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SUBMISSION OF THE ADVOCACY CENTRE FOR THE ELDERLY TO THE STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

November 22, 2016

The Advocacy Centre for the Elderly (ACE) is pleased to provide comments on Bill 41, based upon our extensive experience advocating for older adults in Ontario and our expertise in health law.

After a brief introduction to ACE, we will examine the following concerns raised by Bill 41 as they affect older adults:

- Maintaining equitable access to home care, placement to Long-Term Care Homes (LTCH), supportive housing, chronic care and rehabilitation;
- Maintaining the continued independence of applications for home care and placement to LTCHs;
- Establishing Local Health Integration Network (LHIN) subregions and supporting patient choice; and,
- Ensuring accountability for patient care.

The Advocacy Centre for the Elderly

ACE is a specialty community legal clinic, funded by Legal Aid Ontario. ACE was established to provide a range of legal services to low income older adults in Ontario. These legal services include individual and group client advice and representation, public

legal education, community development, and law reform activities. ACE has been operating since 1984 in Toronto, and is the first and oldest legal clinic in Canada with expertise in legal issues of the older population.

On average, ACE receives over 3500 calls from older adults, families of older adults and health and social service providers annually. Over 65% of the intakes and client cases that ACE assists with are in the area of health law. Most of the telephone inquiries come from the Greater Toronto Area with approximately 20% originating from other areas of the province and some from outside of Ontario.

We would like to take this opportunity to summarize some of ACE's work in health law to highlight the issues that are of importance to our clients and stakeholders:

- ACE assists older adults and their family members in navigating the long-term care and home care systems in Ontario. While the calls may be on any issue related to the system, by far the most frequent calls are on behalf of older adults in hospital who are in the process of being discharged, who are seeking advice and/or legal assistance with respect to their right to apply to long-term care. We often provide direct service to patients to ensure that hospital administrators and the Community Care Access Centre (CCAC) staff comply with the law and uphold older adults' rights in the hospital discharge process regarding applications to long-term care, and admission to rehabilitation and complex continuing care facilities;
- ACE has participated on the Ontario Medical Association President's Advisory Committee on Palliative Care and Advance Care Planning;
- ACE is currently participating on two Law Commission of Ontario Advisory Committees: the Project on Legal Capacity, Decision-Making and Guardianship, and the Project on End of Life Care. ACE has co-authored three commissioned research papers for the LCO: *Health Care Consent and Advance Care Planning in*

Ontario: Legal Capacity, Decision-Making in Guardianship;[1] *Health Care Consent and Advance Care Planning Tools, Policies And Practices: The Challenge To Get It Right*;[2] and *Congregate Living and the Law it Affects Older Adults*.[3]

- ACE is a member of the Long-Term Care Quality Inspection Program Advisory Committee to the Ministry of Health and Long-Term Care which meets regularly to advise the Ministry on issues regarding the inspection of LTCHs and enforcement of the *Long-Term Care Homes Act, 2007* (*LTCHA*) and its regulations;
- ACE co-authored the training materials for health professionals that were produced as part of two of the Alzheimer Society of Ontario Initiatives (# 2 and #7) on Physicians' Education and Advance Directives on Care Choices;
- ACE has engaged for the past four years in a number of education initiatives for health care practitioners on health care consent and advance care planning. These include initiatives in the Erie-St Clair LHIN, Central East LHIN, Hamilton Niagara Haldimand Brant (HNHB) LHIN, and Northwest LHIN. These initiatives have involved interactive, detailed training sessions as well as production of an online training course on health care consent and advance care planning that is a requirement of the Long-Term Care Home Service Accountability Agreements in the HNHB LHIN;
- ACE is a member of the Toronto Central LHIN Alternate Level of Care Task Force on Transition and Flow;
- ACE is working with the Advance Care Planning Education Program - Waterloo Wellington at Hospice Waterloo to provide education on informed consent, advance care planning, and patients' rights in nine sessions directed to the general public, to long-term and community care providers, to hospital staff and administration, to local lawyers and investment counsellors, and to a roundtable of leadership in various organizations in that region; and,

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[1] Judith Wahl, Mary Jane Dykeman and Brendan Gray, Law Commission of Ontario: January 2014, online:<http://www.lco-cdo.org/capacity-guardianship-commissioned-paper-ace-ddo.pdf>

[2] Judith Wahl. Mary Jane Dykeman, and Tara Walton, Law Commission of Ontario: to be published December 2016.

[3] Lisa Romano and Jane Meadus, Law Commission of Ontario: August 2009. online:< http://www.lco-cdo.org/older-adults-commissioned-paper-ace.pdf>

- ACE has worked with Hospice Palliative Care Ontario for the last two years as a member of their Leadership Table and the Health Care Consent and Advance Care Planning Community of Practice to help health practitioners, researchers, hospitals, LTCHs, and the public better understand and promote health care consent and advance care planning in Ontario.

