

2008-2012 H-SAA AMENDING AGREEMENT # 2

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 1st day of April, 2011

B E T W E E N:

NORTH SIMCOE MUSKOKA LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

- AND -

ORILLIA SOLDIERS' MEMORIAL HOSPITAL (the "Hospital")

WHEREAS the LHIN and the Hospital entered into a hospital service accountability agreement that took effect April 1, 2008 and has been amended by agreements made as of April 1, 2010 and April 1, 2011 (the "H-SAA");

AND WHEREAS the Parties acknowledged, in the amending agreement made as of April 1, 2011, that further amendments would be required to the Schedules following the announcement of funding allocations by the Ministry of Health and Long Term Care.

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree as follows:

1.0 Definitions. Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the H-SAA.

2.0 Amendments.

2.1 Agreed Amendments. The Parties agree that the H-SAA shall be amended as set out in this Article 2.

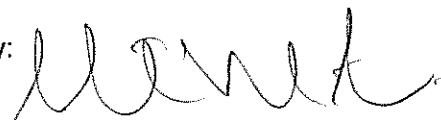
2.2 Schedules.

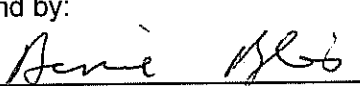
- (a) Schedule B-2 shall be deleted and replaced with Schedule B-2 attached to this Agreement.
- (b) Schedules C-2 shall be deleted and replaced with Schedule C-2 attached to this Agreement.
- (c) Schedules D-2 shall be deleted and replaced with Schedule D-2 attached to this Agreement.
- (d) Schedules G-2 shall be deleted and replaced with Schedule G-2 attached to this Agreement.
- (e) Schedules H-2 shall be deleted and replaced with Schedule H-2 attached to this Agreement.

- 3.0 Effective Date.** The Parties agree that the amendments set out in Article 2 shall take effect on April 1, 2011. All other terms of the H-SAA, those provisions in the Schedules not amended by s. 2.2, above, shall remain in full force and effect.
- 4.0 Governing Law.** This Agreement and the rights, obligations and relations of the Parties will be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable therein.
- 5.0 Counterparts.** This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.
- 6.0 Entire Agreement.** This Agreement together with Schedules B-2, C-2, D-2, G-2 and H-2, constitutes the entire agreement between the Parties with respect to the subject matter contained in this Agreement and supersedes all prior oral or written representations and agreements.

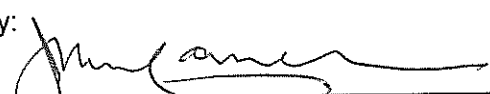
IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.


NORTH SIMCOE MUSKOKA LOCAL HEALTH INTEGRATION NETWORK

By:  Jan. 6, 2012
 Robert Morton, Board Chair Date

And by:  Jan 19, 2012
 Bernie Blais, Chief Executive Officer Date

ORILLIA SOLDIERS' MEMORIAL HOSPITAL

By:  Oct 28/11
 John Cameron, Board Chair Date

And by:  Oct 27/11
 Elisabeth Riley, President and Chief Executive Officer Date

Schedule B2

Performance Obligations for 11/12

1.0 PERFORMANCE CORRIDORS FOR SERVICE VOLUMES AND ACCOUNTABILITY INDICATORS

- 1.1 The provisions of Article 1 of Schedule B apply in Fiscal Year 11/12 with all references to Schedule D being read as referring to Schedule D2.

2.0 PERFORMANCE CORRIDORS FOR ACCOUNTABILITY INDICATORS

- 2.1 The provisions of Article 2 of Schedule B, as amended by B1, apply in Fiscal Year 11/12 subject to the following amendments:

- (a) new sub articles 2.7, 2.8 and 2.9 shall be added as set out below;

2.7 90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients

- a) Definition. The total emergency room (ER) length of stay (LOS) where 9 out of 10 admitted patients completed their visits. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ER.

Steps:

- 1: Calculate ER LOS in hours for each patient.
- 2: Apply inclusion and exclusion criteria.
- 3: Sort the cases by ER LOS from shortest to highest.
- 4: The 90th percentile is the case where 9 out of 10 admitted patients have completed their visits.

