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

**BETWEEN:**

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

- and -

**Central West LHIN Local Health Integration Network ("LHIN")**

### Introduction

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

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

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

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

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

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

Together the MOHLTC and LHINs are working to create a more integrated, sustainable healthcare system that is person-centered, and results-driven. The goal of an integrated system is to improve the individual's experience as they move through the continuum of healthcare services through creating a more coordinated, easy to navigate system while making effective

and efficient use of existing resources. Developing a truly integrated system will improve the quality, accessibility and sustainability of healthcare provided to the people of Ontario.

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

The MOHLTC has implemented a number of measures and mechanisms aimed at providing effective oversight and accountability as well as governing LHIN operations and conduct. This includes the introduction of the *Broader Public Sector Accountability Act, 2010* that mandates new rules and accountability standards to increase transparency for the broader public sector that includes LHINs and hospitals.

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

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

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

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

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

## Section 1 – Primary Purpose of the Agreement

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

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

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

## Section 2 – Principles

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

a) Strategic Alignment with Government Priorities;

b) Consistency;

c) Performance Improvement;

d) Flexibility;

e) Openness and Transparency;

f) Innovation and Creativity;

g) Sustainability of the healthcare system through sound financial management;

h) Achievability; and

i) Quality Person-Centered Care.

## Section 3 – Definitions and Interpretation

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

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

**"Annual Business Plan"** means the plan for spending the funding received by the LHIN

from the MOHLTC and included in this Agreement as required by s.18(2) (d) of the LHSIA.

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

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

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

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

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

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

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

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

**"Primary Purpose" has the meaning set out in section 1 of this Agreement.**

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

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

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

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

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

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

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

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

**Section 4 – Accountability of Each Party**

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

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

4.3 Both parties will collaborate and cooperate to:

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

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

**Section 5 – Performance Improvement**

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

a) A commitment to prudent financial management;
b) A commitment to continuous performance improvement through innovation and creativity;

c) An orientation to problem-solving; and
d) A focus on relative risk of non-performance.

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

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

a) the causes of the Performance Factor;

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

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

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

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

**Section 6 – Next MOHLTC LHIN Agreement**

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

**Section 7 – General**

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

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

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

7.4. Each Schedule applies to the 2010-12 fiscal years, unless stated otherwise in a Schedule. Some of the performance obligations in a Schedule may apply only to one fiscal year, as stated in that Schedule.

# SCHEDULE 1: GENERAL

## PART A. PURPOSE OF SCHEDULE 1

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

## PART B. GENERAL ROLES AND RESPONSIBILITIES

### Government Priorities and Provincial Strategies

1. The **MOHLTC**:

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

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

2. The **LHIN** will:

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

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

### Consistency

3. The **MOHLTC** will:

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

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

4. The **LHIN** will:

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

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

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

**To the MOHLTC:**

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

**Attention:**
Assistant Deputy Minister,
Health System Accountability and Performance

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

**With a copy to:**

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

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

**To the LHIN:**

Central West Local Health Integration Network
8 Nelson Street West, Suite 300
Brampton ON L6X 4J2

**Attention: Chair**

Fax: (905) 455-0427
Telephone: (905) 455-1281

**With a copy to:**

Central West Local Health Integration Network
8 Nelson Street West, Suite 300
Brampton ON L6X 4J2

**Attention: CEO**

Fax: (905) 455-0427
Telephone: (905) 455-1281

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

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

Deb Matthews

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

**Central West Local Health Integration Network**

**By:**

Ms. Maria Britto
Chair

**Local System Coordination and Integration**

5. The **LHIN** will:

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

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

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

**Community Engagement**

6. The **LHIN** will:

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

b) Engage with local planning entities as prescribed under the LHSIA;

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

7. **Both parties** will:

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

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

**Information Management**

8. The **MOHLTC** will:

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

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

c) Receive data and information from health service providers on behalf of the LHIN and provide timely access to the appropriate data to support health system needs;

d) Work with the LHINs to create a forum to identify and discuss data, propose strategies to address data and information gaps, information management requirements, decision support requirements, standards, data quality issues, and other pertinent information management topics.

9. The **LHIN** will:

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

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

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

10. **Both parties** will:

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

**Compliance Protocols**

11. Definitions. In this section on Compliance Protocols:

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

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

12. The **MOHLTC**:

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

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

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

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

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

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

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

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

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

13. The **LHIN** will:

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

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

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

d) Inform the MOHLTC:

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

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

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

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

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

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

**eHealth**

15. The **MOHLTC** will:

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

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

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

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

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

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

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

16. The **LHIN** will:

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

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

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

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

- comply with any technical and information management standards, including those related to architecture, technology, privacy and security, set for health service providers by the MOHLTC or the LHIN within the timeframes set by the MOHLTC or the LHIN as the case may be;
- implement and use the approved provincial eHealth solutions identified in the LHIN eHealth plan; and
- implement technology solutions that are compatible or interoperable with the provincial blueprint and with the LHIN eHealth plan.