Given ACE's experience over the years of working on patient advocacy and health law and policy issues as they affect older adults in Ontario and across Canada, we trust that our submissions concerning the proposed changes to the Ontario health care system will be of assistance.

ISSUE 1: Maintaining the Independence of the Application Process and Ensuring Equitable Access to Home Care, Placement to LTCHs, Supportive Housing, Chronic Care and Rehabilitation

1.1: Independence in Home Care

COMMENTS: Bill 41 transfers responsibility for the provision of "health and related social services and supplies and equipment for the care of persons in home, community and other settings" and of "goods and services to assist caregivers in the provision of care for such persons" from CCACs to LHINs. However, this transfer of power also comes with the ability to delegate the authority to a third party. The Bill permits the Board of a LHIN to delegate "any of its powers or duties under this Act or any other Act to such person or persons as the board considers appropriate and may impose conditions and restrictions with respect to the delegation",[4] save in very specific circumstances such as on integration, investigation and deeming service agreements. Nothing in the Bill stops the Board from delegating its authority on home care to a hospital for example.

[4] Bill 41, *An Act to amend various Acts in the interests of patient-centred care,* Sess. 2, 41st Parl, 2016, cl. 7(1)

This transfer of power would eliminate the independence presently enjoyed by CCACs over these functions, which would be detrimental to the rights and interests of older adults and to the rights and interests of persons in need of CCAC services generally throughout Ontario.

Under the current system, CCACs are responsible for authorizing and arranging the provision of nursing, physiotherapy, speech language pathology, occupational therapy, respiratory therapy, social work service, and personal support services to persons in need of these services in their homes.[5] These services are provided by service providers, with whom CCACs have service agreements.[6] These patients may be living in the community with a chronic illness or disability, waiting for admission to a LTCH, or been discharged from acute care either to recuperate at home or wait for admission to a LTCH. Many of these patients are chronically ill or frail elderly persons.

The CCACs' role in home care has been the subject of criticism,[7] concerns which are shared by ACE. Nevertheless, by eliminating CCACs and allowing delegation of their duties, ACE submits that the legislation erodes the important goal of independent administration of home care.

For example, it has been argued that hospitals could be delegated authority for home care. Many argue that such delegation should occur, given that patients are already being assessed in hospital and this would reduce the number of assessments. However, acute care hospitals are under significant pressure to discharge hospital patients as quickly as possible. We already have many cases where the hospital's efforts to discharge a patient as quickly as possible have resulted in disregard for the patient's requirements for post-hospital care. At present, CCACs are independent of hospital administration, and their duty is to ensure that post-hospital care arrangements, including

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[5] *Home Care and Community Services Act, 1994*, S.O. 1994, c. 26, s. 2
[6] *Ibid.*, ss. 2 and 4
[7] Office of the Auditor General of Ontario, *Community Care Access Centres – Financial Operations and Service Delivery,* Special Report (September 2015), online: <http://www.auditor.on.ca/en/reports_en/CCACs_en.pdf>, p. 5 and 77

home care, are made respecting the patient's needs, not those of the hospital. In ACE's experience, to ensure the primacy of the patient's needs and wishes, it is vital that these administrative functions remain independent from one another to ensure proper post-hospital care and maintain patient choice.

Even with the independence in the current system, we find that patients discharged from hospital continue to struggle with arrangements for post-hospital home care. For example, ACE receives frequent calls from patients who are advised that a home care assessment cannot be completed for them while they are in hospital. However, this is untrue, and prevents a safe transition from hospital to home with home care. With no assessment prior to discharge, the patient returns home without the necessary care and equipment, or without even knowing about their eligibility for said care or equipment. Patients and their families are told that they must simply "trust" that eligibility will be determined and that the services and equipment will be both available and sufficient. Unfortunately, it is not uncommon for patients to be left languishing for days at home before they are assessed and services and supports are put into place. ACE strongly believes that these policies are due to pressures from the hospital to maintain patient flow and free up beds in hospital.

Further, should hospitals be allowed to manage some aspects of home care, we submit that it would increase the inequity in the utilisation of home care dollars. Home care dollars are presently used to a greater extent to return hospital patients home, rather than to provide sufficient services to allow patients to live safely in the community. Such pressure is placed on the home care system to care for patients post-hospital, to the detriment of those who could be cared for in the community. Patients are discharged when they actually require long-term care, so that high levels of home care are required. This has the ripple effect of making fewer dollars available to those who are living at home, which may culminate in those patients being admitted to hospital.

ACE fears that this situation will be worsened if entities such as hospitals were allowed to be responsible for applications for home care. For these reasons, it is imperative that the

authority to designate patients as requiring home care be separate and independent from hospitals. In fact, the Expert Group on Home and Community Care similarly recommended that a lead agency under the LHINs coordinate the delivery of home and community care within each LHIN, but did not recommend that these be hospitals.[8] We submit that this independence must be strengthened in order to provide true patient-centered care in the home care sector.

