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:

CENTRAL LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

STEVENSON 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.

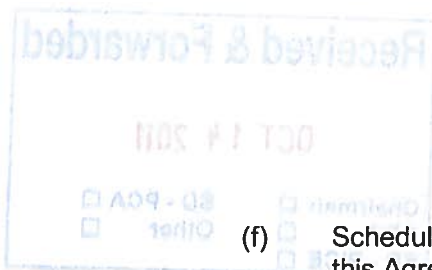
(a) Schedule B-2 shall be deleted and replaced with Schedule B-2 attached to this Agreement.

(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 E-2 shall be deleted and replaced with Schedule E-2 attached to this Agreement.

(e) Schedules F-2 shall be deleted and replaced with Schedule F-2 attached to this Agreement.



(f) Schedules G-2 shall be deleted and replaced with Schedule G-2 attached to this Agreement.

(g) 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, E-2, F-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.

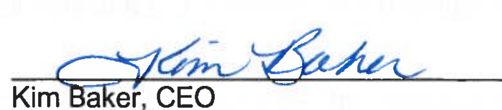
IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

CENTRAL LOCAL HEALTH INTEGRATION NETWORK

By:

John Langs, Chair — Date

And by:



Kim Baker, CEO

Date

STEVENSON MEMORIAL HOSPITAL

By:

Scott Anderson, Chair — Date: OCT 6 2011

And by:

Gary Ryan, CEO — Date: OCT. 6, 2011

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) <u>LHIN Target</u>

(i) For hospitals performing at the LHIN's Accountability Agreement target or better:
PerformanceTarget: 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) <u>Performance Corridor</u>

(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 t 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:
   PerformanceTarget: 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)) <u>Definition</u>. 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) <u>LHIN Target</u>

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.

9.0 LHIN SPECIFIC PERFORMANCE OBLIGATIONS

9.1 The obligations set out in Article 9 of Schedule B1, are replaced by the following provisions which apply to Fiscal Year 2011/12. Without limiting the foregoing, waivers or conditional waivers for 08/09, 09/10 and 10/11 do not apply to 11/12.

9.2. Accountability Indicators

The LHIN and hospital have mutually agreed upon performance targets and performance corridors for 2011/12 as detailed in Schedules D2 and H2. As such, the determination of *LHIN Targets* and *Performance Corridors* as outlined in Articles 2.7, 2.8, 2.9 and 7.1of Schedule B2 do not apply.

Surgical and Diagnostic Volumes	Hospital Funded Incremental Volumes	Central LHIN Funded Volumes
Cataract Surgery	-	-
Hip Replacement Surgery	-	-
Knee Replacement Surgery	-	-
Diagnostic MRI Hours	-	-
Diagnostic CT Hours	390	351

(a) The Hospital shall be considered to perform the hospital funded volumes first, and the Central LHIN funded volumes subsequently. The Central LHIN will recover the funding for Central LHIN funded volumes which were not achieved.

9.3. Hospital Annual Planning Submission Schedules (WERS forms)

The 2011-12 WERS forms focus on service planning and the measurement and evaluation of Hospital services and organizational performance. Data submitted by hospitals in the WERS forms is an integral part of the Hospital performance expectations in exchange for LHIN funding. Roll up of this information at a LHIN level is also essential for system local planning.

(a) The Hospital shall provide the LHIN with a monthly plan for the next 6 months (October 2011 to March 2012) which supports the annual amount in the WERS forms for the Clinical Activity and Patient Services and HAA Performance Indicators.

(b) The Hospital shall notify the LHIN in advance of implementing any planned changes that will affect the monthly amounts in the WERS forms noted in (a) above.

(c) With respect to the monthly plan required in (a), the Hospital shall notify the LHIN of any results variances greater than 5% within 30 days after the month end. The Hospital shall also notify the LHIN if at any time the Hospital is in a year-to-date deficit position.

