South West **LHIN**

Bill 41, Patients First Act
Update to South West LHIN Board of Directors
December 13, 2016

Ontario
Local Health Integration Network

Discussion Points

- Passage of the *Patients First Act* in the Ontario Legislature
- Update on planning work to date
  - Implementation work underway
  - Defining functions and structures to advance the work
  - LHIN-CCAC integration
- Discussion/Questions

Patients First Act – Bill 41

- Act received Royal Assent on December 8, 2016
- Patients First is now an Act, and implementation planning will now accelerate

Key Amendments Since Introduction

At Reintroduction of *Patients First Act*
More procedural protections for deemed service accountability agreements (SAAs)
Enhanced procedural protections for LHIN investigators
More procedural protections around voluntary integrations
Explicit protection in certain instances for denominational organizations
Clarification that LHIN directives would not apply to public hospitals and that policy and operational directives to public hospitals are only at the Minister's discretion
Timeline adjustment: provisions regarding information and reports to LHINs for the purposes of coordinating primary care will come into effect on proclamation
Clarification that the purpose of the above reports is to support collaboration between the LHINs and primary care providers, including physicians
Timeline adjustment: the appointment of LHINs as agents of the ministry for physician contract management to come into effect on proclamation
Highlight the importance of FLS in health equity object

Standing Committee
Clarification that LHINs cannot amend physician contracts
Limit investigator access to personal health information (PHI) except where patient has consented or by regulation
Add further limitations on access, use of, and reporting of PHI for cases where information is accessed
Clarification that PHI cannot be reported to LHINs as part of physician reporting of practice transitions and capacity
Add requirement of notice to Minister when a supervisor is appointed
Addition of health promotion to LHIN objects and revision of health equity object
Addition of requirement that LHINs include priorities and directions that foster health services according to the *French Language Services Act*
Provide authority for shared services organization to receive information from LHINs for Access to Information Requests

Implementation Work

Update on Key Fall deliverables

On track

- LHIN accountability framework plan finalized (e.g. mandate letter, Minister directive(s), MOU, MLAA, MLAA indicators)
- Third party consultant to be engaged with LHINs on readiness assessments
- Non-management staff transition framework developed
- Recruitment package finalized for integrated clinical leadership structure, at the LHIN and sub-region
- Sub-regional primary care capacity assessment framework finalized
- Indigenous engagement plan approved and underway with first round of information sharing complete
- Patient and Family LHIN Renewal Engagement Plan approved

Risk of delay

- Order in Council for new LHIN Board appointments finalized
- LHIN-customized management and organizational structures approved
- Operational dashboard indicators, standardized data sources, and platform identified and validated, and draft roll-out plan developed
- Corporate Services Entity established
- LHIN sub-regions confirmed and publicly communicated
- Ministry-LHIN-French Language Planning Entity framework developed for French Language Services
- Public Health Expert Panel announced