RECOMMENDATION: Amend Bill 41 to provide that the object of providing health and related social services cannot be delegated, other than to a LHIN subregion, as follows:

> **Restrictions on delegation**
>
> (2.3) Despite subsection (2.2), a board of directors may not delegate any power under the following provisions of this Act:
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> 1. Subsection 20 (8) and clause 20 (11) (c).
> 2. Clause 25 (2) (a).
> 3. Section 26.
> 4. Section 27.
> 5. Subsection 5 (m.1).

1. 2: Equitable Access to Home Care

COMMENTS: The Bill does not guarantee equitable access to home care services across the LHINs. This was one of the chief criticisms of the Auditor General's report, which identified that the amount of personal support services a person receives and, in fact, whether a person receives service at all, depends greatly on where the person lives.[9]

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[8] Report of the Expert Group on Home & Community Care, *Bringing Care Home* (January 30, 2015), online:< http://health.gov.on.ca/en/public/programs/ccac/docs/hcc_report.pdf >, p. 27

[9] Office of the Auditor General of Ontario, *2015 Annual Report of the Office of the Auditor General of Ontario,* section 3:01, "CCACs – Community Care Access Centres", online:<http://www.auditor.on.ca/en/reports_en/en15/3.01en15.pdf>, p. 77. There have been complaints about a lack of co-ordination, a concern about the significant expenditures going to indirect care costs rather than direct patient service, inconsistency in service and a lack of accountability. ACE has received many calls and has provided support to clients facing these very issues.

Moreover, supports to caregivers were not consistently available across Ontario.[10] The Report found that the inequity in service levels among CCACs resulted from a significant variance in per client funding for home care among CCACs.[11] ACE's experience corroborates this inequity in access to personal support services, nursing services, therapies and home care equipment.

As alluded to in the previous section, mentioned above, ACE has also observed a disparity between the types of clients who are able to access home care services while in the community. In our experience, home care is more readily available to patients who are being discharged from hospital rather than those who have remained in their homes, despite similar or greater needs. The reason for the inequity is due to hospital bed pressures, requiring people to be discharged back into the community at a much faster rate, as well as the lack of long-term care beds which results in patients being forced home, rather than going to a LTCH from hospital. The difference is not, in our submission, related to the actual care needs of the clients. Such an approach is inequitable and short-sighted; it exacerbates the condition of people in need of home care in the community, with the result being an admission to hospital which might otherwise have been avoided.

RECOMMENDATION: We support the inclusion of cl. 4(2) of Bill 41, which adds the following section to the *Local Health System Integration* Act:

> (2) Section 5 of the Act is amended by adding the following clause:
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> (e.1) to promote health equity, reduce health disparities and inequities, and respect the diversity of communities and the requirements of the French Language Services Act in the planning, design, delivery and evaluation of services;

To support this goal, we submit that Bill 41 be amended to include a review of the legislation in three years, particularly targeted towards ensuring equitable access to services across all regions of Ontario, as follows:

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[10] *Ibid.*, p. 78
[11] *Ibid.*, p. 77

Review of Act

39.1. A committee of the Legislative Assembly shall,

(a) begin a comprehensive review of this Act and the regulations made under it no later than three years from the date that subsection 5 (m.1) enters into force regarding the equitable provision of community services within and as between LHINs and their subregions.

(b) within one year after beginning that review, prepare a report setting out the findings of the review and make recommendations to the Assembly concerning amendments to this Act and the regulations made under it.

1. 3: Independence from Hospitals in the Long-Term Care Application Process

COMMENTS: While home care is vital to Ontario health care, it must be recognized that not everyone can remain in the community, even with supports. Persons who meet the legislated requirements as set out in the *LTCHA* and its regulations, such as requiring 24-hour nursing care and having needs which cannot be met by publicly funded community-based services, have the right to apply to and be admitted to LTCHs.[12] Bill 41 proposes to add managing "the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the *Home Care and Community Services Act, 1994"* to the objects of the LHINs.[13] This is an important function that is now performed by CCACs, which LHINs will now take over.

ACE is concerned about the effect on patients if the independence of this application and placement function were to be lost. In the first nine months of 2016, ACE received approximately 500 calls on behalf of hospital patients who, despite requiring long-term care, are effectively being forced to leave to reside in inappropriate community settings

[12] O. Reg. 79/10, s. 155
[13] Bill 41, *supra,* note **Error! Bookmark not defined.**, cl. 4(3)(m. 2)

rather than go from hospital directly into a LTCH. These community settings, whether at home or in a retirement home, do not meet patients' care needs and in addition, may require that patients and their families spend large amounts of money on private health care. This is an untenable option for most people and contrary to their right to publicly funded health care. These "discharges" occur despite the right of a person to apply for long-term care if eligible, and to move from one health care facility to another, i.e. hospital to long-term care.

