ACCOUNTABILITY AGREEMENT
APRIL 1, 2007 – MARCH 31, 2010

Consolidated Amendments Effective April 1, 2008

BETWEEN:

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

- and -

Waterloo Wellington Local Health Integration Network ("LHIN")

Section 1 – Purpose of the Agreement

1.1 Further to the *Local Health System Integration Act, 2006* (the "Act") this Agreement supports the collaborative 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 health care in local health systems and to manage the health system at the local level effectively and efficiently.

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, 2007 to March 31, 2010 covering the 2007-2008, 2008-2009 and 2009-2010 fiscal years. This is an accountability agreement for the purposes of section 18 of the Act. The Agreement applies to each party's funding and performance obligations for the period April 1, 2007 and ending March 31, 2010 as they are determined for each fiscal year.

Section 2 - Definitions

The following terms have the following meanings in this Agreement:

"Agreement" means this agreement, including any schedules, and any instrument which amends this agreement.

"Annual Service 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 Act.

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

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

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

"MOU" means the memorandum of understanding in effect between the MOHLTC and the LHIN from time to time.

"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. Community Engagement, Planning and Integration;
3. Local Health System Management;
4. Information Management Supports;
5. Financial Management;
6. Financial Processing Protocols;
7. Local Health System Compliance Protocols;
8. Integrated Reporting;
9. Allocations;
10. Local Health System Performance; and
11. e-Health.

Section 3 – Accountability of Each Party

3.1 The MOHLTC will fulfil the performance obligations and provide the performance deliverables set out in the Schedules in accordance with the terms of this Agreement

3.2 The LHIN will fulfil the performance obligations and provide the performance deliverables set out in the Schedules in accordance with the terms of this Agreement. Deliverables will be incorporated into the LHINs quarterly reports to the MOHLTC as set out in the Schedules.

3.3 Both parties will collaborate and cooperate to:

(a) facilitate the achievement of the requirements of this Agreement;
(b) develop clear and achievable performance obligations, and identify risks to performance;
(c) establish clear lines of communication and responsibility; and
(d) work diligently to resolve issues in a proactive and timely manner.

3.4 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 4 – Performance Improvement

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

(a) A commitment to ongoing performance improvement;
(b) An orientation to problem-solving; and
(c) A focus on relative risk of non-performance.

4.2 A party shall notify the other party, as soon as reasonably possible, of any matters that could significantly affect the party's ability to perform its obligations under this Agreement (a "Performance Factor"). Notice shall include a description of any remedial action it is undertaking or plans to undertake to remedy the performance issue and shall indicate whether the party is requesting a meeting to discuss the Performance Factor. Receipt of written notice will be acknowledged by the recipient party within 5 business days of the date of the written notice. Where a meeting has been requested, the parties agree to meet and discuss the Performance Factor within one calendar month of the date of the written notice.

4.3 During the meeting, using the principles set out in section 4.1, the parties will:

(i) discuss the causes of the Performance Factor;

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

(iii) determine the steps in the performance improvement process set out below to be taken to mitigate the impact of the Performance Factor, where possible; and

(iv) revise and amend a party's performance expectations, if necessary.

4.4 The performance improvement process may include, in addition to any other remedies:

(i) For Performance Factors posing lower risk, actions led by the LHIN, such as:
- regular performance reports to the MOHLTC;
- LHIN-MOHLTC quarterly performance improvement meetings;
- external/expert reviews directed by the LHIN; and
- LHIN-developed performance improvement plan for the LHIN discussed with the MOHLTC.

(ii) For Performance Factors posing moderate risk, actions led by the LHIN and the MOHLTC, such as:
- enhanced monitoring of performance by LHIN and MOHLTC;
- enhanced support for LHIN performance from other local health integration networks;
- external/expert reviews jointly directed by the MOHLTC and the LHIN;
- MOHLTC assistance to build LHIN capacity and/or other LHINs and/or experts; and
- joint development of a performance improvement plan for the LHIN.

(iii) For Performance Factors that recur or pose high risk, actions led by the MOHLTC and the LHIN or the MOHLTC alone as appropriate, such as:
- intensive monitoring by the MOHLTC;
- external/expert reviews directed by the MOHLTC;
- implementation of a performance improvement plan directed by the MOHLTC; and
- changes to the governance of the LHIN.

Section 5 – General

5.1 Each Schedule will clearly specify the fiscal period to which it applies. Schedules will be negotiated, and added or amended as appropriate, for the 2008-2009 and 2009-2010 fiscal years according to the timetable set out in the Schedules.

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

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

5.4 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:

Waterloo Wellington Local Health Integration Network
55 Wyndham Street North
Suite 212
Guelph, ON N1H 7T8

Attention: Chair

Fax: (519) 822-5807
Telephone: (519) 822-6208

With a copy to:

Waterloo Wellington Local Health Integration Network
55 Wyndham Street North
Suite 212
Guelph, ON N1H 7T8

Attention: CEO

Fax: (519) 822-5807
Telephone: (519) 822-6208

Made effective this 1st day of April, 2007 by:

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

_____
The Honourable George Smitherman
Minister of Health and Long-Term Care

Waterloo Wellington Local Health Integration Network

By:

_____
Ms. Kathy Durst
Chair

SCHEDULE 1: GENERAL

PART A. PURPOSE OF SCHEDULE 1

- To set out matters of general application to all Schedules.

PART B. INTERPRETATION AND APPLICATION

1. The primary purpose of all the Schedules under the Agreement (the "Primary Purpose") is to support:

   (a) the ongoing devolution of authority from the MOHLTC to the LHIN for its local health system:

      (i) to enable the MOHLTC to become the steward of the healthcare system; and

      (ii) to enable the LHIN to be accountable for funding, planning and integrating services for its local health system;

   (b) the devolution of responsibilities from the MOHLTC to the LHIN in a manner that ensures the stability and continuity of services during the transition period; and

   (c) the establishment of clear and achievable performance obligations,

   and all the Schedules shall be interpreted in accordance with this Primary Purpose.

2. Unless otherwise defined in the Schedule, terms shall have the same meaning as in Sections 1 to 5 of the Agreement.

3. The following terms have the following meanings in all the Schedules:

   "**agreement assigned to the LHIN**" means an agreement between the MOHLTC and a health service provider, or part thereof, that is assigned by the MOHLTC to the LHIN under subsection 19(3) of the Act;

   "**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 LHIN operations;

   "**fiscal year**" means April 1 to March 31;

   "**Primary Purpose**" has the meaning set out in paragraph 1 above.

   "**Regular Report**" means a report that includes a statement of the LHIN's revenues, actual expenditures for both LHIN operations and transfer payments to the date of the report, forecasted expenditures on LHIN operations and transfer payments, an explanation of variances between the forecasted expenditures and revenues, and the identification of any financial and performance risks;
   "**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 Act; and

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

4. 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.

5. Each Schedule applies to the 2007-2008, 2008-2009 and 2009-2010 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.

PART C. PHASE II FOR 2007-2008

6. Through negotiations from April 2007 to the end of May 2007, the parties will develop provisions to address and add to the Schedules in the following areas:

   (a) Schedule 5: Financial Management related to capital;

   (b) Schedule 7: Local Health System Compliance Protocols;

   (c) Schedule 9: Allocations:

      (i) Updated allocations for 2007-2008 for the LHIN in Table 2 of the Schedule;

      (ii) Updated funding targets for 2008-2009 and 2009-2010 for the LHIN in Table 2 of the Schedule; and

      (iii) Dedicated Funding Envelope amounts in Table 4 of the Schedule; and

   (d) Schedule 10: Local Health System Performance, performance benchmarks, baselines, LHIN targets and performance corridors for the performance indicators as set out in Tables A, B and C of the Schedule.

6.1 The parties will continue to work on developing provisions in a timely manner about elements of the financial management framework related to results-oriented planning, fiscal prudence and parameters for the treatment of surplus funds.

PART D. ANNUAL REVIEW AND UPDATE

7. The following 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 3: Local Health System Management;
   Schedule 9: Allocations; and
   Schedule 10: Local Health System Performance.

8. Both parties will work together to complete by Spring 2008 an evaluation of their effectiveness in carrying out the transition and devolution of authority contemplated by

this Agreement, and within 90 days of receiving the report, develop an action plan to address any recommendations arising from the evaluation.

9. Both parties will conduct the reviews, negotiations and updates contemplated by this Agreement based on principles that reflect:

(a) Mutuality;

(b) Flexibility;

(c) Openness;

(d) Transparency;

(e) Achievability;

(f) Strategic alignment; and

(g) Evolutionary process.

SCHEDULE 2: COMMUNITY ENGAGEMENT, PLANNING & INTEGRATION

PART A. PURPOSE OF SCHEDULE 2

- To identify MOHLTC and LHIN performance obligations for community engagement, planning and integration consistent with the Primary Purpose.

PART B. COMMUNITY ENGAGEMENT PERFORMANCE OBLIGATIONS

1. The LHIN will:

   (a) Regularly review its community engagement strategy and plan in order to guide ongoing LHIN functions; and

   (b) Report on community engagement activities in the Annual Report, including:

      (i) The effectiveness of the LHIN's community engagement strategy using a common assessment tool; and

      (ii) The LHIN's engagement with planning entities prescribed under the Act.

PART C. PLANNING PERFORMANCE OBLIGATIONS

2. **Both parties** will:

   (a) Develop and update, as necessary, an Integrated Health System Planning Guide (the "Guide") to support the development of the Provincial Strategic Plan and the Integrated Health Service Plan ("IHSP"); and

   (b) Work together to advance IHSP priorities:

      (i) In areas of provincial mandate, such as primary care, health human resources and chronic disease management; and

      (ii) In areas within the LHIN mandate where there may be a need for MOHLTC assistance to support the implementation of the IHSP.

3. The **MOHLTC** will:

   (a) Develop a process to review the functions of health system planning organizations, other than LHINs; and

   (b) Release the Provincial Strategic Plan.

4. The **LHIN** will:

(a) Within six months of the release of the Provincial Strategic Plan, update, as necessary, the 2007/08 – 2009/10 IHSP, and release the updated IHSP to the MOHLTC and the public;

(b) Develop and release to the MOHLTC and the public in Fall 2009 a new three-year IHSP for fiscal years 2010/11 – 2012/13;

(c) Update and develop its IHSP under paragraphs 4(a) and (b) consistent with the Guide;

(c.1) Demonstrate progress on the implementation of its IHSP priorities;

(d) Provide to the MOHLTC:

(i) Advice on the functions of health system planning organizations, other than LHINs; and

(ii) Information on any significant proposed changes to its IHSP;

(e) Reflect the IHSP in the Annual Service Plan required under Schedule 5; and

(f) Report on the progress of the implementation of its IHSP in the LHIN's annual report.

