COMMUNITY ANNUAL PLANNING SUBMISSIONS (CAPS) GUIDELINES

(FINAL)

Version: October 08, 2008

Note: CAPS Guidelines are subject to change. The Multi-Sectoral Accountability Agreement (M-SAA) takes precedence where there is conflict between these Guidelines and the M-SAA.

1. Introduction

The introduction of 14 Local Health Integration Networks ("LHINs") is a key component of the provincial government's plan to improve the delivery of health care. On April 1, 2007, LHINs assumed full responsibility for planning, funding and integrating health services in their geographic areas pursuant to the terms of the *Local Health System Integration Act, 2006* ("LHSIA"). As a result of this devolution of authority from the Minister of Health and Long-Term Care (the "Minister") the LHINs assumed the Minister's rights and obligations under substantially all of the current funding and accountability agreements with health services providers ("HSPs").

It is a requirement of LHSIA that a LHIN must have a service accountability agreement (SAA) in place with each HSP that it funds. Regulation - O. Reg. 279/07 Exemptions - sets out the timetable by which the funding agreements that were assigned by the Minister to the LHIN will be replaced with SAAs. Public and private hospitals have SAAs effective April 1, 2008. These SAAs are called "hospital service accountability agreements" or H-SAAs.

SAAs for the community health centre (CHC), community care access centre (CCAC), mental health and addiction (MH & A) and community support service (CSS) sectors will take effect on April 1, 2009. These SAAs are called the "multi-sectoral service accountability agreements" or M-SAAs.

In order to facilitate the negotiation of the M-SAAs with HSPs in the CHC, CCAC, MH & A and CSS sectors, each HSP will be required to submit a planning document known as the Community Annual Planning Submission (CAPS).

The CAPS, and the M-SAA that will be negotiated, will cover a two year period. The purpose of these guidelines is to assist HSPs in the CHC, CCAC, MH & A and CSS sectors to complete the 2009–11 CAPS. Central themes of the CAPS are service planning, measurement and evaluation of health services, and organizational performance. The CAPS together with the M-SAA form the basis of a multi-year funding and planning framework. This framework supports the province's efforts to enhance stability and accountability of the health system by providing a more sustainable financial footing and facilitating alignment of the provision of health services.

1.1 LHSIA, 2006

The LHSIA provides the underpinnings for the new accountability relationship between LHINs and the community health service sector. The purpose of the LHSIA is to provide for an integrated health system that will improve the health of Ontarians through (i) better access to high quality health services; (ii) coordinated health care in local health systems and across the province; and (iii) effective and efficient management of the health system at the local level.

LHIN Funding and the Accountability Agreement with the Ministry of Health and Long-Term Care (MOHLTC): The LHINs' relationship to the province is set out in the LHSIA and in a Memorandum of Understanding between each LHIN and the Minister. Funding for the LHINs is provided by the MOHLTC on terms set out in an agreement between the Minister of the MOHLTC and the LHINs, and referred to in the LHSIA as the accountability agreement.

The MOHLTC-LHIN Accountability Agreement (MLAA) sets out, among other items:

a. Performance goals and objectives for the LHIN and the local health system:
b. Performance standards, targets and measures for the LHIN and the local health system;
c. Requirements for the LHIN to report on its performance and that of the local health system;
d. A requirement that the LHIN provide a plan for spending the funding that the LHIN receives from the MOHLTC (the Annual Service Plan); and
e. A progressive performance management process.

Health Service Provider (HSP) *Funding and Service Accountability Agreements (SAAs):* The LHSIA also provides that a LHIN may provide funding to an HSP in respect of the services that the HSP provides in, or for, the geographic area of the LHIN. Funding must be provided on terms and conditions that (a) the LHIN considers appropriate; and that (b) are in accordance with (i) the funding that the LHIN receives from the MOHLTC; (ii) the LHINs accountability agreement with the MOHLTC, and (iii) any other requirements that may be set out in regulations under the LHSIA.

SAAs are subject to the terms of the *Commitment to the Future of Medicare Act, 2004* and must establish one or more of:

a. Performance goals and objectives, roles and responsibilities, service quality, accessibility of services, related health human resources, performance management framework, shared and collective responsibilities for health system outcomes, consumer and population health status, value for money, consistency, and other prescribed matters;
b. A plan and a timeframe for achieving the items noted in clause (a);
c. Requirements for reporting and the provision of information, excluding personal information;
d. Any other matter prescribed by regulation; and
e. The standards and measures to be used with respect to the items noted in clauses (a) to (d).

1.2 CAPS GUIDELINES

These CAPS guidelines are intended to facilitate the completion of the CAPS and highlight the connection between the MOHLTC-LHIN Accountability Agreement, the CAPS and the M-SAAs that will be executed with HSPs. It is important to recognize and appreciate this connection. By aligning the performance objectives of health service providers with the performance objectives for the local health system, the provincial goal of a transformed, integrated and sustainable health system can be realized.

Link to *Local Health System Integration Act, 2006*:

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm

Link to *Commitment to the Future of Medicare Act, 2004*:

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04c05_e.htm

2. Key Planning Considerations for the CAPS and M-SAA

2.1 Changes to Approach, Process and Tools

The 2009-11 M-SAAs will begin a new relationship between HSPs and the LHINs. The table below sets out the major changes between the old funding agreements and the new M-SAAs.

MOHLTC Funding Agreement	CAPS & LHIN M-SAA
Focus on operational oversight.	Focus on performance and accountability.
Focus on organizational activities.	Focus on the system and deliverables with an emphasis on collaboration, cooperation and integration activities within the LHIN.
Agreements linked to activity measures.	Agreements linked to performance/outcome measures.
Agreements aligned with provincial planning and priorities	Agreements aligned with provincial planning and priorities and LHIN Integrated Health Service Plan (IHSP).
Agreement between HSP and MOHLTC.	Agreement between health service provider and LHIN.
Annual agreement (currently ‘evergreen’).	Two year agreement.
Ad hoc operational change proposals.	Standard pre-proposal submissions to be reviewed by LHINs as part of the CAPS process and throughout the year.
Different terms and conditions for each health care sector.	Consistent approach for all health care sectors.

2.2 Principles Guiding the Process

The requirements of the multi-year funding, planning and accountability framework will continue to evolve and change to reflect the changing nature of the health care system within which HSPs and LHINs are now operating. Steps have been taken, and will continue over the coming years, to align the CAPS and M-SAA process more closely with the local LHIN integration priorities and provincial strategic directions.

The 2009-11 CAPS introduces a number of significant changes that reflect a more strategic, performance-based approach to funding and managing the health care system, but this first two-year period is transitional. The CAPS and the M-SAA do not yet capture all elements of the

new model. A legacy of existing funding policies, incomplete Ontario Healthcare Reporting Standards implementation, and the need to test and refine a suite of reliable performance measures requires a hybrid of old and new rules and reporting requirements. As the system evolves and is simplified, so will the CAPS and the M-SAA.

It should be noted that each HSP is responsible for any internal and external communications plan required to explain its CAPS. These communication plans must present information in a spirit of cooperation with its partners, including the LHIN.

HSPs should consider the following principles when preparing their submission and engaging their local and regional partners.

a. Accountability

- The CAPS is owned and managed by the HSP.
- The CAPS will inform the negotiation of the M-SAA between the LHIN and the HSP.
- The LHINs will provide guidance, approve and monitor the performance obligations of the M-SAA.
- HSPs will be accountable to the LHINs for the achievement of the HSP's performance obligations in the M-SAA.

b. Funding and Allocation

- HSPs are expected to plan to achieve a balanced operating position for the total entity for each year of the M-SAA.
- HSPs funding can only be used in accordance with the terms on which it is provided as set out in the M-SAA.

c. Integration and Service Coordination

- HSP planning must reflect the HSP's ongoing responsibility to find efficiencies in administrative and direct service areas including review and/or consultation with other HSPs.

d. Local Health System Planning

- HSP planning must be in alignment with the LHIN IHSP, the government's health care priorities, and reflect best practices, evidence-informed decisions, and the pursuit of efficiency opportunities within the HSP and in collaboration with hospitals, community partners and other HSPs.
- HSP planning must integrate the HSPs obligation under s. 16(6) and s. 24 of the LHSIA.
- **s. 16(6) Engagement by Health Service Providers** Each health service provider shall engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services.
- **s. 24 Identifying integration opportunities** Each LHIN and each HSP shall separately and in conjunction with each other identify opportunities to integrate the services of the local health system to provide appropriate, co-ordinated, effective and efficient services.

e. Local Community Engagement

- HSP planning must clearly include ongoing consultation and engagement by the HSP with local health service providers and other stakeholders with a view towards closer cooperation and partnership between providers and between sectors.

2.3 Multi-Year Funding Targets

The move to multi-year funding targets and accountability agreements provides the HSP stability and capacity to plan their operations effectively and within fiscal parameters. HSPs will be provided with financial planning targets (funding targets) for two years, 2009/10 and 2010/11 by their respective LHIN. HSPs must consider the funding targets when developing their forecasts on service volume and indicator performance.

