MINISTRY-LHIN PERFORMANCE AGREEMENT
APRIL 1, 2010 – MARCH 31, 2012

Consolidated Amendments Effective August 1, 2011

BETWEEN:

Her Majesty the Queen in right of Ontario, as represented by the Minister of Health and Long-Term Care ("MOHLTC")

- and -

Toronto Central Local Health Integration Network ("LHIN")

Introduction

On April 1st 2006, Ontario transformed healthcare services across the province through the establishment of 14 Local Health Integration Networks (LHINs) that are collectively responsible for more than $21 billion in annual health expenditures. Throughout this devolution, Ontario's healthcare system remains a single system with 14 local health systems working together to plan, fund, coordinate and integrate the delivery of care across the province.

The creation of the LHINs and the devolution of responsibilities to the LHINs are underpinned by government's ultimate accountability for expenditure of taxpayers' money on health services. This allows the MOHLTC to exercise an appropriate and legitimate scrutiny of fiscal management and health services delivery through the LHINs.

Devolution of this magnitude requires the MOHLTC to set the tone for the use of public funds through effective stewardship and putting in place effective financial controls. In doing so, the MOHLTC is guided by two fundamental principles: serving the public interest, and maintaining the public trust.

To ensure consistency of healthcare services across the province, the MOHLTC as steward of the healthcare system is responsible for setting provincial strategic direction and priorities, as well as developing legislation, regulations, standards and policies.

As local health system managers LHINs engage broadly with patients and their families, health service providers and other stakeholders when making decisions that impact health services in their geographic area. LHINs play a critical role in achieving the government's strategic priorities for Ontario's health care system, as well as addressing local priorities identified through the LHINs Integrated Health Service Plans.

As Crown agents, LHINs are accountable for working with the MOHLTC and local health service providers to ensure compliance with provincial legislation, regulations, standards and policies and managing performance at the local level. LHINs work together to build capacity within their local health systems, improving quality and access to care and championing innovation. In doing so, LHINs are expected to use a continuous quality improvement process, monitoring and evaluating progress to identify best practices to build capacity in their system in an efficient and effective manner.

Together the MOHLTC and LHINs are working to create a more integrated, sustainable

healthcare system that is person-centered, and results-driven. The goal of an integrated system is to improve the individual's experience as they move through the continuum of healthcare services through creating a more coordinated, easy to navigate system while making effective and efficient use of existing resources. Developing a truly integrated system will improve the quality, accessibility and sustainability of healthcare provided to the people of Ontario.

With funding authority for Hospitals, Long-Term Care Homes, Community Health Centres, Community Care Access Centres, Community Support, Mental Health and Addictions, the LHINs are a key partner with the MOHLTC in ensuring the sustainability of the healthcare system. This Agreement sets out obligations for MOHLTC and LHINs related to ensuring financial accountability, sustainability and performance of the health care system.

The MOHLTC has implemented a number of measures and mechanisms aimed at providing effective oversight and accountability as well as governing LHIN operations and conduct. This includes the introduction of the *Broader Public Sector Accountability Act, 2010 that* mandates new rules and accountability standards to increase transparency for the broader public sector that includes LHINs and hospitals. It also includes the Excellent Care for All Act (ECFAA) which aims to put Ontario patients first by strengthening the health care sector's organizational focus and accountability to deliver high quality patient care. The goal of ECFAA is to blend quality and value in such a way that Ontarians will be able to count on the health care system for generations to come.

The MOHLTC is responsible for determining the funding and establishing the financial framework under which the MOHLTC and LHINs manage Ontario's health system. This financial framework sets out expectations around effective and efficient management, including balanced budget requirements, contingency planning and risk management. These rules promote financial health, accountability and support achievement of performance objectives. LHINs must comply with and manage within these financial rules when planning for and allocating resources as it will help ensure strong financial oversight and effective and efficient management of resources across the local health system.

This Performance Agreement ("Agreement") reflects the evolution of LHINs, the ongoing transformation of Ontario's health system and the importance of accountability between the MOHLTC and LHINs. It replaces the MOHLTC-LHIN Accountability Agreement ("MLAA") effective April 1, 2007 to March 31, 2010, which reflected the relationship of both parties at that time and included process and operational detail.

This Agreement is one document with the accountability framework that defines the roles, responsibilities and accountabilities of the MOHLTC and LHINs. Other accountability instruments include the *Local Health System Integration Act, 2006*, ("LHSIA") which sets out the LHINs legislative authority with respect to their health service providers, and requires the LHINs and MOHLTC to have an accountability agreement. The Memorandum of Understanding (MOU) between the Minister of Health and Long-Term Care and the LHINs is a requirement of the Management Board of Cabinet's Agency Establishment and Accountability Directive. The purpose of the MOU is to clarify the relationship between the Minister and the LHINs as Crown agents.

The three documents, LHSIA, 2006, the MOU and this Performance Agreement, define the accountability framework between the MOHLTC and the LHINs. In addition, LHIN boards provide quarterly compliance declarations, the LHIN Chief Executive Officers meet quarterly with the MOHLTC to review performance, and the LHINs submit detailed financial and risk

reports quarterly.

This Agreement will not modify matters covered by legislation and regulations, government directives, inter-ministerial agreements, inter-governmental agreements, and provincial program standards.

Section 1 – Primary Purpose of the Agreement

1.1 Further to the LHSIA, this Agreement supports the agency relationship between the MOHLTC and the LHIN to carry out the made in Ontario solution to improve the health of Ontarians through better access to high quality health services, to co-ordinate and integrate health care in local health systems and to manage the health system at the local level effectively and efficiently. Maintaining consistent policies and procedures across LHINs is critical to addressing local priorities that support the goal of a single, integrated provincial health system.

1.2 The purpose of this Agreement is to set out the mutual understandings between the MOHLTC and the LHIN of their respective performance obligations in the period from April 1, 2010 to March 31, 2012 covering the 2010-2011, 2011-2012 fiscal years. This is an accountability Agreement for the purposes of section 18 of the LHSIA.

1.3 The LHIN is responsible for managing its performance and the performance of the local health system as set out in this Agreement and using its authority under law. The MOHLTC is responsible for working with the LHIN to achieve those ends. The MOHLTC and the LHIN recognize that issues may arise in the local health system that will require joint MOHLTC-LHIN problem-solving, decision-making and action.

Section 2 – Principles

2.1 **Both parties** will carry out the responsibilities and obligations based on principles that reflect:

a) Strategic Alignment with Government Priorities;

b) Consistency;

c) Performance Improvement;

d) Flexibility;

e) Openness and Transparency;

f) Innovation and Creativity;

g) Sustainability of the healthcare system through sound financial management

h) Achievability;

i) Quality Care; and

j) Person-Centered Care

Section 3 – Definitions and Interpretation

3.1 The following terms have the following meanings in all the Schedules:

“Agreement” means this Agreement, including any schedules, and any instrument which amends this Agreement.

“Annual Business Plan” means the plan for spending the funding received by the LHIN from the MOHLTC and included in this Agreement as required by s. 18(2) (d) of the LHSIA.

"community" has the meaning set out in section s. 16(2) of the LHSIA.

“Consolidation Report” means a report that includes the LHIN’s revenues and expenditures for LHIN operations and transfer payments to health service providers, and balance sheet accounts for the LHIN.

“eHealth” means the coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the healthcare system. Key application areas of eHealth in Ontario include, but are not limited to:

- Electronic health information systems (e.g., electronic medical records, hospital information systems, electronic referral and scheduling systems, digital imaging and archiving systems, chronic disease management systems, laboratory information systems, drug information and ePrescribing systems)
- Electronic health information access systems (e.g., provider portals, consumer eHealth)
- Underlying enabling systems (e.g., client/provider/user registries, health information access layer)
- Remote healthcare delivery systems (e.g., telemedicine services)

“eHealth Ontario” means the government agency responsible to the Minister of Health and Long-Term Care which is a corporation without share capital created and continued in Ontario Regulation 43/02 made under the *Development Corporations Act*.

“fiscal year” means April 1 to March 31.

"health service provider" has the meaning set out in s. 2(1) of the LHSIA.

“IHSP" means the integrated health service plan and "integrated health service plan" has the meaning set out in section 2(1) of the LHSIA.

“Primary Purpose” has the meaning set out in section 1 of this Agreement.

“Regular Report” means a report that includes a statement of the LHIN’s revenues, actual expenditures, forecasted expenditures for LHIN operations, transfer payments, an explanation of variances as required between the forecasted expenditures and revenues, and the identification of any financial and performance risks.

“Schedule” means any one of and “Schedules” means any two or more of the schedules appended to this Agreement, including the following:

1. General;
2. Local Health System Program Management;
3. Funding and Allocations;
4. Local Health System Performance; and
5. Integrated Reporting.

"service accountability agreement" means the service accountability agreement that the LHIN and a health service provider are required to enter into under subsection 20 (1) of the LHSIA.

"**year-end**" means the end of a fiscal year.

3.2 The term "**Dedicated Funding Envelope**" in respect of a specific service means the amount of dollars that must be used by the LHIN to fund the provision of a specific service, and:

a) The LHIN may, at its discretion, provide additional funding for the service; and

b) If the Dedicated Funding Envelope is not used for the specific service, the Dedicated Funding Envelope will be reallocated by the LHIN with the prior approval of the MOHLTC or returned to the MOHLTC.

Section 4 – Accountability of Each Party

4.1 The MOHLTC will fulfil the performance obligations and provide the performance deliverables set out in the Schedules in accordance with the Terms of the Agreement.

4.2 The LHIN will fulfil the performance obligations and provide the performance deliverables set out in the Schedules in accordance with the Terms of the Agreement. Deliverables will be incorporated into the LHIN's quarterly reports to the MOHLTC as set out in the Schedules.

4.3 Both parties will collaborate and cooperate to:

(a) Facilitate the achievement of the requirements of the Agreement;
(b) Promote financial sustainability and efficient utilization of financial resources;
(c) Develop clear and achievable service and financial performance obligations and identify risks to performance;
(d) Establish clear lines of communication and responsibility; and
(e) Work diligently to resolve issues in a proactive and timely manner.