9.4. E-health

In support of the Provincial e-Health strategy the Hospital will comply with any technical and information management standards, including those related to architecture, technology, privacy and security, set for the health service providers by the MOHLTC or the LHIN with the timeframes set by the MOHLTC or the LHIN as the case may be.

The expectation is that any compliance requirements will be rolled out reasonably. In addition the level of available resources will be considered in any required implementations.

9.5 Quality

Hospitals are required to submit a copy of their Quality Improvement Plan to the LHIN prior to submission to Health Quality Ontario.

9.6 Health Equity and Community Engagement

The Hospital will provide the LHIN an annual Health Equity and an annual Community Engagement Plan by November 30, 2011.

The hospital and LHIN will collaborate to determine the contents of the plans. Specifically with respect to community engagement, the hospital will comply with the Central LHIN *Health Service Provider Community Engagement Checklist* as appropriate when undertaking community engagement activities.

9.7 Peer Accountability, Integration and Long-Term Solutions to Advance the Local Health System

The Hospital will continue to work collaboratively with other hospitals, other health service providers and with the Central LHIN to advance the strategic direction of the local health system as outlined in the Integrated Health Service Plan.

The Hospital will consult with the LHIN as appropriate when developing plans and setting priorities for the delivery of its health services.

From time to time, the LHIN may establish special purpose committees or working groups to support the advancement of LHIN and provincial priorities for which equitable representation from the Hospital will be sought.

9.8 Capital Initiatives

When planning for capital initiatives, the Hospital will comply with the requirements outlined in the Ministry of Health & Long-Term Care's *Capital Planning Manual* (1996) and *MOHLTC-LHIN Joint Review Framework for Early Capital Planning Stages* (2010), as may be updated or amended from time to time. In this context, "capital initiatives" refer to initiatives of the Hospital in relation to the construction, renewal or renovation of a facility or site. As outlined in

the 2010 *Joint Review Framework* document, the approval process and eligibility criteria for "Own Funds" capital initiatives (those project that require no capital from the Ministry or the LHIN) are currently determined by the Ministry.

9.9 Ontario Renal Network

The Hospital will collaborate with the Ontario Renal Network and comply with their requirements related to dialysis services and funding.

9.10 ALC Management

In support of the Provincial ED/ALC priority to improve patient access to care the Hospital agrees that it will show progress in the achievement of percentage ALC rate of 17.97%, which represents a 3% absolute improvement over 2010/11 (20.97%).

For the purpose of this indicator, determination of the Hospital's ALC performance will be adjusted for factors beyond the Hospital's control, such as wait lists for long-term care, long-term care outbreak conditions, etc.

9.11 Current Ratio

In consideration for reducing the hospital's 2011/12 current ratio performance target to 0.7, the hospital will provide the LHIN with a two (2) year cash flow forecast and plan to return the hospital's current ratio to within the provincial performance standard of 0.8 to 2.0.

Hospital Multi-Year Funding Allocation

Schedule C2 2011/12

Hospital: ALLISTON Stevenson Memorial

Fac #: 596

	2011/12 Planning Allocation Assumed, Not Approved	
	Base	One-Time
Operating Base Funding	$ 18,238,100	
Multi-Year Funding Incremental Adjustment		
Other Funding		
Funding adjustment 1 (Funding Formula)	$ 275,700	
Funding adjustment 2 (High Growth)	$ 97,800	
Funding adjustment 3 (Small Hospital)	$ 76,500	
Funding adjustment 4 (Excellent Care for All Act)*		$ 64,300
Funding Adjustment 5 (CT)		$ 87,750
Funding Adjustment 6 (Municipal Taxes)		$ 5,775
Critical Care Stategies Schedule E		
PCOP: Schedule F		
PCOP		
Stable Priority Services: Schedule G		
Chronic Kidney Disease		
Cardiac catherization		
Cardiac surgery		
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		
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)		
Health Results (Wait Time Strategy): Schedule H		
Wait Time Strategy - General Surgery		$ 74,200
Wait Time Strategy - Paediatric Surgery		$ 20,200
Wait Time Strategy - Computed Tomography (CT)		$ 64,800
Emergency,Room - Pay for Results		$ 469,500
Total Additional Base and One Time Funding	$ 450,000	$ 786,525
Total Allocation	$ 18,688,100	$ 786,525