The M-SAA will be negotiated and signed using funding targets. The M-SAA schedules will be refreshed regularly in the Fall of each year of the agreement to confirm the current year's allocation and to update the planning targets for each remaining year of the agreement. Additional refresh of the M-SAA schedules will only occur as required on the following two occasions:

a. For the 2010/11 term of the MSAA where actual funding is different than the planning targets for 2009/10 and/or where there are material changes to the funding target for 2010/11.
b. When there is a substantial shift in the lines of business or the volume of business offered by the HSP, i.e. an integration or new funding stream.
c. Where there are material changes to the allocation and/or funding target.

2.4 The 2009 – 11 Monitoring Process

The LHINs will review the HSP performance indicator results against the targets outlined in the 2009–11 M-SAA through the CAPS and *for OHRS/MIS compliant HSPs,* the Management Information System (MIS) Trial Balance Submissions on a quarterly basis.

The WERS will generate, for LHIN and HSP use, reports that can be used to identify variances from the M-SAA performance objectives. HSPs will be required to monitor their performance against variances. HSPs may be required to meet with their LHIN to review any variances, and at the discretion of the LHIN, will be required to propose an improvement plan.

2.5 Data Quality

The reporting of valid and reliable health care clinical and financial/statistical data is essential. This is reflected in s. 2.7 below and the M-SAA. The ability of HSPs to negotiate and meet their performance objectives is highly dependent on how well the historical data reflects actual HSP performance. Improvements in the quality of health care data reported from HSPs will improve the ability of HSPs, LHINs and the province to set and meet performance targets.

2.6 Timelines

HSPs will have six weeks to complete the forms in the WERS, which can be found at www.mohltchb.com. A CAPS Financial and Statistical Forms User's Guide and web forms are expected to be available to HSPs on the WERS web site by the end of September, 2008. HSP Board-approved CAPS must be submitted to the LHINs no later than **November 14, 2008.**

2.7 Financial Penalty

An HSP may be subject to a financial penalty if:

- Its Board-approved CAPS is received by the LHIN after **November 14, 2008**; or
- The CAPS is incomplete or inaccurate; or
- The quarterly performance reports are not provided on a timely basis; or
- Clinical data requirements are late, incomplete or inaccurate.

See Section 8.1(c) of the M-SAA.

2.8 Overview of the 2009-11 HSP Planning and Accountability Cycle

For specific information related to your LHIN, please go to Appendix F for the link to the LHIN website.

3. CAPS Components

The CAPS narrative provides an opportunity to incorporate context and insight into the local environment in which the health service provider operates.

3.1 Part A –Description of Services

The Community Annual Planning Submission (CAPS) Part A – Description of Services must be no more than two (2) pages in length and completed in point form on letter size paper using Arial 11pt font. Do not include attachments or any other documents with the submission.

Provide a brief description of the following:

a. Services Provided

- List the services provided in point form using Appendix B as a reference.

b. Client Population

- Describe the characteristics of the specific client population served and the needs the services are intended to address (for example – adults 16 years of age and older with a physical disability).
- Identify cultural communities served, languages provided by your agency
- Describe how the HSP's initiatives address the health needs of the local Francophone community if the HSP is required to provide services to the public in French under the *French Language Services Act*.

c. Geography Served

- Catchment area of services
- Location of sites where services are provided, for example location of day programs and supportive housing sites

3.2 Part B - Service Plan

a. CAPS – Part B Service Plan Narrative

The Community Annual Planning Submission (CAPS) Narrative Schedule B should be no more than four (4) pages in length and completed in point form on letter size paper using Arial 11pt font. Do not include attachments or any other documents with the submission.

The CAPS Service Plan narrative should provide information for the 2009/10 - 2010/11 fiscal years and must include the following components:

i. Overview

This section must include a snapshot of the HSP including:

- Goals for 2009/10 and 2010/11 *(will be reported on in subsequent CAPS -see section iv. Evaluation of Prior Year Performance).*
- Key messages to the LHIN such as:

  - quality improvement activities
  - internal evaluations or reviews planned or underway
  - communication strategies planned or underway
  - any other notable activity of which the LHIN should be aware

ii. Advancement of the IHSP

Each HSP must describe:

- How the organization's strategic and operating plans contribute to the LHIN IHSP and improve coordination of care/services in the local health system.
- How the organization will meets its obligations under sections 16(6) and 24 of the LHSIA, specifically community engagement and integration of services (see Section 2.2d Local Health System Planning):
- The ***results*** of community engagement and integration activities, specifically the impact these results will have on the community and the HSP's ability to improve service delivery to meet identified community needs.

iii. Situation Analysis

Each HSP must provide:

- Prudent business assumptions and rationale regarding, volumes, overall expenses and revenues;
- A description of significant budgetary and operational risks (no more than three (3)), that are affecting the HSP's ability to meet client care, operational objectives and financial objectives; and
- An outline of the realistic strategies to manage the identified risk(s).
- HSP may submit multiple scenarios, as appropriate.

iv. Evaluation of Prior Year Performance

Each HSP must provide:

- A critical and objective evaluation of prior fiscal year performance highlighting:

  - the attainment of objectives and goals identified in the prior submission (i.e. Overview Section),
  - challenges encountered, and
  - strategies undertaken to address these challenges.

- An explanation of any significant variances or changes between planned and actual results in Total Expenditure, Total Revenue, Clients Served by service, Units of Service by service, Cost per unit of service and Cost per client by service. Significant variance is defined as a +/- 10% variation from approved amounts. Please be specific regarding the years of the variance. The variance calculation will be based on Part B Service Plan (Financial and Statistical) forms.

v. Changes to Operations Summary (Optional)

Each HSP must:

- Highlight changes to operations that are being considered for the 2009/10 and 2010/11 fiscal years. (Changes that require pre-approval from the LHINs cannot be included unless the change has already been approved.)

b. CAPS – Part B Service Plan (Financial and Statistical)

The financial and statistical reporting template will be used to:

- Promote reporting consistency across all community sectors.
- Provide HSP's with a single uniform community MIS compliant budget submission template.
- Provide a means to evaluate the consistency between the narrative and the financial service information.
- Enable the calculation of the performance indicators.
- Set a baseline against which actual performance may be measured.
- Provide information to reflect the financial and service implications of the proposed operating plan.
- Assess the level of value added to the health system through the use of allocated funds.
- Reflect multi-year funding targets.
- Promote full entity reporting including LHIN and Ministry Managed Programs.
- Provide a means to evaluate the provision of French Language Services for those HSP's that are required to do so by the *French Language Services Act*.

3.3 Part C - Reports

A reporting schedule will be set out in the M-SAA which will apply to financial and performance reporting requirements during the term of the M-SAA beginning April 1, 2009.

3.4 Part D – Directives; Guidelines and Policies

To support the M-SAA, a single common policy document with sector specific requirements will be developed for 2011-12.

As an initial step in achieving this goal, Appendix D-1 outlines a consolidated community financial policy that sets out certain financial requirements that Health Service Providers must adhere to as a condition of receiving funding from the LHIN or MOHLTC.

In addition, a listing of all mandatory guidelines, directives and standards is included in Appendix D and D-1 of this document. This listing is subject to revision.

Either the LHIN or the MOHLTC (where applicable for ministry managed programs), will give the Health Service Provider notice of any amendments to these documents.

3.5 Part E - Performance

To assist the HSP to achieve ongoing performance improvement, a performance measurement framework together with a series of performance indicators has been developed for inclusion in Schedule E to the M-SAA. Section 6.3 of this document describes the framework and the process to select performance indicators in more detail while Appendix E provides an inventory of the performance indicators.

A detailed guide to calculating the performance indicators and acceptable corridors of performance is available in the CAPS Financial and Statistical Forms User's Guide.

3.6 Part F – Template for Project Funding

Schedule F, "Project Template" allows the LHIN to fund an HSP to undertake projects for the LHIN during the term of the SAA, without the need to negotiate a separate project funding agreement. The Project Template builds on the existing terms of the SAA between the LHIN and the HSP, and allows a quick start to projects.

3.7 Multi-Year Funding Targets

HSPs will be provided with funding targets for 2009/10 and 2010/11. In completing the CAPS the funding targets must be used to forecast levels of activity. Explanations should be provided in the Part B – Service Plan section if activity levels are beyond the funding targets. Revenue from sources other than the LHIN must be included.

3.8 Other Services

a. French Language Services

Pursuant to the *French Language Services Act*, HSPs must provide services in French if the agency has been:

- Designated under the French Language Services Act;
- Directed by the former Health Services Restructuring Commission ("HSRC");
- Identified by the former District Health Councils or the LHIN to provide services in French.

These agencies are required to provide equitable access to quality professional services in French on a permanent basis. The list of identified/designated agencies can be found at:

http://www.health.gov.on.ca/english/public/program/flhs/identified_mn.html

HSPs on the above-noted list are required to submit a French language implementation report to the LHIN and the MOHLTC which includes:

- Access report
- Accessibility report
- Integration report
- Service report (Implementation or Designation Plan) - if the current plan was prepared in 2006 or earlier, an update is required.