For a patient to be eligible for admission to a LTCH, it must have been determined that:

- They require that nursing care be available on site 24 hours a day,
- They require, at frequent intervals throughout the day, assistance with activities of daily living, or
- They require, at frequent intervals throughout the day, on-site supervision or on-site monitoring to ensure his or her safety or well-being; and,
- The publicly-funded community-based services available to the person and the other caregiving, support or companionship arrangements available to the person are not sufficient, in any combination, to meet the person's requirements; and,
- That the person's care requirements can be met in a LTCH.[14]

By definition, therefore, when a person is determined to be eligible for long-term care, they have been identified as a person who cannot be properly cared for in the community. For this reason, a person cannot be discharged from hospital to a place that cannot meet their care needs, cannot be forced to take on the risks associated with such a decision, cannot be required to pay privately for health care, and their family or other third parties cannot be required to take care of this person.

Nevertheless, misinformation about discharge from hospital is endemic. Hospital staff often attempt to prohibit patients from making applications to long-term care while the patient is in hospital, and attempt to coerce them to move into unsafe situations. Tactics

[14] O Reg. 79/10, *supra*, note 12, s. 155

are used to require patients to choose idle LTCH beds by threatening to charge high per diems (often over $1,000.00 per day) or threatening to take away the authority of substitute decision-makers who refuse to take the patient home. The legislative maximum that can be charged to patients awaiting long-term care admission from the hospital is presently the chronic care co-payment rate of $58.99 per day.[15] Despite the legislative requirements in the *LTCHA*, hospital employees often continue to be the sole arbiters of the discharge process, demanding that family take care of elderly relatives when they are unable to do so, blocking applications for long-term care, and insisting that patients reside in retirement homes although the patient actually requires long-term care.

Retirement homes are often not appropriate options for these patients where they require long-term care, as retirement homes are residential tenancies, not health facilities and have limited regulation relating to the health services made available. Health services at retirement homes are not paid for by public health dollars but are primarily private pay. The result is that retirement homes may not be able to provide the amount of care needed by these patients, and if they do, it is at significant cost which must be borne by the patient or their families. This results in patients and their families paying privately for what should be publicly funded health care. Patients and their families are told to mortgage their homes, cash out RRSPs, and otherwise liquidate assets in order to pay these fees, resulting in a two-tiered medical system being borne by seniors. It must also be understood that retirement homes are not "private nursing homes" and are neither equivalent to or alternatives to provincially funded and regulated long term care homes. Nevertheless, all too often we find that hospital staff promotes the use of retirement homes as such to encourage people to take them as an option, even where they are not appropriate and, in fact, could be dangerous to the health and safety of the patient.

If there is no independent agency responsible for placement to long-term care, ACE fears that this situation will escalate. In ACE's experience, hospitals have an inherent conflict of interest in participating in the long-term care admission process, as their focus has

[15] R.R.O. 1990, Reg. 552, s. 10(6)

become patient flow rather than ensuring the safe discharge of patients. While we understand the pressures on the system, this cannot be accomplished by failing to meet the needs of patients who require long-term care admission.

The power regarding admission to long-term care should similarly not be delegated to LTCHs. In the past, when this authority was allotted to LTCHs, some homes would choose patients who did not have significant care needs, or choose patients who they felt met their "vision" of the home. For example, patients with behavioural issues or wandering tendencies are presently very hard to place within the LTCH system. If LTCHs were permitted to take applications directly, these patients would likely not be offered placements; LTCHs may be motivated to select patients who do not require additional staff and resources. The *LTCHA* was specifically drafted to take the admission process away from LTCHs because of a history of such mismanagement. At present, even with the CCAC involvement, many residents are turned down contrary to the legislation. Unfortunately, these applicants are not aware of their rights to challenge these refusals, and oversight on these issues is inadequate. Continuing to maintain independence from LTCHs is extremely important given that long-term care is a publicly funded health service which should be equally available to all qualified Ontario residents.

RECOMMENDATION: Amend Bill 41 to provide that the object of managing placement into long-term care cannot be delegated, other than to a LHIN subregion, as follows:

Restrictions on delegation

(2.3) Despite subsection (2.2), a board of directors may not delegate any power under the following provisions of this Act:

1. Subsection 20 (8) and clause 20 (11) (c).
2. Clause 25 (2) (a).
3. Section 26.
4. Section 27.
5. Subsection 5 (m.2).

1. 4 Admission to Rehabilitation and Complex Continuing Care Facilities

ACE supports the inclusion of section 4(3) of Bill 41, amending the *Local Health System Integration Act as follows:*

> (3) Section 5 of the Act is amended by striking out "and" at the end of clause (m) and by adding the following clauses:
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> ...
>
> (m.2) to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994;