PART D. INTEGRATION PERFORMANCE OBLIGATIONS

5. The **LHIN** will:

(a) In 2007/2008, consult with the MOHLTC prior to issuing a decision to integrate, or to stop an integration under sections 26 or 27 of the Act; and

(b) Include a report on its integration activities in its Annual Report.

SCHEDULE 3: LOCAL HEALTH SYSTEM MANAGEMENT

PART A. PURPOSE OF SCHEDULE 3

- To identify, in alignment with the Primary Purpose, the scope of the LHIN's decision-making and responsibility in managing its local health system under the Act and the MOHLTC's role in supporting the LHIN, over the term of this Agreement.

PART B. GENERAL PERFORMANCE OBLIGATIONS

1. The **MOHLTC** will:

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

   (b) Assign agreements to the LHIN beginning April, 2007, and set a termination date for those agreements, where applicable;

   (c) As requested by the LHIN, provide contract management advice and support to the LHIN through the MOHLTC's LHIN Liaison Branch;

   (d) Manage and fund, as determined by the MOHLTC, the MOHLTC Managed Programs identified in Part D – MOHLTC Managed Programs;

   (e) Seek LHIN input and advice on the MOHLTC Managed Programs, where appropriate; and

   (f) Advise the LHIN of material changes to the MOHLTC Managed Programs that impact the LHIN's local health system.

2. The **LHIN** will:

   (a) Make decisions about:

      (i) Which health services will be provided by the health service providers in or for the local health system and where the health services will be provided;

      (ii) Which health service providers will be funded to deliver those services and the amount of funding; and

      (iii) Service volumes and performance requirements of the health service providers;

   (c) Require health service providers to comply with agreements assigned by the MOHLTC to the LHIN and service accountability agreements with the LHIN;

   (d) Require health service providers to provide services funded by the LHIN in

accordance with applicable legislation, provincial policies, standards and operating manuals;

(e) Carry out the obligations of the MOHLTC in the agreements assigned to the LHIN;

(f) In 2007-2008, notify and discuss with the MOHLTC any proposed changes to the agreements assigned to the LHIN, including revisions to service volumes, levels, funding or providers, or termination of the assigned agreements;

(g) In order to mitigate potential risks related to financial and performance issues under this Agreement, maintain, as appropriate, regular contact with health service providers;

(h) Develop a plan to negotiate new service accountability agreements as required by the Act and as prescribed; and

(i) Despite paragraph 2(h), negotiate in 2007/2008 with each hospital a service accountability agreement that will commence on April 1, 2008.

3. **Both parties** will:

(a) Review this Schedule annually, and update it as necessary; and

(b) Work together to develop template service accountability agreements for health service providers funded by the LHIN.

PART C. SECTOR SPECIFIC PERFORMANCE PARAMETERS

Application of Part C

4. The parameters set out in Part C of this Schedule apply to the LHIN's obligations set out in paragraph 2. They will be reviewed and updated annually, as set out in paragraph 7 of Schedule 1, to better reflect the Primary Purpose over the term of the Agreement.

Definition – Dedicated Funding Envelopes

5. In Part C, 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.

Hospital Programs Funded Through Base Budgets

6. In paragraphs 7 and 8, Hospital Programs Funded Through Base Budgets are:
(a) Core inpatient, outpatient and day surgery programs, Hospital-based Acquired

Brain Injury (ABI), Cochlear Implants, Regional Geriatrics Program, Cleft Lip and Palate / Craniofacial Dental Services;

(b) Stable priority services including cardiac catheterization, cardiac surgery and Chronic Kidney Disease; and

(c) Specialized Hospital Services, which include Trauma, Sexual Assault and Domestic Violence Treatment Centres, Provincial Regional Genetic Services, HIV Outpatient Clinics, Hemophiliac Ambulatory Clinics, Regional and District Stroke Centres, Cardiac Rehabilitation Services, and Permanent Cardiac Pacemaker Services.

7. The **MOHLTC** will:

(a) Notify the LHIN of any provincial or regional service delivery models for Hospital Programs Funded through the Base Budget that must be maintained in or for the local health system;

(b) Notify the LHIN of designated service coordination functions for Hospital Programs Funded through the Base Budget in the local health system as of April 1, 2007 that must be maintained;

(c) Determine the Dedicated Funding Envelope for Permanent Cardiac Pacemaker Services;and

(d) Determine, in consultation with the LHIN, the hospitals that will provide these services and hospital-specific volumes for these services until April 1, 2011, and notify the LHIN of these hospitals and volumes.

8. The **LHIN** will:

(a) Maintain the provincial or regional service delivery models of which it is notified under paragraph 7(a), subject to any agreement with the MOHLTC for changes to those models;

(b) Maintain the service coordination functions of which it is notified under paragraph 7(b);

(c) Use the Dedicated Funding Envelope for Permanent Cardiac Pacemaker Services and require the hospitals that deliver Permanent Cardiac Pacemaker Services to provide the volumes, where the LHIN is notified under paragraph 7(d).

(d) Consult with the MOHLTC on any proposed service changes regarding Specialized Hospital Services.

Acute Sector - Provincial Resources

9. In paragraph 10, “Provincial Resources” means Bone Marrow Transplants, Adult Interventional Cardiology for Congenital Heart Defects, Cardiac Laser Lead Removals, Pulmonary Thromboendarterectomy Services, and Thoracoabdominal Aortic Aneurysm Repair.

10. The **LHIN** will:

(a) Maintain the funding for the hospitals that provide Provincial Resources at the minimum levels set out in the 2007-2008 Hospital Accountability Agreement ("HAA"); and

(b) Require hospitals that provide Provincial Resources to:

(i) Maintain the volume or activity levels and scope of service delivery at least at the levels set out in the hospital's 2007/08 HAA; and

(ii) Submit a plan for any reductions or discontinuation in Provincial Resources for LHIN approval and the LHIN will work with the MOHLTC to reallocate funding to another hospital.

Acute Sector - Provincial Strategies

11. In paragraphs 12 and 13, "Provincial Strategies" means emerging services, still in pilot / developmental phase: endovascular aortic aneurysm repair, Electrophysiology studies (EPS) / ablation, percutaneous coronary intervention (PCI) (angioplasty), Implantable cardiac defibrillators (ICD), daily nocturnal home hemodialysis, provincial peritoneal dialysis initiative, newborn screening program, living organ donation and organ transplantation services.

12. The **MOHLTC** will:

(a) Determine the strategic and operational program policy including funding methodologies, accountability frameworks, performance indicators, volumes and service delivery models for Provincial Strategies; and

(b) Work with one or more of the LHINs to identify hospitals to deliver the Provincial Strategies.

13. The **LHIN** will:

(a) Incorporate the applicable funding methodologies, accountability frameworks, performance indicators, volumes and service delivery models in service accountability agreements with hospitals funded to deliver Provincial Strategies; and

(b) Provide advice to the MOHLTC about Provincial Strategies.

13.1 **Both parties** will establish a joint working group to review issues related to the management and transition of programs in paragraphs 6 to 13 of this Schedule.

Acute Sector - Cancer Programs

14. The **LHIN** will work with the MOHLTC, hospitals, Cancer Care Ontario and the Paediatric Oncology Group of Ontario to support service delivery of cancer programs in hospitals in or for the local health system.

Acute Sector - Wait Times Strategy

15. The **MOHLTC** will:

(a) For Wait Time Strategy funded incremental cancer surgery, colonoscopy procedures, incremental cardiac services, emergency department services, pediatric and general surgery, determine the Wait Time Strategy specifications, including providers, volumes, funding levels, LHIN-level Dedicated Funding Envelopes, and any other conditions, that will be part of the Wait Time Strategy for these services;

(b) For cataracts, hip and knee, and MRI/CT services, determine the Wait Time Strategy specifications, including funding levels, LHIN-level Dedicated Funding Envelopes, and any other conditions, that will be part of the Wait Time Strategy for these services, but the MOHLTC will not determine providers or the allocations to providers; and

(c) Consult with the LHIN to develop specifications for Wait Time Strategy services, including any new services.

15.1. The **LHIN** will:

(a) For cataracts, hip and knee, and MRI/CT services, determine the providers and the allocations to providers, in accordance with any specifications set by the MOHLTC;

(b) For all services funded under the Wait Time Strategy, incorporate the applicable specifications, determined by the MOHLTC, in service accountability agreements with providers funded to deliver services identified in the Wait Time Strategy; and

(c) Incorporate in service accountability agreements with providers any additional conditions of funding, as determined by the LHIN, that are consistent with the specifications determined by the MOHLTC.

16. **Both parties** will work together in the 2008-2009 fiscal year to move from funding specific wait time procedures to broader classes of related services.

Acute Sector – Critical Care Strategy

16.1. The **MOHLTC** will:

(a) Determine the specifications, including services, providers, volumes, funding levels, Dedicated Funding Envelopes, and any other conditions, that will be part of the Critical Care Strategy, and consult with the LHIN to develop these specifications; and

(b) For 2008/09, review the Critical Care Strategy to determine future directions.

16.2. The **LHIN** will incorporate the applicable specifications in service accountability agreements with providers funded to deliver services identified in the Critical Care Strategy.

16.3. **Both Parties** will select a critical care leader for the LHIN's geographic area in

accordance with their Critical Care Leader Agreement to support the MOHLTC's Critical Care Strategy and both Parties will determine the critical care leader's accountability requirements to the LHIN and the MOHLTC.

Long-Term Care (LTC) Homes - Beds in Abeyance

17. In paragraphs 18 and 19, the term "Beds in Abeyance" means beds that are approved or licensed under applicable legislation and that are approved by the MOHLTC to be out of operation.

18. The **MOHLTC** will approve Beds in Abeyance applications with LHIN recommendation.

19. The **LHIN** will:

    (a) Receive applications from LTC home operators to put beds into abeyance;

    (b) Assess the impact of applications for Beds in Abeyance and make recommendations to the MOHLTC; and

    (c) Monitor the need for the beds that are in abeyance in the local health system and work with the LTC home operator and the MOHLTC to bring these beds back into operation.