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

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

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

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

**Capital - General Provisions**

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

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

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

**Capital Initiatives**

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

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

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

b) Capital Review and Approvals Process: The capital review and approvals process has three early planning submission stages: (i) Pre-Capital; (ii) Stage 1 Proposal; and (iii) Stage 2 Functional Program. Each of these stages is divided into two parts: (i) Part A: Program and Service Elements; and (ii) Part B: Physical and Cost Elements. At each stage, the LHIN will review Part A of each submission and will advise the MOHLTC on the consistency of the proposed initiative with local health system plans and its relative priority in relation to other initiatives. The MOHLTC will consider the LHIN's advice in respect of Part A, when considering both Part A and Part B and determining whether the initiative should proceed to the next stage.

22. The **MOHLTC** will:

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

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

23. The **LHIN** will:

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

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

**Own-Funds Capital Projects**

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

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

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

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

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

27. a) "HIRF" means the health infrastructure renewal fund established to provide capital funding grants of usually less than $1 million for the renewal or renovation of a public hospital; and

b) "PCOP funding" means post-construction operating plan funding provided to a public hospital in the local health system for service expansion and other costs occurring in conjunction with the completion of an approved capital project.

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

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

**Emergency Management**

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

**General Performance Obligations**

31. The **MOHLTC** will:

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

32. The **LHIN** will:

a) Provide a Certificate of Compliance to the MOHLTC of its compliance with applicable: legislation; provincial policies; standards; operating manuals; directives; and guidelines available to the LHINs, as required by the MOHLTC;

b) Require health service providers to provide services funded by the LHIN in accordance with applicable: legislation; provincial policies; standards; operating manuals; directives; guidelines;

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

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

e) require health service providers under the service accountability agreement with the LHIN to comply with the requirements of the *Broader Public Sector Accountability Act, 2010.*

## PART C. ANNUAL REVIEW AND UPDATE

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

# SCHEDULE 2: LOCAL HEALTH SYSTEM PROGRAM SPECIFIC MANAGEMENT

## PART A. PURPOSE OF SCHEDULE 2

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

## PART B. SPECIFIC PROGRAM PERFORMANCE PARAMETERS

### Provincial Programs

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

The **MOHLTC** will:

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

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

   c) Establish:

      (i) Criteria to assess and review provincial programs;

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

      (iii) Performance management, monitoring and evaluation processes.

3. The **LHIN** will:

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

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

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

**Long-Term Care Homes**

4. Definitions. In this section on Long-Term Care Homes

   a) "Funding Policies" includes the funding and financial management policies for LTCHs, including the per diem rate and the per diem envelopes, the reconciliation of funding, and the form, manner and content and date for submission of reports;
   b) "LTCH" means long-term care home;
   c) LTC HSP" means a health service provider that is licensed or approved to operate a LTCH;
   d) "L-SAA" means the LTCH service accountability agreement; and
   e) "service agreement" means the agreement pursuant to which funding is provided to a LTCH HSP and includes an L-SAA.

**Long-Term Care Homes (LTCHs) - Total Funding per Diem**

5. The **MOHLTC** will:

   a) Determine the Funding Policies;

   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 HSPs as reported by LTC HSPs 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 LTCHs 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 LTCH beds that are licensed or approved in the LHIN's geographic area compared to the provincial total number of LTCH beds that are licensed or approved.

6. The **LHIN** will:

   a) Provide to LTC HSPs for each approved or licensed bed, other than a Bed in Abeyance operated in accordance with the applicable legislation, the per diem rate and per diem envelopes in accordance with the Funding Policies including requiring LTCH HSPs to spend the funding in accordance with the per diem envelopes and the Funding Policies and to provide information to LHINs as directed by the Funding Policies for the reconciliation of LTCH funding.

**LTC Homes - Construction Funding Subsidy (CFS)**

7. In paragraphs 8, 9 and 10, "CFS per diem" includes upgrade and retrofit funding for LTCHs and "Development Agreement" means an agreement between MOHLTC and a LTCH HSP to develop, upgrade, retrofit or redevelop LTC home beds.

8. The **MOHLTC** will determine the CFS per diem and LTCH HSPs that will receive the per diem, including any conditions on the funding.

9. The **LHIN** will provide the CFS per diem to LTCH HSPs for each approved or licensed bed that is operated in accordance with the MOHLTC's conditions of funding, applicable legislation or Development Agreement.

10. Every L-SAA entered into between the LHIN and the LTCH HSP during the term of this Agreement and in the future will contain an obligation on the LHIN to provide the CFS per diem to the LTCH HSP for the length of time set out in the particular Development Agreement for the particular beds.

**LTC Homes – Assignment of LTC Service Agreement**

11. Where the **MOHLTC** has entered into an Acknowledgement and Consent Agreement (ACA) with a LTCH HSP and one or more lenders of the LTCH HSP (Lender) prior to the proclamation of the *Long-Term Care Homes Act, 2007*, the **LHIN** will treat MOHLTC's consent to assign the service agreement under the ACA as if MOHLTC had provided the consent on behalf of the LHIN.