Proposed management structure

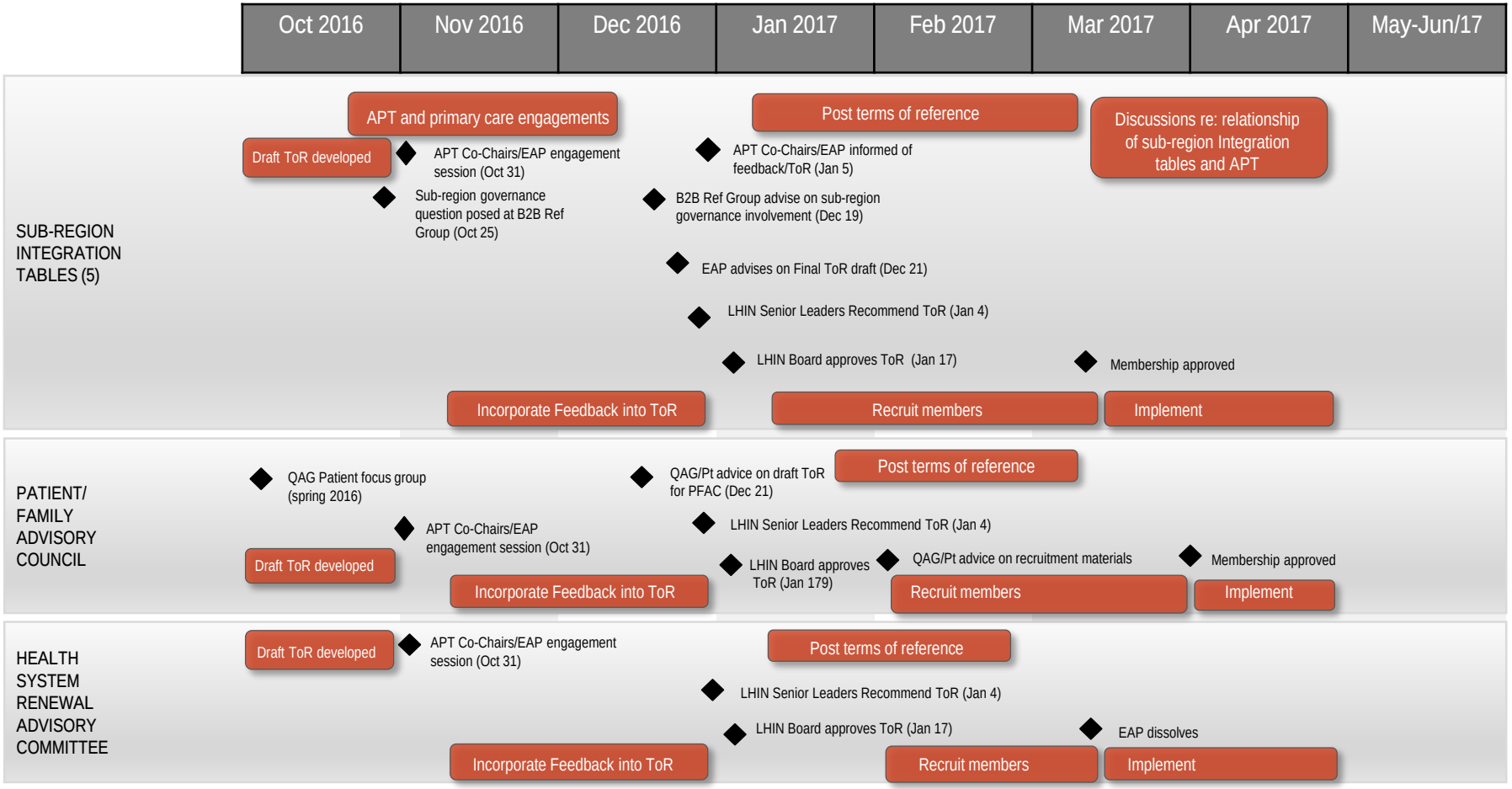
- LHIN CEOs have received materials to support the next steps in local planning on the management structure. LHINs have been working with the ministry to consider the functions of the Enhanced LHIN, to develop a prototypical management structure to support those functions, and to review expected savings.

- LHINs are asked to submit to the ministry their proposed organizational structures and planning and budget templates by December 23, 2016.

- There is an expectation that CCACs will be engaged in organizational design and that the LHIN board will be engaged prior to submission. It is also expected that the findings of this report will guide the planning process, however there is opportunity for an appropriately flexible structure to support differences in geography and local context.

- Providing these materials are planning steps only for the purpose of LHINs being ready to proceed with implementation should the legislation be passed by the Legislative Assembly.

Enhanced South West LHIN Tables – Engagement and Decision Timeline



LHIN-CCAC Integration

LHIN-CCAC Integration

Update on work to date

- Regular joint meetings between senior leadership teams from the South West LHIN and the South West CCAC continue.
- Three work streams patient care, people, systems and structures have been launched.
- Co-Chairs drafted key milestones to be endorsed by LHIN-CCAC Project Team on December 7th.

Keeping stakeholders and partners informed of progress

Successful engagement happens at many levels and at a key points throughout this work

The South West LHIN will continue to engage and consult with patients, caregivers, health service providers, primary care providers, stakeholder associations, Indigenous peoples, Francophone communities, and other system partners including

- ongoing sub-region engagement
- regular updates, webinars and presentations on work underway to the public, health system partners, elected officials, groups, networks and committees
- resources including videos, presentations, and background information posted regularly to the South West LHIN website (southwestlhin.on.ca/patientsfirst)

southwestlhin.on.ca/patientsfirst

Reference materials

Summary of *Patients First Act, 2016*

Part 1: LHIN Governance and Mandate

1. LHIN Objects

- Amend LHIN objects to enable LHINs' expanded mandate, including authority to deliver home care services currently provided by the CCACs, as well as to promote health equity, including equitable health outcomes, reduce or eliminate health disparities and inequities, recognize the impact of social determinants of health and respect the requirements of the *French Language Services Act* in the planning, design, delivery and evaluation of health services. Add LHIN object: to participate in the development and implementation of health promotion strategies.

