MINISTRY-LHIN PERFORMANCE AGREEMENT
APRIL 1, 2013 – MARCH 31, 2015

BETWEEN:

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

- and -

North East Local Health Integration Network ("LHIN")

Introduction

The *Local Health System Integration Act, 2006* (LHSIA), the Memorandum of Understanding (MOU) and the Ministry-LHIN Performance Agreement (Agreement) are the key elements of the accountability framework between the MOHLTC and the Local Health Integration Networks (LHINs).

The Agreement identifies the MOHLTC's key operational and funding expectations of the LHINs that are not already addressed in the LHSIA or the MOU. It recognizes that the MOHLTC and the LHINs have a joint responsibility to serve the public interest and effectively oversee the use of public funds. The Agreement reflects the LHINs' critical role in ensuring enhanced access and quality of healthcare in a fiscally sustainable manner while acknowledging the MOHLTC's responsibility to apply appropriate and legitimate scrutiny of fiscal management and health services delivery by the LHINs.

The MOHLTC has communicated provincial strategic direction that provides a vision for system change and reinforces the principles articulated in the *Excellent Care for All Act*, 2010. The MOHLTC and the LHINs used this vision to develop a Performance Framework focused on better patient outcomes and value for healthcare dollars. The framework includes the following shared system goals:

- Enhanced Person-Centred Care
- Improved System Integration and Enhanced Coordination and Transitions of Care
- Implementation of Evidence-Based Practices to Drive Quality, Value and Improved Health Outcomes
- Financial Sustainability

A number of key initiatives have been introduced to transform the healthcare system and achieve the vision set forth by the MOHLTC. The LHINs will work with health service providers and other providers to enhance collaboration within and between sectors and ensure alignment with current provincial strategies, including:

- Health System Funding Reform: a new funding strategy that features patient based funding to facilitate fiscal sustainability and person-centred care. This will impact hospital, Community Care Access Centre (CCAC), and Long-Term Care Homes (LTCH) budgets.

- Health Links: an innovative approach to enhancing coordinated care for people who access the system frequently and at multiple entry points.

- Seniors Strategy: a provincial initiative to keep seniors healthy and at home longer and reduce pressures on hospitals and LTCHs by increasing capacity in the community.

- Mental Health and Addictions Strategy: an inter-ministerial commitment to improve the well-being of all Ontarians and create healthy, resilient communities.

To further support the transformation agenda and address the demographic and fiscal challenges facing Ontario, comprehensive service capacity planning that includes both the MOHLTC and the LHINs is required.

Primary Purpose of the Agreement

1. The Agreement outlines the mutual understanding between the MOHLTC and the LHIN of their respective performance obligations in the period from April 1, 2013 to March 31, 2015 covering the 2013-2014 and 2014-2015 fiscal years. The Agreement is an accountability agreement for the purposes of section 18 of the LHSIA.

Principles

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

   a) Alignment with provincial priorities and strategies;

   b) Sustainability of the healthcare system by maximizing the efficient and effective use of public funds;

   c) Performance improvement;

   d) High-quality, person-centred service delivery;

   e) Consistency;

   f) Consultation and collaboration among MOHLTC, LHINs, health service providers, other providers and the applicable communities;

   g) Openness and transparency; and

   h) Innovation, creativity and flexibility.

Definitions

3. The following terms have the following meanings in the Agreement:

   "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 the Agreement as required by subclause 18(2) (d) of the LHSIA.

"Community" has the meaning set out in subsection 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.

"**Dedicated Service Funding**" means, in respect of a specific service, the funding that must be used by the LHIN to fund the provision of the specific service.

"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 section 2 of the LHSIA.

"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 the Agreement, including the following:

1. General;
2. Local Health System Program Management;
3. Long-Term Care Homes Program Specific Management;
4. Funding and Allocations;
5. Local Health System Performance; and
6. 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.

Accountability

4. **Both parties** will fulfill their performance obligations in accordance with the terms of the Agreement.