Excludes:

1. ER visits where Registration Date/Time and Triage Date/Time are both missing;
2. ER visits where Left ER Date/Time and Disposition Date/Time are both missing;
3. ER visits where patients are over the age of 125 on earlier of triage or registration date;
4. Negative ER LOS (earlier of registration or triage after date/time patient left ER);
5. Duplicate records within the same functional centre where all data elements have the same values, except Abstract ID number;
6. Non-Admitted Patients (Disposition Codes 01 – 05 and 08 – 15); and
7. Admitted Patients (Disposition Codes 06 and 07) with missing patient left ER Date/Time.

b) LHIN Target

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance
- (ii) For hospitals performing above the LHIN's Accountability Agreement target:
Performance Target: To be negotiated locally taking into consideration contribution to the MLPA target

c) Performance Corridor

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: equal to or less than the LHIN's Accountability Agreement target
- (ii) For hospitals performing above the LHIN's Accountability Agreement target:
Performance Corridor: 10%

2.8 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients

- a) Definition. The total emergency room (ER) length of stay (LOS) where 9 out of 10 non-admitted complex (Canadian Triage and Acuity Scale (CTAS) levels I, II and III) patients completed their visits. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves ER.

Steps

1. Calculate ER LOS in hours for each patient.
2. Apply inclusion and exclusion criteria.
3. Sort the cases by ER LOS from shortest to highest.
4. The 90th percentile is the case where 9 out of 10 non-admitted patients have completed their visits.

Excludes:

1. ER visits where Registration Date/Time and Triage Date/Time are both missing;
2. ER visits where Left ER Date/Time and Disposition Date/Time are both missing;
3. ER visits where patients are over the age of 125 on earlier of triage or registration date;

4. Negative ER LOS (earlier of registration or triage after date/time patient left ER);
5. Duplicate records within the same functional centre where all data elements have the same values;
6. ER visits identified as the patient has left ER without being seen (Disposition Codes 02 and 03);
7. Admitted Patients (Disposition Codes 06 and 07);
8. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with assigned CTAS IV and V;
9. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with missing CTAS; and
10. Transferred Patients (Disposition Codes 08 and 09) with missing patient left ER Date/Time.

b) LHIN Targets

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target. maintain or improve current performance
- (ii) For hospitals performing above the LHIN's Accountability Agreement target with Pay for Results Funding:
Performance Target. To be negotiated locally taking into consideration contribution to the LHIN's Accountability Agreement target

c) Performance Corridors

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor. equal to or less than the LHIN's Accountability Agreement target
- (ii) For hospitals performing above the LHIN's Accountability Agreement target:
Performance Corridor. 10%

2.9 90th Percentile ER Length of Stay for Non-admitted Minor Uncomplicated (CTAS IV-V) Patients

- a) Definition. The total emergency room (ER) length of stay (LOS) where 9 out of 10 non-admitted minor/uncomplicated (Canadian Triage and Acuity Scale (CTAS) levels IV and V) patients completed their visits. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ER.

Steps

1. Calculate ER LOS in hours for each patient.
2. Apply inclusion and exclusion criteria.
3. Sort the cases by ER LOS from shortest to highest.
4. The 90th percentile is the case where 9 out of 10 non-admitted patients have completed their visits.

Excludes:

1. ER visits where Registration Date/Time and Triage Date/Time are both missing;
2. ER visits where Left ER Date/Time and Disposition Date/Time are both missing;
3. ER visits where patients are over the age of 125 on earlier of triage or registration date;
4. Negative ER LOS (earlier of registration or triage after date/time patient left ER);
5. Duplicate records within the same functional centre where all data elements have the same values;
6. ER visits identified as the patient has left ER without being seen (Disposition Codes 02 and 03);
7. Admitted Patients (Disposition Codes 06 and 07);
8. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with assigned CTAS I, II and III;
9. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with missing CTAS; and
10. Transferred Patients (Disposition Codes 08 and 09) with missing patient left ER Date/Time.

b) LHIN Target

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance
- (ii) For hospitals performing above the LHIN's Accountability Agreement target:
Performance Target: To be negotiated locally taking into consideration contribution to the LHIN's Accountability Agreement target

c) Performance Corridor

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target
- (ii) For hospitals performing above the LHIN's Accountability Agreement target with Pay for Results Funding:
Performance Corridor: 10%

and

(b) All references to Schedule D1 shall be read as referring to Schedule D2.