Admission into chronic care (also known as complex continuing care), and rehabilitation is presently up to the hospital and its staff. Each facility has its own internal process, and reasons for admission and/or refusal are often vague or non-existent. There is little equity in the system, and many patients are refused for inappropriate reasons, such as not having a fixed address to return to, that they have been diagnosed with dementia, etc. What the system requires is a clear process for such placement, as well as clear criteria for admission to either rehabilitation or complex continuing care in Ontario. A further complication is that some LHINs appear to have no complex continuing care facilities or beds at all and in other areas, complex continuing care is being transformed into other types of care, such as "slow stream" rehabilitation. As there are specific legal designations for these beds under the *Public Hospitals Act*,[16] and financial consequences to the patients pursuant to the regulations to the *Health Insurance Act*,[17] it important to know exactly what these beds are, how they are being used, and the expectations for the care they can provide.

There is a gap in the health care system for patients who are truly complex and require complex or chronic care. These patients have care needs that are too high for long-term care, but are no longer appropriate for acute care hospital settings as they do not have

[16] R.S.O. 1990, c P. 40, s. 32.1.
[17] Reg. 552, *supra,* note 15, s. 10.

acute care needs. Unfortunately, the trend has been away from "residential" complex continuing care to a system where admission to these facilities is viewed as temporary, resulting in many of these patients being urged to go to long-term care where their needs cannot be met. LTCHs have become the catch-all designation for all persons who require care, even when it is inappropriate, due to budget restrictions and hospital overcrowding. Patients with ventilators, for example, are unlikely to be properly cared for in long-term care, both because of the higher skill level necessary in their care, and also because of the high demand on resources required. Care requirements include frequent suctioning, cleaning and care of the vented patient, which care far exceeds that of most long-term care residents. LTCHs are not adequately funded to provide this high level of care; nevertheless, they are being asked to take on these patients. At times, due to lack of beds in complex care, these patients may remain in an acute care hospital as "Alternate Level of Care" patients although they have no discharge destination.[18] Complex continuing care should be an option for these patients.

The lack of clear criteria for admission has led to discriminatory practices. ACE receives a significant number of calls from older adult patients who have been denied access to rehabilitation hospitals specifically. One of the reasons proffered is that these persons may not be able to go home after treatment and may require long-term care admission or some other form of assisted living. The motive appears to be that if these patients do not recover well enough to go home, they cannot be discharged and the facility will not be able to provide the bed to another patient. However, this reasoning is blatantly discriminatory under the Ontario *Human Rights Code.* The patient is being discriminated against in the provision of medical service for reasons of disability and age.[19] Further, this is contrary to the principal of universality under the *Canada Health Act.*[20] A patient should not be denied rehabilitation opportunities merely because they have a discharge destination that may not be available to them as yet.

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[18] See "Alternate Levels of Care (ALC) Patient Definition", *Ministry of Health and Long-Term Care,* online: http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/alc_definition.aspx
[19] *Human Rights Code*, R.S.O. 1990, c. H.19, ss. 1 and 9 to 11
[20] R.S.C., 1985, c. C-6

Applications to these facilities are not transparent, and who can apply and who will be admitted is a mystery. Given that this is a publicly funded system, legislative guidance is required to ensure that these systems and processes are transparent and equitable.

RECOMMENDATION: Amend Bill 41 to include the power to make regulations under the *Local Health System Integration Act*, 2006 detailing the application process to complex continuing care and rehabilitation hospitals, as follows:

> 37.2 The Lieutenant Governor in Council may make regulations respecting detailing the application process to complex continuing care and rehabilitation hospitals under subsection 5 (m.2).

ISSUE 2: Establishing LHIN Subregions and Supporting Patient Choice

2. 1. Ensuring the Borders of LHIN Subregions are Drawn Effectively

COMMENTS: Clause 14.1 of Bill 41 provides that the LHINs will establish subregions. ACE recognizes the importance of these subregions as some of the LHINs represent very large areas of Ontario and would benefit from local planning and integration of services. However, it is unclear how these subregions will be established and whether these subregions can overlap between LHINs or existing health networks, in the event that these geographic delineations do not align with how people access health care services. For example, the area of Etobicoke in Toronto is part of four different CCACs: Central, Toronto Central, Central West, and Mississauga Halton. Patients in Etobicoke are often confused as to which LHIN or CCAC they should access. ACE argues that this lack of continuity will be replicated under Bill 41 if the present LHIN boundaries continue or LHIN subregions cannot straddle two LHINs. LHIN geographic areas should be amended or subregions should be drawn based on functionally effective borders that people can easily access and understand.

RECOMMENDATION: LHIN subregions should be drawn through an active community mapping exercise with substantial community participation and consultation so that they can reflect actual communities and regions across Ontario, rather than just being available to the public once they have been decided,[21] by amending Bill 41 as follows.