HSPs that are not required to provide services to the public in French under the provisions of the *French Language Service Act,* are required to provide a report to the LHIN that outlines how the HSP will address the needs of the local Francophone community.

b. Preschool Speech and Language Services

These services are funded by the Ministry of Health and Long-Term Care and managed by the Ministry of Children and Youth Services. Any changes or reductions in these services must be negotiated and approved under the terms of the HSP's agreement with the Ministry of Children and Youth Services.

4. Changes Needing LHIN Approval

4.1 Proposing Operational Changes

As noted in Part 3 above, certain types of operational changes will require pre-approval from the LHIN before the proposed change can be incorporated into the HSP's CAPS. These would include any changes affecting funding or service levels, the reduction, elimination or transfer of a service and other integration activities.

4.2 Adding New Services, Service Enhancement

The Health System Improvement Pre-Proposal ("H-SIP") process has been developed and implemented by LHINs to (i) reduce the costs incurred by HSPs when proposing improvements to the local health system and (ii) improve the efficiency and effectiveness of the LHINs ability to respond to these proposals.

This process contemplates the initial submission of a brief pre-proposal, known as an H-SIP, to enable a LHIN to make a preliminary assessment of any request or activity contemplated by an HSP that requires the LHIN's approval (e.g., new service or service enhancement). All H-SIPs will be evaluated against LHIN priorities as outlined in the LHINs IHSP, local health system needs and financial feasibility. Following the LHIN's review and evaluation of the H-SIP, an HSP may be invited to submit a detailed proposal and a business plan for further analysis by the LHIN. Guidelines for the development of a detailed proposal and business case will be provided by the individual LHIN. It is recommended that the LHIN be contacted prior to beginning work on an H-SIP to determine any local variations or specific issues the LHIN wishes to see addressed.

The CAPS should be prepared to support services currently provided within the funding targets provided. Service enhancements that can be accommodated within the funding targets can be included in the CAPS and no H-SIP is required, unless otherwise directed by your LHIN. New and enhanced service proposals (based on H-SIP submissions) that are approved by the LHIN will be incorporated into the CAPS/M-SAA by subsequent re-submission of a new CAPS.

The submission of an H-SIP is not formal notice of a proposed integration to the LHIN as contemplated by s.27 of the LHSIA. The HSP should contact the LHIN for more information.

HSPs that wish to reduce or eliminate services or transfer them to another HSP, must follow the steps set out in Section 4.3 of these guidelines.

4.3 Service Reduction, Transfer or Elimination Proposal

Access to community health services is an important priority for the government, LHINs and HSPs. As a result, any proposed reduction, transfer or elimination of a service should be consistent with the overall goal of an integrated health system that provides access to high quality health services and coordinated health care in an effective and efficient manner. The LHIN must be provided with lead time (at least 60 days) to ensure that essential levels of service (both quality and quantity) are maintained.

A service reduction, transfer or elimination proposal should include:

- Rationale for the service change and alternative measures considered during the decision making process.
- Anticipated funding adjustments, i.e. expected decrease or increase in funding associated with the service change.
- Impact on performance obligations.
- Human resource impact, e.g. staff reduction or re-assignment.
- Strategy for mitigating any anticipated client impacts of the service change.
- Consultation process and outcomes with health care partners and the community.
- Communications plan to communicate to both internal and external audiences.

The H-SIP form should be used as a template for service reduction, transfer, or elimination proposals (while these changes are generally not ‘improvements’ the form still captures the information to begin the decision making process).

Service adjustments are often required to produce a balanced operating position. Service adjustment proposals need only be made where the service change poses a significant risk to a client group, i.e. there is a high probability that the service change will have a significant impact on the health outcomes of a client group.

Please note that section 27 of LHSIA requires an HSP to notify the LHIN of any integration with another person or entity that relates to services that are funded in whole or in part by the LHIN.

H-SIP forms can be downloaded from the LHIN websites.

5. Guidelines for Balanced Operating Plans

5.1 Basic Requirement: A Balanced Operating Position

An HSP seeking funding from the LHIN is expected to submit a CAPS that demonstrates the HSP has achieved a balanced operating position for the total entity and will achieve and maintain a balanced operating position during each year of the M-SAA. A balanced operating position for the total entity is where the total expenses are less than or equal to all sources of revenue.

5.2 Budget Balancing Alternatives

HSP managers have always strived to maintain or enhance service levels within the confines of the available budget. The LHIN will expect HSPs to first consider all possible cost savings alternatives in lieu of reducing service levels such as:

a. Back office integration (combining with other HSPs to reduce the cost of administration, e.g. shared accounting service).

b. Increase supplementary (non-LHIN/MOHLTC) revenue.

c. Program efficiencies, e.g. review of best practices in operations and service delivery.

d. Technology and automation, e.g. use of laptops/PDAs to reduce time spent on paperwork.

e. Enhanced community support, e.g. increased use of volunteers and contributions in kind.

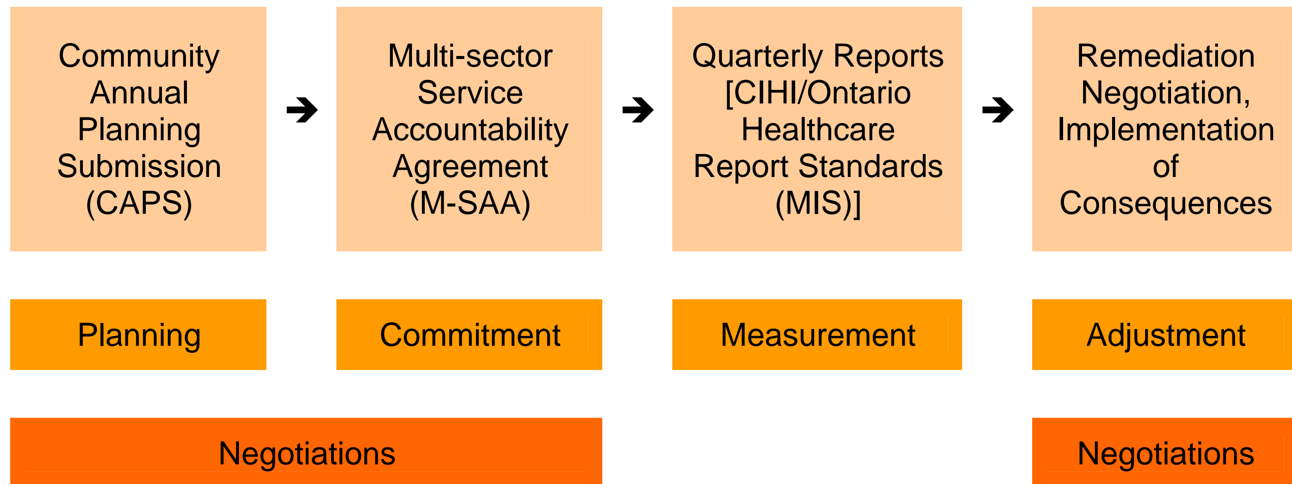
f. Program consolidation (combining or linking programs internally or reducing the number of sites).

g. Combining with another organization to achieve economies of scale and scope.

h. Effectiveness reviews – directing limited resources to the most effective programs and/or most vulnerable clients.

6. CAPS Links to the M-SAA

6.1 Overview of the CAPS/M-SAA Process



Both the CAPS and the M-SAA promote enhanced accountability through multi-year planning and funding projections.

The CAPS focuses on service planning and the measurement and evaluation of HSP services and organizational performance. Data submitted by HSPs is used to calculate targets, corridors and performance standards related to the HSP's:

- financial performance/fiscal health;
- organizational capacity;
- high quality health services;
- patient/client perspective;
- system perspective.

The M-SAA focuses on accountability as an integral part of the ongoing effort to improve health sector performance and provide high-quality, client-centered care. LHINs are committed to achieving a balanced, innovative and realistic M-SAA; one that relies on negotiation and collaboration to the greatest extent possible, while meeting the requirements of the LHSIA and *the Commitment to the Future of Medicare Act, 2004.* Once negotiated, the LHINs and HSPs each have a role in ensuring that the terms of the signed M-SAA are fulfilled.

6.2 MOHLTC, LHIN and HSP Roles

MOHLTC:

- Sets strategic policy direction for the health care system;
- Establishes the legislative framework that enables implementation of the strategic directions;
- Establishes program standards;
- Enables the LHIN to fulfill the LHIN's responsibilities under the LHSIA; and is accountable to the public.

LHIN:

- Provides system planning and integration direction as outlined in the IHSP;
- Negotiates and signs an accountability agreement with the MOHLTC;
- Negotiates and signs an M-SAA with the HSP;
- Provides funding in accordance with the terms of the LHSIA and the MOHLTC-LHIN Accountability Agreement and pursuant to the terms of an M-SAA;
- Monitors HSP performance against set targets; and
- Provides necessary logistical support to enable planning, execution, monitoring and remediation of any variations.

