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# IMPLICATIONS OF THE *PATIENTS FIRST ACT* IN ONTARIO

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## Esther Shainblum, B.A., LL.B., LL.M., CRM

From 2005 to 2017 Ms. Shainblum was General Counsel and Chief Privacy Officer for Victorian Order of Nurses for Canada, a national, not-for-profit, charitable home and community care organization. In that capacity Ms. Shainblum provided support to the board, management and staff in a variety of areas including governance, risk management, privacy and access to information, compliance and corporate/commercial matters. Before joining VON Canada, Ms. Shainblum was Senior Policy Advisor to the Ontario Minister of Health, advising the Minister on a wide range of portfolios, including hospitals, long term care and health care professions. Earlier in her career, Ms. Shainblum practiced health law and corporate/commercial law at McMillan Binch and spent a number of years working in policy development at Queen's Park.

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## OVERVIEW

- Introduction
- History of the *Patients First Act*
- New Role of LHINS Under the *Patients First Act*
- Transfer of CCAC Responsibilities to the LHINS
- Implications of the *Patients First Act*





## A. INTRODUCTION

- The *Patients First Act* ("*Patients First*") received Royal Assent on December 8, 2016
- It is currently in effect, save and except for certain provisions covered below
- Intended to:
  - support patient-centred care;
  - promote health system planning and integration; and
  - improve access to high quality health services
- This presentation will provide selective comments on *Patients First* but does not address the entire statute

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## B. HISTORY OF THE *PATIENTS FIRST ACT*

- Originally introduced in June 2016 as Bill 210 and re-introduced in October 2016 as Bill 41
- Officially titled "*An Act to amend various Acts in the interest of patient-centred care*"
- The bulk of the legislation consists of amendments to the *Local Health System Integration Act, 2006* ("LHSIA")
- *Patients First* is based on the Ontario government's discussion paper released on December 17, 2015, entitled "Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario"
- It expands the role of the Local Health Integration Networks ("LHINs") as part of the government's plan for improving the provincial health system

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## C. NEW ROLE OF LHINS UNDER THE *PATIENTS FIRST ACT*

- *Patients First* has broadened the role of the LHINs, including:
  - primary care, hospices and physiotherapy clinics are brought under LHIN auspices
  - the operations of the Community Care Access Centres (CCACs) are transferred to LHINs and LHINs take over responsibility for home care
  - LHINs are given increased oversight over health service providers
  - LHINs can impose accountability agreements on health service providers

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### 1. Health Service Providers

- Under LHSIA, LHINs fund and enter into service accountability agreements with **"health service providers"**
- *Patients First* expands the definition of **"health service provider"** in section 2(2) of LHSIA to include:
  - not for profit (NFP) entities that operate family health teams;
  - NFP entities that operate nurse-practitioner-led clinics;
  - NFP entities that operate Aboriginal health access centres;

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  - NFP entities that provide palliative care services, including hospices;
  - NFP entities that operate primary care nursing services, maternal care or inter-professional primary care programs/services;
  - Providers of physiotherapy services in clinic settings that are not otherwise health service providers; and
  - Other persons or entities that may be prescribed as health service providers
- LHINs are now able to fund and have accountability agreements with these entities/providers

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- Section 2(2) continues to include under the definition of health service provider:
  - A person or entity approved under the *Home Care and Community Services Act*, 1994 (HCCSA) to provide services
- Under HCCSA, only not-for-profit entities can be approved agencies [s. 2(1)(a), s. 5(1)]
- No change to this definition under *Patients First* but there are implications and possibly some unintended consequences due to other changes that were made by *Patients First* - to be discussed below

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## 2. Exclusions from the Definition of Health Service Provider

- New LHSIA Section 2(4) - excludes entities from which a LHIN ***purchases*** “community services” from the definition of health service provider
- Community services defined under HCCSA as:
  - Community support services (such as meals, transportation, adult day programs)
  - Homemaking services
  - Personal support services
  - Professional services

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- Confusing distinction between ***purchasing*** and ***funding*** community services that may have had unintended consequences
- Before *Patients First,* LHINs could only ***fund*** services and only health service providers could receive funding - by definition health service providers had to be NFP (except LTCs)
- Now section 2(4) of LHSIA allows LHINs to contract out - *i.e.* ***purchase*** - community services
- Section 2(4) also provides that a provider of community services to a LHIN under a **purchased** service contract is excluded from the definition of health service provider under section 2(4)
- This section may mean that suppliers of **purchased** services need not meet the same requirement as **funded** suppliers must meet - *i.e.* that they do not have to be not-for-profit