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

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

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

14. In paragraphs 15 and 16, the term "Beds in Abeyance" are LTCH beds licensed or approved by the MOHLTC, for which the LTCH HSP has obtained written permission from the Director, PICB for the beds not to be available for occupancy.

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

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

17. The **MOHLTC** will:

a) Determine the process for the approval and any conditions that may attach to the approval; and

b) Review the request described in section 16 and may approve the LHIN to temporarily use this funding subject to any conditions that may attach to the approval; and

**LTC Homes - Short-Stay Respite**

18. The **MOHLTC** will determine the minimum threshold for occupancy for short-stay respite beds.

19. The **LHIN** will:

a) Take action as appropriate to improve the utilization of these beds; and

b) 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 to determine the LTCH HSPs that will provide short-stay beds within the existing licensed or approved beds of each home and the number of such beds.

**LTC Homes - Convalescent Care Beds**

20. In paragraphs 21 and 22, the term "Convalescent Care Beds" means:

a) Those short stay beds, licensed or approved under the LTCHA that are part of a convalescent care program for which residents may be eligible for admission in accordance with regulations under the LTCHA.

21. The **MOHLTC** will:

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

b) In consultation with the LHIN, determine the LTCH HSPs 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.

22. The **LHIN** will:

a) Advise the MOHLTC on the matters referred to in subparagraph 21 (b);

b) Use the Dedicated Funding Envelope to fund LTCH HSPs to provide Convalescent Care Beds referred to in subparagraph 21 (b);

c) Determine whether to fund LTCH HSPs 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 in accordance with the Funding Policies;

d) Determine the LTCH HSP that will provide the additional Convalescent Care Beds referred to in subparagraph (c), subject to a pre-occupancy review by the MOHLTC, and

e) In determining the additional Convalescent Care Beds referred to in subparagraph (c), not exceed the number of beds that are licensed or approved by the Ministry under the LTCHA.

**LTC Homes - Interim Beds**

23. In paragraphs 24 and 25, the term "Interim Beds" means:

a) Those long-stay beds that exist for a temporary period of time under the agreed terms and conditions for interim beds for individuals who no longer require acute care services provided by the hospital;

(i) In an existing LTCH that has been approved to exceed its licensed or approved bed capacity; or

(ii) In a new LTCH licensed or approved to provide Interim Beds; or

b) If the LTCHA is proclaimed into force during the term of this Agreement, those beds that would fall within the definition of "interim bed" in accordance with regulations under the LTCHA and any bed described in clause (a) where the bed continues to be occupied by a long-stay resident in accordance with regulations under the LTCHA.

24. 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 LTCH HSP 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.

25. The **LHIN** will:

a) Advise the MOHLTC about the matters referred to in subparagraph 24 (b);

b) Use the Dedicated Funding Envelope for Interim Beds, and incorporate any conditions of funding referred to in subparagraph 24 (c) into L-SAAs;

c) Determine whether to fund LTCH HSPs for additional Interim Beds that are not funded through the Dedicated Funding Envelope;

d) Request that the MOHLTC increase the approved or licensed bed capacity at a LTCH in accordance with the LTCHA or request that the MOHLTC license or

approve a new LTCH for Interim Beds for any 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 HSPs for any additional Interim Beds in accordance with funding policies.

26. The **MOHLTC** will manage and fund LTC Homes directly for certain LTC programs in accordance with funding policies, including the following:

LTC Homes – Municipal Tax Allowance Fund
LTC Homes – Rate Reduction Program
LTC Homes – Exceptional Circumstances Funding
LTC Homes – High Intensity Needs Fund & Lab Cost
LTC Homes – Occupancy Based Funding
LTC Homes – Pay Equity Program
LTC Homes – High Wage Transition Fund
LTC Homes – Structural Compliance.

**Community Health Centres ("CHCs")**

27. The **MOHLTC** will:

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

28. The **LHIN** will:

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

**Community Mental Health**

29. The purpose of the parameters set out in paragraphs 28 and 29 is to ensure that certain provincial interests are addressed, and that the MOHLTC meets its inter-ministerial commitments, including criminal justice and forensic mental health initiatives. The categories of community mental health services for the purposes of paragraphs 28 and 29 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.

30. The **MOHLTC** will:

a) Determine the Dedicated Funding Envelope for the following:

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

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

(iii) Intensive Case Management and ACTT;

(iv) Early Intervention in Psychosis programs;

(v) Forensic Case Management Initiatives;

(vi) Hospitals that provide sessional services;

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

(viii) Eating Disorder services; and

(ix) Consumer Survivor Initiatives;

b) Determine and advise the LHIN of the number and type of forensic mental health beds and the designated hospitals that provide the forensic mental health service, where applicable; and

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

31. The **LHIN** will:

a) Fund the provision by health service providers of a combination of services in each of the categories of community mental health services described in paragraph 28 in or for the local health system;

b) Require a health service provider to provide a service identified under paragraph 29(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 29(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) Work with the MOHLTC and the Eating Disorder Network to allocate any new funding;

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

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

32. Both parties will review the parameters in paragraphs 28 and 29 annually as set out in Schedule 1: General.

**Addictions**

33. 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.