3.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO NURSING ENHANCEMENT/CONVERSION

3.1 The provisions of Article 3 of Schedule B, as amended by B1 apply in Fiscal Year 11/12 subject to the following amendments:

- (a) subsection 3.1 and 3.2(b) shall be deleted; and
- (b) all references to Schedule D1 shall be read as referring to Schedule D2.

4.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO CRITICAL CARE

4.1 The provisions of Article 4 of Schedule B, as amended by B1, apply in Fiscal Year 11/12 subject to the following amendments:

- (a) references to “2010/11” shall be read as referring to “2011/12”; and
- (b) all references to Schedule E1 shall be read as referring to Schedule E2.

5.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO POST CONSTRUCTION OPERATING PLAN FUNDING AND VOLUME

5.1 The provisions of Article 5 of Schedule B, as amended by B1, apply in Fiscal Year 11/12, subject to the following amendments:

- (a) references to Schedule F1 shall be read as referring to Schedule F2; and
- (b) references to “2010/11” shall be read as referring to 2011/12.

6.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO PROTECTED SERVICES

6.1 The Performance Obligations set out in Article 6 of Schedule B, as amended by B1, apply in Fiscal Year 11/12, subject to the following amendments:

- (a) All references to Schedule D1 or Schedule G1 shall be read as referring to Schedules D2 and G2 respectively; and
- (b) All references to “2010/11” shall be read as referring to “2011/12”

7.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO WAIT TIME SERVICES

7.1 The Performance Obligations set out in Article 7 of Schedule B, as amended by B1 apply to Fiscal Year 11/12 subject to the following amendments.

- (a) Sub article 7.2 shall be amended with the addition of the following eight new sub paragraphs (c)-(i):
 - (c) **90th Percentile Wait Times for Cancer Surgery**

- (i) Definition. This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the “90th percentile patient”. If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the “90th percentile patient” is the indicator value

Excludes:

1. Procedures no longer required;
2. Diagnostic, palliative and reconstructive cancer procedures;
3. Procedures on skin - carcinoma, skin-melanoma, and lymphomas;
4. Procedures assigned as priority level 1;
5. Wait list entries identified by hospitals as data entry errors; and
6. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

(ii) LHIN Targets

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Target: Accountability Agreement target or better

(iii) Performance Corridors

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Corridor: 10%

(d) **90th Percentile Wait Times for Cardiac Bypass Surgery**

(i) Definition. 90th percentile wait times for cardiac bypass surgery. This indicator measures the time between a patients' acceptance for bypass surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait time is an actual wait time of a patient and is not estimated. Waiting periods are counted from the date a patient was accepted for bypass surgery by the cardiac service or cardiac surgeon.

Includes: Elective patients who have been accepted for bypass surgery who are Ontario residents.

Excludes: Time spent investigating heart disease before a patient is accepted for a procedure. For example, the time it takes for a patient to have a heart catheterization procedure before being referred to a heart surgeon is not part of the waiting time shown for heart surgery.

(ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding
Performance Target: the LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Corridor: 10%

(e) 90th Percentile Wait Times for Cataract Surgery

- (i) Definition. This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the “90th percentile patient”. If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the “90th percentile patient” is the indicator value.

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors; and
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

(ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:

Performance Target: maintain or improve current performance

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Target: The LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Corridor: 10%

(f) **90th Percentile Wait Times for Joint Replacement (Hip)**

- (i) Definition. This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom.)
3. Count the total number of cases and multiply by 0.90 to get the "90th percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90th percentile patient" is the indicator value.

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;

3. Wait list entries identified by hospitals as data entry errors; and
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

(ii) LHIN Target.

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Target: the LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Corridor: 10%

(g) 90th Percentile Wait Times for Joint Replacement (Knee)

- (i) Definition.** This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90th percentile patient". If this value

has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).

4. The number of wait days for the “90th percentile patient” is the indicator value

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors; and
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients’ wait days. These are considered data entry errors.

(ii) LHIN Target

1. For hospitals performing at the LHIN’s Accountability Agreement target or better:
Performance Target: maintain or improve current performance
2. For hospitals performing above the LHIN’s Accountability Agreement target with incremental wait time funding:
Performance Target: the LHIN’s Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN’s Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN’s Accountability Agreement target
2. For hospitals performing above the LHIN’s Accountability Agreement target with incremental wait time funding
Performance Corridor: 10%

(h) 90th Percentile Wait Times for Diagnostic Magnetic Resonance Imaging (MRI) Scan

- (i) Definition. This indicator measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted. This interval is typically referred to as ‘intent to treat’. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the “90th percentile patient”. If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the “90th percentile patient” is the indicator value

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors;
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients’ wait days. These are considered data entry errors; and
5. As of January 1, 2008, diagnostic imaging cases classified as specified date procedures (timed procedures).