LTC Homes - Short Stay (Respite)

20. The **MOHLTC** will determine the minimum threshold for occupancy for short stay beds.

21. The **LHIN** will:

    (a) Monitor short stay bed utilization of each LTC home operator in the local health system and for the local health system;

    (b) Take action as appropriate to improve the utilization of these beds;

    (c) Have the ability to set, in its discretion, a threshold for occupancy of short stay beds that is higher than the minimum set by the MOHLTC; and

    (d) Determine the operators of short-stay beds and the number of such beds.

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LTC Homes - Convalescent Care Beds

22. In paragraphs 22.1 and 23, the term "Convalescent Care Beds" means those long-term care home beds that are designated to be occupied by patients discharged from hospitals who require convalescent care for stays of less than 90 days.

22.1 The **MOHLTC** will:

    (a) Determine a Dedicated Funding Envelope for Convalescent Care Beds;

    (b) In consultation with the LHIN, determine the LTC home operators that will provide Convalescent Care Beds and the number of such beds to be funded by the Dedicated Funding Envelope provided by the MOHLTC; and

(c) Set any other conditions related to Convalescent Care Beds;

23. The **LHIN** will:

(a) Advise the MOHLTC on the matters referred to in subparagraph 22.1(b);

(b) Use the Dedicated Funding Envelope to fund LTC home operators to provide Convalescent Care Beds referred to in subparagraph 22.1(b);

(c) Determine whether to fund operators for additional Convalescent Care Beds, including the number of such beds, outside the Dedicated Funding Envelope and, if so, provide all related funding for the additional beds from the LHIN's allocation; and

(d) Determine the LTC home operators of additional Convalescent Care Beds referred to in subparagraph (c), subject to a pre-occupancy review by the MOHLTC.

LTC Homes - Total Funding per Diem

24. The **MOHLTC** will:

(a) Determine the per diem rate and the per diem envelopes for LTC homes;

(b) Determine any net projected unused funding for all local health integration networks that, as of September 30 in each fiscal year, has not or is projected not to be used by LTC home operators as reported by LTC home operators through the revenue occupancy reports;

(c) 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 LTC per diem rate; and

(d) 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 LTC beds that are licensed or approved in the LHIN's geographic area compared to the provincial total number of LTC home beds that are licensed or approved.

25. The **LHIN** will provide the per diem rate to LTC home operators for each approved or licensed bed, other than a Bed in Abeyance or a Convalescent Care Bed, operated in accordance with the applicable legislation and the service agreement, including requiring LTC home operators to spend the funding in accordance with the per diem envelopes.

LTC Homes - Construction Cost Funding (CCF)

26. The **MOHLTC** will:

(a) Determine the CCF per diem and LTC home operators that will receive the per diem, including any conditions on the funding; and
(b) Receive applications for CCF from LTC home operators.

27. The **LHIN** will:

(a) Provide the CCF per diem to LTC home operators for each approved or licensed bed that is operated in accordance with the MOHLTC's conditions of funding, applicable legislation, development agreement or service agreement; and

(b) Provide recommendations on new CCF applications to the MOHLTC.

LTC Homes - Interim Beds

28. In paragraphs 28.1 and 29, the term "Interim Bed" means a long-stay, long-term care bed that is approved to exceed the licensed or approved bed capacity of a LTC home for one year.

28.1 The **MOHLTC** will:

(a) Determine the Dedicated Funding Envelope in each fiscal year for the number of Interim Beds funded through that envelope as of March 31, 2008;

(b) In consultation with the LHIN, determine annually the operators of those Interim Beds that were funded through the Dedicated Funding Envelope as of March 31, 2008; and

(c) Set other conditions of funding related to the Dedicated Funding Envelope for those Interim Beds that were funded through the envelope as of March 31, 2008.

29. The **LHIN** will:

(a) Advise the MOHLTC about the matters referred to in subparagraph 28.1 (b);

(b) Use the Dedicated Funding Envelope for Interim Beds, and incorporate any conditions of funding referred to in subparagraph 28.1 (c) into agreements with LTC home operators;

(c) Seek approval under applicable legislation to increase the approved or licensed bed capacity at a LTC home for any additional Interim Beds that are not funded through the Dedicated Funding Envelope; and

(d) Determine whether to fund LTC home operators for additional Interim Beds that are not funded through the Dedicated Funding Envelope, and

(e) From the LHIN's allocation, provide all related funding to LTC home operators for any additional Interim Beds.

Community Health Centres (CHCs)

30. The **MOHLTC** will:

(a) Determine the Dedicated Funding Envelope for the provision of services by CHCs to uninsured persons;

(b) In 2007/08 and 2008/09 approve sponsoring groups, enter into an agreement for CHC-specific services and determine the initial funding allocation for new CHCs; and

(c) In 2007/08 work with LHINs to develop the policy framework for assigning new

CHC agreements to LHINs

31. The **LHIN** will:

(a) Use the Dedicated Funding Envelope for services to uninsured persons for those CHCs of which it is advised; and

(b) Work with the MOHLTC and sponsoring groups in developing new CHCs.

Community Mental Health

32. The purpose of the parameters set out in paragraphs 33 and 34 is to ensure that certain provincial interests are addressed, and that the MOHLTC meets its commitments under the Health Accord and its inter-ministerial commitments, including criminal justice and forensic mental health initiatives. The categories of community mental health services for the purposes of paragraphs 33 and 34 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, and Forensic Mental Health Treatment.

33. The **MOHLTC** will:

(a) Determine and advise the LHIN of the health service providers and the Dedicated Funding Envelope for the following:

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

(ii) Crisis Intervention programs and Short-Term Residential Crisis Beds (Safe Beds) for individuals with serious mental illness who have come into contact with the criminal justice system;

(iii) Intensive Case Management and Assertive Community Treatment Teams (ACTT) funded through the Health Accord;

(iv) Intensive Case Management and Court Diversion/Supports for individuals

with serious mental illness who have come into contact with the criminal justice system;

(v) Supportive Housing – Support Services for individuals with serious mental illness who have come into contact with the criminal justice system;

(vi) Early Intervention in Psychosis programs funded through the Health Accord;

(vii) Forensic Case Management Initiatives; and

(viii) Hospitals that provide sessional services;

(b) Determine and advise the LHIN of the Dedicated Funding Envelope for:

(i) Sessional services provided by community-based agencies;

(ii) Eating Disorder services; and

(iii) Consumer Survivor Initiatives;

(c) 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, where applicable; and

(d) Advise the LHIN of the Health Accord funding and related parameters, and other provincial strategies and interests for community mental health.

34. 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 32 in or for the local health system;

(b) Require a health service provider to provide a service identified under paragraph 33(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 33 (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, or at a ratio of 1 case manager for no greater than 8 clients for individuals with serious mental illness who have come into contact with the criminal justice system;

(f) Provide funding for Consumer Survivor Initiatives at least at 2006/07 levels, and maintain the viability of such services in the local health system;

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

(h) 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

(i) 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.

35. Both parties will review the parameters in paragraphs 33 and 34 annually as set out in Schedule 1: General.

Addictions

36. The **MOHLTC** will:

(a) Determine the Dedicated Funding Envelope for Problem Gambling Treatment Services; and

(b) Determine the Dedicated Funding Envelope for programs for pregnant women with addictions funded through the federal Early Childhood Development Initiative.

37. The **LHIN** will:

(a) Fund the provision by health service providers of (i) withdrawal management, and (ii) counselling, treatment and support services;

(b) Use the Dedicated Funding Envelopes of which it is advised under paragraph 36 for the services specified in paragraph 36; and

(c) Provide funding for methadone case management services at least at 2006/07 levels in or for the local health system.

Community Care Access Centres (CCACs)

38. The **MOHLTC** will:

(a) Determine the Dedicated Funding Envelope for children/youth in Private and Home Schools for Professional Health Services, Personal Support Services and Related Medical/Personal Equipment; and

(b) In 2007/08 determine the volumes and Dedicated Funding Envelope for Acute Hospital Replacement Clients (i.e. Acute Home Care) and End of Life Strategy funded through the Health Accord.

39. The **LHIN** will:

(a) Use the Dedicated Funding Envelopes of which it is advised under paragraph 38 for the services specified in paragraph 38; and

(b) Require the CCAC to achieve the volumes determined by the MOHLTC for Acute Hospital Replacement Clients and End of Life Strategy.

PART D. MOHLTC MANAGED PROGRAMS

40. **MOHLTC Managed Programs** are programs or organizations determined from time to time by the MOHLTC, such as:

Health Human Resources
Public Health
Laboratories
Midwifery
LTC Homes - Municipal Tax Allowance Fund
LTC Homes - Rate Reduction Program
LTC Homes - Exceptional Circumstances Funding
LTC Homes - High Intensity Needs Fund & Lab Cost
Public Information Services
Supportive Housing: Dedicated Portfolio (mortgage)
Supportive Housing (Rent supplement function)
Acquired Brain Injury (ABI) – Specialized Program
Programs under the *Homemaking and Nursing Services Act* (HNSA)
Cancer Care Ontario (CCO)
Trillium Gift of Life Network
Paediatric Oncology Group of Ontario (POGO)
Eye Bank
Eating Disorder Network
Easter Seals Incontinence Supplies Grant Programs
Inter-ministerial Provincial Advisory Committee (IMPAC)
Centre for Independent Living in Toronto (direct funding program only)
Health Professionals Funded by OHIP
Ambulances
Capital
Chronic Disease Program
LTC Homes - Occupancy Based Funding
LTC Homes - Pay Equity Program
LTC Homes - High Wage Transition Fund
LTC Homes - Structural Compliance
Homes for Special Care Program
Cardiac Care Network (CCN)
Telehealth Ontario
Canadian Blood Services
Children's Health Network
Smart Systems for Health
Elderly Persons Centres
Visudyne Therapy

SCHEDULE 4: INFORMATION MANAGEMENT SUPPORTS

PART A. PURPOSE OF SCHEDULE 4

- To identify, consistent with the Primary Purpose, MOHLTC and LHIN performance obligations relating to the collection, storage and use of data and information for health system management over the term of this Agreement.