34. The **LHIN** will:

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

b) Use the Dedicated Funding Envelopes of which it is advised under paragraph 32 for the services specified in paragraph 32.

**Community Care Access Centres ("CCACs")**

35. The **MOHLTC** will:

a) Determine the Dedicated Funding Envelope for children/youth in Private and Home Schools for School Health Support Services.

36. The **LHIN** will:

a) Use the Dedicated Funding Envelopes of which it is advised under paragraph 34 for the services specified in paragraph 34; and

b) Advise the MOHLTC if additional funding is required for School Health Support Services.

**Compensation under Specified Initiatives / Agreements**

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

38. The **LHIN** will require health service providers to use the Dedicated Funding Envelope for the compensation and benefits of persons identified in section 36.

## PART C. MOHLTC MANAGED PROGRAMS

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

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

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

# SCHEDULE 3: FUNDING and ALLOCATIONS

## PART A. PURPOSE OF SCHEDULE 3

- To provide a statement of the total funding to be allocated to the LHIN for the 2010/11 fiscal year and if available, the funding targets for out-years

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

**Definitions**

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

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

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

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

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

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

## PART B. PERFORMANCE OBLIGATIONS

2. **The MOHLTC will:**

a) By June 30, 2010, provide the LHIN with its allocation of funding for 2010-2011, and funding targets for 2011-12 if available in Table 1 – Total LHIN Funding Allocation, Table 2 – Funding Allocation for each LHIN, Table 3 – Dedicated Funding Envelopes for all LHINs of this Schedule; and

b) By June 30, 2010, provide the LHIN with a list of Dedicated Funding Envelopes for 2010-2011 in Table 4 – Dedicated Funding Envelopes for the LHIN of this Schedule and will review it in accordance with Schedule 2: Local Health System Program Management; The LHIN will allocate for fiscal years after 2010-2011, in accordance with the LHSIA, its Annual Business Plan approved by the MOHLTC and this Agreement.

3. The **LHIN** will:

   a) Allocate the funds for 2010/11, in accordance with the LHSIA, this Agreement, including Tables 2 and 4 of this Schedule, and the agreements assigned to the LHIN.

**Annual Balanced Budget Requirements**

4. The **LHIN** will:

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

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

**Multi-Year Expense Limits Requirements**

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

**Financial Management Polices and Guidelines**

6. The **MOHLTC** will:

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

7. The **LHINs** will:

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

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

**Accounting Standards**

8. The **MOHLTC** will:

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

9. The **LHINs** will:

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

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

10. **Both parties** will:

a) Maintain a Chart of Accounts for LHINs that is interoperable between all LHINs and the MOHLTC.

**Table 1: Statement of Total LHIN 2010/11 Funding Allocation**

| | 2010/11 Funding Allocation (000's)[1] | 2011/12 Funding Target (000's) | 2012/13 Funding Target (000's) |
|---|---|---|---|
| **Total LHIN Budget** | **22,119,565.6** | **TBD** | **TBD** |
| Total Operating Budget (see table 1a) | 22,119,565.6 | TBD | TBD |
| Total Capital Budget (see table 1b) | TBD | TBD | TBD |

Note:

1. The 2010/11 funding allocation was updated as of June 30, 2010 from the approved 2010/11 multi-year Results Based Plan and the 2010/11 Printed Estimates. The update was based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2010/11. The realignment occurs within the Ministry's total approved appropriation.

   The 2010/11 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2010/11, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

Table 1a: Statement of Total LHIN 2010/11 Funding Allocation - Operating Budget

| | 2010/11 Funding Allocation (000's)[1] | 2011/12 Funding Target (000's) | 2012/13 Funding Target (000's) |
|---|---|---|---|
| **Total LHIN Operating Budget** | **22,119,565.6** | **TBD** | **TBD** |
| Total Health Service Provider (HSP) Transfer Payments | 22,051,605.7 | TBD | TBD |
| Operation of LHIN | 66,290.0 | TBD | TBD |
| Initiatives [2] | 1,670.0 | TBD | TBD |
| E-Health | TBD | TBD | TBD |
| Total Health Service Provider (HSP) Transfer Payments by Sector: | | | |
| Operations of Hospitals | 14,771,684.8 | TBD | TBD |
| Grants to compensate for Municipal Taxation - public hospitals | 3,682.7 | TBD | TBD |
| Long Term Care Homes [3] | 2,985,515.3 | TBD | TBD |
| Community Care Access Centres | 1,929,097.8 | TBD | TBD |
| Community Support Services | 353,026.0 | TBD | TBD |
| Acquired Brain Injury | 43,023.6 | TBD | TBD |
| Assisted Living Services in Supportive Housing | 189,898.0 | TBD | TBD |
| Community Health Centres | 296,167.7 | TBD | TBD |
| Community Mental Health | 601,462.2 | TBD | TBD |
| Addictions Program | 140,821.7 | TBD | TBD |
| Specialty Psych Hospitals | 637,723.8 | TBD | TBD |
| Grants to compensate for Municipal Taxation - psychiatric hospitals | 141.0 | TBD | TBD |
| Initiatives [4] | 99,360.9 | TBD | TBD |
| E-Health | TBD | TBD | TBD |

*Note:*

1. The 2010/11 funding allocation was updated as of June 30, 2010 from the approved 2010/11 multi-year Results Based Plan and the 2010/11 Printed Estimates. The update was based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2010/11. The realignment occurs within the Ministry's total approved appropriation.