* Subject to reconciliation and recovery of unspent funds

Performance Indicators

Schedule D2 2011/12

Hospital ALLISTON Stevenson Memorial

Fac # 596

	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	18.90	≤ 18.9
90th Percentile ER LOS for Non-admitted Complex Patients	Hours	6.70	≤ 6.70
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated Patients	Hours	4.40	≤ 4.4
Explanatory Indicators			
Emergency Department Activity	Weighted Cases		
Emergency Department Visits	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	0.70	0.70 - 2.0
Total Margin (Consildated)	Percentage	0.00%	0.00%
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	2,528	2,275 - 2,781
Complex Continuing Care	RUG Weighted Patient Days	0	0
Mental Health	Inpatient Days	0	0
ELDCAP	Inpatient Days	0	0
Rehabilitation	Inpatient Days	0	0
Ambulatory Care***	Visits	22,294	> 16,721

* 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*)

Critical Care Funding

Schedule E2 2011/12

Hospital ALLISTON Stevenson Memorial

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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 or B2. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement

Post-Construction Operating Plan Funding and Volume

Schedule F2 2011/12

Hospital ALLISTON Stevenson Memorial

TBD. This section has been intentionally left blank

Once negotiated, an amendment (Sch F2.1) 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 or B2. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement

Protected Services

Schedule G2 2011/12

Hospital ALLISTON Stevenson Memorial

Fac # 596

	Units of Service	2011/12 Interim Performance Target	2011/12 Performance Standard
Stable Priority Services			
Chronic Kidney Disease	Weighted Units	TBD	TBD
Cardiac catherization	Procedures	N/A	N/A
Cardiac surgery	Weighted Cases	N/A	N/A
Provincial Strategies			
Organ Transplantation*	Cases	N/A	N/A
Endovascular aortic aneurysm repair			
Electrophysiology studies EPS/ablation			
Percutaneous coronary intervention (PCI)			
Implantable cardiac defibrillators (ICD)			
Daily nocturnal home hemodialysis			
Provincial peritoneal dialysis initiative			
Newbom screening program			
Specialized Hospital Services			
Cardiac Rehabilitation	Number of patients treated	N/A	N/A
Visudyne Therapy	Number of insured Visudyne vials administered	N/A	N/A
Total Hip and Knee Joint Replacements (Non-WTS)	Number of Implant Devices	N/A	N/A
Magnetic Resonance Imaging	Hours of operation	N/A	N/A
Regional Trauma	Cases	N/A	N/A
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,B3

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 ALLISTON Stevenson Memorial

Fac # 596

	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)	0	0	0	0
Cataract Surgeries (Total Procedures)	117	0	117	0
Magnetic Resonance Imaging (MRI) (Total Hours)	0	0	0	0
Computed Tomography (CT) (Total Hours)	0	341	1,308	259

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
90th Percentile Wait Times for Cancer Surgery	Days	N/A	N/A
90th Percentile Wait Times for Cardiac Surgery	Days	N/A	N/A
90th Percentile Wait Times for Cataract Surgery	Days	38	≤ 38
90th Percentile Wait Times for Hip Replacement Surgery	Days	N/A	N/A
90th Percentile Wait Times for Knee Replacement Surgery	Days	N/A	N/A
90th Percentile Wait Times for MRI Scan	Days	N/A	N/A
90th Percentile Wait Times for CT Scan	Days	34	≤ 34

+ Exclude LHIN-funded one-time volumes