PART B. PERFORMANCE OBLIGATIONS

1. **The MOHLTC** will:

   As health system steward,

   (a) Develop data standards, data quality definitions, and reporting timelines for the provincial health system in collaboration with LHINs and others, and communicate these to the LHIN;

   (b) Develop a repository of data and information to support health system needs, and provide access to that repository to the LHIN;

   To support the LHIN,

   (c) Provide a one-window support centre to fulfill LHIN routine data and information requests, supported by health analytics capabilities, other than requests for financial transaction data. Specialized or highly customized requests would be subject to prioritization through discussions between the MOHLTC and the LHIN;

   (d) Receive data and information from health service providers on behalf of the LHIN and provide timely access to data and information to the LHIN; and

   (e) Conduct routine data timeliness and quality checks on data and information as it is submitted by health service providers, including:

      (i) Contacting health service providers on behalf of the LHIN about late reports, missing data, and inconsistent data;

      (ii) Measuring the timeliness and quality of data submitted by health service providers; and

      (iii) Providing reports to the LHIN when there is an issue with data timeliness and quality submissions by health service providers.

2. **The LHIN** will:

   (a) Require health service providers to submit data and information as set out in paragraph 1(a) to the MOHLTC, CIHI, or other third party under the terms of agreements assigned to the LHIN, service accountability agreements or the Act; and

(b) Work with health service providers to improve data quality and timeliness as necessary based on reports provided by the MOHLTC under paragraph 1(e).

3. **Both parties** will:

(a) Develop a provincial forum, such as an Information Management Advisory Committee, for the purposes of identifying and discussing data and information gaps, information management requirements, decision support requirements, standards, data quality issues, and other pertinent information management topics, and making recommendations to the MOHLTC; and

(b) Work together to:

(i) Coordinate communications with health service providers about information management issues, including data standards, data quality definitions and reporting timelines set by the MOHLTC under paragraph 1(a); and

(ii) Avoid duplicating data and information sources and holdings.

SCHEDULE 5: FINANCIAL MANAGEMENT

PART A. PURPOSE OF SCHEDULE 5

- To promote sound financial management to help create a system that is sustainable, improves local health system performance, and supports the achievement of provincial targets.

- To set out the following elements for effective financial management:

  (a) multi-year funding targets,
  (b) annual balanced budget requirements,
  (c) multi-year expense limit policy,
  (d) parameters for in-year and year-end reallocation,
  (e) results-oriented planning,
  (f) fiscal prudence, and
  (g) parameters for the treatment of surplus funds.

PART B. PERFORMANCE OBLIGATIONS

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 13;

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

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

Multi-year Funding Targets

2. The **MOHLTC** will:

   (a) Provide the LHIN with multi-year funding targets for each of its Operating and Transfer Payment Budgets for the three years covered by this Agreement. These targets will be set out in Schedule 9: Allocations and reviewed annually; and

   (b) In 2007/08, provide the LHIN with parameters to implement multi-year funding targets for health service providers, other than public hospitals, as required by paragraph 3(d).

3. The **LHIN** will:

   (a) Develop an Annual Service Plan within the multi-year funding targets set out in

Schedule 9: Allocations that (i) outlines a three-year spending plan for each of its Operating and Transfer Payment Budgets; and (ii) reflects its Integrated Health Service Plan;

(b) Treat the multi-year funding targets provided for the two out-years as planning targets only that are subject to adjustment by the MOHLTC;

(c) Advise each public hospital in the local health system of its multi-year funding targets for inclusion in its service accountability agreement; and

(d) In 2007/08, prepare a plan to implement multi-year funding targets for health service providers, other than public hospitals, as part of the process to negotiate service accountability agreements with those health service providers, subject to any parameters set by the MOHLTC referred to in paragraph 2(b).

Annual Balanced Budget Requirements

4. The **MOHLTC** will, in 2007/08, identify any health service providers, in addition to public hospitals and Community Care Access Centres, for which the LHIN will be required to establish annual balanced budget provisions in either the agreements assigned to the LHIN or service accountability agreements, as applicable.

5. The **LHIN** will:

(a) Plan for an annual balanced budget for its Operating and Transfer Payment Budgets for the LHIN in each Annual Service Plan for each year covered by the Annual Service Plan and achieve an annual balanced budget;

(b) Submit annual balanced budget forecasts to the MOHLTC in accordance with Schedule 8: Integrated Reporting; and

(c) Include an annual balanced budget provision in agreements with public hospitals, CCACs and other health service providers as required by paragraph 4, and require compliance in accordance with the terms of those agreements and applicable legislation.

6. **Both parties** will:

(a) Work jointly to develop policies and plans to introduce the annual balanced budget provisions required under paragraph 4; and

(b) Work jointly to identify budgetary flexibility and manage in-year risks and pressures to ensure that annual balanced budget requirements are achieved.

Multi-Year Expense Limits Policy

7. 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 Schedule 9: Allocations.

In-year and Year-end Reallocations

8. The **MOHLTC** will:

(a) Provide parameters or guidelines for in-year and year-end reallocations of funds by the LHIN to, between, and among health service providers;

(b) Provide materials to the LHIN to facilitate knowledge transfer relating to the management of expenditures, risks and pressures in-year and at year-end;

(c) Monitor the LHIN's reallocation decisions and management of expenditures, and develop any additional guidelines and parameters, as required, to ensure effective financial management; and

(d) Work with the LHIN to provide a forecast of the LHIN's year-end position in the LHIN's Third Quarter Report, the updated Third Quarter final forecast referred to in paragraph 9(d) and Fourth Quarter Reallocation Report referred to in paragraph 9(e).

9. The **LHIN** will:

(a) Reallocate funding in-year across its local health system, within, between and among sectors, subject to the following:

(i) Reallocation decisions will be consistent with the objectives and action plans of the LHIN as identified in the Integrated Health Service Plan, Annual Service Plan and the performance obligations in this Agreement;

(ii) Reallocation decisions will consider the impact on future financial and performance plans;

(iii) Reallocation decisions will preserve the use of Dedicated Funding Envelopes for identified programs or services, as required by Schedule 9: Allocations and Schedule 3: Local Health System Management;

(iv) No reallocation of funding from the LHIN's Transfer Payment Budget to the LHIN's Operating Budget is permitted;

(v) Any additional parameters identified by the MOHLTC after discussion with the LHIN; and

(vi) No reallocation will be processed after March 15 for the fiscal year;

(b) Report quarterly on any planned in-year reallocations and actual in-year reallocations as set out in Schedule 8: Integrated Reporting;

(c) As part of the Third Quarter Regular Report, provide a forecast of the LHIN's year-end position, including any in-year reallocations planned for the fourth quarter;

(d) By the last business day of January, provide an updated forecast of the LHIN's year-end position if there are changes to the forecast provided in the Third Quarter Regular Report arising from more up-to-date information, new funding, or if the LHIN has made or is proposing any reallocation after December 31 with another local health integration network;

(e) By March 15 of a fiscal year, provide a Fourth Quarter Reallocation Report that identifies any in-year reallocations in the fourth quarter; and

(f) After December 31 of a fiscal year, undertake only those reallocations set out in the Third Quarter Regular Report, the updated Third Quarter Final Forecast, the Fourth Quarter Reallocation Report or that have been approved by the MOHLTC.

Risk Management Framework

10. The **MOHLTC** will develop LHIN Risk Management Tools and Policies in accordance with the Ontario Public Service (OPS) Risk Management Framework (2001) and the Risk Management Policy (2002), and will provide these tools and policies to the LHIN by April 30, 2007.

11. The **LHIN** will:

(a) Use the LHIN Risk Management Tools and Policies to identify and manage risk; and

(b) Report on identified risks and related mitigation strategies in its Annual Service Plan and quarterly regular reports as set out in Schedule 8: Integrated Reporting.

12. **Both parties** will work jointly on the implementation of the LHIN Risk Management Tools and Policies

Accounting Standards

13. The **MOHLTC** will issue interpretations and modifications relating to the Public Sector Accounting Board (PSAB) standards, based on advice from the Office of the Provincial Controller, particularly in relation to the annual balanced budget requirement.

14. The **LHIN** will prepare its financial reports and statements on its Operating and Transfer Payment Budgets, including its Annual Service Plan, based on the Public Sector Accounting Board (PSAB) standards, subject to modifications and interpretations issued from time to time by the MOHLTC.

15. **Both parties** will develop a Chart of Accounts for LHINs that is inter-operable between all LHINs and the MOHLTC.

Performance Expectations and Measures

16. **Both parties** will work jointly on the development of performance indicators relating to the obligations outlined in this Schedule.

Capital - General Provisions

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

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

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

(a) Carry out capital planning in alignment with the Provincial Strategic Plan and the Guide referred to in Schedule 2: Community Engagement, Planning and Integration; and

(b) Coordinate approvals for service reconfigurations or expansions by health service providers that may require capital projects.

Capital Initiatives

20. In paragraph 21, the term "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 part of the HIRF as those terms are defined in paragraphs 22 and 24.

21. **Both parties** will work together to enable the LHIN to provide advice about the consistency of a health service provider's Capital Initiative with local health system needs during Capital Initiative review and approval processes, including pre-proposal, business case or functional program stages.

Own-Funds Capital Projects

22. In paragraph 23, 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.

23. **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-proposal, business case or 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)

24. In paragraphs 25 to 27, the term "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.

25. The **MOHLTC** will:

(a) Provide the LHIN with guidelines for the HIRF by June 30, 2007, including guidelines about the eligibility, approval and funding of HIRF projects, and will update the guidelines by June 30 of each fiscal year if necessary;

(b) Determine the amount of the Dedicated Funding Envelope for the HIRF for each fiscal year;

(c) For the 2007-2008 fiscal year, determine, in consultation with the LHIN, the allocation of the Dedicated Funding Envelope from the HIRF for public hospitals

in the local health system, including any conditions of such funding, and provide such funding to the public hospital in conjunction with the approval of a HIRF project by the LHIN; and

(d) For fiscal years after 2007-2008, determine, in consultation with the LHIN, the Dedicated Funding Envelope for the HIRF for the LHIN and provide that funding to the LHIN.

26. The **LHIN** will:

(a) Starting in Fall 2007, approve eligible HIRF projects in the local health system in accordance with the MOHLTC's guidelines referred to in paragraph 25(a), and, for the 2007-2008 fiscal year, advise the MOHLTC of which projects are approved;

(b) For fiscal years after 2007-2008, provide advice to the MOHLTC on the amount of the Dedicated Funding Envelope for the HIRF for the LHIN; and

(c) For fiscal years after 2007-2008, use the Dedicated Funding Envelope for the HIRF to provide funding to public hospitals in accordance with the HIRF guidelines and incorporate any conditions of the funding into service accountability agreements with public hospitals.

27. **Both parties** will work together to enable the LHIN to begin approving HIRF projects starting in Fall 2007.

Post-Construction Operating Plan (PCOP)

28. In paragraphs 29 and 30, the term "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 constructed capital project.