2. LHIN Operations initiatives include Aboriginal Community Engagement, French Language Health Services, and LHIN Collaborative.

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

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

Table 1b: Statement of Total LHIN 2010/11 Funding Allocation - Capital Budget

| | 2010/11 Funding Allocation (000's) | 2011/12 Funding Target (000's) | 2012/13 Funding Target (000's) |
|---|---|---|---|
| **Total Capital Budget** | **TBD** | **TBD** | **TBD** |
| Total Health Service Provider (HSP) Transfer Payments | TBD | TBD | TBD |
| LHIN-Specific Capital Initiatives | N/A | TBD | TBD |
| Total Health Service Provider (HSP) Transfer Payments by Sector: | | | |
| Hospitals [1] | TBD | TBD | TBD |
| Long Term Care Homes | N/A | TBD | TBD |
| Acquired Brain Injury | N/A | TBD | TBD |
| Assisted Living Services in Supportive Housing | N/A | TBD | TBD |
| Community Health Centres | N/A | TBD | TBD |
| Community Mental Health | N/A | TBD | TBD |
| Addictions Program | N/A | TBD | TBD |
| Other Capital Initiatives | N/A | TBD | TBD |

*Note:*

1. The allocation under "Hospitals" represents the approved LHIN allocation to support grants for public and specialty psychiatric hospitals in 2010/11 under the 2010/11 Health Infrastructure Renewal Fund (HIRF), and in accordance with 2010/11 HIRF Guidelines which the ministry has provided to LHINs. The allocation approved for LHINs for this purpose is available in 2010/11 only. As of June 30, 2010, the total HIRF funding is pending for approval.

**Table 2: Statement of Central West LHIN 2010/11 Funding Allocation**

| | 2010/11 Funding Allocation (000's)[1] | 2011/12 Funding Target (000's) | 2012/13 Funding Target (000's) |
|---|---|---|---|
| **Total LHIN Budget** | **744,074.9** | **TBD** | **TBD** |
| Total Operating Budget (see table 2a) | 744,074.9 | TBD | TBD |
| Total Capital Budget (see table 2b) | N/A | TBD | TBD |

Note:

1. The 2010/11 funding allocation was updated as of June 30, 2010 from the approved 2010/11 multi-year Results Based Plan and the 2010/11 Printed Estimates. The update was based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2010/11. The realignment occurs within the Ministry's total approved appropriation.

   The 2010/11 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2010/11, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

Table 2a: Statement of Central West LHIN 2010/11 Funding Allocation - Operating Budget

| | 2010/11 Funding Allocation (000's)[1] | 2011/12 Funding Target (000's) | 2012/13 Funding Target (000's) |
|---|---|---|---|
| **Total LHIN Operating Budget** | **744,074.9** | **TBD** | **TBD** |
| Total Health Service Provider (HSP) Transfer Payments | 739,630.5 | TBD | TBD |
| Operation of LHIN | 4,336.8 | TBD | TBD |
| Initiatives [2] | 107.5 | TBD | TBD |
| E-Health | TBD | TBD | TBD |
| Total Health Service Provider (HSP) Transfer Payments by Sector: | | | |
| Operations of Hospitals | 465,252.3 | TBD | TBD |
| Grants to compensate for Municipal Taxation - public hospitals | 99.5 | TBD | TBD |
| Long Term Care Homes [3] | 137,945.4 | TBD | TBD |
| Community Care Access Centres | 81,573.6 | TBD | TBD |
| Community Support Services | 7,890.1 | TBD | TBD |
| Acquired Brain Injury | 321.3 | TBD | TBD |
| Assisted Living Services in Supportive Housing | 5,414.5 | TBD | TBD |
| Community Health Centres | 7,702.0 | TBD | TBD |
| Community Mental Health | 29,116.2 | TBD | TBD |
| Addictions Program | 3,467.2 | TBD | TBD |
| Specialty Psych Hospitals | 0.0 | TBD | TBD |
| Grants to compensate for Municipal Taxation - psychiatric hospitals | 0.0 | TBD | TBD |
| Initiatives [4] | 848.5 | TBD | TBD |
| E-Health | TBD | TBD | TBD |

*Note:*

1. The 2010/11 funding allocation was updated as of June 30, 2010 from the approved 2010/11 multi-year Results Based Plan and the 2010/11 Printed Estimates. The update was based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2010/11. The realignment occurs within the Ministry's total approved appropriation.
2. LHIN Operations initiatives include Aboriginal Community Engagement, and French Language Health Services.
3. The LTC Homes funding allocation is an estimate only, and is subject to change, as the Ministry adjusts the funding allocation for the LTC Homes based on changes in CMI, bed numbers, resident revenue and construction cost funding.
4. Transfer payment initiatives by LHIN will be allocated by sector by the LHIN at a later date. Initiatives that are unallocated include Aging at Home and Urgent Priorities Funds. It should be noted that as the LHIN allocates by sector, the allocation will be distributed at the sector level.