(ii) LHIN Target

1. For hospitals performing at the LHIN’s Accountability Agreement target or better:
Performance Target: maintain or improve current performance
2. For hospitals performing above the LHIN’s Accountability Agreement target with incremental wait time funding:
Performance Target: the LHIN’s Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN’s Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN’s Accountability Agreement target

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Corridor: 10%

(i) 90th Percentile Wait Times for Diagnostic Computed Tomography (CT) Scan

- (i) Definition. This indicator measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted. This interval is typically referred to as 'intent to treat'. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90th percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90th percentile patient" is the indicator value

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors;
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors; and
5. As of January 1, 2008, diagnostic imaging cases classified as specified date procedures (timed procedures).

ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:

Performance Target: maintain or improve current performance

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding: *Performance Target:* the LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better: *Performance Corridor:* less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding: *Performance Corridor:* 10%

and

- (b) All references to Schedules A, G, or H being read as referring to Schedules A1, G2 or H2 respectively.

8.0 REPORTING OBLIGATIONS

8.1 The reporting obligations set out in Article 8 of Schedule B, as amended by B1, apply to Fiscal Year 11/12.

8.2 The following reporting obligations are added to Article 8 of Schedule B:

(a) **French Language Services.** If the Hospital is required to provide services to the public in French under the provisions of the *French Language Services Act*, the Hospital will be required to submit a French language implementation report to the LHIN. If the Hospital is not required to provide services to the public in French under the provisions of the *French Language Service Act*, it will be required to provide a report to the LHIN that outlines how the Hospital addresses the needs of its local Francophone community.”

9.0 LHIN SPECIFIC PERFORMANCE OBLIGATIONS

9.1 Except where specifically limited to a given year, the obligations set out in Article 9 of Schedule B, as amended by B1, apply to Fiscal Year 11/12. Without limiting the foregoing, waivers or conditional waivers for 08/09, 09/10 and 10/11 do not apply to 11/12.

9.2

(a)

- i. The hospitals will be required to report on the obligations and expectations listed in Table 1 and the indicators listed in Table 2. Non-acute hospitals will report only on relevant indicators.

Table 1

LHIN Specific Performance Obligation	Definition
Risk Management Plans	HSP Boards must ensure that an established and documented Risk Management Process is in place such that risks are identified and reported to the LHIN when there is a moderate or serious risk of impact on the achievement of the Accountability Agreements.
Client Experience	HSP's will provide the LHIN with a summary of the satisfaction survey results required under section 5 of the Excellent Care for all Act. The summary will include overall client satisfaction and overall satisfaction of employees and others working for the HSP.
Falls Prevention and Reduction Program	<p>HSPs will ensure that a falls prevention and reduction program is established for at-risk clients. The program will be aligned with the LHIN-wide Integrated Regional Falls Program. Minimum requirements of this program will include:</p> <ul style="list-style-type: none"> • The identification of individuals at risk for falls • The collection of information about the number of clients experiencing falls, falls resulting in harm, falls resulting in ER visits, and falls resulting in inpatient admissions • A strategy to reduce the number of falls resulting in harm
Wound Care	HSPs will ensure that risk identification and prevention activities to address Wound Care in alignment with the NSM LHIN Guidelines for Wound Care and that data is collected and reported to the LHIN.
Reporting of Clinical Data Submissions to CIHI and MOHLTC	HSPs will ensure that all clinical data submission timelines for CIHI submission are adhered to.