29. The **MOHLTC** will:

(a) Provide the LHIN by June 30, 2007 with guidelines for the eligibility, approval and funding of projects using PCOP funding, and will update the guidelines by June 30 of each fiscal year if necessary;

(b) Consult with the LHIN about allocations of PCOP funding to a public hospital in the local health system; and

(c) Determine the PCOP Dedicated Funding Envelope for a public hospital in the local health system for each fiscal year, including any conditions of such funding, and provide that funding to the LHIN.

30. The **LHIN** will:

(a) Advise the MOHLTC about allocations of PCOP funding to a public hospital in the local health system for each fiscal year and the conditions of such funding; and

(b) Provide the PCOP Dedicated Funding Envelope of which it is advised under paragraph 29(c) in accordance with applicable guidelines and incorporate any conditions of the funding into service accountability agreements with the public hospital.

Definition

31. In paragraphs 25, 26, 29 and 30, the term “Dedicated Funding Envelope” has the same meaning as “Dedicated Funding Envelope” in paragraph 5 of Part C of Schedule 3: Local Health System Management.

SCHEDULE 6: FINANCIAL PROCESSING PROTOCOLS

PART A. PURPOSE OF SCHEDULE 6

- To support sound financial management for the local health system through the efficient operation of financial processes and cooperation between the MOHLTC and the LHIN.

PART B. PERFORMANCE OBLIGATIONS

1. The **MOHLTC** will:

   (a) For 2007/08, on behalf of the LHIN, establish (i) a payment schedule for payments to health service providers and (ii) the deadlines by which the LHIN must request the payments;

   (b) Process the initial payment for 2007/2008 to each health service provider funded by the LHIN;

   (c) Process subsequent payments as directed by the LHIN to health service providers;

   (d) Support the LHIN in responding to inquiries from health service providers concerning payment processing;

   (e) By April 30, 2007, establish a data base that will enable the LHIN to:

      (i) Access information on their health service provider allocations, including payment details by health service provider;

      (ii) Give the MOHLTC direction on payments to be made to health service providers; and

      (iii) Document payment directions to the MOHLTC;

   (f) Provide the LHIN with quarterly year-to-date and year-end expenditures, recoverables and payables related to its transfer payments in accordance with the timelines set out in Schedule 8: Integrated Reporting;

   (g) Receive financial reports from health service providers on behalf of the LHIN, and provide the LHIN with access to the financial information;

   (h) Conduct routine timeliness and quality checks on financial information submitted by health service providers, including:

      (i) Contacting health service providers on behalf of the LHIN about late reports, missing data, and inconsistent data;

      (ii) Measuring the timeliness and quality of data submitted by health service providers; and

(iii) Providing reports to the LHIN when there is an issue with data timeliness and quality submissions by health service providers.

(i) As instructed by the LHIN, prepare year-end reconciliations of health service provider expenditures, and settle financial obligations with health service providers;

(j) Receive expenditure forecasts through the LHIN's quarterly and year-end reports, and set up controls so that the total appropriation for the LHIN's Operating and Transfer Payment Budgets is not exceeded; and

(k) Provide on a timely basis to the LHIN and update, as necessary, financial transaction processing manuals.

2. The **LHIN** will:

(a) Identify those LHIN personnel who are authorized to approve payments to health service providers, and will provide their names to the MOHLTC together with the effective start and end dates of the authorization, the maximum authorized payment amounts;

(b) Advise the MOHLTC of any changes to the information referred to in paragraph 2(a);

(c) Maintain documentation to support all payment instructions;

(d) Request payments be made and adjustments to payments to health service providers by the deadlines set by the MOHLTC under paragraph 1(a);

(e) Monitor the financial information of health service providers, and direct the MOHLTC on potential reallocations and in-year adjustments in accordance with Schedule 5: Financial Management;

(f) Review, and direct the MOHLTC on, settlements to health service providers based on year-end audited financial statements and annual reconciliation reports of the health service providers, including a review of actual expenditures against the approved budget;

(g) Require health service providers to submit financial information to the MOHLTC, including financial statements and audited financial reports, under the terms of agreements assigned to the LHIN, service accountability agreements, or the Act; and

(h) Provide expenditure forecasts in quarterly and year-end reports as set out in Schedule 8: Integrated Reporting.

SCHEDULE 7: LOCAL HEALTH SYSTEM COMPLIANCE PROTOCOLS

PART A. PURPOSE OF SCHEDULE 7

- To set out LHIN and Ministry roles and responsibilities for compliance, inspection and enforcement functions in the local health system of the LHIN.

PART B. PERFORMANCE OBLIGATIONS

1. The **MOHLTC**:

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

   (b) Except as provided in paragraph 1(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 under a statute;

      (iii) Proposing to revoke or revoking an approval or licence of a health service provider under a statute; 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, in exceptional circumstances, take any action listed set out in subparagraphs 1(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 1(b) and (c), will exercise its statutory authorities at its discretion and as required under law respecting licensing, approving, inspecting and enforcing long-term care home legislation, and, for greater certainty, will inspect, as appropriate, long-term care home operators for compliance with legislation respecting resident trust funds, payments by residents to long-term care home operators and any MOHLTC Managed Programs under Part D of Schedule 3: Local Health System Management

   (e) Will inform the LHIN as soon as reasonably possible of any non-compliance (either legislative or otherwise) by a long-term care home operator that may raise financial or other issues relevant to the local health system; and

   (f) Will provide the LHIN with access to long-term care home data, including information on the compliance status of long-term care home operators, short-stay bed utilization and the occupancy of residents.

2. The **LHIN**:

(a) Will, in managing the health service providers for its local health system as described in Schedule 3: Local Health System Management, 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 long-term care homes as performed by the MOHLTC For greater certainty, the LHIN will conduct, as necessary or as required under law, audits and reviews of long-term care home operators related to financial matters, other than for MOHLTC Managed Programs under Part D of Schedule 3: Local Health System Management;

(b) Will inform the MOHLTC as soon as reasonably possible of:

(i) Any non-compliance by a health service provider with an assigned agreement, a service accountability agreement, or legislation, including program standards; or

(ii) 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 1 (b)(i) to (iv) against the health service provider; and

(c) In addition to paragraph 2 (b), will inform the MOHLTC:

(i) As soon as reasonably possible of a long-term care home operator experiencing financial issues that may cause non-compliance with resident care or resident rights standards under long-term care home legislation; or

(ii) Immediately of a critical or urgent matter related to alleged non-compliance with long-term care home legislation.

3. **Both parties** will:

(a) Work together to proactively assess and mitigate risks to the local health system that arise or may arise from the MOHLTC's activities described in subparagraphs 1(b)(i) to (iv);

(b) Beginning in 2007-08, jointly develop guidelines for the LHIN on conducting audits, inspections, and reviews of health service providers, other than inspections under long-term care home legislation, to ensure consistency among LHINs, where appropriate, in managing the local health system; and

(c) Beginning in 2007-08, jointly develop protocols for the consultations and information exchanges between the LHIN and the MOHLTC about the issues described in paragraphs 1 and 2 of this Schedule.

SCHEDULE 8: INTEGRATED REPORTING

PART A. PURPOSE OF SCHEDULE 8

- 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 summarized in the attached Calendarized Reporting Chart.

2. The **MOHLTC** will:

   (a) By June 30 of each fiscal year, provide to the LHIN for planning and reporting purposes the approved allocation for that fiscal year and the multi-year funding targets for the next three fiscal years; and

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

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.

Consolidation Opening Balance (2007/08 only)

4. The **MOHLTC** will provide a consolidation opening balance form by April 30, 2007.

5. The **LHIN** will submit to the MOHLTC its consolidation opening balance by May 31, 2007 using the form provided by the MOHLTC.

Quarterly Regular and Consolidation Reports

6. The **MOHLTC** will:

   (a) Provide to the LHIN with a preliminary annual calendarized cash flow schedule by sector for 2007-2008 by April 15, 2007, and finalized cash flow schedule for

that fiscal year by July 31, 2007;

(b) Provide to the LHIN the forms for quarterly Regular and Consolidation Reports by April 30 of each fiscal year;

(c) Provide to the LHIN on or about June 8, September 7 and December 7 of each fiscal year a report confirming year-to-date expenditures, recoverables and payables related to its transfer payments;

(d) Provide to the LHIN the data on the performance indicators as set out in Schedule 10: Local Health System Performance;

(e) Work with the LHIN to provide a forecast of the LHIN's year-end position in the LHIN's Third Quarter Regular Report; and

(f) Provide the LHIN by February 15 with a form for the LHIN's Fourth Quarter Reallocation Report.

7. The **LHIN**:

(a) Will submit to the MOHLTC quarterly Regular and Consolidation Reports using the forms provided by the MOHLTC by the following dates:

QUARTER	DUE DATE
First Quarter Report (Q1)	June 30
Second Quarter Report (Q2)	September 30
Third Quarter Report (Q3)	December 31

(b) Include in each quarterly Regular Report under paragraph 7(a):

(i) A forecast of the LHIN's year-end position, including planned in-year reallocations, and actual in-year reallocations;

(ii) Identified risks and related mitigation strategies; and

(iii) Mitigation strategies and performance improvement plans for performance indicators in Tables A to C as set out in Schedule 10: Local Health System Performance, where variance has been identified and until the variance is resolved; and

(c) Submit a Fourth Quarter report on March 31 of each fiscal year in respect of mitigation strategies and performance improvement plans for performance indicators in Tables A to C as set out in Schedule 10: Local Health System Performance, where variance has been identified and until the variance is resolved.

Year-end Reports

8. The **MOHLTC** will:

(a) Provide to the LHIN by February 15 of each fiscal year the forms and requirements for the Annual Report related to non-financial content;

(b) Provide to the LHIN by March 31 of each fiscal year the form for the financial content of the Annual Report and, by April 30 of each fiscal year, the form for the Year-end Consolidation Report for that fiscal year;

(c) Starting in 2008, provide to the LHIN by April 15 a report confirming interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year;

(d) Starting in 2008, provide the LHIN by April 30 of each year, the following information for the preceding fiscal year on its transfer payments to support the preparation of Year-end Reports:

(i) Report with final year-end expenditures by sector and by health service provider;

(ii) Operating Assets Report (recoverables); and

(iii) Liabilities Report (payables), based on a list of liabilities on MOHLTC records and reconciliation discussions with the LHIN; and

(e) Provide the LHIN with the data on the performance indicators as set out in Schedule 10: Local Health System Performance.