> 2. (1) Subsection 3 (4) of the Act is amended by adding the following clause:
> (b.1) change the geographic area of one or more local health integration networks following public consultations in each of the LHINs;
> ...
>
> 14.1 (1) Each local health system integration network shall establish geographic subregions in its local health system for the purposes of planning, funding and integrating services within those geographic subregions based on public consultation.

2. 2. Ensuring Patient Mobility

COMMENTS: While the creation of LHIN subregions are intended to provide patients with a local centre for their health care concerns, there should not be any restriction on mobility of patients outside the subregions. While the expectation is that the subregion provides information about services to the public[22] and co-ordinate services, the services offered should not be limited to services available in the LHIN in which the patient is situated. This is particularly the case where a particular specialist is required for complex cases. ACE strongly supports Bill 41's clear statement that a LHIN should not enter into an arrangement that "restricts or prevents an individual from receiving services based on the geographic area in which the individual resides."[23] This will ensure that the patient can continue to access services from providers of their choice.

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[21] Bill 41, *supra,* note 4, cl. 14.1(2)
[22] Bill 41, *supra,* note 4, cl. 4(3) m.3
[23] *Ibid.,* cl. 20.1(1)

ISSUE 3: Ensuring Accountability for Patient Care

3. 1: LHIN Powers to Ensure Accountability

COMMENTS: ACE applauds the new accountability measures that are included in Bill 41. One of the major critiques of the LHINs in the 2015 Auditor General of Ontario's report is that the Ministry should have greater oversight over the LHINs.[24] The Auditor General advises that the Ministry should communicate best practices, assist in analyzing causes of persistent problems and ensure that reasonable timeframes are established for change.[25] Giving the Ministry the ability to issue operational or policy directives to local health integration networks [26] and to use their powers to investigate the LHIN by appointing investigators to investigate and report on the quality of the management of the LHIN is a first step in ensuring accountability. It is vital that these powers be used in a robust fashion, not just where there are complaints or issues identified. Regular investigations will help the Ministry identify potential issues and recommend corrective action, being able to build on some experience from other LHINs as well. For these reasons, the Ministry should conduct annual investigations of LHINs.

RECOMMENDATION: Amend Bill 41 to include annual investigations of LHINs, as follows:

> 12.1(1) The Minister shall appoint one or more investigators to investigate and report on the quality of the management and administration of a local health integration network, or any other matter relating to a local health integration network, at least once a year and more frequently where the Minister considers it in the public interest to do so.

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[24] Office of the Auditor General of Ontario, *2015 Annual Report of the Office of the Auditor General of Ontario,* section 3:08, "LHINs – Local Health Integration Networks", online:<http://www.auditor.on.ca/en/reports_en/en15/3.08en15.pdf>, p. 331
[25] *Ibid.,* p. 332
[26] Bill 41, *supra,* note **Error! Bookmark not defined.**, cl. 11.1

COMMENTS: ACE has identified that Bill 41 differs from the previous parliament's Bill 210 in a significant way. Bill 41 now exempts public hospitals from the health service providers to which LHINs can issue operational and policy directives and to which LHINs can appoint a person as a health service provider supervisor.[27]

Bill 41 also exempts LTCHs from these provisions, which is logical given that the *LTCHA already* includes a mechanism for inspections directly by Ministry of Health and Long-Term Care staff, both annually and pursuant to complaints. Inspection reports and orders by the Ministry resulting from the inspections must be posted within the LTCH, and the Ministry publishes the reports on-line. Unfortunately, at present, there is no similar oversight of public hospitals in Ontario.

Under Bill 41, while hospitals are not exempt from the LHINs' power to investigate, exempting them from the LHINs' authority to issue operational and policy directives limits the ability of LHINs to make broad-based change and will exacerbate the lack of oversight. For example, if a LHIN discovers an issue during an investigation of a particular hospital, it cannot then issue a directive to all other hospitals to ensure that this problem is not being replicated in other settings.

Further, the ability to appoint a hospital supervisor was also important, which would be determined by the LHIN as and when necessary. This power is integral to the LHIN should there be an emergency situation in a public hospital which the LHIN felt jeopardized the public interest. While the fear may be that hospital autonomy may be threatened, the decision to exempt public hospitals from LHIN oversight removes an important tool for LHINs to review and correct errors where they exist in public hospitals. Hospitals are publicly funded institutions, answerable to the community and the province. Failing to provide LHINs with the tools to address issues with hospitals as they arise is not patient centred care.

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[27] *Ibid.*, cl. 21.2

RECOMMENDATION: Amend Bill 41 to remove the exemption of public hospitals from receiving operational and policy directives from the LHINs, as follows:

> 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.
>
> (2) Subsection (1) does not apply to a licensee within the meaning of the *Long-Term Care Homes Act, 2007*.
>
> ...
>
> 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 when it considers it to be appropriate to do so in the public interest.
>
> (2) This section does not apply with respect to a health service provider that is a licensee within the meaning of the *Long-Term Care Homes Act, 2007*.