LHIN Specific Performance Expectation	Definition
Care Connections Participation	<p>HSPs are expected to collaborate with system partners and Local Leadership Councils to implement the 12 Areas of Focus for Care Connections.</p> <p>HSPs will ensure Senior Management or delegate representation at all meetings for Care Connections oversight structures as agreed to between the HSP and the LHIN, and other meetings that may be scheduled from time to time as appropriate.</p>

Table 2

LHIN Specific Indicator	Definition
Total ALC Days (as reported by NSM LHIN Hospitals)	<p>Total number of inpatient days designated as ALC in a given time period</p> <p>Includes:</p> <ol style="list-style-type: none"> 1. Data from acute care hospitals, including those with psychiatric beds (AP hospitals) and without psychiatric beds (AT hospitals) 2. Individuals designated as ALC <p>Excludes:</p> <ol style="list-style-type: none"> 1. Newborns and stillborns 2. Records with missing or invalid "Discharge Date"
Average (mean) length of stay for ALC patients	<p>Total number of inpatient days designated as ALC in a given time period divided by the total number of discharges designated ALC</p> <p>Includes:</p> <ol style="list-style-type: none"> 1. Data from acute care hospitals, including those with psychiatric beds (AP hospitals) and without psychiatric beds (AT hospitals) 2. Individuals designated as ALC <p>Excludes:</p> <ol style="list-style-type: none"> 1. Newborns and stillborns 2. Records with missing or invalid "Discharge Date"
Proportion of Diabetics getting HbA1c testing	<p>The percentage of ambulatory care diabetic patients age 18 and older who have received hemoglobin A1C (HbA1C) tests within the appropriate guideline period.</p> <p>Includes:</p> <ul style="list-style-type: none"> • Number of unique patients age >18 registered with Hospital Diabetic Education Centers <p>Excludes:</p> <ul style="list-style-type: none"> • women with gestational diabetes
Proportion of Diabetics getting LDL testing	<p>The percentage of ambulatory care diabetic patients age 18 and older who have received a lipoprotein-cholesterol LDL-C test within the appropriate guideline period.</p> <p>Includes:</p> <ul style="list-style-type: none"> • Number of unique patients age >18 registered with Hospital Diabetic Education Centers <p>Excludes:</p> <ul style="list-style-type: none"> • women with gestational diabetes
Proportion of Diabetics getting Retinal Exams	<p>The percentage of ambulatory care diabetic patients age 18 and older who have received retinal eye exams within the appropriate guideline period</p> <p>Includes:</p> <ul style="list-style-type: none"> • Number of unique patients age >18 registered with Hospital Diabetic Education Centers <p>Excludes:</p> <ul style="list-style-type: none"> • women with gestational diabetes

LHIN Specific Indicator	Definition
Proportion of Diabetics with Diabetes in Control (HbA1c <=7)	<p>The percentage of ambulatory diabetic patients age 18 and older who have received hemoglobin A1C (HbA1C) test with a measurement value of less than or equal to 7.0%.</p> <p>Includes:</p> <ul style="list-style-type: none"> • Number of unique patients age >18 registered with Hospital Diabetic Education Centers <p>Excludes:</p> <ul style="list-style-type: none"> • women with gestational diabetes
Total number of Falls among clients (patients)	A count of the total number of occurrences of falls among those clients presenting at the Emergency Room.
Total numbers of Falls resulting in harm (Severity of Harm Scale)	<p>Number of harmful falls that take place in hospital each month that are categorized as a 2, 3, 4, 5, or 6 on the severity of harm scale which ranges from "Temporary Harm" to "Death".</p> <p>Includes:</p> <ul style="list-style-type: none"> • Category 1 = No Harm to the patient/client. May require temporary monitoring to ensure no harm has occurred. • Category 2 = Temporary harm to the patient/client and required intervention. • Category 3 = Temporary harm to the patient/resident and required initial or prolonged hospitalization • Category 4 = Permanent consequences to the patient/client • Category 5 = Intervention necessary to sustain life • Category 6 = Death
Total numbers of clients visiting a hospital ER due to a fall in the last 90 days	Total numbers of clients visiting a hospital ER due to a fall in the last 90 days.
Total numbers of clients being admitted to a hospital following a fall in the last 90 days	Total numbers of clients being admitted to a hospital following a fall in the last 90 days.
Pressure Ulcer Prevalence	Total number of inpatients with a new pressure ulcer (stage 2 or higher)

- ii. The hospitals will be required to report to the LHIN according to the schedule in Table 3.