5. **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.

6. The **LHIN** is responsible for managing its performance, the performance of the local health system, and collaborating with other providers to support provincial goals, as set out in the Agreement and using its authority under law. The **MOHLTC** is responsible for collaborating 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.

Performance Improvement

7. **Both parties** will follow a proactive and responsive approach to performance improvement based on the following principles:

   a) Prudent financial management of public healthcare resources;
   b) Better access to high quality, person-centred services;
   c) Strengthened transitions in care across the entire patient journey;
   d) Ongoing performance improvement;
   e) An orientation to problem-solving; and
   f) A focus on relative risk of non-performance.

8. Where matters arise that could significantly affect either the LHIN or MOHLTC's ability to perform their obligations under the 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 five business days of the date of the notice.

9. **Both parties** agree to meet and discuss the "Performance Factor" within one calendar month of the date of the notice. During the meeting, using the principles set out in paragraph 7 above, 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.

10. Where a LHIN Performance Factor is not mutually resolved, the Minister will determine the remedies to improve performance, depending on the extent, exposure or level of risk.

Next MOHLTC LHIN Agreement

11. **Both Parties** will enter into a new agreement under section 18 of the LHSIA to be effective at the end of the Agreement. If the new agreement is not signed by the Parties by April 1, 2015 the Agreement will continue in force until the new agreement is signed. Both Parties will make their best efforts to sign a new agreement as soon as they are able.

General

12. Any amendment to the Agreement will only be effective if it is in writing and signed by the authorized representative(s) of each party.

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

14. 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.

15. Each Schedule applies to the 2013-15 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.

16. **Each party** will communicate with each other about matters pertaining to the Agreement through the following persons:

To the MOHLTC:
Ministry of Health and Long-Term Care,
Health System Accountability and Performance Division
Hepburn Block, 5th 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
Email: Catherine.Brown@ontario.ca

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) 326-9734
Telephone: (416) 314-1864
Email: Kathryn.McCulloch@ontario.ca

To the LHIN:
North East Local Health Integration Network
555 Oak Street East, 3rd Floor
North Bay, ON P1B 8E3

Attention: Chair

Fax: (705) 840-0142
Telephone: (705) 840-2872
Email: neboard.chair@lhins.on.ca

With a copy to:
North East Local Health Integration Network
555 Oak Street East, 3rd Floor
North Bay, ON P1B 8E3

Attention: CEO

Fax: (705) 840-0142
Telephone: (705) 840-2872
Email: Louise.Paquette@lhins.on.ca

Made effective this 1st day of April, 2013 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

North East Local Health Integration Network

By:

Elaine Pitcher
Chair

SCHEDULE 1: GENERAL

Provincial Priorities and Strategies

1. The **MOHLTC** will establish provincial priorities and strategies for the health system and communicate these priorities to the LHIN.

2. The **LHIN** will:

   a) Work with the MOHLTC, health service providers and other providers in the local health system to achieve and accelerate provincial priorities and strategies;

   b) Work to align the Quality Improvement Plan objectives and priorities of its health service providers to improve the quality of care across sectors and the healthcare system.

3. **Both parties** will work together to develop a collaborative process to support current and future service capacity planning so that decisions about local service provision will advance provincial priorities and strategies.

Provincial Health Agencies

4. The **MOHLTC** will work with the following provincial health agencies to ensure they equally consider the role of the LHINs as local health system managers:

   a) Cancer Care Ontario;
   b) eHealth Ontario;
   c) Health Quality Ontario; and
   d) Ontario Agency for Health Protection and Promotion ("Public Health Ontario").

5. The **LHIN** will work with the provincial health agencies listed in paragraph 4 of this Schedule to support the fulfillment of provincial priorities and strategies.

Consistency

6. The **MOHLTC** will identify common issues and services for which a consistent approach across LHINs is required.

7. The **LHIN** will work collaboratively with other LHINs, and in accordance with the MOU, to ensure a consistent approach for common issues and services, including those identified by the MOHLTC under paragraph 6 of this Schedule.