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- This provision may permit LHINs to purchase community support services from for-profit entities
- Community support services were provided solely by NFPs before *Patients First*
- Ministry of Health and Long Term Care (MOHLTC) appeared to agree - proposed amendments to O.Reg. 386/99 that would have limited LHINs to contracting with not-for-profit entities for the delivery of community support services
- Amendments to O.Reg. 386/99 have been dropped
- NFPs in the sector are under pressure due to competition with for-profit, lower-paying providers already delivering the other community services, *i.e.* homemaking, personal support and professional services
- It would be helpful if the Ministry were to put forward robust guidelines to govern/restrict the LHINs' ability to contract with for-profit suppliers for community support services

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- The exclusion for purchased services may also apply to the providers who currently supply services to the CCACs pursuant to the template CCAC service agreements
- Information from the sector indicates that the CCAC service contracts will continue to be managed separately from the existing LHIN accountability agreements
- If that is correct, those providers would not be health service providers under LHSIA

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### 3. Additional Objects of the LHINS

- The objects of the LHINs as set out in section 5 of LHSIA have been amended to include new roles, such as:
  - Identifying and planning for local health system needs, including physician resources;
  - Promoting health equity;
  - Developing and implementing health promotion strategies;
  - Providing health and related social services and supplies and equipment for the care of persons in home, community and other settings;
  - Providing goods and services to assist caregivers in the provision of care for persons in home, community and other settings; and
  - Managing the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs where community services are provided

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## 4. Planning and Community Engagement

- Section 14.1 of LHSIA now requires each LHIN to establish geographic sub-LHIN regions for the purposes of planning, funding and integrating services, and to make a map of the sub-regions available to the public
- These sub-LHINs are intended to facilitate patient-centred planning and integration at the local level
- Sub-LHINs will not be separate entities

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## D. TRANSFER OF CCAC RESPONSIBILITIES TO THE LHINS

- Probably the most anticipated provisions of *Patients First* are those that deal with the transfer of responsibility for home and community care from the CCACs to the LHINs
- The provincial government signalled its intention to transfer responsibility for home care in its Patients First proposal back in December 2015
- Ontario's Auditor General had identified that inconsistencies between CCACs were leading to inequities in service levels and quality of care

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### 1. The Community Care Access Centres

- *Patients First* repeals the *Community Care Access Corporations Act, 2001*
- *Patients First* adds Part V.1 to LHSIA, creating the framework for the transfer of responsibilities from the CCACs to the LHINs
- Paragraphs 34.2(1)(a) and (b) of LHSIA give the Ontario Minister of Health and Long Term Care (the "Minister") the power to order the transfer of all the assets, liabilities and employees of a CCAC to the LHIN within the same geographic boundaries
- The LHIN essentially steps into the shoes of the CCAC, assuming all of its assets, liabilities, operations and activities and taking on a new role in home and community care service delivery

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- The change would be seamless to employees and to the terms of any charitable gifts or bequests, which would apply to the LHIN as they had to the CCAC
- Subsection 34.4(1) provides that all employees of the affected CCAC are transferred to the LHINs
- As the LHINs were not set up to manage the delivery of home and community care, they do not have the staff or infrastructure to take on their new roles
- Some CCAC staff was needed to fill those functions
- Orders made under Part V.1 of LHISIA have been issued for each of the CCACs, specifying the date of transfer of all assets, liabilities, rights, obligations, records and employees to the respective LHIN
- The transfers commence on May 3rd and are expected to terminate on June 21st, as set out in the following table:

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## Timeline for the transfer of CCAC responsibilities to the LHINs

| LHIN | Integration Date |
|---|---|
| North Simcoe Muskoka | May 3, 2017 |
| Hamilton Niagara Haldimand Brant | May 10, 2017 |
| Waterloo Wellington | May 17, 2017 |
| South East | May 17, 2017 |
| South West | May 24, 2017 |
| Champlain | May 24, 2017 |
| Mississauga Halton | May 31, 2017 |
| Central West | May 31, 2017 |
| North East | May 31, 2017 |
| Toronto Central | June 7, 2017 |
| Central | June 7, 2017 |
| Erie St. Clair | June 21, 2017 |
| North West | June 21, 2017 |
| Central East | June 21, 2017 |





- Each order mandates the dissolution of the affected CCAC as of the date of transfer
- Dissolution was within the discretion of the Minister under section 34.5(1) but was not mandatory

### 2. The Ontario Association of Community Care Access Centres

- Sections 39 and 40 of LHSIA provide for the transfer of assets, liabilities and employees from the Ontario Association of Community Care Access Centres (“OACCAC”) to a new not-for-profit entity incorporated to provide shared services to the LHINs
- As with the transfer from CCACs to the LHINs, the new provisions transfer all existing OACCAC functions and employees from the OACCAC to the new entity
- Health Shared Services Ontario was established by O. Reg. 456/16 and assumed responsibility for all OACCAC functions/staff/assets by a Minister’s transfer order made January 31, 2017