Table 3

LHIN Specific Performance Obligation	Frequency of reporting	Due Dates
Risk Management Plans	Annual (once) – any change to be reported to the LHIN	July 31, 2011
Client Experience	Annual	June 30, 2012
Falls Prevention and Reduction Program	Quarterly	July 31, 2011
Wound Care	Quarterly	October 31, 2011
Reporting of Clinical Data Submissions to CIHI and MOHLTC	Quarterly	January 31, 2012 April 30, 2012
LHIN Specific Indicators		
Total ALC Days (as reported by NSM LHIN) Hospitals	Quarterly	July 31, 2011 October 31, 2011 January 31, 2012 April 30, 2012
Reduction in Average (mean) length of stay for ALC patients	Quarterly	
Proportion of Diabetics getting HbA1c testing	Quarterly	
Proportion of Diabetics getting LDL testing	Quarterly	
Proportion of Diabetics getting Retinal Exams	Quarterly	
Proportion of Diabetics with Diabetes in Control (HbA1c <=7)	Quarterly	
Total numbers of Falls among clients (patients)	Quarterly	
Total numbers of Falls resulting in harm (Severity of Harm Scale)	Quarterly	
Total numbers of clients visiting a hospital ER due to a fall in the last 90 days	Quarterly	
Total numbers of clients being admitted to a hospital following a fall in the last 90 days	Quarterly	
Pressure Ulcer Prevalence	Quarterly	

- iii. Orillia Soldiers' Memorial Hospital Targets and Corridors are listed in Table 4. Each hospital agrees on their individual target for the reduction in total ALC days.

Table 4

LHIN Specific Indicator	Performance Target	Corridor and Reporting Variance
Total ALC Days* Hospital = ORILLIA SOLDIERS' MEMORIAL HOSPITAL	Reduction of a minimum 480 ALC days per fiscal year from FY 2010/11 totals	Quarterly reductions of 120 ALC days per quarter +/- 15 ALC days
Average (mean) length of stay for ALC patients	Year 1 - Explanatory Indicator	
Proportion of Diabetics getting HbA1c testing	Year 1 - Explanatory Indicator	Hospitals with Diabetes Education Centers (DECs)
Proportion of Diabetics getting LDL testing	Year 1 - Explanatory Indicator	Hospitals with Diabetes Education Centers (DECs)
Proportion of Diabetics getting Retinal Exams	Year 1 - Explanatory Indicator	Hospitals with Diabetes Education Centers (DECs)
Proportion of Diabetics with Diabetes in Control (HbA1c <=7)	Year 1 - Explanatory Indicator	Hospitals with Diabetes Education Centers (DECs)
Total numbers of Falls among clients	Year 1 - Explanatory Indicator	
Total numbers of Falls resulting in harm (Severity of Harm Scale)	Year 1 - Explanatory Indicator	
Total numbers of clients visiting a hospital ER due to a fall in the last 90 days	Year 1 - Explanatory Indicator	
Total numbers of clients being admitted to a hospital following a fall in the last 90 days	Year 1 - Explanatory Indicator	
Pressure Ulcer Prevalence	15.0% reduction	

(b) Reporting in a template agreed by LHIN and hospitals will be submitted to the LHIN according to the schedule in section 9.3 (a) (ii).

(c) The LHIN may ask for supplementary reporting as and when the LHIN will deem

required.

(d) The LHIN may ask for more details and/or supporting documents as and when the LHIN will deem required.