HSP:

- Negotiates and signs an M-SAA with the LHIN; and
- Delivers accessible, appropriate services funded pursuant to the terms of an M-SAA that:
    - Maximizes service levels and outcomes aligned with the MOHLTC-LHIN Accountability Agreement and the LHIN IHSP;
    - Meets planned and agreed performance targets, including achieving a balanced operating position for both terms of the M-SAA; and
    - Establishes agreed mechanisms to manage the consequences of falling short of agreed performance targets.

6.3 Development of Performance Indicators

The Indicator Development Process

In the summer of 2007, the LHIN and MOHLTC began the development of a measurement framework for service accountability agreements together with an inventory of indicators that would assist HSPs in demonstrating that performance expectations were being met.

Following the conceptual development of the framework, the Service Accountability Agreement – Indicator Framework Team (SAA-IFT) then generated a list of indicators for consideration in the SAA schedules; assembled criteria to assess these indicators; and in May of 2008 facilitated a process that resulted in a draft list of performance indicators to be included in SAA schedules. Draft indicators were included in the sector consultation sessions in the

summer of 2008. Feedback from those sessions was considered in the final decision of the LHIN Boards to establish performance indicators for the M-SAA. The specific indicator targets for individual health service providers will be negotiated between the HSP and their respective LHIN.

The Framework

In inventorying existing indicators and constructing a performance framework the following were reviewed and considered:

- Ontario Health System Strategy Map
- Ontario Health Quality Council reports
- Current use and development of performance indicators in existing agreements in LHIN funded sectors
- Relevant sector strategy maps and scorecards
- LHIN Blueprint Core Indicators project measures (LHIN-wide)
- Ministry-LHIN Accountability Agreement (MLAA)

The resulting performance framework is consistent with the goals of Ontario health system partners and is aligned with existing frameworks. The framework builds on the Kaplan and Norton balanced scorecard with a dimension added to reflect the health service providers' role as an integral part of the local health system (LHIN) and in advancing the transformation agenda. The framework reflects the requirement for clear accountability among HSPs. It gives HSPs the parameters within which results must be demonstrated while supporting continuous improvement. The dimensions are as follows:

HSP Performance Dimensions

1. **Fiscal / Financial Health**
   - The HSP demonstrates sound business practices and efficiency in service delivery.

2. **Organizational Capacity**
   - The HSP has the capacity / demonstrates the ability to deliver the services for which it receives LHIN funding.

3. **High Quality Health Services**
   - The HSP delivers the services specified in its service plan that are accessible, appropriate, integrated with appropriate health system partners, effective (evidence-based), outcome focused, and safe.

4. **Patient / Client Perspective**
   - The HSP's services provided are client and outcome focused and the client perspective is paramount.

5. **System Perspective**
   - The HSP contributes to system performance and local population health outcomes as part of the local LHIN.

Indicators

The core indicators (those required for reporting across all sectors) include:

Financial / Fiscal Health

- Total margin
- Current ratio
- Cost per unit service (D)
- Cost per individual served (D)

Organizational Capacity

- Variance budget and forecast $
- Variance budget and forecast units of service
- % spent on direct care (D)
- Vacancy rate (D)
- Turnover rate (D)

High Quality Health Services

- Service activity / volumes based on MIS functional centres
- Wait time from referral to assessment
- Wait times from assessment to service initiation
- High risk occurrences (D)
- Client achieves goals e.g., on discharge (D)

Client Perspective

- Client Experience (D)

System Perspective*

- Alternate levels of Care
- ED Visits that could be managed elsewhere / and ED wait times
- Hospitalizations for Ambulatory Care Sensitive Conditions
- Median wait time to LTC placement

* HSPs will not be given accountability for a specific numerical target for these measures, instead they will be expected to contribute to the LHIN system outcomes, stated for example as "the HSP will help the LHIN achieve their system outcomes for ED visits as specified in the LHIN MLAA" .

Performance/Developmental Indicators

Indicators are described as either "performance" (can be measured and reported on now in all sectors), or "developmental", as indicated above (D). "Developmental" means work is required on an indicator before it can be a performance measure—in terms of the technical specification of the indicator, data capture or data quality. The timeframe for development varies. An indicator may:

- be developed in the first year of the agreement (2009-10) for reporting as a performance indicator in the second year (2010-11);
- require two full years before becoming a performance measure (2009-11);
- be developed and deemed to show no merit as a performance measure and may be dropped from being recommended as an indicator for the subsequent SAA (2011-13).

In addition to the core indicators, sector specific indicators were developed as a part of the sector consultation process on the service accountability agreements, see Appendix E of the M-SAA.

Target setting process

Following the submission of the CAPS, LHINs and HSPs will negotiate the performance indicator targets appropriate to the organization and local circumstance. Targets are expected to reflect continuous improvement. Where provincial indicator targets or clinical benchmarks exist, the LHIN and HSPs will take these into consideration.

Corridors

All targets established through negotiations between the HSPs and the LHIN will have an associated performance corridor. A corridor is a range around an indicator target that is established for variance reporting purposes. The corridor takes into account expected variation such as statistical and seasonal fluctuations and other factors that affect a performance indicator. Variances any time during the year that are outside the performance corridor will require a provider to report to the LHIN. The report will include the amount of variance, the likely cause, identification of any related risks and the strategies being implemented to address those risks and the overall performance.

Definitions

Indicator: linked to an established strategic priority or goal, an indicator is a measurement that demonstrates progress towards stated targets and identifies areas for improvement (helps the HSP to understand its current state and identify where it should focus attention).

Performance corridor: a range around a performance indicator target established for variance reporting purposes; takes into account expected variation such as statistical and seasonal fluctuations in performance.

Performance indicator: indicators that can be measured and with specific targets and corridors established today (assumes a certain degree of data quality) similar to the LHIN accountability agreement indicator.

Core indicator: a required indicator relevant to all LHINs and all community sectors.

Sector-specific indicator: a required indicator relevant to a specific sector.

LHIN-specific indicator: an indicator determined locally to be relevant.

Developmental indicator: a measure that needs to be better defined and developed before being considered a performance indicator; for example there may be significant data quality issues that need to be addressed.

7. Appendix A: Glossary

Terms used throughout these guidelines are defined below. Terms that appear in a single section or part are defined there for ease of reference.

Accountability Agreement or MOHLTC-LHIN Accountability Agreement means the accountability agreement that must be signed between the LHINs and the Minister pursuant to the terms of the LHSIA. Further information can be found at s.18 of the LHSIA.

Annual Balanced Budget / Balanced Operating Position means that, in a given fiscal year, the total expenses of an entity are less than or equal the total revenue, from all sources, for the entity.

CAPS means Community Annual Planning Submission which is a document used to negotiate a two year service accountability agreement between the LHIN and HSP.

CMFA means the *Commitment to the Future of Medicare Act, 2004.* The CMFA contains provisions applicable to SAAs. Further information can be found in Part III of the CFMA. Link to Act: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04c05_e.htm

FLS means French Language Services.

FLSA means *French Language Services Act.* Link to Act:
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f32_e.htm

H-SIP means a Health System Improvement Pre-proposal, a document submitted by HSPs to the LHIN to determine whether a formal proposal should be submitted.

HSP means health service provider as that term is defined in the LHSIA.

IHSP means the IHSP developed and published by each LHIN pursuant to s.15 of the LHSIA. A copy of a LHIN's IHSP is available through the LHIN's office or on its web site

Integration has the same meaning as is set out in part 1 of the LHSIA, specifically: "integrate" includes (a) to co-ordinate services and interactions between different persons and entities; (b) to partner with another person or entity in providing services or in operating; (c) to transfer, merge or amalgamate services, operations, persons or entities; (d) to start or cease providing services; (e) to cease to operate or to dissolve or wind up the operations of a person or entity; and "integration" has a similar meaning. Further information on integration can be found in Part V of the LHSIA.

LHIN means Local Health Integration Network. The LHINs are 14 networks established by the LHSIA across the province. Specific information about geographic parameters and contact information can be found at www.lhins.on.ca.

LHSIA means the *Local Health System Integration Act, 2006.* This is the legislation that established the LHINS, and sets out the terms by which the LHINs may exercise the powers devolved from the Minister in respect of planning, funding and integration of their local health system. Link to the Act:
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm

M-SAA means Multi-sector Service Accountability Agreement. The M-SAA is the service accountability agreement that the LHINs are required to enter into with the HSPs pursuant to the terms of LHSIA. More information on the service accountability agreement can be found in s. 20 of LSHIA and Part III of the CFMA.

Minister means the Minister of Health and Long-Term Care.

MIS (Management Information System) is the term used to identify and report data organized in a format consistent with Ontario Health Care Reporting Standards.

MOHLTC means the Ministry of Health and Long-Term Care.