4.4 The LHIN is responsible for managing its performance and the performance of the local health system as set out in the Agreement and using its authority under law. The MOHLTC is responsible for working with the LHIN to achieve those ends. The MOHLTC and the LHIN recognize that issues may arise in the local health system that will require joint MOHLTC-LHIN problem-solving, decision making and action.

Section 5 – Performance Improvement

5.1 The parties agree to adopt and follow a proactive and responsive approach to performance improvement, based on the following principles:

a) A commitment to prudent financial management;
b) A commitment to continuous performance improvement through innovation and creativity;
c) An orientation to problem-solving; and
d) A focus on relative risk of non-performance.

5.2 Where matters arise that could significantly affect either the LHIN or MOHLTC's ability to perform their obligations under this Agreement, they shall provide written notice to the other party as soon as reasonably possible (a "Performance Factor"). Notice shall include a description of any remedial action the party has taken or plans to take to remedy the issue. Receipt of notice will be acknowledged within 5 business days of the date of the notice. The parties agree to meet and discuss the "Performance Factor" within one calendar month of the date of the notice.

5.3 During the meeting, using the principles set out in section 5.1, the parties will discuss:

(a) the causes of the Performance Factor;

(b) the impact of the Performance Factor and whether it poses a "low", "moderate" or "high" risk to achieving the obligations of the Agreement;

(c) the steps in the performance improvement process to be taken to mitigate the impact of the Performance Factor; and

(d) whether revisions or amendments to a party's performance obligations are required.

5.4 Where a LHIN Performance Factor is involved, the MOHLTC will determine the remedies to improve performance, depending on the extent, exposure or level of risk.

Section 6 – Next MOHLTC LHIN Agreement

6.1 The Parties will enter into a new agreement under section 18 of the LHSIA to be effective at the end of this Agreement. If the new agreement is not signed by the Parties by April 1, 2012 this Agreement will continue in force until the new agreement is signed. The Parties will make their best efforts to sign a new agreement as soon as they are able.

Section 7 – General

7.1 Any amendment to this Agreement will only be effective if it is in writing and executed by the authorized representative of each party.

7.2 The LHIN will not assign any duty, right or interest under this Agreement without the written consent of the MOHLTC.

7.3 If a due date for materials falls on a weekend or on a holiday recognized by the MOHLTC, the materials are due on the next business day.

7.4. Each Schedule applies to the 2010-12 fiscal years, unless stated otherwise in a

Schedule. Some of the performance obligations in a Schedule may apply only to one fiscal year, as stated in that Schedule.

7.5 Each party will communicate with each other about matters pertaining to this Agreement through the following persons:

To the MOHLTC:
Ministry of Health and Long-Term Care,
Health System Accountability and Performance Division
Hepburn Block, 10th Floor
80 Grosvenor Street,
Toronto, ON M7A 1R3

Attention:
Assistant Deputy Minister,
Health System Accountability and Performance

Fax: (416) 212-1859
Telephone: (416) 212-1134

With a copy to:
Director, Local Health Integration Network (LHIN) Liaison Branch
80 Grosvenor St.
5th Floor, Hepburn Block
Toronto, ON M7A 1R3

Fax: (416) 326-0018
Telephone: (416) 314-1864

To the LHIN:

Toronto Central Local Health Integration Network
425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4

Attention: Chair

Fax: (416) 921-0117
Telephone: (416) 921-7453

With a copy to:

Toronto Central Local Health Integration Network
425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4

Attention: CEO

Fax: (416) 921-0117
Telephone: (416) 921-7453

Made effective this 1st day of April, 2010 by:

Her Majesty the Queen in right of Ontario, as represented by the Minister of Health and Long-Term Care:

_____
The Honourable Deb Matthews
Minister of Health and Long-Term Care

Toronto Central Local Health Integration Network

By:

_____
Angela Ferrante
Chair

SCHEDULE 1: GENERAL

PART A. PURPOSE OF SCHEDULE 1

- To set out general obligations for the MOHLTC and LHINs with respect to their roles and responsibilities.

PART B. GENERAL ROLES AND RESPONSIBILITIES

Government Priorities and Provincial Strategies

1. The **MOHLTC**:

   a) Will establish priorities for the provincial health system and communicate these priorities to the LHINs. These priorities may be revised from time to time to reflect changes in the government's priorities as the health system continues to evolve; and

   b) May develop provincial strategies to support the achievement of the government's priorities for the health system and determine any specifications and conditions of funding, including Dedicated Funding, related to these strategies and communicate these to the LHIN.

2. The **LHIN** will:

   a) Work with the MOHLTC and LHIN local health service providers to achieve government priorities in their local health system; and

   b) Work with the MOHLTC and LHIN health service providers to implement provincial strategies based on any specifications and conditions of funding, including Dedicated Funding, as identified by the MOHLTC.

   c) Work with Health Quality Ontario in supporting hospitals' quality improvement requirements under ECFAA.

Consistency

3. The **MOHLTC** will:

   a) Identify issues and initiatives for which consistency across LHINs is required and develop the principles and parameters for the LHINs to follow in developing policies, procedures, and practices to achieve consistency;

   b) Consult with the LHINs on the principles and may at its discretion consult with the LHINs on the parameters.

4. The **LHIN** will:

   a) Work with other LHINs to identify issues and initiatives requiring a consistent approach; and

b) Develop and implement the procedures and practices based on MOHLTC criteria where applicable, necessary to achieve consistency.

Local System Coordination and Integration

5. The **LHIN** will:

a) Develop, implement and monitor achievement of the Integrated Health Services Plan reflective of local priorities and service needs

b) Work with their health service providers and other LHINs using available resources within the local health system to improve governance, coordination and integration of health care delivery across the continuum of care and between and among LHINs; and

c) Optimize and utilize the capacity and full potential of its local Community Care Access Centres (CCACs).

Community Engagement

6. The **LHIN** will:

a) Regularly review its community engagement activities/strategies to align with best practices;

b) Engage with French language health planning entities selected by the Minister under Ontario Regulation 515/09 made under LHSIA about the matters prescribed in the regulation, and comply with any obligations set out in the agreement with the French language health planning entities required under the regulation; and

c) Report on their community engagement activities and related performance measurement results in their Annual Report.

7. **Both parties** will:

a) Work together to develop guidelines for community engagement including principles, best practices, and performance indicators to measure the effectiveness of LHIN community engagement strategies; and

b) Publicly post performance indicators for community engagement and the performance measurement results by LHIN on the MOHLTC and LHIN websites.

Information Management

8. The **MOHLTC** will:

a) Develop and communicate data standards, data quality definitions, and reporting timelines;

b) In collaboration with the LHIN, identify LHIN data/information requirements to support data infrastructure for LHIN operational needs;

c) Receive data and information from health service providers on behalf of the LHIN

and provide timely access to the appropriate data to support health system needs.

9. The **LHIN** will:

a) Require health service providers to submit data and information as set out in clauses 8(a) and (b) to the MOHLTC, Canadian Institute for Health Information ("CIHI"), or other third party under the terms of agreements assigned to the LHIN, service accountability agreements or the LHSIA;

b) Identify LHIN data/information requirements to support LHIN analysis at the local level, and work collaboratively with the MOHLTC to develop appropriate methodology, consistent data analysis and reporting;

c) Work with health service providers to improve data quality and timeliness as necessary.

10. **Both parties** will:

a) Avoid duplicating data and information management infrastructure and processes, determine and prioritize data and information products, and streamline reporting requirements and timelines for the LHIN and health service providers

b) Continue to work collaboratively to identify and discuss data, propose strategies to address data and information gaps, information management requirements, decision support requirements, standards, data quality issues, and other pertinent information management topics.

<u>Compliance Protocols</u>

11. Definitions. In this section on Compliance Protocols:

a) "LTCH" means long-term care home; and

b) "LTC health service provider" means a health service provider that is licensed or approved to operate a LTCH.

12. The **MOHLTC**:

a) Will retain its compliance, inspection and enforcement authorities under legislation;

b) Except as provided in paragraph 12(c), will consult with the LHIN when considering the following activities:

i) Appointing an investigator or supervisor for a health service provider under a statute;

ii) Ordering a health service provider to suspend or cease an activity or taking over or closing the operations of a health service provider, other than a LTCH under legislation;

iii) Proposing to revoke or revoking or suspending an approval or license of a health service provider under a legislation; or

iv) Terminating the rent supplement agreement or the operating agreement for a building with a health service provider that provides supportive housing and receives funding from the LHIN for support services.

c) May, take any action set out in subparagraphs 12(b)(i) to (iv) without consulting the LHIN where the MOHLTC considers that it is in the public interest to do so, or where the MOHLTC considers that there is a need to exercise its statutory authority and there is insufficient time in the circumstances to consult the LHIN. In either event, the MOHLTC will advise the LHIN as soon as reasonably possible of the MOHLTC's actions;

d) Subject to paragraphs 12(a) and (b), will exercise its statutory authorities at its discretion and as required under law respecting licensing, approving, inspecting and enforcing LTCH legislation, and, for greater certainty, will inspect, as appropriate, LTC health service providers for compliance with legislation respecting resident trust funds, payments by residents to LTC health service providers and any MOHLTC managed programs; and

e) Will inform the LHIN as soon as reasonably possible on matters related to compliance, inspection and enforcement in LTCHs through a mutually agreeable reporting schedule.

13. The **LHIN** will:

a) In managing its local health system, exercise its legislative and contractual authorities as necessary or as required under law, including conducting or commissioning audits and reviews of health service providers, other than inspections of LTCHs as performed by the MOHLTC;

b) Conduct, as necessary or as required under law, audits and reviews of LTC health service providers related to financial matters and performance, other than for MOHLTC Managed Programs;

c) Consult with the MOHLTC prior to any decision to terminate or reduce funding to a LTC health service providers that has the potential to negatively impact resident care;

d) Inform the MOHLTC:

i) As soon as reasonably possible of non-compliance by a health service provider with an assigned agreement, a service accountability agreement, or legislation, including program standards; or

ii) As soon as reasonably possible of the results of any audit or review of a health service provider conducted by or commissioned by the LHIN, which may establish grounds for the MOHLTC to take any action described in subparagraphs 12 (b)(i) to (iv) against the health service provider; and

e) In addition to paragraph 13 (d), inform the MOHLTC:

(i) As soon as reasonably possible of a LTC health service provider experiencing financial issues that may cause non-compliance with resident care or resident rights standards under LTCH legislation; or

(ii) Immediately of a critical or urgent matter related to alleged non-compliance with LTCH legislation.