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## E. NEW OVERSIGHT POWERS OF LHINS

- The most noteworthy provisions of *Patients First* are those giving the LHINs various broad oversight powers over health service providers where they consider it to be in the public interest to do so

### 1. Power to issue Operational or Policy Directives

- Section 20.2(1) of LHSIA gives LHINs the power to issue operational or policy directives that are binding on health service providers to which they provide ***funding***, where they consider it to be in the public interest to do so
- Section 20.2(1) does not apply to long term care homes, public hospitals or the University of Ottawa Heart Institute
- Section 20.2(1) also does not apply to providers of ***purchased*** services

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- Section 20.2(3) requires a LHIN to give notice of the directive to the Minister and to the health service provider to which it is intended to be issued
- The LHINs' powers under this section are somewhat circumscribed by section 20.2(4), which provides that a LHIN will not unjustifiably (as determined under section 1 of the Canadian Charter of Rights and Freedoms) require a religious health service provider to provide a service that is contrary to the religion related to the organization
- Section 20.2(5) provides that directives are binding on health service providers

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## 2. Power to appoint Investigators

- Section 21.1(1) of LHSIA gives LHINs the power to appoint investigators to investigate and report on the quality of the management, care and treatment or any other matter relating to a health service provider *[other than long term care homes, section 21.1(2)]* to which they provide ***funding***, where they consider it to be in the public interest to do so
- Section 21.1(3) requires a LHIN to give notice of the directive to the Minister and to the health service provider before appointing an investigator
- These investigators have broad powers
- Section 21.1(4) allows investigator to enter premises *[other than a private dwelling - section 21.1(5)]* without a warrant to inspect the premises, the services provided on the premises and the records relevant to the investigation





- Section 21.1(7) gives investigators various powers, including the power to:
  - require the production of records
  - examine and copy any record or thing
  - remove a record or thing for review or copying
  - question a person on matters relevant to the investigation
- Section 21.1(8) requires health service providers and their personnel to produce records and things and to assist investigators to interpret or read the record
- Subsections 21.1(9) through (13) deal with the protection of personal health information and other confidential information accessed by investigators in the course of carrying out their investigations
- Section 21.1 does not apply to providers of **purchased** services

### 3. Power to appoint a Supervisor

- Section 21.2 of LHSIA gives LHINs the power to appoint a person as the supervisor of a health service provider to which they provide ***funding***, *[other than a public hospital, a private hospital or a long term care home, per subsection 21.2(2)]* where they consider it to be in the public interest to do so
- Section 21.2(3) requires the LHIN to give the Minister and the governing body of the health service provider at least 14 days notice before appointing the supervisor





- Section 21.2(5) provides that the appointment of a supervisor is valid until it is terminated by the LHIN
- Section 21.2(6) provides that a supervisor has the exclusive right to exercise all of the powers of the governing body of the health service provider and its directors, officers, members or shareholders unless the order provides otherwise
- Section 21.2(7) allows the LHIN to specify the powers and duties of the supervisor and the terms and conditions governing those powers and duties

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- Section 21.2(9) provides that a supervisor 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 governing body and the provider
- Section 21.2(13) and (14) permit a LHIN to issue directions to a supervisor and the supervisor is required to carry out every such direction
- Sections 21.2(10) and (12) deal with the personal health information that the supervisor may collect, use or disclose while carrying out their duties
- Section 21.2 does not apply to providers of **purchased** services

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## 4. Exercising Oversight Powers

- Although the oversight powers given to LHINs under sections 20.2, 21.1 and 21.2 are subject to the notice and privacy requirements just described, these provisions do not limit or constrain the exercise of the oversight powers in any way
- Further, the requirement that the decision to exercise one of these powers must be "in the public interest" is of little substantive assistance

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- Under section 35 of LHSIA, a LHIN **may** consider any matter it regards as relevant in determining whether a decision is in the public interest including, without limitation:
  - 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





- The wording of section 35 does not give much guidance as to what circumstances would enable a LHIN to exercise its oversight powers
  - As such, there will be little that does not fall within the scope of this broad and open-ended language
- A document entitled “LHIN Renewal Questions and Answers” found at https://goo.gl/q9IWUU, in respect of the same provision in the predecessor Bill 210, indicates that these powers would only be exercised in particular circumstances, such as where a health service provider is acting in contravention of legislation, directives or policies, is experiencing governance and accountability challenges or is persistently underperforming on its accountability agreement indicators and/or obligations