Multi-year Funding Targets means an allocation for the first fiscal year of the agreement and funding targets for up to two additional years, consistent with the term of the agreement. Funding targets are to be used for planning purposes only and may be revised upward or downward at the discretion of the LHIN.

OHRS (Ontario Healthcare Reporting Standards) is a set of reporting standards and chart of accounts consistent with national health care reporting standards.

SAA means a Service Accountability Agreement as that term is defined in the CFMA. SAAs are executed between LHINs and HSPs and include the H-SAA and the M-SAA.

Transfer Payment Business Entity (TPBE) is a sector within the overall funding envelope, e.g. Community Support Services, Community Mental Health, etc.

TPBE	TPBE Description
ABI	Acquired Brain Injury
AO	Attendant Outreach
ASTHMA	ASTHMA
CCAC	Community Care Access Centre
CHC	Community Health Centres
CHCX	CHCX
CMH	Children's Mental Health
CMHP	Community Mental Health Program
CSS	Community Support Services
DP	DP
EPC	Elderly Persons Centres
HNSA	Homemaking & Nurses Services Act
HOSP	Operation of Hospitals
NH	Nursing Homes
OMHF	Ontario Mental Health Foundation

TPBE	TPBE Description
OSTEO	OSTEO
PALC	Palliative Care
PG	Problem Gambling
PHOSP	Private Hospitals
POMS	Psychiatric Outpatient Medical Salaries
PSW	Personal Support Work – Training Grants
SAP	Substance Abuse Program
SH	Supportive Housing
SPH	Specialty Psychiatric Hospital

WERS means Web Enabled Reporting System. It can be found at www.mohltchb.com.

8. Appendix B: Listing of Services Provided

Please use the following as a reference for listing the services in *"Part A Section 1. Services Provided"*. (Note: Based on OHRS version 6.2)

Service	MIS Account
CLINICAL MANAGEMENT:	72 5 05
COM Clinical Management	72 5 07 10
MEDICAL RESOURCES:	72 5 07
Medical Resources - Psychiatrists	72 5 07 10
Medical Resources - Other Medical Staff	72 5 07 20
CASE MANAGEMENT:	72 5 09
Case Management	72 5 09 30
Case Management Mental Health	72 5 09 76
Case Management Addictions	72 5 09 78
PRIMARY CARE CLINIC:	72 5 10
PC - Primary Care Practice	72 5 10 05
PC - Nursing Clinic	73 5 10 15
PC - Combined Clinic	74 5 10 30
PC - Therapy Clinic	72 5 10 40
PC - MH Counseling and Treatment	72 5 10 76 12
PC - MH Assertive Community Treatment Teams	72 5 10 76 20
PC - MH Community Clinic	72 5 10 76 30
PC - MH Vocational /Employment	72 5 10 76 40
PC - MH Clubhouses	72 5 10 76 41
PC - MH Concurrent Disorders	72 5 10 76 45
PC - MH Child/Adolescent	72 5 10 76 50
PC - MH Early Intervention	72 5 10 76 51
PC - MH Forensic	72 5 10 76 55
PC - MH Diversion and Court Support	72 5 10 76 56
PC - MH Abuse Services	72 5 10 76 60
PC - MH Eating Disorders	72 5 10 76 70
PC - MH Social Rehab./Recreation	72 5 10 76 81
PC - MH Dual Diagnosis	72 5 10 76 95
PC - MH Psycho-geriatric	72 5 10 76 96
PC - Other MH Services not elsewhere identified	72 5 10 76 99
PC - Addictions Treatment-Substance Abuse	72 5 10 78 11

Service	MIS Account
PC - Addictions Treatment-Problem Gambling	72 5 10 78 12
PC - Addictions Withdrawal Mgmt	72 5 10 78 20
PC - Initial Assessment and Treatment	72 5 10 78 30
CRISIS INTERVENTION:	72 5 15
Crisis Intervention - Hot Lines	72 5 15 10
Crisis Intervention - Abuse Services	72 5 15 15
Crisis Intervention - Quick Response	72 5 15 20
Crisis Intervention - Victim Services	72 5 15 25
Crisis Intervention - Combined	72 5 15 30
Crisis Intervention - Mental Health	72 5 15 76
DAY/NIGHT CLINIC:	72 5 20
D/N - Combined Clinic	72 5 20 30
D/N - Mental Health	72 5 20 76
D/N - Addictions Treatment	72 5 20 78
HH - IN HOME HEALTH CARE:	72 5 30 40
HH - IH Visiting Nursing	72 5 30 40 11
HH - IH Shift Nursing	72 5 30 40 12
HH - IH Respiratory Service	72 5 30 40 35
HH - IH Nutrition	72 5 30 40 45
HH - IH Physiotherapy	72 5 30 40 50
HH - IH Occupational Therapy	72 5 30 40 55
HH - IH Speech Language Pathology	72 5 30 40 62
HH - IH Social Work	72 5 30 40 70
HH - IH Psychology	72 5 30 40 75
HH - PRIVATE/ HOME SCHOOLS:	72 5 30 42
HH - PH Visiting Nurses	72 5 30 42 11
HH - PH Shift Nursing	72 5 30 42 12
HH - PH Nutrition	72 5 30 42 45
HH - PH Physiotherapy	72 5 30 42 50
HH - PH Occupational Therapy	72 5 30 42 55
HH - PH Speech Language Pathology	72 5 30 42 62
HH - PUBLICLY FUNDED SCHOOLS:	72 5 30 44
HH - PS Visiting Nurses	72 5 30 44 11
HH - PS Shift Nursing	72 5 30 44 12
HH - PS Nutrition	72 5 30 44 45
HH - PS Physiotherapy	72 5 30 44 50
HH - PS Occupational Therapy	72 5 30 44 55
HH - PS Speech Language Pathology	72 5 30 44 62

Service	MIS Account
HOME SUPPORT:	72 5 35 40
HS - IH Personal Support	72 5 35 40 10
HS - IH Homemaking Services	72 5 35 40 20
HS - IH Combined Personal Support and Homemaking	72 5 35 40 30
HS - PRIVATE/HOME SCHOOL SUPPORT SERVICES	72 5 35 42
HS - PS Personal Support	72 5 35 42 10
HS - RESPITE SERVICES	72 5 35 45
HS - Respite Service	72 5 35 45
RESIDENTIAL - MENTAL HEALTH:	72 5 40 76
Res. Mental Health - Homes for Special	72 5 40 76 10
Res. Mental Health - Support within Housing	72 5 40 76 30
Res. Mental Health - Housing Bricks & Mortar	72 5 40 76 40
Res. Mental Health - Short Term Crisis Support Beds	72 5 40 76 60
RESIDENTIAL – ADDICTIONS:	72 5 40 78
Residential Addiction - Treatment Services-Substance Abuse	72 5 40 78 11
Residential Addiction - Treatment Services-Problem Gambling	72 5 40 78 12
Residential Addiction - Treatment Services-Supportive Treatment	72 5 40 78 30
Residential Addiction - Treatment Services-Withdrawal	
Management Centres	72 5 40 78 45
RESIDENTIAL HOSPICE - END OF LIFE:	72 5 40 95
Residential Hospice - End of Life - Nursing	72 5 40 95 10
Residential Hospice - End of Life - Personal	72 5 40 95 20
Residential Hospice - End of Life - Therapies Combined	72 5 40 95 44
HEALTH PROMOTION AND EDUCATION	
Health Promotion and Education	72 5 50
CONSUMER/SURVIVOR/FAMILY INITIATIVES:	72 5 51
Consumer Survivor Initiatives - Peer/Self Help	72 5 51 76 11
Consumer Survivor Initiatives - Alternative Businesses	72 5 51 76 12
Consumer Survivor Initiatives - Family Initiatives	
COM - INFORMATION AND REFERRAL SERVICES:	72 5 70
COM Information and Referral Service-Provincial MH	72 5 70 76
COM Information and Referral Service-Provincial SA	72 5 70 78 11
COM Information and Referral Service-Provincial PG	72 5 82 18 12
PROVINCIAL HEALTH SYSTEM DEVELOPMENT	72 5 75