14. **Both parties** will jointly develop guidelines for the LHIN on conducting audits, inspections, and reviews of health service providers, other than inspections under LTCH legislation, to ensure consistency among LHINs, where appropriate, in managing the local health system;

eHealth

15. The **MOHLTC** will:

(a) Seek input, as appropriate, from the LHIN about provincial strategic directions and priorities for eHealth;

(b) Provide the LHIN with provincial strategic directions and priorities for eHealth and provide any updates of them as they are made from time to time;

(c) Provide the LHIN with guidance on the alignment of provincial eHealth strategic directions with other MOHLTC priorities and programs;

(d) Provide support to the LHIN and eHealth Ontario, if required, in the development of their agreement to implement specific eHealth initiatives;

(e) Provide funding to the LHIN for the implementation of specific eHealth initiatives, as recommended by eHealth Ontario or as sponsored by MOHLTC;

(f) Set technical and information management standards related to eHealth and, in consultation with the LHIN, implementation / compliance timeframes for the interoperability of the health system in Ontario, including standards related to architecture, technology, privacy and security; and

(g) Develop and implement policies required for the implementation and/or operation of eHealth initiatives.

16. The **LHIN** will:

(a) Provide input to the MOHLTC and eHealth Ontario, as requested, about provincial strategic directions and priorities for eHealth;

(b) Prepare an annual LHIN eHealth plan that aligns with the provincial eHealth priorities and strategic directions;

(c) Use the funding it receives from the MOHLTC to implement the specific approved eHealth initiatives;

(d) Include eHealth commitments in service accountability agreements with health service providers, including commitments to:

- comply with any technical and information management standards, including those related to architecture, technology, privacy and security,

set for health service providers by the MOHLTC or the LHIN within the timeframes set by the MOHLTC or the LHIN as the case may be;

- implement and use the approved provincial eHealth solutions identified in the LHIN eHealth plan; and
- implement technology solutions that are compatible or interoperable with the provincial blueprint and with the LHIN eHealth plan.

(e) Report on eHealth initiatives in the LHIN annual report.

17. Both parties will work together and in conjunction with eHealth Ontario as appropriate to:

(a) Participate in forums for the discussion of eHealth issues at a provincial level to identify options to support the roll out of eHealth initiatives and related eHealth issues including local health system needs, challenges, and opportunities and eHealth standards, definitions, and architectural frameworks; and

(b) Inform one another of significant issues or initiatives that contribute to or impact on provincial or local eHealth issues, strategies or work plans.

Capital - General Provisions

18. The **MOHLTC** will consider recommendations from the LHIN about the capital needs of the local health system.

19. The **LHIN** will make recommendations to the MOHLTC about the capital needs of the local health system.

20. **Both parties** will work together to implement the jointly developed capital planning framework for the early capital planning stages (Pre-capital, Stage 1 Proposal and Stage 2 Functional Program).

Capital Initiatives

21. a) Definitions. In reference to the capital review and approvals process set out in paragraphs 21 through 24:

"Capital Initiatives" means any initiative of a health service provider related to the construction, renewal or renovation of a facility or site that is not an Own-Funds Capital Project or funded out of the Health Infrastructure Renewal Fund (HIRF); and

"Endorsement" means a LHIN Board recommendation to the MOHLTC for the program and service elements of a health service provider's capital submission as outlined in applicable guidelines.

b) Capital Review and Approvals Process: The capital review and approvals process has three early planning submission stages: (i) Pre-Capital; (ii) Stage 1 Proposal; and (iii) Stage 2 Functional Program. Each of these stages is divided into two parts: (i) Part A: Program and Service Elements; and (ii) Part B: Physical and Cost Elements. At each

stage, the LHIN will review Part A of each submission and will advise the MOHLTC on the consistency of the proposed initiative with local health system plans and its relative priority in relation to other initiatives. The MOHLTC will consider the LHIN's advice in respect of Part A, when considering both Part A and Part B and determining whether the initiative should proceed to the next stage.

22. The **MOHLTC** will:

a) With consideration for a LHIN's advice and/or Endorsement as the case may be, review Parts A and B of a health service provider's Pre-Capital Proposal, and Functional Program submissions and determine whether the initiative should be advanced to the next stage; and

b) In the event the MOHLTC's review process at any stage results in a material change to the Part A submission of that stage, the MOHLTC will ask the LHIN to reconsider its advice or Endorsement as the case may be, before the MOHLTC determines whether the submission as revised, should be approved and the initiative advanced to the next stage.

23. The **LHIN** will:

a) Review Part A of each of a health service provider's Pre-Capital, Proposal, and Functional Program submissions based on applicable guidelines;
b) Provide advice on the consistency of the program and service elements outlined in Part A with local health system needs;
c) Where Part A is consistent with local health system needs, provide an Endorsement; and
d) Where a MOHLTC review at any stage results in a material change to the Part A submission of that stage, the LHIN will consider the revisions and provide advice or an Endorsement to the MOHLTC as set out in (b) and (c) above, on the revised Part A.

24. **Both parties** will work together to ensure local and provincial program alignment as well as alignment between the programs and services, and physical and cost elements, of a health service provider's submission at the early planning stages.

<u>Own-Funds Capital Projects</u>

25. The term "Own-Funds Capital Projects" means capital projects funded by a public hospital without capital funding from the Government of Ontario, including the MOHLTC and the LHIN.

26. **Both parties** will work together to:

(a) Enable the LHIN to provide advice about the consistency of a public hospital's Own-Funds Capital Project with local health system needs during review and approval processes, including Pre-Capital, Proposal, and Functional Program stages; and

(b) Devolve the review and approval process for Own-Funds Capital Projects from the MOHLTC to the LHIN, as appropriate, and subject to any eligibility criteria

established by the MOHLTC for these projects.

Health Infrastructure Renewal Fund (HIRF) and Post-Construction Operating Plan (PCOP)

27. (a) "HIRF" means the health infrastructure renewal fund established to provide capital funding grants of usually less than $1 million for the renewal or renovation of a public hospital; and
    (b) "PCOP funding" means post-construction operating plan funding provided to a public hospital in the local health system for service expansion and other costs occurring in conjunction with the completion of an approved capital project.

28. The **MOHLTC** will determine the amount of the Dedicated Funding Envelope for HIRF funding and for PCOP funding for a public hospital in the local health system for each fiscal year, including any conditions of such funding;

29. The **LHIN** will use the Dedicated Funding Envelope for the HIRF and for PCOP to provide funding to public hospitals in accordance with the conditions of such funding and incorporate any conditions of the funding into service accountability agreements with public hospitals.

Emergency Management

30. **Both parties** will jointly develop guidelines and/or protocols clarifying roles and responsibilities related to emergency management.

General Performance Obligations

31. The **MOHLTC** will:

    a) Provide the LHIN with, and develop as appropriate, those provincial standards (such as operational, financial or service standards and policies, operating manuals and program eligibility), directives and guidelines that apply to health service providers, including providing the LHIN with relevant program manuals;

32. The **LHIN** will:

    a) Provide a Certificate of Compliance to the MOHLTC in form and substance as required by the MOHLTC;

    b) Require health service providers to provide services funded by the LHIN in accordance with applicable legislation as well as those provincial standards, directives and guidelines provided pursuant to paragraph 31 (a) above;

    c) Carry out the obligations of the MOHLTC in any agreements that may be assigned to the LHIN.

    d) effective April 1, 2011, comply with its obligation to make attestations under section 14 of the *Broader Public Sector Accountability Act, 2010*, including the requirement to post the attestations on the LHIN's website; and

    e) require health service providers under the service accountability agreement with the

LHIN to comply with the requirements of the *Broader Public Sector Accountability Act, 2010.*

32.1 The LHIN will reduce its executive office costs by 10 per cent over fiscal years 2011/12 and 2012/13, with a minimum of 5 per cent reduction to be made in fiscal year 2011/12. Executive offices consist of the office of the chief executive officer of the LHIN and the office of every member of senior management at the LHIN that reports directly to the chief executive officer. The costs of executive offices includes all costs for those offices, including office space, supplies, salaries and wages of the officers and staff of the offices, conferences held for or by those offices and travel expenses of the officers and staff of the offices. The LHIN will report to the MOHLTC annually about the reduction in executive office costs as required by the MOHLTC. The MOHLTC and the LHIN will work together to identify the executive offices and the costs of the executive offices of the LHIN that are included for the purposes of this section

32.2 The LHIN will also require hospitals and CCACs to reduce their executive office costs by 10 per cent over fiscal years 2011/12 and 2012/13 by amending their service accountability agreements with hospitals and CCACs to include this requirement. Executive offices of hospitals and CCACs consist of the office of the chief executive officer, chief operating officer or executive director, and the office of every member of senior management of a hospitals or CCAC that reports directly to the chief executive officer, chief operating officer or executive director. The costs of executive offices includes all costs for those offices, including office space, supplies, salaries and wages of the officers and staff of the offices, conferences held for or by those offices and travel expenses of the officers and staff of the offices. The LHIN will report to the MOHLTC annually about the reduction in hospital and CCAC executive office costs as required by the MOHLTC.

PART C. ANNUAL REVIEW AND UPDATE

33. The Schedules will be reviewed and updated annually, as necessary to better reflect the Primary Purpose, within 120 days of a budget announcement of the Government of Ontario.

SCHEDULE 2: LOCAL HEALTH SYSTEM PROGRAM SPECIFIC MANAGEMENT

PART A. PURPOSE OF SCHEDULE 2

- To identify the MOHLTC and LHIN's accountability and responsibility in managing specific programs within the local health system.

PART B. SPECIFIC PROGRAM PERFORMANCE PARAMETERS

Provincial Programs

1. The MOHLTC and the LHIN are committed to establishing a coordinated and effective system for provincial program management. These programs are supported by provincial standards and guidelines.