Local System Coordination and Integration

8. The **LHIN** will work with its health service providers and other LHINs to improve governance, coordination and integration of healthcare delivery across the continuum of care both within and between LHINs.

Community Engagement

9. The **LHIN** will fulfill its community engagement requirements in accordance with the LHIN Community Engagement Guidelines and Toolkit (dated February 2011) to ensure greater clarity and transparency of process.

Information Management

10. The **MOHLTC** will:

    a) Develop, maintain and support health data standards; communicate health data reporting requirements and standards to the LHIN and health service providers; advise/inform health service providers of reporting and data quality issues; and inform the LHINs and health service providers of reporting timelines;

    b) Consult with the LHIN to identify LHIN data/information requirements that support data infrastructure for LHIN operational needs, and prepare data sharing agreements and / or amendments to existing agreements as required; and

    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.

11. The **LHIN** will:

    a) Require health service providers to submit data and information as communicated by the MOHLTC under subparagraph 10(a) of this Schedule to the MOHLTC, Canadian Institute for Health Information, or other third party;

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

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

12. **Both parties** will 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

13. The **MOHLTC** will:

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

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

14. The **LHIN** will:

a) Exercise its legislative and contractual authorities as necessary or as required under law, including conducting or requiring audits and reviews of health service providers; and

b) Inform the MOHLTC as soon as reasonably possible:

i) Of non-compliance by a health service provider with an assigned agreement, a service accountability agreement or legislation that has not been resolved to the LHIN's satisfaction; or

ii) Of a health service provider that is licensed or approved to operate a LTCH,

a) That is experiencing financial issues;

b) Where the LHIN is aware that there is risk to resident health and/or safety in a LTCH; or

c) Where the results of an audit or review conducted or required by a LHIN identify problems.

eHealth

15. The **MOHLTC** will:

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

b) Review annual LHIN Cluster eHealth plans as submitted by the LHINs.

16. The **LHIN** will:

a) Assist its respective LHIN Cluster to prepare an annual LHIN Cluster eHealth plan that aligns with the provincial eHealth priorities for 2013-15, to be submitted to the MOHLTC for review;

b) Include eHealth commitments in service accountability agreements requiring health service providers to:

i) Assist the LHIN to implement provincial eHealth priorities for 2013-15;

ii) Comply with any technical and information management standards, including those related to data, 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;

iii) Implement and use the approved provincial eHealth solutions identified in the LHIN Cluster eHealth plan;

iv) Implement technology solutions that are compatible or interoperable with the provincial blueprint and with the LHIN Cluster eHealth plan; and

v) Include, in their annual planning submissions, plans for achieving eHealth priority initiatives, including full adoption by all hospitals of Ontario Laboratory Information System by March 2015.

17. **Both parties** will work together, and in conjunction with eHealth Ontario and Ontario Telemedicine Network 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 have an impact on provincial or local eHealth issues, strategies or work plans.

Capital

18. **Both parties** will:

a) Follow the November 2010 *MOHLTC-LHIN Joint Review Framework for Early Capital Planning Stages*;

b) Work together during the term of the Agreement to develop a revised or updated capital planning and delivery model for the early capital planning stages informed by service capacity planning by the MOHLTC, the LHINs and other provincial health agencies;

c) Follow the MOHLTC's current *Health Infrastructure Renewal Fund Guidelines*; and

d) Work together to devolve the review and approval process for Own-Funds Capital Projects from the MOHLTC to the LHIN, as appropriate.

Emergency Management

19. **Both parties** will work together to implement the approved policy: "The LHIN Role in Emergency Management" (dated August 2012).

General Performance Obligations

20. The **MOHLTC** will provide the LHIN with, and develop as appropriate, those provincial standards (such as operational, financial or service standards and policies, operating manuals and program eligibility), directives and guidelines that apply to health service providers, including providing the LHIN with relevant program manuals.