Service	MIS Account
CSS - IN-HOME AND COMMUNITY SERVICES:	72 5 82
CSS IH COM - Service Arrangement/Coordination	72 5 82 05
CSS IH COM - Case Management	72 5 82 09
CSS IH COM - Meals Delivery10	72 5 82 10
CSS IH COM - Social and Congregate Dining	72 5 82 12
CSS IH COM - Transportation - Client	72 5 82 14
CSS IH COM - Crisis Intervention and Support	72 5 82 15
CSS IH COM - Day Services	72 5 82 20
CSS IH COM - Homemaking	72 5 82 31
CSS IH COM - Home Maintenance	72 5 82 32
CSS IH COM - Personal Support/Independence Training	72 5 82 33
CSS IH COM - Respite	72 5 82 34
CSS IH COM - Comb. PS/HM/Respite Services	72 5 82 35
CSS IH COM - Overnight Stay Care	72 5 82 40
CSS IH COM - Assisted Living Services	72 5 82 45
CSS IH COM - Caregiver Support	72 5 82 50
CSS IH COM - Emergency Response Support Services	72 5 82 55
CSS IH COM - Visiting - Social and Safety	72 5 82 60
CSS IH COM - Visiting - Hospice Services	72 5 82 65
CSS IH COM - Foot Care Services	72 5 82 70
CSS IH COM - Vision Impaired Care	72 5 82 75
CSS IH COM - Hearing Impaired Care	72 5 82 77
CSS IH COM - Elderly Person Centre Services	72 5 82 80
CSS - ABI SERVICES:	72 5 83
CSS ABI - Day Services	72 5 83 20
CSS ABI - Vocational Training and Education Services	72 5 83 30
CSS ABI - Personal Support/Independence Training	72 5 83 33
CSS ABI - Assisted Living Services	72 5 83 45
RESEARCH:	72 7
RE Community and Social Service Research	72 7 50
RE Mental Health General	72 7 76 10
RE Mental Health/Addictions Combined	72 7 76 30
RE Addictions Substance Abuse	72 7 78 10
RE Addictions Problem Gambling	72 7 78 20
EDUCATION:	72 8
In-service Education	72 8 40

Service	MIS Account
UNDISTRIBUTED FUNCTIONAL CENTRES:	72 9
NSF Non-Service Recipient Food Services	72 9 10
(MSK) Marketed Services	72 9 20
COMMUNITY HEALTH CENTRES:	
To be listed by the Community Health Centre on Schedule A.	

9. Appendix C: Reporting
(To populate Schedule C)

A chart identifying reporting requirements and due dates will be included as Schedule C to the M-SAA

10. Appendix D: Applicable Directives, Guidelines and Policies *(To populate Schedule D)*

All Sectors

Community Annual Planning Submission (CAPS) Guidelines

Note: Where there is a conflict between the CAPS Guidelines and the requirements listed in this Schedule, the CAPS Guidelines take precedence.

Community Mental Health and Addictions Services

Operating Manual for Community Mental Health and Addiction Services (2003)

Chapter	Name	Section
1	**Organizational Components**	▪ Organizational Structure, Roles and Relationships (1.2) ▪ Developing and Maintaining the HSP Organization / Structure (1.3) ▪ Dispute Resolution (1.5)
2	**Program & Administrative Components**	▪ Budget Allocations/ Problem Gambling budget allocations (2.3) ▪ Service Provision Requirements (2.4) ▪ Client Records, Confidentiality and Disclosure (2.5) ▪ Service Reporting Requirements (2.6) ▪ Issues Management (2.8) ▪ Service Evaluation/Quality Assurance (2.9) ▪ Administrative Expectations (2.10)
3	**Financial Record Keeping and Reporting Requirements**	▪ Personal Needs Allowance for Clients in Some Residential Addictions Programs (3.2) ▪ Internal Controls (3.6) ▪ Human Resource Controls (3.7) ▪ Financial Reviews (3.10)

Program Standards and Policies – CMH&A

- Ontario Program Standards for ACT Teams (2005)
- Intensive Case Management Service Standards for Mental Health Services and Supports (2005)
- Crisis Response Service Standards for Mental Health Services and Supports (2005)
- Early Intervention in Psychosis Standards (2008)
- Common Assessment Tool for Community Mental Health and Addictions Services (2007)
- Community Mental Health and Addictions Dual Diagnosis Standards (1997)

- Addictions Ontario Withdrawal Management Standards (2004)
- Psychiatric Sessional Funding Guidelines (2004)
- Assessment Tools for Ontario Addiction Agencies (2000)
- Admission Discharge Criteria (2000)
- South Oaks Gambling Screen (SOGS)

Community Care Access Centres

CCAC Sector- Client Services Policy Manual (2007)

Chapter	Name	Section
3	**Eligibility Criteria for CCAC Services**	▪ Overview of Eligibility Criteria (3.1) ▪ Validation of Ontario Health Cards (3.2 ▪ Residency Requirements for OHIP Coverage (3.3) ▪ Persons without OHIP Coverage are Ineligible for CCAC Services (3.4) ▪ Out-of-Province Applicants to Ontario's Long-Term Care Homes (require prior approval of OHIP coverage) (3.5) ▪ OHIP Coverage/CCAC Services for Homeless Persons (OHIP coverage is required) (3.6) ▪ OHIP Coverage/CCAC Services for Refugees (3.7) ▪ OHIP Coverage/CCAC Services for a Person on Leave of Absence from a LTC Home (OHIP coverage is required) (3.8) ▪ Eligibility for Enhanced Respite Funding (3.10) ▪ Services to First Nations Persons (3.11)
4	**Consent to Treatment, Admission to Long-Term Care Home and Community Services**	ALL
5	**Information and Referral Services**	ALL
6	**CCAC Case Management**	ALL
7	**CCAC Home Care Services**	ALL
8	**Supplementary Services**	ALL
9	**CCAC School Services**	ALL
10	**CCAC Complaints and Appeals**	ALL

Program Standards and Policies - CCAC

- Prioritization of Hospital-Based ALC Applicants When There Are Severe Hospital Pressures (2007)
- Long-Term Care Action Line – Expanded Service (2007)

Community Support Services

Program Standards and Policies – CSS

- Ontario Healthcare Reporting Standards – OHRS/MIS
- CSS Complaints Policy (2004)
- Supportive Housing Policy and Implementation Guidelines (1994)
- Attendant Outreach Service Policy Guidelines and Operational Standards (1996)
- Screening of Personal Support Workers (2003)

Community Health Centres

Community Health Centre Policies and Procedures Manual (2001)

Chapter	Name	Section
2	**CHC Program Model**	ALL
4	**CHC as a Non-profit corporation and the role of the CHC Board**	ALL
5	**Provision of Service Requirements**	ALL
7	**Capital Planning**	▪ Ministry approval on capital projects (7.1.1)

Program Standards and Policies – CHC

- Guide to Enrolment for CHCs as posted on www.chciss.org

11. Appendix D-1: Community Financial Policy

INTRODUCTION

HSPs funded by the LHIN or MOHLTC are expected to adhere to the terms of their M-SAA or their Ministry funding agreement and to meet certain financial requirements as set out below. These requirements apply to both LHIN-managed and Ministry-managed programs and replace the financial policies that are outlined in the following policy manuals or documents:

- 2001/2002 Planning, Funding & Accountability Policy & Procedures Manual for Long-Term Care Community Services, 8th Edition, December 2000.
- Operating Manual for Mental Health Services and Addiction Treatment Services (Substance Abuse and Problem Gambling Services) Funded by the Ministry of Health and Long-Term Care, December 2003.
- Community Health Centre Policies & Procedures Manual, December 2001.
- MOHLTC Funding Policy (included with the CCAC Business Plan/Budget Package).

a. EXPENSES – FUNDED AND NON-FUNDED

i. Funded Expenses

Expenditures that are deemed to be reasonable and necessary for the provision of the service are usually funded for calculating the operating subsidy. These expenditures must be authorized in accordance with the policies of the HSP, consistent with government policies, approved by the LHIN or MOHLTC (whichever is the applicable funder) and supported by acceptable documentary evidence.

Funded Expenses with prior written approval

- **Capital Items:** May be negotiated and included in the operating budget with LHIN or MOHLTC approval (i.e., new equipment or replacements).

- **Non-Arms Length Transactions:** All expenditures arising from transactions not conducted at arms length. A non-arms length transaction is one in which a director or authorized officer of the HSP can influence the value or cost of goods or services to exceed the item's fair market value.

- **Incorporation or Reorganization Costs**

- **Interest on Capital and Operating Loans**

- **Lease/Rental Costs when paid to Non-Arms Length Corporations:** Admissible, providing charges do not exceed those which would be paid if the transactions were at arms length.

- **Mortgage Payments (including both interest and principal):** Before approving mortgage financing, the LHIN will recommend to the Ministry and the MOHLTC will determine if this is the most effective accommodation option. If so, the Ministry's contribution to a mortgage should not exceed a reasonable cost for rent. The Ministry will protect the provincial interest in real property according to the approved financial practices of the Ministry.

- **Property Taxes:** Note: Municipal grants in lieu of taxes must be used to offset LHIN or MOHLTC subsidies.

ii. Non-Funded Expenses

- **Expenses in Excess of the Approved Budget**

- **Sick Time:** Accruals that are part of regular operations and would be paid out are required reporting as per GAAP and CICA Not for profit guidelines. Reported on Balance Sheet 425 50 Accrued Current Liabilities. – Sick Leave Benefits Payable (vested).

- **Appropriations:** Setting aside funds from surplus for example capital purposes.

- **Amortization of Capital Assets:** Amortization is to be recorded in the appropriate amortization expense accounts, eg: F 750 00 Amortization on Major Equipment – Distributed expense code. These will be part of the year end reconciliation process.