2. The **MOHLTC** will:

   (a) Determine provincial programs and communicate these to the LHINs. These programs may be revised from time to time to reflect the need for centralized coordination outside the scope of any LHIN and/or to identify highly specialized services available in a limited number of locations in the province;

   (b) Determine any specifications and conditions of funding, including a dedicated funding envelope, related to these provincial programs and communicate these to the LHIN; and

   (c) Establish:

      (i) Criteria to assess and review provincial programs;

      (ii) Define roles and responsibilities related to provincial program delivery; and

      (iii) Performance management, monitoring and evaluation processes.

3. The **LHIN** will:

   a) Work with the MOHLTC in the rollout of new programs as required;

   b) Monitor the local delivery of provincial programs and report to MOHLTC according to MOHLTC specifications and conditions; and

   c) Work with other LHINs to coordinate provincial program service delivery.

Other Programs

3.1.1 There may be other programs for which the LHINs are accountable where the MOHLTC will want to establish certain expectations and requirements for the programs; if the MOHLTC does establish such expectations and requirements, it will advise the LHIN of these expectations and requirements for the specific program.

3.1.2 If the MOHLTC advises the LHIN of expectations and requirements for a specific program, the LHIN will require health service providers that provide the specific program to provide services in accordance with the expectations and requirements established by the MOHLTC.

Devolution of Ministry Programs

3.2.1. Definitions. For the purposes of Schedule 2 the following terms shall have the following meanings.

"**Lead LHIN**" means the LHIN selected by the MOHLTC to administer a province-wide program following its devolution.

"**Lead LHIN model**" means a funding and administration model that enables a single LHIN to assume accountability for a province-wide program;

"province-wide program" means a province-wide program that the MOHLTC funds through a single health service provider;

3.2.2 Where the MOHLTC chooses to devolve a province-wide program to the LHINs, the MOHLTC will identify a Lead LHIN, and the particular terms and conditions applicable to the funding and administration of the province-wide program after its devolution, and provide this information to all LHINs. When the MOHLTC is advised by the LHINs that the devolution of the province-wide program has been accepted, the MOHLTC will add the accountability for the devolved province-wide program to its accountability agreement with the Lead LHIN.

3.2.3 The LHIN will

(i) Consider and respond to any request by the MOHLTC to devolve a province-wide program to the LHINs in accordance with the terms of the "Agreement Concerning the Devolution of Provincial Programs" effective April 1, 2011, also known as the Lead LHIN Model Agreement;
(ii) Abide by any program specific terms and conditions identified by the MOHLTC in respect of the devolved province-wide program;
(iii) Administer the devolved province-wide program in accordance with the terms and conditions of the Lead LHIN Model Agreement;
(iv) Post a copy of the Lead LHIN Model Agreement on its website; and
(v) Confirm any proposed changes to the Lead LHIN Model Agreement with the MOHLTC prior to implementation.

3.2.4 The governance and administration of each devolved provincial program may be reviewed by the LHINs and the MOHLTC as required.

Long-Term Care Homes

4. Definitions in this section on Long-Term Care Homes:

a) "Acknowledgement and Consent Agreement" means an agreement entered into between the MOHLTC, the operator of a LTCH, and one or more lenders or secured

parties, by which the MOHLTC consented to, or agreed to request a consent to, any of the following: (a) a mortgage of real property associated with the LTCH, (b) an assignment of a Development Agreement with the MOHLTC, and/or (c) an assignment of a service agreement. Acknowledgement and Consent Agreements are generally not entered in to by the Ministry since July 1, 2010.

b) "CFS per diem" means any per diem funding paid pursuant to a Development Agreement;

c) "Development Agreement" means an agreement between the MOHLTC and a LTC health service provider to develop, upgrade, retrofit or redevelop LTCH beds;

d) "Funding Policies" means the funding and financial management policies determined by the MOHLTC for LTCHs. Funding Policies establish the rates, amounts and envelopes of all funding provided to LTC health service providers by the MOHLTC or the LHIN, including the per diem rate and the per diem envelopes, the Registered Practical Nurses in Long-Term Care Homes Initiative funding, and Other Funding. Funding Policies also establish the applicable conditions for funding, the funding reconciliation rules, and the form, manner and content and date for submission of reports;

e) "LTCH" means long-term care home;

f) "LTCH Protocol" means the document titled "Long-Term Care Homes Protocol" as prepared and amended by the MOHLTC;

g) "LTCHA" means the *Long-Term Care Homes Act, 2007* and regulations thereunder;

h) "LTC health service provider" means a health service provider that is a licensee within the meaning of s. 2(1) of the LTCHA;

i) "Other Funding" means funding for LTCH beds paid in accordance with the Funding Policies, other than the funding paid in accordance with paragraphs 12 and 14, and includes but is not limited to:
- Accreditation Premium
- High Intensity Need Fund (HINF)
- Laboratory Services Funding
- Municipal Tax Funding
- Equalization Adjustment Funding
- RAI-MDS Funding
- Physician On-Call Funding;

j) "service agreement" means the agreement pursuant to which funding is provided to a LTC health service provider and includes a service accountability agreement; and

k) "service accountability agreement" means the service accountability agreement between a LHIN and a LTC health service provider required by s. 20 of LHSIA; .

LTCHs - Total Funding per Diem

5. The **MOHLTC** will:

   a) Determine the Funding Policies and the amount of funding that a LTC health service provider may receive from MOHLTC and LHINs under the Funding Policies;

   b) Provide to the LHIN the Funding Policies and the amount of funding to be provided by the LHIN to the LTC health service providers.

   c) Determine any net projected unused funding for all LHINs that, as of September 30 in each fiscal year, has not or is projected not to be used by LTC health service providers as reported by LTC health service providers through the revenue occupancy reports;

   d) Reallocate a share of the net projected unused funding referred to in subparagraph (b) to the LHIN if the LHIN is projected to be overspent on its funding for the LTCH per diem rate; and

   e) If there is net projected unused funding remaining after the reallocation referred to in subparagraph (c), allocate to the LHIN by December 31 of each year a share of the unused funding in proportion to the number of LTCH beds that are licensed or approved and in operation in the LHIN's geographic area compared to the provincial total number of LTCH beds that are licensed or approved.

6. The **LHIN** will distribute the funding provided under paragraph 11 to LTC health service providers in accordance with the Funding Policies and pursuant to the terms of a service accountability agreement that is consistent with and requires adherence to the Funding Policies.

LTCHs - Construction Funding Subsidy (CFS)

7. The **MOHLTC** will

   (a) determine the CFS per diem and the LTC health service providers in the geographic area of the LHIN that will receive the per diem, including any conditions on the funding and the number of beds for which the LTC health service provider will receive the CFS per diem; and

   (b) provide the CFS per diem to the LHIN.

8. The **LHIN** will provide the CFS per diem to LTC health service providers for each approved or licensed bed that is identified in paragraph 7 and operated in accordance with the MOHLTC's conditions of funding, applicable legislation or Development Agreement.

9. Every service accountability agreement entered into between the LHIN and the LTC health service provider during the term of this Agreement and in the future will contain an obligation on the LHIN to provide the CFS per diem to the LTC health service provider for the length of time set out in the particular Development Agreement for the particular beds.

LTCHs – Assignment of LTC Service Agreement

10. Where the **MOHLTC** has entered into an Acknowledgement and Consent Agreement with a LTC health service provider and one or more lenders of the LTC health service provider (Lender) prior to the proclamation of the LTCHA, the **LHIN** will treat the MOHLTC's consent to assign the service agreement under the Acknowledgement and Consent Agreement as if MOHLTC had provided the consent on behalf of the LHIN.

11. Where an Acknowledgement and Consent Agreement or a Development Agreement between the MOHLTC and the LTC health service provider provides that the MOHLTC will request the LHIN to consent to an assignment of the service agreement, to the Lender or person designated by the Lender, the **LHIN** will consent to the assignment of the service agreement to that person where the MOHLTC so requests, and the consent shall be subject to terms and conditions similar to those of the Acknowledgement and Consent Agreement or the Development Agreement as the case may be.

12. In addition, the LHIN will not unreasonably withhold consent requested from a Lender, or from a receiver or receiver and manager appointed by a Lender or by a court order, to assign its or the LTC health service provider's right, title and interest in the service agreement or any part thereof or interest therein to another party, subject to all applicable legislative requirements.

13. Where the **MOHLTC**

    (a) has entered into a Development Agreement with a LTCH health service provider or a proposed LTCH health service provider (an "Operator");
    (b) has consented to the grant of a security interest to a Lender under the Development Agreement; and
    (c) has directed the LHIN to consent to the assignment of the Operator's rights under a service accountability agreement,

    then the **LHIN**,

    (i) Shall deliver to the Lender a commitment, in the MOHLTC's standard form, to provide the LHIN's consent to the assignment of the Operator's rights under the service accountability agreement between the Operator and the LHIN;
    (ii) Upon the grant of a licence to the Operator in respect of the Home, and for so long as a CFS is to be paid in respect of the Home, shall consent to the grant of a security interest in the service accountability agreement between the LHIN and the Operator in respect of the Home, provided that:

        1) the security interest in the service accountability agreement may only be exercised together with the exercise of a security interest in the licence for the beds; and

        2) the security interest is subject to all applicable statutory requirements and restrictions, including section 107 of the LTCHA and sections 2(2), 19 and 20 of LHSIA; and

(iii) Shall amend section 15.8 of the service accountability agreement in respect of the Home to remove the following sentence: “No assignment or subcontract shall relieve the HSP from its obligations under this Agreement or impose any liability upon the LHIN to any assignee or subcontractor.”

LTCHs - Beds in Abeyance

14. In paragraphs 15 and 16 the term “Beds in Abeyance” are LTCH beds licensed or approved by the MOHLTC, for which the LTC health service provider has obtained written permission from the Director, PICB, in accordance with the LTCHA for the beds not to be available for occupancy.

15. The **MOHLTC** will review and may approve Beds in Abeyance applications with LHIN recommendation as set out in the Beds in Abeyance policy and LTCH Protocol.