2. Additional Health Service Providers

- Allow LHINs to fund and have accountability relationships with additional Health Service Providers (HSPs), including Family Health Teams (non-physician funding), Aboriginal Health Access Centres, hospices, and nurse-practitioner-led clinics.

3. LHIN Sub-Regions

- Require LHINs to establish sub-regions as the focal point for local planning and performance monitoring and management.

4. LHIN Governance

- Expand LHIN board membership from 9 to 12 members to reflect the expanded mandate.
- Change the total length of time a person may be a Board member (e.g., may exceed a maximum of six years when a person is appointed as a Board Chair after having served at least three years as a member).

5. Shared Services Entity

- Allow for the establishment, by regulation, of a shared services entity to support LHINs with the necessary shared services (e.g., payroll, financial, IT services and supports).

6. Patient and Family Advisory Committees

- Require each LHIN to have one or more Patient and Family Advisory Committees to support community engagement.

Summary of *Patients First Act, 2016*

Part 2: Primary Care

- Add primary care models (not physicians) as health service providers funded by LHINs.
- Add "physician resources" to planning objects of LHINs.
- Give LHINs the ability to act on behalf of the Minister to monitor and manage (but not negotiate or amend) contracts with physicians. This will come into effect only on proclamation.
- Add regulation-making authority regarding the provision of information about practice changes (e.g., transitions in practice, such as retirements) and practice and service capacity from primary care providers, including physicians, to the LHINs. This will come into effect only on proclamation.

Part 3: Home and Community Care

1. LHINs to Provide Home and Community Services

- Give the Minister the authority to order the transfer of CCAC staff and assets to LHINs.
- Enable the LHINs to assume responsibility for the management and delivery of home and community care (directly or through contracts with service providers), including the placement of patients into long-term care homes.

2. Labour Considerations

- LHINs will become successor employers under collective agreements.
- To implement new functions, LHINs will establish an integrated management structure.

3. Wind Down CCACs

- Enable dissolution of CCACs by Minister's order after CCAC staff and assets have been transferred to the LHINs.

Summary of *Patients First Act, 2016*

Part 4: Public Health

1. Population and Public Health Planning

- Establish a formal relationship between LHINs and local boards of health to support joint health services planning.

Part 5: Enhanced Oversight and Accountability

1. Enhanced LHIN Oversight

- Give LHINs the ability to issue directives, investigate and supervise health service providers (on notice to the Minister and health service provider), as necessary, with the exception of public hospitals (no directive or supervision authorities) and long-term care homes (no new authorities due to existing powers in the *Long-Term Care Homes Act, 2007*). Investigators will not be able to access personal health information without patient consent.

2. Enhanced Minister Oversight

- Give the Minister the ability to issue directives, investigate, or supervise LHINs, as well as enhanced power to issue directives to public and private hospitals. The Minister would also have the authority to set standards for LHINs and health service providers.

Part 6: Complementary Legislative Changes

If the Bill is passed by the Ontario Legislature, the proposed amendments would:

1. Integrated Clinical Care Council

- Allow for an integrated clinical care council to be established within Health Quality Ontario to develop and make recommendations to the Minister on clinical standards in priority areas (e.g. home care, primary care).

2. Patient Ombudsman

- Give the Patient Ombudsman oversight of complaints regarding home and community care and related health service functions provided or arranged by the LHINs. The Provincial Ombudsman would retain oversight over LHINs in their services planning and other functions that are not patient-facing.

3. Provincial Patient and Family Advisory Council

- Allow for the establishment of a provincial Patient and Family Advisory Council.

Key Issue at Standing Committee: Personal Health Information and Investigators

- Patient health records will remain confidential under the *Patients First Act, 2016*. Personal health information is being protected according to the same high standards set out in existing privacy legislation.
- Nothing in the Act will permit a LHIN to appoint an investigator for a physician practice.
- LHINs would be able to appoint an investigator for a "Health Service Provider".
- As managers and integrators of the local health systems, LHINs need appropriate oversight powers to address issues in the system and with Health Service Providers. The Act lays out a system of graduated remedies, one of which is an investigator.
- **Investigators will only be permitted to access personal health information with a patient's consent or as permitted by regulation.**
- Where personal health information is accessed with patient consent, the Act lays out a number of additional procedural safeguards to protect the information.
- All provisions of the Act related to personal health information were reviewed by the Information and Privacy Commissioner and their input was incorporated.