COMMENTS: ACE is concerned about another change observed between Bill 210 to Bill 41: that Bill 41 now requires LHINs to provide notice to the health service provider of its intention to appoint an investigator prior to the investigator's appointment.[28] We submit that this limits the ability of investigators to conduct investigations, as the health service provider will be able to prepare for the visit. We have been in many health facilities where signs are posted to advise staff of accreditation reviews, and we have no doubt that preparation and care during that period is geared towards that review. It is our position that to notify the hospital in advance of the appointment of an investigator would similarly limit the ability of the investigator to capture a true picture of the health services being provided, rather than an experience which has been managed by the hospital. This change will limit the effectiveness of the investigations.

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[28] Bill 41, *supra*, note 4, cl. 21.1(3)

RECOMMENDATION: Bill 41 should be amended to remove the notice provisions regarding investigations of health service providers, as follows:

> (3) Before appointing an investigator, the local health integration network shall not be required to give notice of its intention to appoint an investigator to the Minister and the health service provider.

3.2. Public posting of the reports

COMMENTS: Bill 41 seeks to make every directive, standard, and every report of an investigator or supervisor available to the public. However, the legislation is not clear on the format that public reporting will take. The availability of these documents is vital to ensuring that the public is aware of concerns with health service providers so that members of the public can make informed choices about their health care.

An example of public reporting in health care is in the long-term care sector. The *LTCHA* requires that every licensee of a LTCH post "copies of the inspection reports from the past two years for the long-term care home", and "orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years".[29] These reports and orders must be available "in a conspicuous and easily accessible location"[30] and must be communicated to residents who cannot read the information.[31] These reports are also published by the Ministry of Health and Long-Term Care and available in a central location online. Such specificity on what information to post ensures that the information will be available to all who need it, and most importantly available to persons who are receiving care from the health service provider, not just those who have access to the Internet. Public reporting also serves as a catalyst of change, as hospitals will be aware of what the issues are, and will be more likely to change due to pressure from both the LHIN and the community at large.

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[29] *LTCHA*, S.O. 2007, c. 8, ss. 79 (3) (k) and (l)
[30] *Ibid.*, 79(1)
[31] *Ibid.*, 79(2)

RECOMMENDATION: Amend Bill 41 to specify that the directives and reports be posted at a public location in the offices of the health service provider and online, as follows:

> 22.1: (1) In this part, "required information" means the directives under subsections 11.1(5), 11.2(7), 12.1(9), 13.1(9), 20.2(9), 21.1(12) and 21.2(12).
> (2) The Minister or the local health integration network, as appropriate, shall make the required information under this part available to the public.
> (3) Every health service provider shall ensure that the required information from the past two years is posted in at the offices of the health service provider, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.
> (4) Every health service provider shall ensure that the required information is communicated, in a manner that complies with any requirements that may be provided for in the regulations, to residents who cannot read the information.

3.3 Protecting Personal Health Information of Patients and Clients

COMMENTS: Bill 41 amends the section on funding and accountability in the *Local Health System Integration Act, 2006,* by excepting section 4(3) of the *Personal Health Information Protection Act, 2004 (PHIPA),*[32] from the definition of personal health information in that section. Subsection 4(3) provides that:

> Personal health information includes identifying information that is not personal health information described in subsection (1) but that is contained in a record that contains personal health information described in that subsection.[33]

It is unclear why this type of personal health information should be exempt from personal health information that would otherwise be protected by the *Local Health System*

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[32] Bill 41, *supra,* note 4**Error! Bookmark not defined.**, cl. 16.1
[33] *PHIPA*, S.O. 2004, c. 3, Sched. A, ss. 4(3)

Integration Act, 2006. Such protection would ensure that that type of information is redacted in publicly available reports by investigators or supervisors or that this information does not find its way into funding applications or LHIN financial reports to the Minister. Other acts with similar reporting requirements, such as the *LTCHA*, do not contain such an exemption.

RECOMMENDATION: Amend Bill 41 to remove the exemption for subsection 4(3) of *PHIPA,* as follows:

> 16.1 In this Part, "personal health information" has the same meaning as in section 4 of the *Personal Health Information Protection Act, 2004.*

3.4. Oversight by an Independent Patient Ombudsman:

COMMENTS: ACE is encouraged by the patient and family advisory committees at the Ministry and the LHIN level, especially as it includes patient perspectives. However, we note that there has been no specific creation of a complaints mechanism within LHINs. This is despite the criticism of the Auditor General that the LHINs lack a common complaint management process and that the LHINs did not follow up appropriately on patient complaints or track them.[34] Although Bill 41 amends the *Excellent Care for All Act, 2010,* which requires that health sector organizations have an internal complaints mechanism, the amendment does not include LHINs as a whole, but only with respect to:

> (i) professional services, personal support services and homemaking services as defined in the *Home Care and Community Services Act, 1994* provided by or arranged by a local health integration network under that Act,
>
> (ii) the placement of a person into,
>
> a. a long-term care home within the meaning of the *Long-Term Care Homes Act, 2007,*
>
> b. a supportive housing program funded by the Ministry of Health and Long-Term Care or a local health integration network under the Home Care and Community Services Act, 1994,
>
> c. a chronic care or rehabilitation bed in a hospital within the meaning of the *Public Hospitals Act*, or

[34] Office of the Auditor General of Ontario, *supra,* note 24, p. 318

d. an adult day program that is provided under the *Home Care and Community Services Act, 1994*, or

(iii) any other services that are prescribed

From this, it is unclear whether LHINs will have to set up a comprehensive complaints process in conjunction with its expanded role.