16. The **LHIN** may request approval from the MOHLTC to temporarily use the amount of funding available as a result of any approved Beds in Abeyance under paragraph 15, and if the MOHLTC approves the amount under paragraph 17 the LHIN will use the funding in accordance with the approval, including any conditions that may attach to the approval.

17. The **MOHLTC** will review the request described in paragraph 16 and may approve the LHIN to temporarily use this funding subject to any conditions that may attach to the approval.

LTCHs - Short-Stay Program Beds

18. Definitions in paragraphs 18.1 and 19

a) “Convalescent Care Beds” means those short-stay beds, licensed or approved under the LTCHA, that are part of a short-stay convalescent care program for which residents may be eligible for admission in accordance with regulations under the LTCHA.

b) “Dedicated Funding Envelope for Convalescent Care Beds” means the Dedicated Funding Envelope for Convalescent Care Beds funded through that envelope on or before March 31, 2008 as determined by the MOHLTC and adjusted by the MOHLTC from time to time.

c) “Dedicated Funding Envelope for Interim Beds” means the Dedicated Funding Envelope for Interim Beds funded through that envelope on or before March 31, 2008 as determined by the MOHLTC and adjusted by the MOHLTC from time to time.

d) “Interim Beds” means those licensed or approved beds under the LTCHA that would fall within the definition of “interim bed” in accordance with regulations under the LTCHA.

e) “Short-Stay Respite Beds” means those short-stay beds, licensed or approved under the LTCHA, that are part of a short-stay respite care program for which residents may be eligible for admission in accordance with regulations under the

LTCHA.

18.1. The **MOHLTC** will:

a) Determine the minimum threshold for occupancy for Short-Stay Respite Beds;

b) Determine and provide the Dedicated Funding Envelope for Convalescent Care Beds and the Dedicated Funding Envelope for Interim Beds;

c) In consultation with the LHIN, determine the LTC health service providers that will provide the Convalescent Care Beds and the Interim Beds and the number of those beds to be funded by the Dedicated Funding Envelope for Convalescent Care Beds and the Dedicated Funding Envelope for Interim Beds respectively; and

d) Set other conditions of funding related to beds funded with the Dedicated Funding Envelope for Convalescent Care Beds and the Dedicated Funding Envelope for Interim Beds.

19. The **LHIN** will:

a) Take action as appropriate to improve the utilization of Short-Stay Respite Beds;

b) Have the ability to set, in its discretion, a threshold for occupancy of Short-Stay Respite Beds that is higher than the minimum set by the MOHLTC;

c) Determine which LTC health service providers will provide Short-Stay Respite Beds within the existing licensed or approved beds of each home and the number of such beds;

d) Advise MOHLTC about matters referred to in subparagraph 18.1 (c);

e) Use the Dedicated Funding Envelope for Interim Beds and the Dedicated Funding Envelope for Convalescent Care Beds to fund the LTC health service providers referred to in subparagraph 18.1 (c);

f) Incorporate any conditions of funding referred to in subparagraph 18.1 (d) in service accountability agreements;

g) At its discretion, request that the MOHLTC approve the conversion of existing licensed beds in the long-stay program to Convalescent Care Beds in accordance with the LTCH Protocol; and

h) Provide from its allocation, all additional funding for the MOHLTC approved converted Convalescent Care Beds to LTC health service providers in accordance with the Funding Policies, including the additional subsidy for Convalescent Care Beds and the resident co-payment portion of the base level-of-care per diem funding.

LTCHs – LHIN-Requested LTCH Beds

20. In paragraphs 21 and 22 "LHIN Requested LTCH Beds" means a LTCH bed funded by the LHIN out of its allocation, other than its allocation for LTCHs:
    i. that would increase the bed capacity of an existing LTCH licence issued under s.99, or an approval granted under s. 130 of the LTCHA; or
    ii. in the case of a development or redevelopment, that is over and above the number of LTCH beds that the MOHLTC has approved a LTC health service provider for development or redevelopment.

21. The **LHIN** will:

    a) At its discretion, request LHIN Requested LTCH Beds;

    b) In its request identify the number of LHIN Requested LTCH Beds requested, the estimated amount of funding required to support the beds in accordance with the Funding Policies, including Other Funding and funding that would be paid in accordance with paragraphs 12 and 14 in this Schedule, and where the funding will be found within the LHIN's allocation, other than its allocation for LTCHs; and

    c) Fund the LHIN Requested LTCH Beds in accordance with the Funding Policies and paragraphs 6 and 8 of this Schedule if the LHIN's request for LHIN Requested LTCH Beds is granted by the MOHLTC.

22. The **MOHLTC** will:

    a) Consider the LHIN's request for LHIN Requested LTCH Beds and decide whether to grant the request.

    b) Confirm the amount of the funding required to support the beds in accordance with the Funding Policies, including Other Funding and funding that would be calculated pursuant to paragraphs 5 and 7 in this Schedule; and

    c) Reallocate the confirmed funding from the sources identified by the LHIN to (i) the LHIN's allocation for LTCH beds for all funding to be paid in accordance with paragraphs 6 and 8 of this Schedule; and (ii) the MOHLTC's allocation for Other Funding when the LHIN Requested LTCH Beds are available for occupancy.

LTCHs – LHIN-Requested Temporary LTCH Beds

23. In paragraphs 24 and 25, "LHIN Requested Temporary LTCH Beds" means a LTCH bed for which the MOHLTC would issue a temporary licence in accordance with s. 111 of the LTCHA or increase the bed capacity of a temporary licence in accordance with the LTCHA, on the condition that the LTCH bed will be funded by the LHIN out of the LHIN's allocation.

24. The **LHIN** will:

    a) At its discretion, make a request for LHIN Requested Temporary LTCH Beds for a term of no longer than 5 years;

b) In its request identify the number of LHIN Requested Temporary LTCH Beds requested, the estimated amount of funding required to support the beds in accordance with the Funding Policies, including Other Funding and funding that would be paid in accordance with paragraph 6 and where the funding will be found within the LHIN's allocation; and

c) Provide all Other Funding and all funding in accordance with paragraph 6 of this Schedule for the LHIN Requested Temporary LTCH Beds in accordance with the Funding Policies for the term of the temporary licence issued by the MOHLTC, including any increases in this funding and Other Funding after the date the temporary licence is issued by the MOHLTC for these beds, if the LHIN's request for LHIN Requested Temporary LTCH Beds is granted by the MOHLTC.

25. The **MOHLTC** will:

a) Consider the LHIN's request for LHIN Requested Temporary LTCH Beds and decide whether to grant the request;

b) Confirm the amount of funding required to support the beds in accordance with the Funding Policies, including Other Funding and the funding paid in accordance with paragraph 6 of this Schedule.

LTCHs – MOHLTC Direct Funding

26. The **MOHLTC** will manage and fund LTC health service providers directly for certain LTC programs in accordance with the Funding Policies and pursuant to a Direct Funding Agreement, a RAI-MDS Funding Agreement, and any other agreement between the MOHLTC and a LTC health service provider.

LTCHs – LHIN Direct Funding

26.1. For greater certainty, the LHIN may not fund LTC health service providers for the provision of LTCH services except as provided in the Funding Policies and this Schedule.

Community Health Centres ("CHCs")

27. The **MOHLTC** will:

a) Determine the Dedicated Funding Envelope for the provision of services by CHCs to uninsured clients.

28. The **LHIN** will:

a) Use the Dedicated Funding Envelope for services to uninsured clients for those CHCs of which it is advised.

Community Mental Health

29. The purpose of the parameters set out in paragraph 30 is to ensure that certain provincial interests are addressed, and that the MOHLTC meets its inter-ministerial

commitments, including criminal justice and forensic mental health initiatives. The categories of community mental health services for the purposes of paragraph 30 are:

a) Crisis Services, which are any of the following: Crisis Intervention services, Short-Term Residential Crisis Beds ("Safe Beds"), mobile crisis services, and sexual assault services;

b) Case Coordination/Management Services, which are any of the following: Intensive Case Management, case coordination, Assertive Community Treatment Teams ("ACTT"), Court Diversion and Court Supports, and out reach services;

c) Supportive Housing – Support Services, which are support services to enable individuals with serious mental illness to live independently;

d) Functional Rehabilitation Services, which are any of the following: vocational rehabilitation, social rehabilitation, and peer supports, such as consumer survivor initiatives; and

e) Treatment Services, which are any of the following: Schedule 1-5 services, as categorized by the designation of mental health facilities under the *Mental Health Act*, acute care beds, community treatment programs, Early Intervention in Psychosis, Psychiatric Sessional Fees, Community Treatment Order ("CTO") programs, Eating Disorders, the Psychiatric Outpatient Medical Salaries and Forensic Mental Health Treatment.

30. The **MOHLTC** will:

a) Determine the Dedicated Funding Envelope for the following:

(i) Crisis Intervention programs and services funded through the Health Accord;

(ii) Crisis Intervention programs, Safe Beds, Intensive Case Management, Court Diversion/Supports, and supportive housing for individuals with serious mental illness who have come into contact with the criminal justice system;

(iii) Intensive Case Management and ACTT

(iv) Early Intervention in Psychosis programs;

(v) Forensic Case Management Initiatives;

(vi) Hospitals that provide psychiatric sessional services;

(vii) Psychiatric Sessional services provided by community-based agencies;

(viii) Eating Disorder services;

(ix) Consumer Survivor Initiatives; and

(x) The Psychiatric Outpatient Medical Salaries.

b) Determine and advise the LHIN of the number and type of forensic mental health beds and the designated hospitals that provide the forensic mental health service and of the required service delivery capacity and/or service levels, where applicable; and

c) Advise the LHIN of related parameters, and other provincial strategies and interests for community mental health.