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## 5. Oversight of the LHINS

- *Patients First* contains mirror provisions empowering the Minister to make the same orders in respect of LHINs, including orders to appoint a supervisor, displace the governing body and exercise the powers of the governing body and chief executive officer of the affected LHIN, all where the Minister considers it to be "in the public interest"
- However, the LHINs are creatures of statute and of the provincial government
- LHINs are fully funded by MOHLTC and exist solely to further the objects of the provincial government in respect of the administration and management of and planning for the province's health care system

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- The provincial government has almost identical powers to take over the governance and operation of public hospitals under the *Public Hospitals Act*, where again the entities in question are fully funded by and operate under the authority of MOHLTC
- Given the essentially public nature of these bodies and their mandates, it makes sense for the provincial government to have the power to issue binding operational or policy directives, appoint an investigator or displace the governing body of a LHIN or of a public hospital
- It is not clear that it is equally reasonable for a LHIN to have the power to do the same in respect of an independent entity that is essentially private in nature

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### 6. LHIN Oversight Not Restricted to LHIN Funded Operations

- While most health service providers possess multiple sources of funding, the LHINs' power to appoint a supervisor over health service providers is not restricted to programs or operations that are funded by the LHINs
- A LHIN could appoint a supervisor to take control over all assets and funds of a health service provider, regardless of the source of the funds
- While subsection 21.2(6) provides that the supervisor has the exclusive right to exercise all the **powers** of the governing body of the health services provider, it does not explicitly state that the supervisor is subject to the same **obligations and liabilities** as the governing body





- It is therefore not clear whether a supervisor would be required to abide by any restrictions on use or disposition of charitable funds and assets held by a charitable entity
- In a case in which a supervisor is appointed for a charitable health services provider, it would be helpful for the LHIN to specify that the supervisor is subject to those charitable requirements pursuant to subsection 21.2(7) of LHSIA, which permits the LHIN to specify the terms and conditions governing the powers and duties of the supervisor
- If the LHIN does not do so, the charity's stakeholders may want to consider seeking legal advice in order to ensure that its charitable assets are protected

### 7. Application of the LHINs’ oversight powers to different types of providers

- As noted earlier in this presentation, Section 2(4) excludes suppliers of ***purchased*** services from the definition of health service provider
- The LHINs broad oversight powers only apply to health service providers, *i.e.* entities to which the LHIN provides ***funding*** pursuant to service accountability agreements
- As discussed, only NFPs can be funded by a LHIN under LHSIA





- As a result, for-profit home and community care providers are not subject to the LHINs’ powers to issue binding directives, appoint investigators and appoint supervisors
- NFPs that provided services to CCACs will be suppliers of purchased services to LHINs and therefore will also be excluded. However, many of those are also funded by LHINs pursuant to accountability agreements and so will be caught through the other side of their operations
- It is not clear whether MOHLTC intended for-profit providers to be exempted from the LHIN oversight powers
- These uncertainties could be addressed by way of regulations or guidelines from MOHLTC

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## 8. Oversight Powers Not Yet in Force

- It should be noted that section 20.2 (the power to issue binding directives), section 21.1 (the power to appoint investigators) and section 21.2 (the power to appoint supervisors) are not yet in force and will not come into force until a future date to be named by proclamation of the Lieutenant Governor
- It would be useful if MOHLTC were to provide additional guidelines and safeguards to outline what would constitute an appropriate exercise of the LHINs' new supervisory and other powers before these provisions are proclaimed in force

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## F. RISKS TO THE NOT-FOR-PROFIT SECTOR

- There are risks to the not-for-profit sector - largely community-based organizations serving vulnerable communities and already under pressure from for-profit competitors
- Both Ontario Community Support Association and Ontario Non-profit Network have raised concerns about the lack of appeal mechanisms, due process and other safeguards in the legislation

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## G. PREPARING FOR THE UPCOMING CHANGES

- Organizations with CCAC contracts should note that their contracts will be transferred to the applicable LHIN in accordance with the schedule outlined earlier and that they will become suppliers of purchased services to the LHIN
- As noted above, such organizations may not be integrated into the service accountability agreement stream, at least for the time being. Until that happens, the LHINs' broad oversight powers will not apply to them, unless they are separately funded under a service accountability agreement with a LHIN

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- NFP health service providers still have some time to prepare for the LHINs' new powers
- They should be taking steps to minimize their risks including, without limitation, ensuring that they are not in contravention of any legislation, directives or policies, that their governing bodies are functioning appropriately and in accordance with governance best practices and that they are meeting all obligations set out in their accountability agreements with the LHINs

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