9. The **LHIN** will:

(a) Submit to the MOHLTC the year-end consolidation report, including Audited Financial Statements, using the forms provided by the MOHLTC, by May 31 of each fiscal year to which this Agreement applies; and

(b) Submit by June 30 of each year to the MOHLTC an Annual Report for the previous fiscal year in accordance with MOHLTC requirements, and include in the Annual Report the following:

(i) The effectiveness of the LHIN's community engagement strategy using the common assessment tool referred to in Schedule 2: Community Engagement, Planning and Integration;

(ii) The LHIN's engagement with planning entities prescribed under the Act;

(iii) A report on the LHIN's integration activities; and

(iv) A report on the performance of the local health system on all performance indicators as set out in Schedule 10: Local Health System Performance.

Annual Service Plan

10. Commencing in the 2008-2009 fiscal year, the Annual Service Plan will contain the following components:

(a) An Annual Business Plan;

(b) A Multi-Year Risk Report; and

(c) A Multi-Year Consolidation Report.

10.1 The **MOHLTC** will:

(a) By May 31 of each fiscal year, provide to the LHIN the forms and information requirements for the Annual Business Plan and Multi Year-Risk Report components of the Annual Service Plan; and

(b) By August 31 of each fiscal year, provide to the LHIN the forms and information requirements for the Multi-Year Consolidation Report component of the Annual Service Plan.

11. The **LHIN** will:

(a) By September 30 of a fiscal year, submit to the MOHLTC the Multi-Year Risk Report component of the Annual Service Plan using the form provided under and containing the information required by paragraph 10.1; and

(b) By October 31 of each fiscal year, submit to the MOHLTC a draft Annual Business Plan and Multi-year Consolidation Report using the forms provided under and containing the information required by paragraph 10.1.

12. **Both parties** will finalize the Annual Service 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.

SCHEDULE 8: INTEGRATED REPORTING CALENDARIZED REPORTING CHART				
Date	**Description of Item**	**From**	**To**	**Schedule Reference (*)**
2008/2009				
MARCH				
March 31, 2008	Forms for the Annual Report (financial content)	MOHLTC	LHIN	8 (b)
March 31, 2008	Q4 Report on Performance Variance (if required)	LHIN	MOHLTC	7 (c)
APRIL				
April 15, 2008	Preliminary annual calendarized cash flow schedule by sector for 2008/09	MOHLTC	LHIN	6 (a)
April 30, 2008	Forms for Year-end Consolidation Report	MOHLTC	LHIN	8 (b)
April 30, 2008	Quarterly Regular and Consolidation Reports form	MOHLTC	LHIN	6 (b)
MAY				
May 15, 2008	2007/08 Q3 Performance Data for Indicators in Schedule 10, Tables B & C, and 2007/08 Q4 Performance Data for Indicators in Schedule 10, Table A.	MOHLTC	LHIN	Schedule 10: Tables A to C
May 31, 2008	Annual Service Plan requirements for the annual business plan and multi year risk report	MOHLTC	LHIN	10.1 (a)
May 31, 2008	Submit Year-End Consolidation Report	LHIN	MOHLTC	9 (a)
JUNE				
On or about June 8, 2008 (date may vary slightly depending on availability of data on IFIS)	Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments	MOHLTC	LHIN	6 (c)
June 30, 2008	Annual report for fiscal year 07/08	LHIN	MOHLTC	9(b)
June 30, 2008	The approved allocation for the current fiscal year and the funding targets for the next three fiscal years	MOHLTC	LHIN	2 (a)
June 30, 2008	Q1 Report using the forms provided by the MOHLTC	LHIN	MOHLTC	7 (a)
JULY				
AUGUST				
August 15, 2008	2006/07 2007/2008 Performance Data for Q4 for performance indicators in Schedule 10, Tables B & C, and 2008/09 Performance Data for Q1 for performance indicators in Schedule 10, Table A.	MOHLTC	LHIN	Schedule 10: Tables A to C
August 31, 2008	Annual Service Plan requirements for the Multi-year Consolidation Report	MOHLTC	LHIN	10.1 (b)

***** *Unless noted, reference is to Schedule 8*

SCHEDULE 8: INTEGRATED REPORTING CALENDARIZED REPORTING CHART				
Date	**Description of Item**	**From**	**To**	**Schedule Reference (*)**
SEPTEMBER				
On or about September 7, 2008 (date may vary slightly depending on availability of data on IFIS)	Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments	MOHLTC	LHIN	6 (c)
September 30, 2008	Q2 Report using the forms provided by the MOHLTC	LHIN	MOHLTC	7 (a)
September 30, 2008	Multi-Year Risk Report using the form provided by the MOHLTC	LHIN	MOHLTC	11 (a)
OCTOBER				
October 31, 2008	Draft annual business plan using the form provided by MOHLTC	LHIN	MOHLTC	11 (a)
October 31, 2008	Multi-year Consolidation Report using the form provided by the MOHLTC	LHIN	MOHLTC	11 (b)
NOVEMBER				
November 15, 2008	2008/2009 Performance Data for Q1 for Median Wait Time to Long-Term Care Home Placement, and 2008/09 Performance Data for Q2 for performance indicators in Schedule 10, Table A.	MOHLTC	LHIN	Schedule 10: Tables A to C
DECEMBER				
On or about December 7, 2008 (date may vary slightly depending on availability of data on IFIS)	Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments	MOHLTC	LHIN	6 (c)
December 31, 2008	Q3 Report including final year-end forecast using the forms provided by the MOHLTC	LHIN	MOHLTC	7 (a)
JANUARY				
January 30 2009	Update Q3 Regular Forecast using the forms provided by the MOHLTC	LHIN	MOHLTC	Schedule 5.9(d)
FEBRUARY				
February 15, 2009	2008/09 Q2 performance data for performance indicators in Schedule 10, Tables B & C, and 2008/09 Performance Data for Q3 for performance indicators in Schedule 10, Table A.	MOHLTC	LHIN	Schedule 10: Tables A to C
February 15, 2009	Annual Report requirements (non-financial content)	MOHLTC	LHIN	8 (a)

***** *Unless noted, reference is to Schedule 8*

February 15, 2009	Form to report in Q4 on planned vs actual expenditures related to in-year reallocations	MOHLTC	LHIN	6 (f)

SCHEDULE 8: INTEGRATED REPORTING CALENDARIZED REPORTING CHART				
Date	**Description of Item**	**From**	**To**	**Schedule Reference (*)**
MARCH				
March 15 2009	Q4 Reallocation Report on planned vs actual expenditures related to in-year reallocations	LHIN	MOHLTC	Schedule 5.9(e)
March 31, 2009	Forms for the Annual Report (financial content) and	MOHLTC	LHIN	8 (b)
March 31, 2009	Q4 Report on Performance Variance (if required)	LHIN	MOHLTC	7 (c)
2009/2010				
APRIL				
April 15, 2009	Preliminary annual calendarized cash flow schedule by sector for 2008/09	MOHLTC	LHIN	6 (a)
April 30, 2009	Quarterly Regular and Consolidation Reports form	MOHLTC	LHIN	6 (b)
April 30, 2009	Forms for Year-end Consolidation Report	MOHLTC	LHIN	8 (b)
MAY				
May 15, 2009	2008/09 Q3 Performance Data for Indicators in Schedule 10, Tables B & C, and 2008/09 Q4 Performance Data for Indicators in Schedule 10, Table A.	MOHLTC	LHIN	Schedule 10: Table A to C
May 31, 2009	Annual Service Plan requirements	MOHLTC	LHIN	10
May 31, 2009	Submit Year-End Consolidation Report	LHIN	MOHLTC	9 (a)

***** *Unless noted, reference is to Schedule 8*

SCHEDULE 9: ALLOCATIONS

PART A. PURPOSE OF SCHEDULE 9

- To provide a statement of the total funding to be allocated to the LHIN for the 2008/09 fiscal year and the funding targets for the 2009/10 and 2010/2011 fiscal years.

- To set out a plan for the spending of funds by the LHIN for each fiscal year of this Agreement.

PART B. PERFORMANCE OBLIGATIONS

1. **The MOHLTC** will:

   (a) By June 30, 2007, provide the LHIN with its allocation of funding for 2007-2008 and revised funding targets for 2008-2009 and 2009-2010, and by June 30 of each subsequent year, provide the allocation for the fiscal year and funding targets in Table 1 – Funding Targets for all LHINs, Table 2 – Funding Targets for the LHIN, Table 3 – Dedicated Funding Envelopes for all LHINs of this Schedule;

   (b) By June 30, 2007, the MOHLTC will provide the LHIN with a list of Dedicated Funding Envelopes for 2007-2008, and by June 30 of each subsequent year, in Table 4 – Dedicated Funding Envelopes for the LHIN of this Schedule and will review it in accordance with Schedule 3: Local Health System Management; and

   (c) Discuss and revise the funding targets for 2009/10 and 2010/11 with the LHIN as part of the Annual Service Plan submission process.

2. **The LHIN** will allocate the funds:

   (a) For 2007-2008, in accordance with the Act, this Agreement, including Tables 2 and 4 of this Schedule, and the agreements assigned to the LHIN; and

   (b) For fiscal years after 2007-2008, in accordance with the Act, its Annual Service Plan approved by the MOHLTC and this Agreement.

Table 1: Statement of Total LHIN 2008/09 Funding Allocation and Multi-Year Funding Target

Final - as of June 30th	2008/09 Funding Allocation (000's) [1]	2009/10 Funding Target (000's) [1]	2010/11 Funding Target (000's) [1]
Total LHIN Budget	**20,285,533.6**	**20,545,937.6**	**20,786,811.8**
Total Health Service Provider (HSP) Transfer Payments	20,217,653.7	20,545,437.6	20,786,311.8
Operation of LHIN [2]	65,579.9	TBD	TBD
Initiatives [3]	500.0	500.0	500.0
E-Health	1,800.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector:			
Operations of Hospitals [4]	13,896,316.2	14,006,893.8	13,990,893.8
Grants to compensate for Municipal Taxation - public hospitals	3,705.4	3,705.4	3,705.4
Long Term Care Homes [5]	2,668,310.7	2,668,310.7	2,668,310.7
Community Care Access Centres	1,683,919.3	1,747,727.8	1,835,114.2
Community Support Services	282,725.3	277,620.7	283,867.2
Acquired Brain Injury	34,671.9	35,326.4	36,121.2
Assisted Living Services in Supportive Housing	155,833.4	158,832.4	162,406.1
Community Health Centres	192,365.7	192,365.7	192,365.7
Community Mental Health	566,759.6	578,066.8	590,559.1
Addictions Program	129,197.6	131,166.9	134,116.6
Specialty Psych Hospitals	524,005.3	534,706.3	534,706.3
Grants to compensate for Municipal Taxation - psychiatric hospitals	112.1	112.1	112.1
Initiatives [6]	79,731.2	210,602.6	354,033.6

Note:

1. The 2008/09 funding allocation and the 2009/10 and 2010/11 funding targets are updated as of June 30, 2008 from the approved 2008/09 multi-year Results Based Plan and the 2008/09 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. They include base and one-time realignments for 2008/09 and only base realignments for 2009/10 and 2010/11 (except for the Operations of Hospitals which includes some one-time funding agreements). The realignment occurs within the Ministry's total approved appropriation. Additional details and formal adjustments for these programs will be confirmed as part of the 2009/10 Provincial Budget.