21. The **LHIN** will:

a) Require health service providers to provide services funded by the LHIN in accordance with provincial standards, directives and guidelines provided pursuant to paragraph 20 of this Schedule;

b) Provide certificates of compliance, or attestations as the case may be, to the MOHLTC in form and substance as required by the MOHLTC;

c) Maintain the 10% reduction in executive office costs that it achieved between April 1, 2011 and March 31, 2013 against its 2010/11 budget;

d) Require its hospitals and CCAC to maintain the 10% reduction that they achieved between April 1, 2011 and March 31, 2013 against their respective 2010/11 budgets;

e) Not use, nor permit its hospitals and CCAC to use, funding provided under the Agreement to increase executive office budgeted costs during the term of the Agreement; and

f) Report on their executive costs in an attestation to the MOHLTC, and require its hospitals and its CCAC to report on their respective executive office costs in an attestation to the MOHLTC.

22. **Both parties** will work together to ensure that government priorities and implementation of provincial strategies are reflected in accountability planning submission templates, service accountability agreements and schedules with health service providers and other providers.

Annual Review and Update

23. **Both Parties** agree to review and update the Schedules 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

Provincial Programs

1. The **MOHLTC** and the **LHIN** will establish a coordinated and effective system for the management of provincial programs.

2. The **MOHLTC** will:

   a) Identify provincial programs, determine any terms and conditions, including dedicated service funding, related to these provincial programs and communicate these to the LHIN; and

   b) Establish:

      (i) Roles and responsibilities related to provincial program delivery; and

      (ii) Performance management, monitoring and evaluation processes.

3. The **LHIN** will fulfill requirements as may be identified under paragraph 2 of this Schedule and work with other LHINs to coordinate provincial program service delivery.

Other MOHLTC Programs

4. If the **MOHLTC** establishes expectations and requirements for other programs, it will advise the LHIN.

5. The **LHIN** will require health service providers that provide the specific program to provide program services in accordance with the expectations and requirements established by the MOHLTC.

Devolution

6. The **MOHLTC**:

   a) Will determine the devolution of province-wide programs to the LHINs;

   b) Will consult with LHINs before identifying a Lead LHIN; and

   c) May specify the terms and conditions applicable to the funding and administration of the province-wide program after its devolution.

7. The **LHIN** will:

   a) Administer the devolved program in accordance with the "Agreement Concerning the Devolution of Provincial Programs", also known as the Lead LHIN Model Agreement and any terms and conditions specified by the MOHLTC; and

b) Confirm any proposed changes to the Lead LHIN Model Agreement with the MOHLTC prior to implementation.

Community Health Centres ("CHCs")

8. The **MOHLTC** will support the development of Quality Improvement Plans by providing the required templates, guidance and accompanying supports.

9. The **LHIN** will require each CHC to submit a Quality Improvement Plan to Health Quality Ontario that is aligned with and supports local health system priorities.

Mental Health

10. The **MOHLTC** will:

a) Determine and advise the LHIN of the number of housing units that receive rent supplements for persons with serious mental illness and the specific agencies that receive the rent supplements for these units from the MOHLTC;

b) Determine and advise the LHIN of the required service levels for supports to housing services for persons with serious mental illness who occupy the housing units that receive rent supplements as described in subparagraph 10(a) of this Schedule;

c) For forensic mental health services, determine and advise the LHIN of:

(i) the number and type of forensic mental health inpatient beds, the forensic case management initiatives, and the Transitional Rehabilitation Housing Programs' numbers and models;

(ii) the designated hospitals that provide forensic mental health services; and

(iii) the required service levels for forensic mental health services;

and

d) Determine and advise the LHIN of the type (adult or paediatric, inpatient, residential, day treatment or outpatient) and quantity of specialty eating disorder services, where applicable.