- **Donations to Individuals or Organizations**

- **Bonuses, Gifts, Honoraria:** Expenses for gifts/tributes, and staff entertainment or parties. Bonuses and Honoraria are not admissible when paid to staff or board members. Honoraria and modest gifts are admissible for guest speakers and trainers for workshops and seminars. Modest gifts are admissible for long service staff and board members. In these cases to be admissible, the Health Service Provider must have a written policy approved by the governing body.

- **Fundraising Costs**: These costs are netted against fundraising revenues, however fundraising revenue and expenses must be reported separately in MIS using the appropriate coding.

- **Loans to Clients or Staff**

- **Fines**: Incurred because of a breach of law (e.g., parking tickets) or financial inattentiveness, negligence or incompetence (e.g., fees for NSF cheques).

- **Items for personal use/consumption:** Unless they are necessary for the program (e.g., meals for staff in a residential facility)

- **Employee Transportation Costs:** To and from home and the regular place of business.

- **Rent for Premises**: Not funded if capital subsidies have been paid or premises are owned by the Health Service Provider. In these cases the program should be charged a fair share of operating costs.

- **Retainer Fees Applicable to Subsequent Periods**: Accrual Accounting is required per GAAP and CICA Not for profit guidelines. These fees are recorded as a Prepaid Expenses in the Balance Sheet using account 126 00. These will be part of the year end reconciliation process.

- **"In kind" or Contributed Services where an Actual Transfer of Funds Does Not Occur:** For example, donations of equipment are not recognized as eligible expenditures for subsidy. Volunteer time cannot be assigned a monetary value and claimed as revenue. These services will be recorded in the HSP's corporate MIS reporting according to GAAP, but are excluded for funding purposes).

- **Provisions For Bad Debts**

- **Contributions or Donations to Political Organizations**

- **Expenditures for Brokered Services other than Administration and Coordination**. Expenditures which are deemed to be reasonable and necessary for the operation of the service are usually admissible for calculating the operating subsidy. These expenditures must be authorized in accordance with the policies of the HSP, consistent with government policies, approved by the LHIN or MOHLTC and supported by acceptable documentary evidence.

iii. Sector Specific Requirements

Mental Health and Addictions

- **Medications/Emergency Dental Expenses:** In general, HSPs should not be responsible for underwriting the cost of client medications or emergency dental expenses, except in specific treatment programs. These costs should be paid by the individual, private insurance, the Ontario Drug Benefit plan (for those who are eligible) or the Trillium Drug Program.

  Exceptions to this are:

  - HSPs with clients eligible for the Personal Needs Allowance and drug and dental coverage.
  - HSPs sponsored by hospitals that may be expected to provide medications from the global hospital budget.

- HSPs that provide certain medications or supplements (e.g., thiamin), based on best practices in addiction treatment.

HSPs are encouraged to seek out other sources of coverage for medications (e.g., Ontario Works, Trillium), and to help their clients apply for programs that will continue to assist them when they are no longer in a treatment program that provides medication.

b. REVENUE, EXCLUSIONS AND INCLUSIONS FROM THE SUBSIDY CALCULATION

i. Revenue to be ***Excluded*** from Subsidy Calculation (Retainable Revenue):

These sources of revenue must be clearly identified so that there is no possibility that they are included in the subsidy calculation. These funds may be used to support other services provided by the HSP and/or accumulated in one or more funds for designated purposes. If these sources of revenue are maintained from one fiscal year to another, it is essential that they be clearly identified on the balance sheet of the audited financial statement. Otherwise income may be deemed for operating purposes.

- **Donations Received for General Purposes:** These are donations in excess of the sum determined in the budgeting process for providing funded services.
- **Specific Capital Donations, Endowments or Bequests:** These are generally received for capital acquisitions, improvements or equipment.
- **Fundraising**: This is any revenue raised through fundraising activities NOT involving the use of LHIN or MOHLTC funded resources (e.g., HSP staff or assets subsidized by the LHIN or MOHLTC funding).
- **Interest Income**: Income arising from the investment of general or capital donations not designated for ministry programs.
- **Revenue Related to Brokered Services**: (e.g., client fees and donations).

ii. Revenue to be ***Included*** in the Subsidy Calculation (Non-Retainable Revenue):

If Health Service Providers are generating income from assets or services already funded 100% by LHIN or MOHLTC, they are either required to use the funds to support LHIN or MOHLTC funded programs or to repay the funds.

- **Expenditure Recoveries:** "Recoveries occur when financial resources, which were intended to fund a specific activity, are temporarily used and then repaid".

- **Refunds or recoveries of previous expenditures:** Refunds or recoveries of previous expenditures are treated as a reduction of the related expense (the amount of the refund or recovery is deducted from the total invoice): This includes items such as GST rebates, recovery of overpayments, refunds of sales, gasoline, property or municipal taxes paid.

- **Interest Income:** Interest earned on advances/subsidy must be included in the income of LHIN and MOHLTC-funded programs. HSPs may use interest income earned on LHIN or MOHLTC funds to support LHIN or MOHLTC funded activities within the same fiscal year.

- **Other Income:** Income arising from charges levied for the use of LHIN or MOHLTC subsidized resources such as parking fees, staff or visitor accommodation or meals, space or equipment rentals, transportation charges etc.

- **Other Grants or Subsidies (non-LHIN/MOHLTC):** Payments received from other ministries, government bodies or community agencies for costs ordinarily subsidizable. These revenues are not recorded or accounted for separately.

- **Reporting on Funds from Different Sources:** HSPs that receive funding from more than one source must allocate expenses – including central administration costs – fairly and appropriately to each funding source, keep separate financial records for LHIN or MOHLTC funding, and report separately on their use of these funds.

- **Client Fees to be used in the Subsidy Calculation:** Income arising from charges made for the provision of LHIN or Ministry funded services.

- **Fundraising and Donations:** The specific amount of local contributions will be determined through the budgeting process.

- **Consulting or Training Fees:** This includes fees charged for services provided to other Organizations (e.g. training, consulting or other related services).

- **Rental Fees:** Any income generated from renting space paid for by LHIN or MOHLTC funding. This income must be used to cover any expenses related to the rentals. Any excess can be used to support/enhance LHIN or MOHLTC funded activities in the same fiscal year. At the end of the fiscal year, any rental income that is not spent on program activities will be recovered.

iii. Sector Specific Requirements

<u>Mental Health and Addictions</u>

- **Fees for Services Not Funded by LHIN or MOHLTC**
  HSPs may not charge fees for any mental health and addiction services funded by the LHIN or MOHLTC. These services must be made available to the community without cost.

  However, mental health and addictions HSPs may charge:

  - Clients for related activities that are not funded by LHIN or MOHLTC, such as transportation fees or entertainment fees.
  - Fees to cover the cost of photocopying when clients request a copy of their files.
  - Third parties for services provided, such as the Children's Aid Society, lawyers and insurance plans for completing required forms.
  - Private insurance companies and clients from outside Ontario for treatment services.

  As with fund raised dollars, these funds should be reported as other income and must be used to cover the cost of providing the non-LHIN/MOHLTC services. Any excess funds can be used to support other program activities.

- **Other Program/Service Fees**

  HSPs that receive funding from other payers to run distinct programs (e.g., Back on Track) out of a LHIN or MOHLTC-funded program or to provide services using beds funded by LHIN or MOHLTC must report all income from these sources.

  In the case of funding from programs, such as Back on Track, the HSP can allocate a portion of the funding received to overhead expenses, and use that funding to support office expenses and LHIN or MOHLTC-funded activities. The remainder must be reported as other income and can be used however the HSP chooses.

  If an HSP is charging a third party (e.g., private insurer, client from outside Ontario) for beds/staff time that are already paid for by LHIN or MOHLTC, then the HSP must report the income earned.

c. REALLOCATION (Subject to revision pending finalization of the M-SAA template)

i. In-Year Budget Reallocation

After the budget has been approved, Health Service Providers may, within the **fiscal year,** reallocate funds in order to:

- Meet approved service targets,

- Respond to service demands by:

    - providing additional approved services above the service targets.
    - substituting one type of approved service for another.

Reallocated funds can only be used for allowable expenses (*see policy regarding "Expenses – Funded and Non-Funded").*

Prior written approval from the LHIN or MOHLTC (whichever is the applicable funder) is required in advance to reallocate funds:

- To provide a service that was not in the approved budget.
- Between Transfer Payment Business Entities *(see definition in Glossary)* or Dedicated Funding Envelopes.

- From a dedicated funding envelope such as:

    - Sessional fee funding.
    - Non-insured client funding.
    - Physician salary funding.

ii. Permanent Budget Reallocation

To transfer funds permanently, HSPs should use the CAPS process. The HSP will submit a CAPS that reflects the transfer and note the LHIN pre-approved change in the Narrative that accompanies the budget (see Section 4 of CAPS Guidelines). When the budget is approved, then the permanent change is approved.

iii. Allowable Uses of In-Year Unspent Recoverable Funds

Requests to use in-year unspent/surplus funds must be made in writing to the LHIN or MOHLTC (whichever is the applicable funder). Use of the funds must be approved and the funds expended before the end of the fiscal year.

iv. SECTOR SPECIFIC REQUIREMENTS

Mental Health and Addictions

- **Sessional Fees**: The sessional fee allocation cannot be used for any other purposes and must be paid at the prescribed rate. The funds shall be used for the following types of indirect psychiatric services only: Case Conferences; Client Consultation; Staff Consultation; Program Consultation; Program Direction; Educational Services; and System Coordination.