   The 2008/09 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2008/09, 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.

   The 2009/10 and 2010/11 funding targets are for planning purposes and are base funding targets only (except for the Operations of hospitals which includes some one-time funding agreements). They are subject to the annual Results Based Plan, Printed Estimates and Provincial Budget approvals.

2. The LHIN Operation funding targets for 2009/10 and 2010/11 are to be determined as they are subject to further review.

3. LHIN Operations initiatives include Aboriginal Community Engagement.
4. Operation of Hospitals allocations and funding targets include private and public hospitals. It may also include, as appropriate, any approved PCOP funding as described further in Table 3 - Dedicated Funding.
5. Out-year funding targets of LTC homes for 2009/10 and 2010/11 exclude acuity and stabilization increases due to pending 2008/09 base approvals which will impact out-years.
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, Flo Collaborative, and Emergency Department Action Plan that are unallocated. It should be noted that as the LHIN allocates by sector, the allocation will be distributed at the sector level.

Table 2: Statement of Waterloo Wellington LHIN 2008/09 Funding Allocation and Multi-Year Funding Target

Final - as of June 30th	2008/09 Funding Allocation (000's) [1]	2009/10 Funding Target (000's) [1]	2010/11 Funding Target (000's) [1]
Total LHIN Budget	**825,430.4**	**834,936.4**	**849,608.4**
Total Health Service Provider (HSP) Transfer Payments	821,036.3	834,931.4	849,603.4
Operation of LHIN [2]	4,269.0	TBD	TBD
Initiatives [3]	5.0	5.0	5.0
E-Health	120.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector:			
Operations of Hospitals [4]	506,476.8	508,346.4	508,346.4
Grants to compensate for Municipal Taxation - public hospitals	159.2	159.2	159.2
Long Term Care Homes [5]	129,132.6	129,132.6	129,132.6
Community Care Access Centres	85,636.1	89,037.4	93,489.2
Community Support Services	10,972.9	11,094.2	11,343.8
Acquired Brain Injury	1,143.4	1,169.1	1,195.4
Assisted Living Services in Supportive Housing	5,336.5	5,456.6	5,579.4
Community Health Centres	13,867.2	13,867.2	13,867.2
Community Mental Health	26,412.2	26,982.4	27,565.3
Addictions Program	6,493.2	5,809.1	5,939.8
Specialty Psych Hospitals	28,803.5	29,358.5	29,358.5
Grants to compensate for Municipal Taxation - psychiatric hospitals	0.0	0.0	0.0
Initiatives [6]	6,602.8	14,518.8	23,626.6

Note:

1. The 2008/09 funding allocation and the 2009/10 and 2010/11 funding targets are updated as of June 30, 2008 from the approved 2008/09 multi-year Results Based Plan and the 2008/09 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. They include base and one-time realignments for 2008/09 and only base realignments for 2009/10 and 2010/11 (except for the Operations of Hospitals which includes some one-time funding agreements). The realignment occurs within the Ministry's total approved appropriation. Additional details and formal adjustments for these programs will be confirmed as part of the 2009/10 Provincial Budget.

   The 2008/09 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2008/09, 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.

   The 2009/10 and 2010/11 funding targets are for planning purposes and are base funding targets only (except for the Operations of hospitals which includes some one-time funding agreements). They are subject to the annual Results Based Plan, Printed Estimates and Provincial Budget approvals.

2. The LHIN Operation funding targets for 2009/10 and 2010/11 are to be determined as they are subject to further review.
3. LHIN Operations initiatives include Aboriginal Community Engagement.
4. Operation of Hospitals allocations and funding targets include private and public hospitals. It may also include, as appropriate, any approved PCOP funding as described further in Table 3 - Dedicated Funding.
5. Out-year funding targets of LTC homes for 2009/10 and 2010/11 exclude acuity and stabilization increases due to pending 2008/09 base approvals which will impact out-years.
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, Flo Collaborative, and Emergency Department Action Plan that are unallocated. It should be noted that as the LHIN allocates by sector, the allocation will be distributed at the sector level.

Table 3: Statement of Total LHIN 2008/09 Dedicated Funding by Sector

	2008/09 Dedicated Funding Envelopes [1]
Hospitals	
Permanent Cardiac Care Pacemaker Services	$60,422,150
Critical Care	$80,884,800
Wait Times Strategy [2]	$166,568,100
Health Infrastructure Renewal Fund	TBD
Post Construction Operating Plan [3]	$421,582,372
E-Health	TBD
LTC Homes	
Convalescent Care Beds [4]	$23,926,134
Interim and Transitional Beds [4]	$27,597,774
Community Health Centres	
Uninsured persons services	$2,886,782
Community Mental Health	
Crisis Intervention programs and services (funded through Health Accord and Service Enhancements)	$43,817,593
Short-Term Residential Crisis Beds (Safe Beds)	$11,297,893
Assertive Community Treatment Teams (ACTT)	$31,490,000
Intensive Case Management (funded through Health Accord and Service Enhancements)	$29,672,466
Court Diversion/Supports	$4,606,000
Supportive Housing Supports	$10,387,000
Early Intervention in Psychosis programs (funded through Health Accord)	$21,121,506
Forensic Case Management Initiatives	$2,040,000
Sessional services in hospitals (Psychiatric Out-Patient Medical Salaries)	$12,386,805
Sessional services provided by community-based agencies	$10,470,610
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
Community Care Access Centres	
Private and Home Schools for Professional Health Services	$3,731,410
Personal Support Services and Related Medical/Personal Equipment for children/youth)	$3,768,438

(1) Actual dollar amounts
(2) Select Wait Times Services Based on April 13, 2008 announcement
(3) Excludes facility and amortization funding
(4) Estimated amount based on occupancy rates and resident revenue as of March 31, 2008

Table 4: Dedicated Funding by Sector for Waterloo Wellington

	2008/09 Dedicated Funding Envelopes [1]
Hospitals	
Permanent Cardiac Care Pacemaker Services	$3,586,000
Critical Care	$2,537,300
Wait Times Strategy [2]	$8,688,000
Health Infrastructure Renewal Fund	TBD
Post Construction Operating Plan [3]	$6,505,200
E-Health	TBD
LTC Homes	
Convalescent Care Beds [4]	$718,503
Interim Beds [4]	NA
Community Health Centres	
Uninsured persons services	$27,000
Community Mental Health	
Crisis Intervention programs and services (funded through Health Accord and Service Enhancements)	$3,336,202
Short-Term Residential Crisis Beds (Safe Beds)	$695,641
Assertive Community Treatment Teams (ACTT)	$1,900,000
Intensive Case Management (funded through Health Accord and Service Enhancements)	$1,295,433
Court Diversion/Supports	$252,000
Supportive Housing Supports	$336,000
Early Intervention in Psychosis programs (funded through Health Accord)	$1,206,000
Forensic Case Management Initiatives	NA
Sessional services in hospitals (Psychiatric Out-Patient Medical Salaries)	$538,437
Sessional services provided by community-based agencies	$533,741
Eating disorder services	NA
Consumer Survivor Initiatives	$751,675
Addictions	
Problem Gambling Treatment Services	$351,400
Programs for pregnant women with addictions (funded through federal Early Childhood Development Initiative)	$100,000
Methadone case management services	$42,630
Community Care Access Centres	
Private and Home Schools for Professional Health Services	$145,007
Personal Support Services and Related Medical/Personal Equipment for children/youth)	$226,914

(1) Actual dollar amounts
(2) Select Wait Times Services Based on April 13, 2008 announcement
(3) Excludes facility and amortization funding
(4) Estimated amount based on occupancy rates and resident revenue as of March 31, 2008

SCHEDULE 10: LOCAL HEALTH SYSTEM PERFORMANCE

PART A. PURPOSE OF SCHEDULE 10

- 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:

"**Developmental indicator**" means a measure of local health system performance that requires development due to factors such as the need for methodological refinement, testing, consultation, or analysis of reliability, feasibility or data quality before being considered to be added as a performance indicator;

"**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; and

"**Variance**" means a result for a performance indicator that falls outside the acceptable range of results around a LHIN target for that performance indicator.

General Obligations

2. The **MOHLTC** will:

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

(i) 90th Percentile Wait Times for Cancer Surgery;
(ii) 90th Percentile Wait Times for Cardiac By-Pass Procedures;
(iii) 90th Percentile Wait Times for Cataract Surgery;
(iv) 90th Percentile Wait Times for Hip and Knee Replacement;
(v) 90th Percentile Wait Times for Diagnostic (MRI/CT) Scan;
(vi) Readmission Rates for Acute Myocardial Infarction (AMI);

(vii) Percentage of Alternate Level of Care (ALC) Days;
(viii) Rate of Emergency Department Visits that could be Managed Elsewhere;
(ix) Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC); and
(x) Median Wait Time to Long-Term Care Home Placement;

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

(c) Calculate local and provincial results on the following developmental indicators and, starting at the end of the second quarter of the 2008-2009 fiscal year, provide the LHIN with a status report at the end of each quarter, thereafter:

(i) emergency department length of stay;
(ii) emergency department time to physician assessment;
(iii) dental/oral (pediatric) surgery wait time;
(iv) psychiatric readmission rates in hospitals;
(v) percentage of individuals with multiple psychiatric hospitalizations in the past fiscal year;
(vi) perception of change in quality of care;
(vii) hospital standardized mortality ratio; and
(viii) change in hospital productivity.

(d) Provide to the LHIN technical documentation on the performance indicators set out in Tables A through D and the developmental indicators, such as methodology, inclusions and exclusions; and

(e) Establish provincial or local benchmarks, as appropriate, by February 2008 for performance indicators after consultation with the LHIN using the process referred to in paragraph 4(e).