Table 2b: Statement of Central West LHIN 2010/11 Funding Allocation - Capital Budget

| | 2010/11 Funding Allocation (000's) | 2011/12 Funding Target (000's) | 2012/13 Funding Target (000's) |
|---|---|---|---|
| **Total Capital Budget** | **0.0** | **TBD** | **TBD** |
| Total Health Service Provider (HSP) Transfer Payments | 0.0 | TBD | TBD |
| LHIN-Specific Capital Initiatives | 0.0 | TBD | TBD |
| Total Health Service Provider (HSP) Transfer Payments by Sector: | | | |
| Hospitals[1] | TBD | TBD | TBD |
| Long Term Care Homes | N/A | TBD | TBD |
| Acquired Brain Injury | N/A | TBD | TBD |
| Assisted Living Services in Supportive Housing | N/A | TBD | TBD |
| Community Health Centres | N/A | TBD | TBD |
| Community Mental Health | N/A | TBD | TBD |
| Addictions Program | N/A | TBD | TBD |
| Other Capital Initiatives | N/A | TBD | TBD |

*Note:*

1. The allocation under "Hospitals" represents the approved LHIN allocation to support grants for public and specialty psychiatric hospitals in 2010/11 under the 2010/11 Health Infrastructure Renewal Fund (HIRF), and in accordance with 2010/11 HIRF Guidelines which the ministry has provided to LHINs. The allocation approved for LHINs for this purpose is available in 2010/11 only. As of June 30, 2010, the allocation for the Central West LHIN is pending for approval.

**Table 3: Statement of Total 2010/11 Dedicated Funding by Sector**

| | 2010/11 Dedicated Funding Envelope [1] |
|---|---|
| **Hospitals** | |
| Cardiac Services | TBD |
| Chronic Kidney Disease | TBD |
| Critical Care | $80,734,800 |
| Wait Times Strategy | $173,321,400 |
| Health Infrastructure Renewal Fund | TBD |
| Post Construction Operating Plan | TBD |
| **eHealth** | TBD |
| **Long Term Care Homes** | |
| Convalescent Care Beds [2] | $25,216,426 |
| Interim Beds [2] | $19,524,189 |
| **Community Health Centres** | |
| Uninsured Persons Services | $2,886,782 |
| **Community Mental Health** | |
| Crisis Intervention programs and services (funded through Health Accord and Service Enhancement) | $43,817,593 |
| Short-Term Residential Crisis Beds (Safe Beds) | $11,297,893 |
| Assertive Community Treatment Teams (ACTT) | $32,308,000 |
| Intensive Case Management (funded through Health Accord and Service Enhancement) | $29,672,466 |
| Court Diversion / Supports | $4,606,000 |
| Supportive Housing Supports | $10,387,000 |
| Early Intervention in Psychosis programs (funded through Health Accord) | $22,202,188 |
| Forensic Case Management Initiatives | $2,040,000 |
| Sessional services in hospitals (Psychiatric Out-Patient Medical Salaries) | $12,386,805 |
| Sessional services provided by community-based agencies | $10,456,648 |
| 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 |
| **Other** | |
| Compensation Under Specified Initiatives / Agreements | TBD |

Notes

(1) Actual Dollar Amounts

(2) Estimated amount based on occupancy rates and resident revenue as of March 31, 2010

**Table 4: Dedicated Funding by Sector for Central West LHIN**

| | 2010/11 Dedicated Funding Envelope [1] |
|---|---|
| **Hospitals** | |
| Cardiac Services | TBD |
| Chronic Kidney Disease | TBD |
| Critical Care | $2,037,300 |
| Wait Times Strategy | $7,347,300 |
| Health Infrastructure Renewal Fund | TBD |
| Post Construction Operating Plan | TBD |
| **eHealth** | TBD |
| **Long Term Care Homes** | |
| Convalescent Care Beds [2] | $2,996,066 |
| Interim Beds [2] | NA |
| **Community Health Centres** | |
| Uninsured Persons Services | $213,000 |
| **Community Mental Health** | |
| Crisis Intervention programs and services (funded through Health Accord and Service Enhancement) | $4,243,200 |
| Short-Term Residential Crisis Beds (Safe Beds) | $1,562,125 |
| Assertive Community Treatment Teams (ACTT) | $3,800,000 |
| Intensive Case Management (funded through Health Accord and Service Enhancement) | $2,386,366 |
| Court Diversion / Supports | $196,000 |
| Supportive Housing Supports | $588,000 |
| Early Intervention in Psychosis programs (funded through Health Accord) | $255,000 |
| Forensic Case Management Initiatives | NA |
| Sessional services in hospitals (Psychiatric Out-Patient Medical Salaries) | $239,502 |
| Sessional services provided by community-based agencies | $322,979 |
| Eating Disorder Services | NA |
| Consumer Survivor Initiatives | $434,887 |
| **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 | NA |
| **Community Care Access Centres** | |
| Private and Home Schools for Professional Health Services | $174,730 |
| Personal Support Services and Related Medical / Personal Equipment for children/ youth | $163,283 |
| **Other** | |
| Compensation Under Specified Initiatives / Agreements | TBD |

