for the uses of their new authorities?

A. Under LHSIA, the Minister of Health and Long-Term Care has the authority to direct or investigate a LHIN where the Minister considers it in the public interest to do so. On recommendation of the Minister, the Lieutenant Governor in Council may appoint a supervisor to a LHIN where it is in the public interest to do so.

In general, the LHINs are held accountable to the public and the Ministry through a number of mechanisms. The Ministry-LHIN Accountability Agreement (MLAA) with each LHIN outlines the funding and performance expectations (including targets and reporting obligations). The MLAA complements the accountability measures contained LHSIA, and the Memorandum of Understanding (MOU) that is signed between the Minister and each LHIN.

In support of the expanded mandate of the LHINs, the ministry worked with LHINs to enhance the current agreements (e.g., the MOU and MLAA) to ensure that the LHINs are held accountable for their new mandate, supported by the *Patients First Act, 2016*.

In addition to enhancing the accountability agreements, the ministry and LHINs have worked together to develop an escalation process to address any LHIN performance issues including concerns about the ability to meet local health system targets.

The LHINs must also submit quarterly performance reports to the Ministry, publicly report on key indicators and publicly report on their plans and progress through their Annual Business Plan and Annual Report against the Minister's expectations as set out in the Minister's annual mandate letter to the LHINs posted on the LHINs websites.

The *Patients First Act, 2016*, strengthened the LHINs' accountability for local health service planning and performance as well as supported the goal of providing care that is more integrated and responsive to local needs.

Under the *Patients First Act, 2016*, each LHIN is required to establish a patient and family advisory committee, which will enhance the voice of patients and families in health care planning.

25. Many HSPs are multi-service organizations that provide community services other than health services (e.g., day care, women's programs). What expertise does the LHIN have to investigate or supervise an HSP?

A. LHINs have been in operation for ten years and have developed knowledge about the health and health care needs of their local communities. The experience, insight and structure of the LHINs make them the proper mechanism for regional leadership for transforming the health care system.

In considering who to appoint as an investigator or supervisor to an HSP, it is expected that the LHIN would carefully consider the structure and mandate of the affected HSP and identify a person with the appropriate competencies, knowledge and expertise to effectively address the scope of issues to be resolved through the appointment.

Where appropriate, it is expected that an HSP investigator or supervisor would seek out the expertise required to understand and address the range of programs delivered by a multi-service provider that are within its scope.

26. What recourse does an HSP have if it disagrees with a LHIN directive or a LHIN's appointment of an investigator or supervisor?

A. The legislation sets out that the issuance of a LHIN directive or a LHIN appointment of an investigator or supervisor must be on notice to the Minister and the HSP. The guidelines set out the principles and a proposed intervention framework for the use of these new LHIN authorities. It is intended that a collaborative and responsive process be followed by the LHINs and their HSPs to effectively resolve HSP performance issues. When an HSP performance issue escalates to the LHIN, each successive level of intervention should involve discussion between the LHIN and HSP senior leadership.

The principles in the guidelines include an expectation that an HSP may, upon receipt of notification from the LHIN, respond by writing to the Minister or LHIN, or requesting a meeting with the Minister or LHIN to outline any concerns. It is anticipated that any HSP concerns would be adequately addressed through these processes.