31. The **LHIN** will:

a) Fund the provision by health service providers of a combination of services in each of the categories of community mental health services described in paragraph 30 in or for the local health system;

b) Require a health service provider to provide a service identified under paragraph 30(a) unless otherwise agreed to by the MOHLTC;

c) Use the Dedicated Funding Envelopes of which it is advised by the MOHLTC for the provision of services specified under paragraphs 30 (a) and (b);

d) Maintain or increase the number of ACTT at or above 2006/07 levels in or for the local health system;

e) Maintain the Supportive Housing – Support Services that are funded by the LHIN at a ratio of 1 case manager for no greater than 10 clients, and at a ratio of 1 case manager for no greater than 8 clients for the supportive housing funded under the Service Enhancement Initiative for individuals with serious mental illness who have come into contact with the criminal justice system;

f) Work with the MOHLTC and the Eating Disorder Network to allocate any new funding;

g) Require hospitals, as designated by the MOHLTC, to provide Schedule 1-5 services under the *Mental Health Act* at least at the service levels provided in 2006-2007, and discuss any material changes to the service delivery or service levels with the MOHLTC; and

h) Require designated hospitals to provide the number and type of Forensic Mental Health beds as determined by the MOHLTC and discuss any changes to the service delivery or service levels with the MOHLTC.

32. Both parties will review the parameters in paragraphs 30 and 31 annually as set out in Schedule 1: General.

Addictions

33. The **MOHLTC** will determine the Dedicated Funding Envelope for :

a) Problem Gambling Treatment Services;

b) Programs for pregnant women with addictions funded through the federal Early Childhood Development Initiative; and

c) Psychiatric Sessional Fees.

34. The **LHIN** will:

a) Fund the provision by health service providers of (i) withdrawal management, and (ii) counseling, treatment and support services, (iii) methadone case management (at 2006/07 level), (iv) supportive housing for People with Problematic Substance Use;

b) Use the Dedicated Funding Envelopes to fund the specific purpose for which it is funded; and

c) Maintain the Supportive Housing – Support Services that are funded by the LHIN for individuals with problematic substance use issues at a ratio of 1 case manager for no greater than 8 clients.

Community Care Access Centres ("CCACs")

35. The **MOHLTC** will determine the Dedicated Funding Envelope for:

a) All School Health Professional Services and School Health Personal Support Services.

36. The **LHIN** will:

a) Use the Dedicated Funding Envelopes for which it is advised under paragraph 43 for the services specified in paragraph 35; and

Compensation under Specified Initiatives / Agreements

37. The **MOHLTC** will determine the Dedicated Funding Envelope for compensation and benefits under specific initiatives or agreements for persons who are paid directly by health service providers for the provision of health services.

38. The **LHIN** will require health service providers to use the Dedicated Funding Envelope for the compensation and benefits of persons identified in section 37.

PART C. MOHLTC MANAGED PROGRAMS

39. The **MOHLTC** will retain responsibility for other health programs and services and will:

(a) Seek LHIN input and advice on these other health programs and services, where appropriate; and

(b) Advise the LHIN of material changes to these other health programs and services that impact the LHIN's local health system.

SCHEDULE 3: FUNDING and ALLOCATIONS

PART A. PURPOSE OF SCHEDULE 3

- To provide a statement of the total funding to be allocated to the LHIN for the 2011/12 fiscal year and if available, the funding targets for out-years.

- To set out financial management requirements and policies to create a system that is sustainable, optimizes the use of financial resources, improves local health system performance and supports the achievement of provincial targets.

Definitions

1. In this Schedule, the following terms have the following meanings:

   "Annual Balanced Budget" means that, in a fiscal year, the total revenues for an entity are greater than or equal to the total expenses for the entity, and, for the LHIN, the annual balanced budget is subject to Public Sector Accounting Board (PSAB) rules and any interpretations under paragraph 6.

   "Operating Budget" means the budget for the LHIN's corporate operations.

   "Transfer Payment Budget" means the budget for the LHIN's funding of health service providers.

   "Multi-year funding" means an allocation for the first fiscal year and funding targets for up to two additional years. Funding targets are to be used for planning purposes only and may be revised upward or downward at the discretion of the MOHLTC.

   "Multi-Year Expense Limits" means that a LHIN will plan and manage their expenditures within their allocation and multi-year funding targets.

PART B. PERFORMANCE OBLIGATIONS

2. The **MOHLTC** will:

   a) By August 15, 2011, provide the LHIN with the 2011-12 funding allocation as of July 31st, 2011 Table 1 – Statement of Total LHIN 2011-12 Funding Allocation, Table 2 – Statement of each LHIN 2011-12 Funding Allocation for all 14 LHINs, Table 3 – Statement of Total 2011-12 Dedicated Funding by Sector, and Table 4 – Dedicated Funding by Sector for each LHIN of this Schedule; and

   b) Provide the LHIN with a list of Dedicated Funding Envelopes for 2011-2012 in Table 4 – Dedicated Funding Envelopes for the LHIN of this Schedule and review it in accordance with Schedule 2: Local Health System Program Management. The LHIN will allocate for fiscal years after 2011-2012, in accordance with the LHSIA, its Annual Business Plan approved by the MOHLTC and this Agreement.

3. The **LHIN** will:

a) Allocate the funds for 2011/12, in accordance with the LHSIA, this Agreement, including Tables 2 and 4 of this Schedule, and the agreements assigned to the LHIN

Annual Balanced Budget Requirements

4. The **LHIN** will:

a) Plan for an Annual Balanced Budget for its operations and transfer payments; and

b) Require health service providers to achieve an Annual Balanced Budget in accordance with the Parameters for the Financial Health Framework.

Multi-Year Expense Limits Requirements

5. The LHIN will plan and manage LHIN forecasted expenses for the LHIN's Operating and Transfer Payment Budgets within the multi-year funding targets set out in this schedule.

Financial Management Polices and Guidelines

6. The **MOHLTC** will:

a) Develop and issue policies, directives and guidelines related to financial management.

7. The **LHINs** will:

a) Comply with the following list of financial management policies and directives:

i) Multi-Year Funding Framework;
ii) Parameters for Financial Health Framework;
iii) Fiscal Prudence through Contingency Planning Policy;
iv) Parameters for In Year and Year End Reallocations Policy;
v) Any other policies, directives and guidelines provided by MOHLTC.

Accounting Standards

8. The **MOHLTC** will:

a) Issue interpretations and modifications relating to Public Sector Accounting Board (PSAB) standards, based on advice from the Office of the Provincial Controller.

9. The **LHINs** will:

a) Prepare its financial reports and statements on its Operating and Transfer Payment Budgets, including its Annual Business Plan, based on the Public Sector Accounting Board (PSAB) standards, subject to modifications and interpretations issued as per paragraph 6.

b) Maintain documentation to support all financial statements and related payment instructions.

Table 1: Statement of Total LHIN 2011/2012 Funding Allocation

	2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total LHIN Budget	**23,328,428.9**	**TBD**	**TBD**
Total Capital Budget (see table 1b)	.0	TBD	TBD
Total Operating Budget (see table 1a)	23,328,428.9	TBD	TBD

1 The 2011/12 funding allocation are updated as of July 31, 2011 from the approved 2011/12 multi-year Results Based Plan and the 2011/12 Printed Estimates. The update is based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2011/12. The realignment occurs within the Ministry's total approved appropriation.

2 The 2011/12 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2011/12, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

Table 1a: Statement of Total LHIN 2011/2012 Funding Allocation - Operating Budget

		2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total LHIN Operating Budget		**23,328,428.9**	**TBD**	**TBD**
Total Health Service Provider (HSP) Transfer Payments by Sector		23,251,999.7	TBD	TBD
Operation of LHIN		67,284.4	TBD	TBD
Initiatives	(3)	9,144.8	TBD	TBD
E-Health	(4)	.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector				
Operations of Hospitals		15,611,759.5	TBD	TBD
Grants to compensate for Municipal Taxation - public hospitals		3,741.9	TBD	TBD
Long Term Care Homes	(5)	3,240,847.3	TBD	TBD
Community Care Access Centres		2,016,592.9	TBD	TBD
Community Support Services		401,088.6	TBD	TBD
Acquired Brain Injury		44,707.0	TBD	TBD
Assisted Living Services in Supportive Housing		212,805.8	TBD	TBD
Community Health Centres		314,728.7	TBD	TBD
Community Mental Health		631,420.7	TBD	TBD
Addictions Program		154,490.7	TBD	TBD
Specialty Psych Hospitals		596,677.8	TBD	TBD
Grants to compensate for Municipal Taxation - psychiatric hospitals		121.0	TBD	TBD
Initiatives	(6)	23,017.8	TBD	TBD

1 The 2011/12 funding allocation are updated as of July 31, 2011 from the approved 2011/12 multi-year Results Based Plan and the 2011/12 Printed Estimates. The update is based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2011/12. The realignment occurs within the Ministry's total approved appropriation.

2 The 2011/12 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2011/12, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

3 LHIN Operations initiatives include Aboriginal Community Engagement, French Language Health Services, French Planning Entities, ER/ALC Performance Leads, ED LHIN Leads, and LHIN Collaborative.

4 The funding for E-Health Project Management Office will be flowed by E-Health Ontario to the LHINs starting from 2011/12.

5 The LTC Homes funding allocation is an estimate only, and is subject to change, as the Ministry adjusts the funding allocation for the LTC Homes based on changes in CMI, bed numbers, resident revenue and construction cost funding.

6 Transfer payment initiatives by LHIN will be allocated by sector by the LHIN at a later date. Initiatives include Aging at Home, Urgent Priorities Funds, and Aging At Home Supplementary ER/ALC Funding that are unallocated. It should be noted that as the LHIN allocates by sector, the allocation will be distributed at the sector level.

Table 1b: Statement of Total LHIN 2011/2012 Funding Allocation - Capital Budget				
		2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total Capital Budget		**.0**	**TBD**	**TBD**
Total Health Service Provider (HSP) Transfer Payments by Sector		.0	TBD	TBD
LHIN-Specific Capital Initiatives		.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector				
Hospitals	(1)	.0	TBD	TBD
Long Term Care Homes		.0	TBD	TBD
Acquired Brain Injury		.0	TBD	TBD
Assisted Living Services in Supportive Housing		.0	TBD	TBD
Community Health Centres		.0	TBD	TBD
Community Mental Health		.0	TBD	TBD
Addictions Program		.0	TBD	TBD

1 The allocation under "Hospitals" represents the approved LHIN allocation to support grants for public and specialty psychiatric hospitals in 2011/12 under the 2011/12 Health Infrastructure Renewal Fund (HIRF), and in accordance with 2011/12 HIRF Guidelines which the ministry has provided to LHINs. The allocation approved for LHINs for this purpose is available in 2011/12 only.