* Please refer to the NSM LHIN ALC Background document for details

Hospital Multi-Year Funding Allocation

Schedule C2 2011/12

Hospital		2011/12 Approved Allocations	
ORILLIA Soldiers' Memorial		Base	One-Time
Fac #	745		
Operating Base Funding		97,917,000	
Multi-Year Funding Incremental Adjustment		1,297,600	
Other Funding			
Funding adjustment - High Growth		239,100	
Funding adjustment - ER Pay for Results			777,200
Funding adjustment - LHIN-wide Complex Continuing Care (CCC)			241,750
Funding adjustment - Chronic Care Co-Payment			7,400
Funding Adjustment - RICN Base Transfer Annualization Adj.		(125,000)	
Funding Adjustment - Nurse-Led Outreach Team (NLOT)			250,000
Funding adjustment - OTN Telemedicine Nurse		53,138	
Prior Years' Payments			
Critical Care Strategies Schedule E			
PCOP: Schedule F			
PCOP		1,397,400	
Stable Priority Services: Schedule G			
Chronic Kidney Disease			
Cardiac catheterization			
Cardiac surgery			
Organ Transplantation*			
Provincial Strategies: Schedule G			
Organ Transplantation			
Endovascular aortic aneurysm repair			
Electrophysiology studies EPS/ablation			
Percutaneous coronary intervention (PCI)			
Implantable cardiac defibrillators (ICD)			
Daily nocturnal home hemodialysis			
Provincial peritoneal dialysis initiative			
Newborn screening program			
Specialized Hospital Services: Schedule G			
Cardiac Rehabilitation			
Visudyne Therapy			
Total Hip and Knee Joint Replacements (Non-WTS)			
Magnetic Resonance Imaging			
Regional Trauma			
Regional & District Stroke Centres			
Sexual Assault/Domestic Violence Treatment Centres			
Provincial Regional Genetic Services			
HIV Outpatient Clinics			
Hemophilic Ambulatory Clinics			
Permanent Cardiac Pacemaker Services			
Provincial Resources			
Bone Marrow Transplant			
Adult Interventional Cardiology for Congenital Heart Defects			
Cardiac Laser Lead Removals			
Pulmonary Thromboendarterectomy Services			
Thoracoabdominal Aortic Aneurysm Repairs (TAA)			
Health Results (Wait Time Strategy): Schedule H			
Selected Cardiac Services			
Total Hip and Knee Joint Replacements			158,300
Cataract Surgeries			
Magnetic Resonance Imaging (MRI)			624,000
Computed Tomography (CT)			93,800
Total Additional Base and One Time Funding		2,862,238	2,152,450
Total Allocation		102,931,688	

Allocations not provided in this schedule for 2011/12 will be provided to hospitals in subsequent planning cycles. Hospitals should assume, for planning purposes, funding for similar volumes (as in 2010/11) for Priority Services in out-years.

Performance Indicators

Schedule D2 2011/12

Hospital

Fac #

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
PERSON EXPERIENCE: Access, Safe, Effective, Person-Centred			
Accountability Indicators			
90th Percentile ER LOS for Admitted Patients	Hours	<input type="text" value="24.30"/>	<input type="text" value="24.3-26.73"/>
90th Percentile ER LOS for Non-admitted Complex Patients	Hours	<input type="text" value="5.60"/>	<input type="text" value="5.6-6.8"/>
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated Patients	Hours	<input type="text" value="3.40"/>	<input type="text" value="3.4-4.0"/>
Explanatory Indicators			
Emergency Department Activity	Weighted Cases		
Emergency Department Vists	Visits		
30-day readmission of patients with stroke or transient ischemic attack (TIA) to acute care for all diagnoses	Percentage		
Percent of stroke patients discharged to rehabilitation	Percentage		
Percent of stroke patients managed on a designated stroke unit	Percentage		
Wait Time Volumes (Per Schedule H2)	Cases		
Rehabilitation Separations	Separations		
ORGANIZATIONAL HEALTH: Efficient, Appropriately Resourced, Employee Experience, Governance			
Accountability Indicators			
Current Ratio (consolidated)	Ratio	<input type="text" value="0.18"/>	<input type="text" value=">0.16"/>
Total Margin (Consolidated)	Percentage	<input type="text" value="0.00"/>	<input type="text" value="0%"/>
Explanatory Indicators			
Total Margin (Hospital Sector Only)	Percentage		
Percentage Full Time Nurses	Percentage		
Percentage Paid Sick Time	Percentage		
Percentage Paid Overtime	Percentage		
SYSTEM INTEGRATION: Integration, Community Engagement, eHealth			
Explanatory Indicators			
Percentage ALC Days	Days		
Repeat Unplanned Emergency Visits within 30 days for Mental Health Conditions	Visits		
Repeat Unplanned Emergency Visits within 30 days for Substance Abuse Conditions	Visits		
GLOBAL VOLUMES			
Accountability Indicators			
Total Acute Activity, incl. Inpatient and Day Surgery*	Weighted Cases	<input type="text" value="10,700"/>	<input type="text" value="10,000-11,300"/>
Complex Continuing Care	RUG Weighted Patient Days	<input type="text" value="15,000"/>	<input type="text" value=">12,750"/>
Mental Health	Inpatient Days	<input type="text" value="7,130"/>	<input type="text" value=">6,410"/>
ELDCAP	Inpatient Days	<input type="text" value=""/>	<input type="text" value=""/>
Rehabilitation	Inpatient Days	<input type="text" value="2,800"/>	<input type="text" value=">2,380"/>
Ambulatory Care***	Visits	<input type="text" value="87,000"/>	<input type="text" value=">69,600"/>