- **Problem Gambling Budget Allocation Expectations:** All HSPs designated to provide problem gambling services receive funding for a minimum of one full-time equivalent (FTE) position. Of the first funded FTE, each HSP is expected to allocate a 0.5 FTE equivalent on prevention awareness activities. For HSPs that provide problem gambling services, there are three approaches to budget allocation, depending on the size of the program:

    - HSPs that receive funding for one FTE position, of which a minimum of 0.5 FTE is committed to prevention awareness activities, are expected to allocate the remaining FTE position to direct client activities.
    - HSPs that receive funding for more than one full-time equivalent, of which a 0.5 FTE is committed to prevention awareness activities, are expected to allocate the remaining FTE positions to direct client service.
    - HSPs with multiple FTEs may be approved to operate with a similar budget allocation as substance abuse services.

<u>**Community Health Centres**</u>

- **Non-Insured Clients:** People residing in Ontario who do not have health insurance are considered a priority population for the purposes of CHC services as they face a significant barrier to accessing appropriate primary care.

  Funding for non-insured clients cannot be reallocated unless approved by the MOHLTC on recommendation from the LHIN.

- **Physician Salaries and Benefits:** Funding for physician salaries cannot be reallocated without prior approval from the LHIN and the MOHLTC.

d. ASSETS

A Registry of Assets must be maintained for physical assets such as buildings, building service equipment and land, vehicles, computers and software, furniture and other equipment that have been purchased by HSPs with funds provided by provincial and community funding. The expectation is that these assets will be used for the provision of services. The LHIN may ask for a copy of the inventory at any time.

It is also expected that when an HSP closes or ceases to provide services, the LHIN or MOHLTC (whichever is the applicable funder) will approve the disposition of assets for which it has provided funding.

- **Instructions for the Registry of Assets:**

    1. List all assets with an original cost in excess of $5,000 with a useful life longer than one year ("original cost" is defined as the original cost of the asset including transportation and set-up, net of discounts or the total cost of a capital lease).

2. List assets by category: Buildings and Land, Building Service Equipment, Leasehold Improvements, Vehicles, Computers & Software, Furniture, Other Equipment and Other (Specify). Details should include date of purchase, cost, description (serial number if possible) and amortization rate.

3. There must be a notation of the source of funds used for the purchase of the asset (i.e., ministry, fundraising or donation).

4. There must be a policy on the disposal of assets. The registry should include a separate list of the items disposed of, including date, methods of disposition and proceeds from disposition. As per the M-SAA Section 4.9, the HSP shall not, without the LHIN's prior written consent, sell, lease or otherwise dispose of any assets purchased with Funding, the cost of which exceeded [$25,000] at the time of purchase.

5. The asset registry must be kept current and must balance with the total year-end asset and amortization accounts on the balance sheet.

6. HSPs use straight-line amortization per CIHI guidelines. Current Year's Purchases (e.g., recorded in Balance Sheet Accounts 32854, 32862, 32871, or 32884) are recorded in the year-end submission to meet the needs of Statistics Canada. These accounts are cleared at the beginning of the new fiscal year to their related Total Asset accounts (e.g., 32850, 32857, 32870, 32880).

e. OTHER FINANCIAL REQUIREMENTS

i. Generic

- **Basis of Accounting:** Health Service Providers must maintain financial records in accordance with Generally Accepted Accounting Principles (GAAP).

- **Restriction on Borrowing:** Health Service Providers may not use LHIN or MOHLTC funding or fixed assets purchased with LHIN or MOHLTC funds as collateral when borrowing money without the prior written consent of LHIN or MOHLTC.

- **Other Payments:** Where fees are appropriate and possible, Health Service Providers should collect fees from third parties such as the Workplace Safety and Insurance Board (WSIB). All funds collected for other direct billing services are recoverable by the ministry.

- **Unspent Recoverable Funds:** All unspent recoverable funds are the property of the government and are returned to the government at the end of the fiscal year.

Unspent funds cannot be carried forward from one fiscal year to the next. The LHIN or MOHLTC (whichever is the applicable funder) will recover unspent funds as soon as possible after an HSP submits its settlement forms and audited financial statements.

The LHIN or MOHLTC (whichever is the applicable funder) recovers funds by reducing future payments/cash flow to the HSP. Interim recovery is based on the HSP's submitted settlement forms. Further adjustments may be made after the final budget review by the LHIN or MOHLTC (whichever is the applicable funder).

- **Purchases Under $5,000:** Minor capital expenses under $5,000 can be incurred without LHIN or MOHLTC (whichever is the applicable funder) approval. However, all purchases must be essential to the delivery of services and made prior to the end of the fiscal year.

- **Purchases Over $5,000:** After the budget is approved, HSPs are required to seek LHIN or MOHLTC approval (whichever is the applicable funder) in writing for any capital purchase over $5,000 (e.g., equipment, leasehold improvements, renovations). The HSP is expected to request at least three quotes for the items, and to keep the quotes on file. If the agency did not secure three quotes, it must include in its request the justification for purchasing from the supplier (e.g., only supplier able to deliver, only supplier to provide support, quality of product).

- **Procurement of Goods and Services:** HSPs shall have a procurement policy in place that requires the acquisition of supplies, equipment or services valued at over $25,000 through a competitive process that ensures the best value for funds expended. If the HSP acquires supplies, equipment or services with LHIN or MOHLTC funding (whichever is applicable) it shall do so through a process that is consistent with this policy. Assets purchased at a cost of which exceeds [$25,000] at the time of purchase must be reported to the LHIN or MOHLTC (whichever is the applicable funder) annually.

- **Funding for Major Capital Expenses (more than $100,000):** HSPs requiring major capital funding (more than $100,000) for building renovations can apply to another source of funding within MOHLTC. To qualify for this funding, HSPs must first submit a proposal using the Capital Project Request Form to the LHIN for confirmation of support or endorsement and then to the MOHLTC copying the LHIN. Additional information on major capital funding is available in the MOHLTC Capital Planning Manual.

ii. SECTOR SPECIFIC REQUIREMENTS

Community Support Services

- **Funding for Community Services:** The LHIN or MOHLTC will fund up to 100% of approved expenditures minus revenue from other sources such as client fees and local fundraising for eligible services.

- **Client Fees:** Client fees must be charged for meals-on-wheels, wheels-to-meals/diners club, transportation, the meals and transportation services of the adult day service, home maintenance and repair.

  In the case of brokered services a client fee may be paid directly to the person or company that performs the work. Client fees for brokered services are not included in the budget.

Community Health Centres

Non-Insured Clients: Some CHCs receive funding to provide diagnostic services (laboratory and x-ray) and/or specialist care (OHIP listed procedures) for their non-insured clients. Funding provided to purchase these services shall not be used for any other purpose.

CHCs that purchase these services shall:

- Ensure payments made for such services are in accordance with OHIP fee schedules;
- Cover specialists' services only if provided in a provider's office, at the client's home or in a hospital; and
- Cover only those hospital-related costs that the MOHLTC would cover for an Ontario resident with OHIP coverage.

CHCs receiving non-insured client funding shall report on the expenditure of these funds. Any unspent funds are subject to recovery.

12. Appendix E: Listing of Performance Dimensions and Indicators

Indicators will be made available when the M-SAA consultations are complete.

13. Appendix F: LHIN Contact Information

Readers are directed to each LHIN's web site for contact information. Each LHIN will have a "CAPS/M-SAA" page on the website to provide updates, FAQs, etc.

Listed below is the home page for each LHIN's web site and a link to a page devoted to CAPS/M-SAA information including contact information, forms, and FAQ's.

LHIN	Web Site Home Page	CAPS/M-SAA Link (TBC)
Central	http://centrallhin.on.ca/	
Central East	http://www.centraleastlhin.on.ca/	
Central West	http://www.centralwestlhin.on.ca/	
Champlain	http://www.champlainlhin.on.ca/	
Erie St. Clair	http://www.eriestclairlhin.on.ca/	
Hamilton Niagara Haldimand Brant	http://www.hnhblhin.on.ca/	
Mississauga Halton	http://www.mississaugahaltonlhin.on.ca/	
North Simcoe Muskoka	http://www.nsmlhin.on.ca/	
North East	http://www.nelhin.on.ca/	
North West	http://www.northwestlhin.on.ca/	
South East	http://www.southeastlhin.on.ca/	
South West	http://www.southwestlhin.on.ca/	
Toronto Central	http://www.torontocentrallhin.on.ca/	
Waterloo Wellington	http://www.waterloowellingtonlhin.on.ca/	