Table 2: Statement of LHIN 2011/2012 Funding Allocation

	2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total LHIN Budget	**4,424,550.2**	**TBD**	**TBD**
Total Capital Budget (see table 1b)	.0	TBD	TBD
Total Operating Budget (see table 1a)	4,424,550.2	TBD	TBD

1 The 2011/12 funding allocation are updated as of July 31, 2011 from the approved 2011/12 multi-year Results Based Plan and the 2011/12 Printed Estimates. The update is based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2011/12. The realignment occurs within the Ministry's total approved appropriation.

2 The 2011/12 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2011/12, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

Table 2a: Statement of LHIN 2011/2012 Funding Allocation - Operating Budget

		2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total LHIN Operating Budget		**4,424,550.2**	**TBD**	**TBD**
Total Health Service Provider (HSP) Transfer Payments by Sector		4,417,184.1	TBD	TBD
Operation of LHIN		5,826.4	TBD	TBD
Initiatives	(3)	1,539.7	TBD	TBD
E-Health	(4)		TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector				
Operations of Hospitals		3,394,946.8	TBD	TBD
Grants to compensate for Municipal Taxation - public hospitals		747.3	TBD	TBD
Long Term Care Homes	(5)	250,975.6	TBD	TBD
Community Care Access Centres		202,721.8	TBD	TBD
Community Support Services		71,692.2	TBD	TBD
Acquired Brain Injury		1,840.6	TBD	TBD
Assisted Living Services in Supportive Housing		44,259.7	TBD	TBD
Community Health Centres		81,709.7	TBD	TBD
Community Mental Health		102,301.2	TBD	TBD
Addictions Program		26,044.9	TBD	TBD
Specialty Psych Hospitals		238,828.1	TBD	TBD
Grants to compensate for Municipal Taxation - psychiatric hospitals		44.6	TBD	TBD
Initiatives	(6)	1,071.6	TBD	TBD

1 The 2011/12 funding allocation are updated as of July 31, 2011 from the approved 2011/12 multi-year Results Based Plan and the 2011/12 Printed Estimates. The update is based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2011/12. The realignment occurs within the Ministry's total approved appropriation.

2 The 2011/12 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2011/12, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

3 LHIN Operations initiatives include Aboriginal Community Engagement, French Language Health Services, French Planning Entities, ER/ALC Performance Leads, ED LHIN Leads, and LHIN Collaborative.

4 The funding for E-Health Project Management Office will be flowed by E-Health Ontario to the LHINs starting from 2011/12.

5 The LTC Homes funding allocation is an estimate only, and is subject to change, as the Ministry adjusts the funding allocation for the LTC Homes based on changes in CMI, bed numbers, resident revenue and construction cost funding.

6 Transfer payment initiatives by LHIN will be allocated by sector by the LHIN at a later date. Initiatives include Aging at Home, Urgent Priorities Funds, and Aging At Home Supplementary ER/ALC Funding that are unallocated. It should be noted that as the LHIN allocates by sector, the allocation will be distributed at the sector level.

Table 2b: Statement of LHIN 2011/2012 Funding Allocation - Capital Budget				
		2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total Capital Budget		.0	**TBD**	**TBD**
Total Health Service Provider (HSP) Transfer Payments by Sector		.0	TBD	TBD
LHIN-Specific Capital Initiatives		.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector				
Hospitals	(1)	.0	TBD	TBD
Long Term Care Homes			TBD	TBD
Acquired Brain Injury			TBD	TBD
Assisted Living Services in Supportive Housing			TBD	TBD
Community Health Centres			TBD	TBD
Community Mental Health			TBD	TBD
Addictions Program			TBD	TBD

1 The allocation under "Hospitals" represents the approved LHIN allocation to support grants for public and specialty psychiatric hospitals in 2011/12 under the 2011/12 Health Infrastructure Renewal Fund (HIRF), and in accordance with 2011/12 HIRF Guidelines which the ministry has provided to LHINs. The allocation approved for LHINs for this purpose is available in 2011/12 only.

Table 3: Statement of Total 2011/12 Dedicated Funding by Sector

	2011/12 Dedicated Funding Envelope [1]
Hospitals	
Cardiac Services	$31,469,700
Chronic Kidney Disease	$0
Critical Care	$86,318,486
Wait Times Strategy	$269,575,200
Health Infrastructure Renewal Fund	TBD
Post Construction Operating Plan	$219,634,400
Long Term Care Homes	
Convalescent Care Beds [2]	$25,752,327
Interim Beds [3]	$18,897,828
Community Health Centres	
Uninsured Persons Services	$2,886,782
Community Mental Health	
Crisis Intervention programs and services (funded through Health Accord and Service Enhancement)	$43,817,593
Short-Term Residential Crisis Beds (Safe Beds)	$11,297,893
Assertive Community Treatment Teams (ACTT)	$34,541,300
Intensive Case Management (funded through Health Accord and Service Enhancement)	$29,672,466
Court Diversion / Supports	$4,606,000
Supportive Housing Supports	$10,387,000
Early Intervention in Psychosis programs (funded through Health Accord)	$22,202,188
Forensic Case Management Initiatives	$2,040,000
Sessional services in hospitals (Psychiatric Out-Patient Medical Salaries)	$13,967,953
Sessional services provided by community-based agencies	$15,881,658
Eating Disorder Services	$15,460,113
Consumer Survivor Initiatives	$12,000,355
Addictions	
Problem Gambling Treatment Services	$10,108,400
Programs for pregnant women with addictions (funded through federal Early Childhood Development initiative)	$3,200,000
Methadone Case Management Services	$740,680
Sessional services provided by community-based agencies	$748,358
Community Care Access Centres	
School Health Professional and Personal Support Services	$84,091,615
Chronic Kidney Disease	$1,562,300
Other	
Direct Funding Self-Managed Attendant Services (Centre for Independent Living Toronto)	$24,117,702
Compensation Under Specified Initiatives / Agreements	TBD

Notes

(1) Actual Dollar Amounts

(2) Convalescent care funding is based on levels of care per diem and convalescent care top-up.
As per March 2011 Payment Notice, there are 337 convalescent care beds.
Excludes convalescent care beds funded by the Urgent Priority Fund and Aging at Home.

(3) Interim Bed funding is based on 100 CMI and 85% of collection rate for the resident revenue.
As per March 2011 Payment Notice, there are 505 interim beds.
Excludes Interim beds funded by the Urgent Priority Fund and Aging at Home.

Table 4: Dedicated Funding by Sector for Toronto Central LHIN

	2011/12 Dedicated Funding Envelope [1]
Hospitals	
Cardiac Services	$6,802,700
Chronic Kidney Disease	$0
Critical Care	$30,751,814
Wait Times Strategy	$39,231,900
Health Infrastructure Renewal Fund	TBD
Post Construction Operating Plan	$21,741,800
Long Term Care Homes	
Convalescent Care Beds [2]	$1,604,744
Interim Beds [3]	NA
Community Health Centres	
Uninsured Persons Services	$1,683,692
Community Mental Health	
Crisis Intervention programs and services (funded through Health Accord and Service Enhancement)	$4,945,000
Short-Term Residential Crisis Beds (Safe Beds)	$1,040,362
Assertive Community Treatment Teams (ACTT)	$3,129,800
Intensive Case Management (funded through Health Accord and Service Enhancement)	$3,014,400
Court Diversion / Supports	$252,000
Supportive Housing Supports	$2,383,500
Early Intervention in Psychosis programs (funded through Health Accord)	$3,286,000
Forensic Case Management Initiatives	$510,000
Sessional services in hospitals (Psychiatric Out-Patient Medical Salaries)	$2,152,634
Sessional services provided by community-based agencies	$3,236,708
Eating Disorder Services	$3,044,445
Consumer Survivor Initiatives	$2,485,656
Addictions	
Problem Gambling Treatment Services	$1,754,200
Programs for pregnant women with addictions (funded through federal Early Childhood Development initiative)	$667,000
Methadone Case Management Services	$101,500
Sessional services provided by community-based agencies	$39,158
Community Care Access Centres	
School Health Professional and Personal Support Services	$5,216,756
Chronic Kidney Disease	$88,400
Other	
Direct Funding Self-Managed Attendant Services (Centre for Independent Living Toronto)	$24,117,702
Compensation Under Specified Initiatives / Agreements	TBD

Notes

(1) Actual Dollar Amounts

(2) Based on levels of care per diem and convalescent care top-up.
Excludes convalescent care beds funded by the Urgent Priority Fund and Aging at Home.

(3) Based on 100 CMI and 85% of collection rate for the resident revenue.
Excludes Interim beds funded by the Urgent Priority Fund and Aging at Home.

SCHEDULE 4: LOCAL HEALTH SYSTEM PERFORMANCE

PART A. PURPOSE OF SCHEDULE 4

- To set out performance indicators for the local health system to improve local health system performance and support the achievement of provincial targets and the Primary Purpose.

PART B. PERFORMANCE OBLIGATIONS

Definitions

1. In this Schedule, the following terms have the following meanings:

"**LHIN baseline"** means the result at a given time for a performance indicator that provides a starting point for measuring changes in local health system performance and for establishing LHIN targets for future local health system performance;

"**LHIN target**" means a planned result for an indicator against which actual results can be compared;

"**Performance indicator**" means a measure of local health system performance for which a LHIN target will be set, and the LHIN will be held accountable for achieving results under the terms of this Agreement for the local health system in connection with a performance indicator;

"**Provincial target**" means an optimal performance result for an indicator, which may be based on expert consensus, performance achieved in other jurisdictions, or provincial expectations;

"CTAS" means Canadian Emergency Department Triage and Acuity Scale; and

"CMG" means Case Mix Group.

General Obligations

2. Under the Act and the *Commitment to the Future of Medicare* Act, the **LHIN** will measure and plan to improve performance at the local level through service accountability agreements with health service providers.