* Global volumes based on CIHI Case mix Group (CMG)+ methodology and RIW weights.
 **Volume Performance Indicators under Global Volumes vary in application based on hospital type.
 ***Ambulatory Care includes OHRS Primary account codes 7134* (excluding 7134055), 712*, 7135*,715* OHRS secondary statistical account codes:447*,450*,5* (excluding 50*,511*,512*,513*,514*,518*,519*,521*)

Protected Services

Schedule G2 2011/12

Hospital

Fac #	<input type="text" value="745"/>		
	Units of Service	2011/12 Interim Performance Target	2011/12 Performance Standard
Stable Priority Services			
Chronic Kidney Disease	Weighted Units	<input type="text" value="62,000"/>	<input type="text" value="62,000"/>
Cardiac catheterization	Procedures	<input type="text"/>	<input type="text"/>
Cardiac surgery	Weighted Cases	<input type="text"/>	<input type="text"/>
Provincial Strategies			
Organ Transplantation* Endovascular aortic aneurysm repair Electrophysiology studies EPS/ablation Percutaneous coronary intervention (PCI) Implantable cardiac defibrillators (ICD) Daily nocturnal home hemodialysis Provincial peritoneal dialysis initiative Newborn screening program	Cases	<input type="text"/>	<input type="text"/>
Specialized Hospital Services			
Cardiac Rehabilitation	Number of patients treated	<input type="text"/>	<input type="text"/>
Visudyne Therapy	Number of insured Visudyne vials administered	<input type="text"/>	<input type="text"/>
Total Hip and Knee Joint Replacements (Non-WTS)	Number of Implant Devices	<input type="text" value="59"/>	<input type="text" value="59"/>
Magnetic Resonance Imaging	Hours of operation	<input type="text" value="2,080"/>	<input type="text" value="2,080"/>
Regional Trauma	Cases	<input type="text"/>	<input type="text"/>
Regional & District Stroke Centres Sexual Assault/Domestic Violence Treatment Centres Provincial Regional Genetic Services HIV Outpatient Clinics Hemophiliac Ambulatory Clinics Permanent Cardiac Pacemaker Services			
Provincial Resources			
Bone Marrow Transplant Adult Interventional Cardiology for Congenital Heart Defects Cardiac Laser Lead Removals Pulmonary Thromboendarterectomy Services Thoracoabdominal Aortic Aneurysm Repairs (TAA)			

* Organ Transplantation - Funding for living donation (kidney & liver) included as part of organ transplantation funding. Hospitals are funded retrospectively for deceased donor management activity, reported and validated by the Trillium Gift of Life Network.

Note: Additional accountabilities assigned in Schedule B, B1, B2

Funding and volumes for these services should be planned for based on 2010/11 approved allocations. Amendments, pursuant to section 5.2 of this Agreement, may be made during the quarterly submission process.

Wait Time Services

Schedule H2 2011/12

Hospital

Fac # <input type="text"/>	2010/11 Funded		2011/12 Funded	
	Base Volumes	Incremental Volumes*	Base Volumes	Incremental Volumes **
Selected Cardiac Services	Refer to Schedule G for Cardiac Service Volumes and Targets			
Total Hip and Knee Joint Replacements (Total Implantations)	59	46	59	23
Cataract Surgeries (Total Procedures)				
Magnetic Resonance Imaging (MRI) (Total Hours)	2,080	1,914	2,080	2,400
Computed Tomography (CT) (Total Hours)	2,277	385	2,277	375

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
90th Percentile Wait Times for Cancer Surgery	Days		
90th Percentile Wait Times for Cardiac Surgery	Days		
90th Percentile Wait Times for Cataract Surgery	Days		
90th Percentile Wait Times for Hip Replacement Surgery	Days	182	10%***
90th Percentile Wait Times for Knee Replacement Surgery	Days	182	10%***
90th Percentile Wait Times for MRI Scan	Days	90	10%***
90th Percentile Wait Times for CT Scan	Days	28	10%***

* The 2010/11 Funded volumes are as a reference only

** Once negotiated, an amendment will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in Schedule B,B1, B2. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement.

*** For hospitals performing at the LHIN's Accountability Agreement target or better, Performance Corridor: less than or equal to Accountability Agreement target. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding, Performance Corridor:10%