Further, the Patient Ombudsman, who is responsible for complaints in public hospitals, long-term care and CCACs, will only be responsible for the home and patient care functions of the LHINs under this section. However, there are other powers that the LHIN exercises that the Patient Ombudsman should properly be reviewing. For example, if there is an incident at a hospital and the LHIN failed to conduct an investigation which may have, in the opinion of the Patient Ombudsman, have assisted in alleviating the issue, it would be most effective for the Patient Ombudsman to also provide input to the LHIN about their process.

RECOMMENDATION: Amend Bill 41 to include LHINs, without qualification, as Health Sector Organizations under the *Excellent Care for All Act*, 2010 as follows:

37. (1) Clause (b) of the definition of "health sector organization" in section 1 of the Excellent Care for All Act, 2010 is repealed.

(2) The definition of "health sector organization" in section 1 of the Act is amended by striking out "and" at the end of clause (c) and by adding the following clause:
(c.1) a local health integration network within the meaning of the *Local Health System Integration Act, 2006.*

COMMENTS: In debates regarding Bill 41, it has been argued that the Ontario Ombudsman should continue to have oversight of the LHINs because of the Ontario Ombudsman's independence. This is because, at present, the Patient Ombudsman is an employee of Health Quality Ontario[35] and ultimately answers to the Minister of Health

[35] *Excellent Care for All Act, 2010,* S.O. 2010, c. 14, ss. 13(1)(3)

and Long-Term Care, rather than being an independent officer of the Legislature" like the Ontario Ombudsman.

Bill 41 provides the government with the opportunity to rectify this problem by amending the *Excellent Care for All Act, 2010,* making the Patient Ombudsman independent of the Ministry of Health and Long-Term Care and make her an officer of the Legislature. In this way, Patient Ombudsman would have clear authority, be truly autonomous and the public would be assured of the Patient Ombudsman's independence.

RECOMMENDATION: Amend Bill 41 to make the Patient Ombudsman an independent officer of the legislature, as follows:

37. (9.1) Section 13.1 (1), (3) to (7) of the *Act* is repealed and the following substituted:

13.1 (1) There shall be appointed, as an officer of the Legislature, a Patient Ombudsman to exercise the powers and perform the duties prescribed by this Act.

(2) The Patient Ombudsman shall be appointed by the Lieutenant Governor in Council on the address of the Assembly.

(3) The Patient Ombudsman shall hold office for a term of five years and may be reappointed for a further term or terms, but is removable at any time for cause by the Lieutenant Governor in Council on the address of the Assembly.

(4) The Patient Ombudsman shall devote himself or herself exclusively to the duties of the Patient Ombudsman's office and shall not hold any other office under the Crown or engage in any other employment.

(5) The Patient Ombudsman is not a public servant within the meaning of the Public Service of Ontario Act, 2006.

6. (1) The Patient Ombudsman shall be paid a salary to be fixed by the Lieutenant Governor in Council.

(2) The salary of the Patient Ombudsman shall not be reduced except on address of the Assembly.

(3) The Patient Ombudsman is entitled to be paid reasonable travelling and living expenses while absent from his or her ordinary place of residence in the exercise of the Patient Ombudsman's functions under this *Act*.

(4) The Patient Ombudsman is a member of the Public Service Pension Plan.

(8) Subject to the approval of the Lieutenant Governor in Council, the Patient Ombudsman may employ such employees as the Patient Ombudsman considers necessary for the efficient operation of his or her office and may determine their salary and remuneration and terms and conditions of employment.

37. (9.2) Section 13.5 (1) and (2) of the *Act* is repealed and the following substituted:

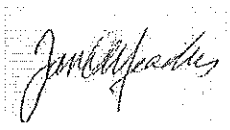
13.5 (1) The Patient Ombudsman shall report to the Legislature on the activities and recommendations of the Patient Ombudsman at least annually, and otherwise as the Patient Ombudsman considers appropriate.

Conclusion

We thank you for the opportunity to provide our submissions in this regard. ACE would be happy to participate in any further consultations or discussions with the Committee.

SUBMITTED ON BEHALF OF THE ADVOCACY CENTRE FOR THE ELDERLY

Graham Webb
Executive Director



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