3. The **LHIN** will:

(a) Achieve the LHIN's performance targets for the performance indicators, except as provided in paragraph 3(b), as set out in Tables A through D;

(b) Work with the MOHLTC, Cancer Care Ontario and health service providers to achieve the results for the 90th Percentile Wait Times for Cancer Surgery performance indicator as set out on Table A;

(c) Report quarterly on mitigation strategies and performance improvement plans for performance indicators in Tables A through D where variance has been identified and until the variance has been resolved; and

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

4. **Both parties** will:

(a) By June 30, 2007, develop appropriate LHIN baselines for all performance indicators;

(b) By June 30, 2007, develop LHIN targets and performance corridors for 2007-08,

2008-09, and 2009-2010 for the following performance indicators:

(i) 90th Percentile Wait Times for Priority Services (five indicators);

(c) By June 30, 2008, develop appropriate LHIN targets and performance corridors for 2008-09 and 2009-2010 for the following performance indicators:

(i) Readmission Rates for Acute Myocardial Infarction (AMI);
(ii) Rate of Emergency Department Visits that could be managed elsewhere;
(iii) Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC);
(iv) Median Wait Time to Long-Term Care Home Placement; and
(v) Percentage of Alternate Level of Care (ALC) days.

(d) In 2007-08, develop and implement a LHIN performance dashboard to monitor local health system performance, identify variance, and identify risks to performance on the performance indicators set out in Tables A through D, and to report on developmental indicators;

(e) Establish a collaborative process with all LHINs:

(i) to identify performance and developmental indicators;
(ii) to select, develop, and evaluate performance and developmental indicators,
(iii) to recommend the retirement of performance and developmental indicators,
(iv) to recommend provincial or local targets for indicators, and
(v) to identify needs for, and recommend, new data sets to support the measurement of local health system performance, and

(f) Using the process referred to in paragraph 4(e), consider:

(i) As a priority, transitioning “Change in hospital productivity” from a developmental indicator to a performance indicator;

(ii) Developing in the future an indicator to measure local health system productivity; and

(iii) Developing indicators to measure the following areas of performance:

a. Pediatric Surgeries Wait Times;
b. Emergency Department Wait Times;
c. Patient Safety; and
d. Mental Health Continuity of Care.

Table A: Access

- Objective: To improve **access** to appropriate levels of health care services for the local health system.
- Expected Outcome: Patients/clients in the local health system will experience shorter waiting times for access to the health care services identified below.
- Other indicators are being considered as a measure of this expected outcome

INDICATOR	Provincial target	LHIN Baseline	LHIN Target			Data Release Dates
			2007-08	2008-09	2009-10	
90th Percentile Wait Times for Cancer Surgery	Provincial Priority IV Target: 84 days	62	60	50	TBD	Feb. 15 May 15 Aug. 15 Nov. 15
90th Percentile Wait Times for Cardiac By-Pass Procedures	Provincial Priority IV Target: 182 days	40	40	40	40	Feb. 15 May 15 Aug. 15 Nov. 15
90th Percentile Wait Times for Cataract Surgery	Provincial Priority IV Target: 182 days	222	182	95	95	Feb. 15 May 15 Aug. 15 Nov. 15
90th Percentile Wait Times for Hip and Knee Replacement	Provincial Priority IV Target: 182 days	Hip: 298 Knee: 377	Hip: 285 Knee: 286	Hip: 182 Knee: 182	Hip: 182 Knee: 182	Feb. 15 May 15 Aug. 15 Nov. 15
90th Percentile Wait Times for Diagnostic (MRI/CT) Scan	Provincial Priority IV Target: 28 days	MRI: 184 CT: 65	MRI: 150 CT: 39	MRI: 60 CT: 28	MRI: 28 CT: 28	Feb. 15 May 15 Aug. 15 Nov. 15

* *Wait Time* is the time from the "decision to treat, to time treatment received". The *90th Percentile* means the point at which nine out of 10 patients received their treatment.

Table B: Quality

- Objective: To improve the **quality** of care and service provision for the local health system.
- Expected Outcome: Users of health care services identified below will receive safer and more effective service.
- Other indicators are being considered as a measure of this expected outcome

INDICATOR	Provincial target	LHIN Baseline	LHIN Target			Data Release Dates
			2007-08	2008-09	2009-10	
Readmission Rates for Acute Myocardial Infarction (AMI)	3.8%	3.3	Maintain or improve performance from baseline	3.1	3.1	Feb. 15 May 15 Aug. 15

Table C: Integration

- Objective: To improve **coordination and integration** of health care among health service providers in the local health system
- Expected Outcome: More patients/clients in the local health system will receive health care in the most appropriate setting as determined by their needs
- Other indicators are being considered as a measure of this expected outcome

INDICATOR	Provincial Target	LHIN Baseline	LHIN Target			Data Release Dates
			2007-08	2008-09	2009-10	
Percentage of Alternate Level of Care (ALC) Days	9.46%	13	Not applicable	11.2	9.46	Feb. 15 May 15 Aug. 15
Rate of Emergency Department Visits that could be Managed Elsewhere	11.79 per 1,000 population	18.35	Maintain or improve performance from baseline	15	11.79	Feb. 15 May 15 Aug. 15
Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)	290.76 per 100,000 population	347.93	Maintain or improve performance from baseline	276	248	Feb. 15 May 15 Aug. 15
Median Wait Time to Long-Term Care Home Placement	50 days	78	Maintain or improve performance from baseline	74	50	Feb. 15 May 15 Aug. 15 Nov. 15

Table D: Sustainability

- Objective: To contribute to the **sustainability** of the Ontario health care system.
- Expected Outcome: More health care services in the local health system will be delivered in a more efficient and productive manner.
- Indicators are being considered as a measure of this expected outcome

INDICATOR	Provincial Target	LHIN Baseline	LHIN Target			Data Release Dates
			2007-08	2008-09	2009-10	

SCHEDULE 11: e-HEALTH

Part A: Purpose of Schedule 11

- To identify MOHLTC and LHIN performance obligations related to provincial e-Health priorities and strategic directions and the Provincial e-Health Work Plan.

Part B: Definitions

1. The following terms have the following meanings in this Schedule:

"LHIN e-Health Strategy" means a multi-year e-Health strategy based on provincial e-Health priorities and strategic directions and aligned with the LHIN's IHSP that sets out the strategic directions enabling the transformation of the local health system through the implementation of e-Health initiatives;

"LHIN e-Health Work Plan" means an annual or multi-year summary of tasks, timeframes, and responsibilities aligned with the Provincial e-Health Work Plan to implement the LHIN e-Health Strategy; and

"Provincial e-Health Work Plan" means the MOHLTC's annual or multi-year summary of province-wide e-Health-focused tasks, timeframes, and responsibilities aligned with provincial e-Health priorities and strategic directions.

Part C: Governance and Coordination of e-Health Initiatives

2. The **MOHLTC** will:

(a) Seek input, as appropriate, from the LHIN about provincial e-Health priorities and strategic directions;

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

(c) Inform the LHIN of a provincial e-Health governance model that will be established to oversee the implementation of provincial e-Health priorities and strategic directions;

(d) Review and approve, as appropriate, the LHIN e-Health Strategy as soon as possible after it is submitted to the MOHLTC by the LHIN; and

(e) Provide a Dedicated Funding Envelope, as appropriate, to the LHIN for the implementation of specific e-Health initiatives.

3. The **LHIN** will:

(a) Provide input to the MOHLTC, as requested, about provincial e-Health priorities and strategic directions;

(b) Within 3 months, or within such other time period mutually agreed upon by the parties, of receiving provincial e-Health priorities and strategic directions or any updates, submit to the MOHLTC a LHIN e-Health Strategy, or an updated

strategy if necessary, and, after approval by the MOHLTC, release the approved LHIN e-Health Strategy or any necessary update to the public;

(c) Within 3 months of being informed of a provincial e-Health governance model, develop and implement its e-health governance model for the local health system to oversee the development and management of the LHIN e-Health Strategy and to contribute to the implementation of provincial e-Health priorities and strategic directions;

(d) Starting in the 2008-2009 fiscal year, develop a LHIN e-Health Work Plan as part of the LHIN's Annual Service Plan as set out in paragraphs 10-12 of Schedule 8: Reporting;

(e) Implement the approved LHIN e-Health Strategy through its LHIN e-Health Work Plan and service accountability agreements with health service providers;

(f) Select an e-Health lead for the local health system to lead the development of the LHIN e-Health Strategy and implementation of the LHIN e-Health Work Plan; and

(g) Use the Dedicated Funding Envelope to provide funding to implement specific e-Health initiatives and report on those initiatives in the quarterly and annual reports described in Schedule 8: Reporting.

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

(a) Provide a forum for the discussion of e-Health issues at a provincial level and, where appropriate, to advise each other about e-Health issues including local health system needs, challenges, and opportunities and e-Health standards, definitions, and architectural frameworks;

(b) Coordinate communications with health service providers about e-Health issues, including standards, architectural frameworks, and implementation timelines set by the MOHLTC in collaboration with the LHIN; and

(c) Inform one another of significant issues or initiatives that contribute to or impact on provincial or local e-Health issues, strategies or work plans.

5. The term "Dedicated Funding Envelope" in paragraphs 2 and 3 has the same meaning as "Dedicated Funding Envelope" in paragraph 5 of Part C of Schedule 3: Local Health System Management.

Part D: Technology Infrastructure

6. The **MOHLTC** will:

(a) Seek LHIN advice, as appropriate, on the technology infrastructure to enable the MOHLTC to implement provincial e-Health priorities and strategic directions;

(b) Work with the LHIN and Smart Systems for Health Agency ("SSHA") on local health system priorities, performance and any issues related to the LHIN's e-Health Strategy; and

(c) Set, in consultation with the LHIN and others, as appropriate, technical standards related to e-Health and implementation timeframes for the interoperability of the

health system in Ontario, including standards related to architecture, technology, privacy and security.

7. The **LHIN** will:

(a) Identify to the MOHLTC any critical technical or integrated deployment requirements affecting the local health system related to SSHA's common technology infrastructure;

(b) By June 30 of each fiscal year, advise the MOHLTC of any e-Health-related technical or integrated deployment requirements to be considered for SSHA's business and operational plans for the following fiscal year; and

(c) Comply with and require health service providers through service accountability agreements to comply with applicable standards and timeframes referred to in paragraph 6(c).