Specific Obligations

3. The **MOHLTC** will:

(a) Calculate the results for the following performance indicators set out below:

(i) 90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients;
(ii) 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients;
(iii) 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated

(CTAS IV-V) Patients;

(iv) Percentage of Alternate Level of Care (ALC) Days;

(v) Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions;

(vi) Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions;

(vii) 90th Percentile Wait Time from Community for CCAC In-Home Services – Application from Community Setting to First CCAC Service (excluding case management);

(viii) Readmission within 30 Days for Selected CMGs;

(ix) 90th Percentile Wait Times for Cancer Surgery;

(x) 90th Percentile Wait Times for Cardiac By-Pass Procedures;

(xi) 90th Percentile Wait Times for Cataract Surgery;

(xii) 90th Percentile Wait Times for Hip Replacement;

(xiii) 90th Percentile Wait Times for Knee Replacement;

(xiv) 90th Percentile Wait Times for Diagnostic MRI Scan; and

(xv) 90th Percentile Wait Times for Diagnostic CT Scan.

(b) Provide the LHIN with calculated results for the performance indicators by the release dates set out in Table A, and supporting performance information as requested, such as the performance of health service providers; and

(c) Provide to the LHIN technical documentation on the performance indicators set out in Table A including the methodology, inclusions and exclusions.

4. The **LHIN** will:

(a) Work to achieve the LHIN's performance targets for the performance indicators;

(b) Report quarterly on the performance of the local health system on all performance indicators; and

(c) Report on the performance of the local health system on all performance indicators in the LHIN Annual Report.

Table A: Performance Indicators				
▪ Objective: To improve persons' access and outcomes as they move through the continuum of healthcare services. ▪ Expected Outcome: Persons will experience improved access and outcomes related to the health care services identified below. ▪ Other indicators may be considered as a measure of this expected outcome.				
INDICATOR	**Provincial target**	**LHIN Baseline 2011-12**	**LHIN Target 2011-12**	**Data Provided to LHINs**
90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients	8 hours	27.72 hours	23 hours	May 13, 2011 August 12, 2011 November 14, 2011 and February 10, 2012
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	8 hours	8.2 hours	8 hours	
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4 hours	5.12 hours	4.5 hours	
Percentage of Alternate Level of Care (ALC) Days	9.46%	10.78%	10.00%	
Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions*	TBD	25.80%	25.00%	
Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions*	TBD	37.40%	35.00%	
90th Percentile Wait Time from Community for CCAC In-Home Services – Application from Community Setting to First CCAC Service (excluding case management)**	TBD	33 days	31.4 days	
Readmission within 30 Days for Selected CMGs	TBD	19.17%	18.00%	
90th Percentile Wait Times for Cancer Surgery	Provincial Priority IV Target: 84 days	65 days	70 days	
90th Percentile Wait Times for Cardiac By-Pass Procedures	Provincial Priority IV Target: 182 days	48 days	44 days	

Table A: Performance Indicators				
▪ Objective: To improve persons' access and outcomes as they move through the continuum of healthcare services. ▪ Expected Outcome: Persons will experience improved access and outcomes related to the health care services identified below. ▪ Other indicators may be considered as a measure of this expected outcome.				
INDICATOR	**Provincial target**	**LHIN Baseline 2011-12**	**LHIN Target 2011-12**	**Data Provided to LHINs**
90th Percentile Wait Times for Cataract Surgery	Provincial Priority IV Target: 182 days	106 days	100 days	
90th Percentile Wait Times for Hip Replacement	Provincial Priority IV Target: 182 days	124 days	135 days	
90th Percentile Wait Times for Knee Replacement	Provincial Priority IV Target: 182 days	125 days	140 days	
90th Percentile Wait Times for Diagnostic MRI Scan	Provincial Priority IV Target: 28 days	132 days	115 days	
90th Percentile Wait Times for Diagnostic CT Scan	Provincial Priority IV Target: 28 days	33 days	28 days	

* New indicators for 2010/11. The MOHLTC and the LHINs will monitor performance in 2010/11 and work together to refine quality and consistency of data. The methodology for these indicators has been revised to include planned and unplanned ER visits. Therefore, targets for 11/12 may be higher than those established for 2010/11.
** New indicator methodology to be confirmed for 2010/11. The MOHLTC and the LHINs will monitor results and work together to improve data collection and coding. Targets will be established for 2011/12.

SCHEDULE 5: INTEGRATED REPORTING

PART A. PURPOSE OF SCHEDULE 5

- To summarize, in one schedule, all the reporting obligations of each of the MOHLTC and the LHIN under this Agreement, including the Schedules.

PART B. PERFORMANCE OBLIGATIONS

General Obligations

1. The reporting obligations of each party are listed in the table below:

2. The **MOHLTC** will:

   (a) Provide any necessary training, instructions, materials, templates, forms, and guidelines to the LHINs to assist the LHINs with the completion of the reports listed in this Schedule;

   (b) As required, develop reporting requirements relating to government priorities and notify the LHINs of the requirements; and

   (c) Provide to the LHIN the data on the performance indicators as set out in Schedule 4: Local Health System Performance.

3. **Both parties** will:

   (a) Work together to ensure a timely flow of information to fulfill the reporting requirements of both parties;

   (b) Respond in a timely manner to requests for information and access to records of one another, including financial records, to fulfill the reporting and other obligations of the parties under this Agreement; and

   (c) Jointly evaluate the reporting processes each year, and recommend process and content improvements for future implementation that are consistent with the Primary Purpose.

   (d) Finalize the Annual Business Plan within 120 days of a budget announcement by the Government of Ontario as part of the annual review set out in Schedule 1: General.

Due Date	Description of Item
2011/2012	
APRIL	
April 18, 2011	MOHLTC will provide to the LHIN a Report confirming interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year
April 30, 2011	MOHLTC will provide to the LHIN the forms for the Year-end Consolidation Report
By April 30, 2011	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
MAY	
May 13, 2011	MOHLTC will provide the LHIN with the most recent quarter of data for indicators in Schedule 4: Local Health System Performance
May 16, 2011	MOHLTC will provide to the LHIN a Report with updated interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year
May 17, 2011	The MOHLTC will provide to the LHIN for planning and reporting purposes the initial preliminary allocation for 2011-12
May 27, 2011	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
May 31, 2011	The LHIN will submit to the MOHLTC the year-end consolidation report using forms provided by the MOHLTC and the draft Audited Financial Statement if the signed statements are not ready by May 31 of each fiscal year to which this agreement applies
JUNE	
On or about the 7th working day (date may depending on the IFIS GL close)	MOHLTC will provide to the LHIN a Q1 Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments
June 30, 2011	The LHIN will submit to the MOHLTC an Annual Report for the previous fiscal year in accordance with MOHLTC requirements
June 30, 2011	The LHIN will submit to the MOHLTC Q1 Regular and Consolidation Report using the forms provided by the MOHLTC
August 30, 2011	MOHLTC will provide to the LHIN the forms and information requirements for the 2012/13 Annual Business Plan
JULY	
By July 29,2011	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
AUGUST	
August 2, 2011	The LHINs will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
August 12, 2011	The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 4: Local Health System Management
August 15, 2011	The MOHLTC will provide the preliminary approved allocation for the current fiscal year, as of July 31, 2011, and the funding targets for the next year, if available.
August 26, 2011	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
August 31, 2011	MOHLTC will provide to the LHIN the forms and information requirements for the Multi-year Consolidation Report

Due Date	Description of Item
SEPTEMBER	
On or about the 7th working day (date may vary on IFIS GL close)	MOHLTC will provide to the LHIN a Q2 Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments
September 30, 2011	The LHIN will submit to the MOHLTC Q2 Regular and Consolidation Report using the forms provided by the MOHLTC
OCTOBER	
October 31, 2011 (or date necessary to meet central agency reporting requirements)	The LHIN will submit to the MOHLTC a Multi-year Consolidation Report using the form provided by the MOHLTC
By October 31, 2011	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
October 31, 2011	The LHINs will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
NOVEMBER	
November 14, 2011	MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 4: Local Health System Management
November 25, 2011	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
DECEMBER	
On or about the 7th working day (date may vary depending on the IFIS GL close)	MOHLTC will provide to the LHIN a Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments
December 30, 2011	LHIN will submit to the MOHLTC Q3 Regular and Consolidation Report including final year-end forecast using the forms provided by the MOHLTC
JANUARY	
January 31, 2012	The LHIN will submit to the MOHLTC a Draft 2012/13 Annual Business Plan using the forms provided by the MOHLTC
January 31, 2012	MOHLTC will provide the LHIN with year end instructions (including templates)
By January 31, 2012	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
January 31, 2012	The LHINs will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
FEBRUARY	
February 10, 2012	MOHLTC will provide the LHIN with most recent quarter of performance data for indicators in Schedule 4: Local Health System Performance
February 15, 2012	MOHLTC will provide to the LHIN the forms and requirements for the Annual Report (non-financial content)
February 24, 2012	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
February 24, 2012	The LHIN will submit to the MOHLTC Year-End Reallocation Report on planned vs. actual expenditures related to in-year reallocations
MARCH	
March 30, 2012	MOHLTC will provide to the LHIN the forms for the Annual Report (financial content)

Due Date	Description of Item
2012/2013	
APRIL	
April 16, 2012	MOHLTC will provide to the LHIN a Report confirming interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year
April 30, 2012	MOHLTC will provide to the LHIN the forms for the Year-end Consolidation Report
By April 30, 2012	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
April 30, 2012	The LHINs will submit to the MOHLTC a Expense Report using the forms provided by the MOHLTC
MAY	
May 14, 2012	The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 4: Local Health System Performance
May 14, 2012	MOHLTC will provide to the LHIN a Report with updated interim actual expenditures, recoverables and payables related to its transfer payments as of March 31, of the preceding fiscal year
May 18, 2012	The MOHLTC will provide to the LHIN for planning and reporting purposes the initial preliminary allocation for 2010-11
May 28, 2012	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
May 31, 2012	The LHIN will submit to the MOHLTC the year-end consolidation report using forms provided by the MOHLTC and the draft Audited Financial Statement if the signed statements are not ready by May 31 of each fiscal year to which this agreement applies