Notes

(1) Actual Dollar Amounts

(2) Estimated amount based on occupancy rates and resident revenue as of March 31, 2010

# SCHEDULE 4: LOCAL HEALTH SYSTEM PERFORMANCE

## PART A. PURPOSE OF SCHEDULE 4

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

## PART B. PERFORMANCE OBLIGATIONS

### Definitions

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

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

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

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

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

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

**"CMG"** means Case Mix Group.

### General Obligations

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

### Specific Obligations

3. The **MOHLTC** will:

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

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

(CTAS IV-V) Patients;;

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

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

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

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

(viii) Readmission within 30 Days for Selected CMGs;

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

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

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

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

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

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

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

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

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

4. The **LHIN** will:

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

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

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

## Table A: Performance Indicators

- Objective: To improve persons' access and outcomes as they move through the continuum of healthcare services.
- Expected Outcome: Persons will experience improved access and outcomes related to the health care services identified below.
- Other indicators may be considered as a measure of this expected outcome.

| INDICATOR | Provincial target | LHIN Baseline | LHIN Target | | Data Provided to LHINs |
|---|---|---|---|---|---|
| | | | 2010-11 | 2011-12 | |
| 90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients | 8 hours | 35.0 hours | 27.2 hours | TBD | May 14, August 13, November 12, and February 11 |
| 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients | 8 hours | 9.5 hours | 8.4 hours | TBD | |
| 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients | 4 hours | 5.0 hours | 4 hours | TBD | |
| Percentage of Alternate Level of Care (ALC) Days | 9.46% | 10.13% | 9.5% | TBD | |
| Repeat Unplanned Emergency Visits within 30 days for Mental Health Conditions * | To be determined (TBD) | 14.2% | 12.1% | TBD | |
| Repeat Unplanned Emergency Visits within 30 days for Substance Abuse Conditions * | TBD | 17.0% | 14.5% | TBD | |
| 90th Percentile Wait Time for CCAC In-Home Services – Application from Community Setting to First CCAC Service (excluding case management) ** | TBD | TBD | NA | TBD | |
| Readmission within 30 Days for Selected Case Mix Groups (CMGs) | TBD | 15.2% | 14.7% | TBD | |
| 90th Percentile Wait Times for Cancer Surgery | Provincial Priority IV Target: 84 days | 57 days | Maintain or improve baseline | TBD | |
| 90th Percentile Wait Times for Cardiac By-Pass Procedures | Provincial Priority IV Target: 182 days | Not Applicable (NA) | NA | NA | |
| 90th Percentile Wait Times for Cataract Surgery | Provincial Priority IV Target: 182 days | 90 days | Maintain or improve baseline | TBD | |

## Table A: Performance Indicators

- Objective: To improve persons' access and outcomes as they move through the continuum of healthcare services.
- Expected Outcome: Persons will experience improved access and outcomes related to the health care services identified below.
- Other indicators may be considered as a measure of this expected outcome.

| INDICATOR | Provincial target | LHIN Baseline | LHIN Target | | Data Provided to LHINs |
|---|---|---|---|---|---|
| | | | 2010-11 | 2011-12 | |
| 90th Percentile Wait Times for Hip Replacement | Provincial Priority IV Target: 182 days | 156 days | Maintain or improve baseline | TBD | |
| 90th Percentile Wait Times for Knee Replacement | Provincial Priority IV Target: 182 days | 161 days | Maintain or improve baseline | TBD | |
| 90th Percentile Wait Times for Diagnostic MRI Scan | Provincial Priority IV Target: 28 days | 110 days | 94 days | TBD | |
| 90th Percentile Wait Times for Diagnostic CT Scan | Provincial Priority IV Target: 28 days | 31 days | 28 days | TBD | |

* New indicators for 2010/11. The MOHLTC and the LHINs will monitor performance in 2010/11 and work together to refine quality and consistency of data.
** New indicator methodology to be confirmed for 2010/11. The MOHLTC and the LHINs will monitor results and work together to improve data collection and coding. Targets will be established for 2011/12.

