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).

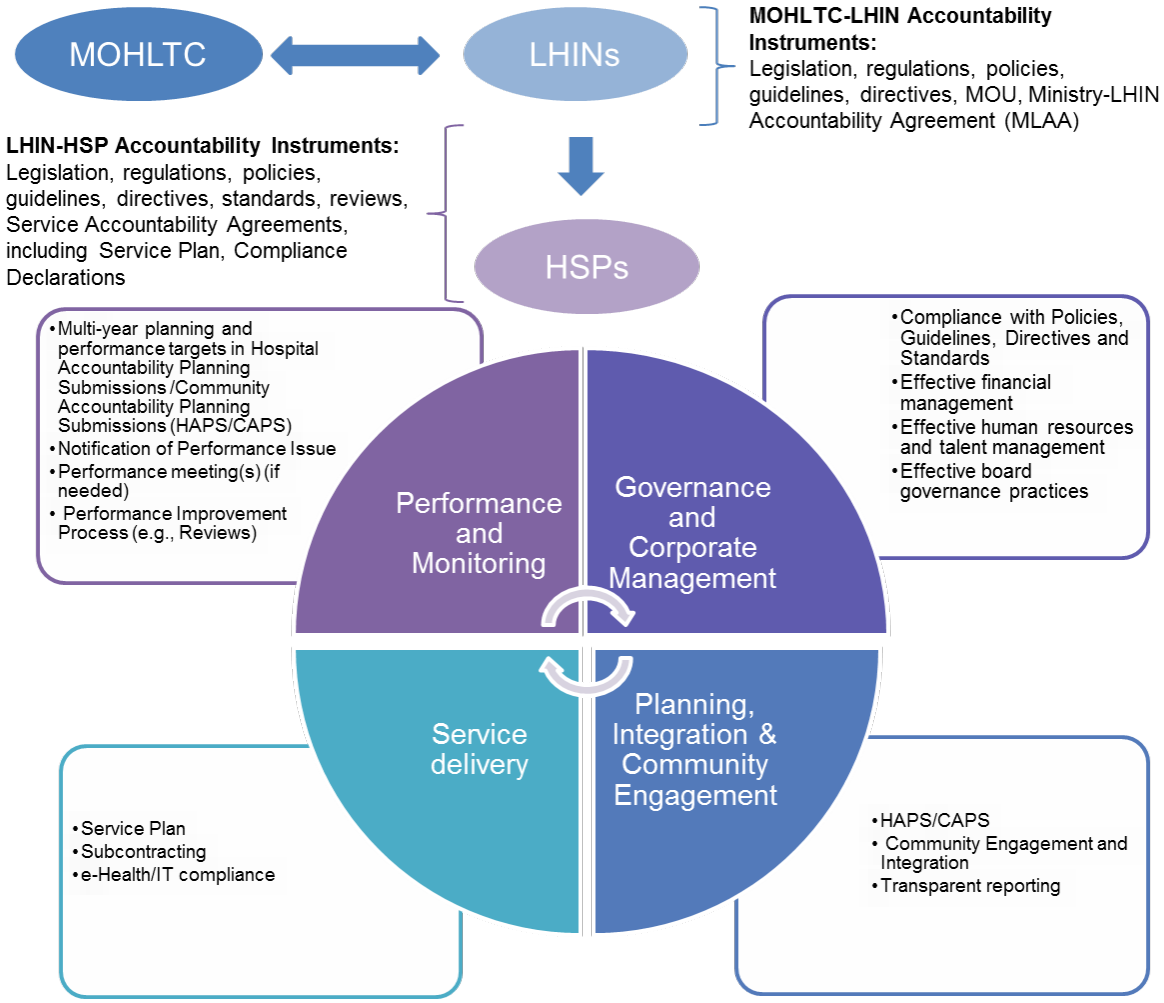
The MLAA establishes key funding and operational expectations of LHINs and the Ministry. LHINs are accountable to the Ministry for improving performance at the LHIN level, as measured against system priorities and targets identified by the Ministry. LHINs are also responsible for preparing reports documenting 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.