Key Issue at Standing Committee: LHIN Sub-Regions

- Under *The Patients First Act, 2016*, LHINs will be asked to identify smaller geographic areas within their regions – or sub-regions – that reflect community-level care and patient referral patterns, such as those currently used by Health Links.
- **Sub-regions will be the focal point for population-based planning, performance improvement and service integration.**
- By organizing LHINs into sub-regions, the health system is organized into more manageable and rational units that coincide with patient needs and referral patterns.
- Health care is most effective when services are tailored to the specific needs of a community. Each LHIN encompasses approximately 1-2 million Ontarians and the regions are very diverse.
- The establishment of sub-regions has been characterized in some public comments as an "added layer of bureaucracy" but a sub-region is not an organization or administration in and of itself; it is a planning area for the LHINs. Sub-regions are part of the LHIN; they will not be separate organizations and will not have their own board.
- A sub-region is a geographical unit within a LHIN; **it is not a boundary that will restrict patients in their care.** Patient care and treatment will, as always, be decided by the appropriate front-line health care professionals together with patients.
- The LHINs will work with new local clinical leads to improve primary care with home and community care at the sub-region level.

Key Issue at Standing Committee: Appointment of Supervisors

- The *Patients First Act, 2016* gives the LHINs the ability to appoint a supervisor to a health service provider to which it provides funding when it considers it to be appropriate to do so in the public interest.
- The appointment of a supervisor would be an unusual and carefully considered step taken in the public interest and must be approved by the LHIN board. The appointment could only occur after notice to the Ministry and to the health service provider.
- **The ability for LHINs to appoint a supervisor will allow them to make improvements in the delivery of patient care where providers are not meeting expectations.**
- Several stakeholder groups expressed concern about this provision as some health service providers may only receive a portion of their funding from LHINs. The Act is applicable regardless of the specific level of funding received by the health service provider.
- LHIN authority to appoint an investigator or 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.
- The ministry intends to provide guidelines to the LHINs and health service providers to clarify expectations in cases where a LHIN supervisor is appointed to a health service provider that receives funding from multiple sources.

Key Issue at Standing Committee: Role of Not-For-Profits and For-Profits

- A number of stakeholders have expressed concern that the bill could "open the door" to LHIN's contracting with for-profit organizations to provide service delivery.
- *The Patients First Act, 2016* does not change the ability of an "approved agency" (e.g. a CCAC today or a LHIN in the future) to purchase services from either a for-profit or a not-for-profit organization.
- The existing framework for home care and community services will be transferred to LHINs, and includes services from both not-for-profit and for-profit service providers.
- CCACs will transfer their contracts and employees to LHINs and ensure continuity of patient care.
- Both not-for-profit and for-profit organizations provide important health care services.
- **The priority is to ensure that patients have access to the best possible care.**
- It is not intended to expand the use of for profit entities for community support services, and this will be addressed by the Ministry.

Key Issue at Standing Committee: Building Capacity at LHINs

- LHINs have been in operation for ten years and have developed knowledge about the health and health care needs of our local communities; under the Act they will expand their authority over key areas of the health system.
- LHINs will be supported to build their capacity to successfully execute their enhanced role in the health care system.
- **Partners from across the ministry and the LHINs are working together on capacity and readiness planning and activities to address LHIN readiness and building capacity to enable a smooth and seamless transition.**
- A third party is being engaged to conduct readiness assessments at each LHIN in advance of transition day and to support readiness for transition to the new LHIN roles.
- Readiness assessments will inform a staged transition of CCACs into LHINs in Spring/Summer 2017. Individual transitions will occur following a public order from the Minister.

Key Issue at Standing Committee: French Language Services

- The *Patients First Act, 2016* builds on previous legislation and practice, highlighting the importance of providing health services in French and of considering French language services in planning.
- The Act reinforces the expectation that LHINs comply with the *French Language Services Act* in the planning, design, delivery and evaluation of services.
- To recognize the importance of French Language Services to Ontarians within all LHINs, the legislation emphasizes LHINs' responsibility of promoting health equity and diversity, including respect for the diversity of French-speaking communities.
- The legislation also ensures that the LHINs' planning and community engagement responsibilities are guided by the Minister's provincial strategic plan and include priorities and directions that foster health services according to the *French Language Services Act.*
- Ontario will continue working with French language health leaders to ensure their voices are heard, in particular with respect to equitable access to services that meet their unique needs.