# SCHEDULE 5: INTEGRATED REPORTING

## PART A. PURPOSE OF SCHEDULE 5

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

## PART B. PERFORMANCE OBLIGATIONS

**General Obligations**

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

2. The **MOHLTC** will:

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

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

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

3. **Both parties** will:

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

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

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

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

| Due Date | Description of Item |
|---|---|
| **2010/2011** | |
| **APRIL** | |
| April 16, 2010 | MOHLTC will provide to the LHIN a Report confirming interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year |
| April 30, 2010 | MOHLTC will provide to the LHIN the forms for the Year-end Consolidation Report |
| April 30, 2010 | MOHLTC will provide to the LHIN the forms for Consolidation Reports |
| By April 30, 2010 | The LHIN will submit to the MOHLTC a Declaration of Compliance |
| **MAY** | |
| May 14, 2010 | The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 4: Local Health System Performance |
| May 14, 2010 | MOHLTC will provide to the LHIN a Report with updated interim actual expenditures, recoverables and payables related to its transfer payments as of March 31, of the preceding fiscal year |
| May 17, 2010 | The MOHLTC will provide to the LHIN for planning and reporting purposes the initial preliminary allocation for 2010-11 |
| May 28, 2010 | The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC |
| May 31, 2010 | The LHIN will submit to the MOHLTC the year-end consolidation report using forms provided by the MOHLTC and the draft Audited Financial Statement if the signed statements are not ready by May 31 of each fiscal year to which this agreement applies |
| **JUNE** | |
| On or about the 7th working day (date may depending on the IFIS GL close) | MOHLTC will provide to the LHIN a Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments |
| June 30, 2010 | The LHIN will submit to the MOHLTC an Annual Report for the previous fiscal year in accordance with MOHLTC requirements |
| June 30, 2010 | The LHIN will submit to the MOHLTC Q1 Regular and Consolidation Report using the forms provided by the MOHLTC |
| June 30. 2010 | MOHLTC will provide to the LHIN the forms and information requirements for the Annual Business Plan |
| **JULY** | |
| July 31 2010 | The MOHLTC will provide the preliminary approved allocation for the current fiscal year, as of June 30, 2010, and the funding targets for the next year, if available. |
| By July 31,2010 | The LHIN will submit to the MOHLTC a Declaration of Compliance |
| **AUGUST** | |
| August 13, 2010 | The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 4: Local Health System Management |
| August 27, 2010 | The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC |
| August 31, 2010 | MOHLTC will provide to the LHIN the forms and information requirements for the Multi-year Consolidation Report |
| **SEPTEMBER** | |
| On or about the 7th working day (date may vary on IFIS GL close) | MOHLTC will provide to the LHIN a Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments |
| September 30, 2010 | The LHIN will submit to the MOHLTC Q2 Regular and Consolidation Report using the forms provided by the MOHLTC |

| Due Date | Description of Item |
|---|---|
| **OCTOBER** | |
| October 31, 2010 (or date necessary to meet central agency reporting requirements) | The LHIN will submit to the MOHLTC a Multi-year Consolidation Report using the form provided by the MOHLTC |
| By October 31, 2010 | The LHIN will submit to the MOHLTC a Declaration of Compliance |
| **NOVEMBER** | |
| November 12, 2010 | MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 4: Local Health System Management |
| November 26, 2010 | The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC |
| **DECEMBER** | |
| On or about the 7th working day (date may vary depending on the IFIS GL close) | MOHLTC will provide to the LHIN a Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments |
| December 31, 2010 | LHIN will submit to the MOHLTC Q3 Regular and Consolidation Report including final year-end forecast using the forms provided by the MOHLTC |
| **JANUARY** | |
| January 31, 2011 | The LHIN will submit to the MOHLTC a Draft Annual Business Plan using the forms provided by the MOHLTC |
| January 31, 2011 | MOHLTC will provide the LHIN with year end instructions (including templates) |
| By January 31, 2011 | The LHIN will submit to the MOHLTC a Declaration of Compliance |
| **FEBRUARY** | |
| February 11, 2011 | MOHLTC will provide the LHIN with most recent quarter of performance data for indicators in Schedule 4: Local Health System Performance |
| February 15, 2011 | MOHLTC will provide to the LHIN the forms and requirements for the Annual Report (non-financial content) |
| February 25, 2011 | The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC |
| February 28, 2011 | The LHIN will submit to the MOHLTC Year-End Reallocation Report on planned vs. actual expenditures related to in-year reallocations |
| **MARCH** | |
| March 31, 2011 | MOHLTC will provide to the LHIN the forms for the Annual Report (financial content) |
| **2011/2012** | |
| **APRIL** | |
| April 18, 2011 | MOHLTC will provide to the LHIN a Report confirming interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year |
| April 30, 2011 | MOHLTC will provide to the LHIN the forms for the Year-end Consolidation Report |
| By April 30, 2011 | The LHIN will submit to the MOHLTC a Declaration of Compliance |
| **MAY** | |
| May 13, 2011 | MOHLTC will provide the LHIN with the most recent quarter of data for indicators in Schedule 4: Local Health System Performance |
| May 16, 2011 | MOHLTC will provide to the LHIN a Report with updated interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year |
| May 27, 2011 | The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC |

| Due Date | Description of Item |
|---|---|
| May 31, 2011 | The LHIN will submit to the MOHLTC the year-end consolidation report using forms provided by the MOHLTC and the draft Audited Financial Statement if the signed statements are not ready by May 31 of each fiscal year to which this agreement applies |