11. The **LHIN** will:

a) Fund the provision by health service providers of a combination of community mental health services for the local health system, including services for people who have been in conflict with the criminal justice system;

b) Fund the provision by health service providers of the following services:

(i) Supports to housing services for persons who occupy the housing units that receive rent supplements at the service levels as described in subparagraph 10(b) of this Schedule;

(ii) forensic mental health services that include forensic mental health inpatient beds, forensic case management initiatives, and the Transitional Rehabilitation Housing Programs at the service levels as described in subparagraph 10(c) of this Schedule; and

(iii) specialty eating disorder services as described in subparagraph 10(d) of this Schedule;

c) Require health service providers, designated as psychiatric facilities under the *Mental Health Act,* to provide the essential mental health services in accordance with the specific designation for that site and discuss any material changes to the service delivery models or service levels with the MOHLTC; and

d) Not make any changes to the types and/or levels of service as specified under paragraph 10 of this Schedule without MOHLTC approval.

Addictions

12. The **MOHLTC** will:

a) Determine and advise the LHIN of type and quantity of problem gambling treatment and prevention services;

b) Determine and advise the LHIN of the number of housing units that receive rent supplements for persons with problematic substance use and the specific agencies who receive the rent supplements for these units from the MOHLTC; and

c) Determine and advise the LHIN of the required service levels for supports to housing services for persons with problematic substance use who occupy the housing units that receive rent supplements as described in paragraph 12(b) of this Schedule.

13. The **LHIN** will:

a) Fund the provision by health service providers of the following services:

(i) Problem gambling treatment and prevention services as described in subparagraph 12(a) of this Schedule;

(ii) Supports to housing services for persons who occupy the housing units that receive rent supplements as described in subparagraph 12(c) of this Schedule; and

(iii) A combination of substance abuse treatment services for the local health system;

and

b) Not make any proposed changes to types and/or levels of service as specified under paragraph 12 of this Schedule without MOHLTC approval.

SCHEDULE 3: LONG-TERM CARE HOMES PROGRAM SPECIFIC MANAGEMENT

Definitions

1. Definitions below apply to Schedule 3: Long-Term Care Homes and Schedule 4: Funding and Allocations:

"Acknowledgement and Consent Agreement" means an agreement entered into between the MOHLTC, the operator of a LTCH, and one or more lenders or secured parties, by which the MOHLTC consented to, or agreed to request a consent to, any of the following: (a) a mortgage of real property associated with the LTCH, (b) an assignment of a Development Agreement with the MOHLTC, and/or (c) an assignment of a service agreement;

"Beds in Abeyance" means LTCH beds licensed or approved by the MOHLTC, for which the LTC health service provider has obtained written permission from the Director, PICB, in accordance with the LTCHA for the beds not to be available for occupancy.;

"Construction Funding Subsidy per diem" or **"CFS per diem"** means any per diem funding paid pursuant to a Development Agreement;

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

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

"Funding Policies" means the funding and financial management policies determined by the MOHLTC for LTCHs as the same may be amended from time to time. Funding Policies establish the rates, and amounts and envelopes of all funding provided to LTC health service providers by the MOHLTC or the LHIN, including Supplementary Funding. Funding Policies also establish the applicable conditions for funding, the funding reconciliation rules, and the form, manner and content and date for submission of reports;

"Interim Beds" means those short-stay beds that are licensed or approved under the LTCHA and that fall within the definition of "interim bed" in accordance with regulations under the LTCHA;

"LTCH" means long-term care home;

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

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

"LTC health service provider" means a health service provider that is a licensee within

the meaning of subsection 2(1) of the LTCHA;

"Supplementary Funding" means funding for LTCH beds provided directly by the MOHLTC to LTC health service providers in accordance with applicable Funding Policies and pursuant to a funding agreement between MOHLTC and the LTC health service provider;

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

"service accountability agreement" means the service accountability agreement between a LHIN and a LTC health service provider required by section 20 of the LHSIA; and

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

Funding

2. The **MOHLTC** will:

   a) Determine and provide to the LHIN, the amount of funding that a LHIN may provide to a LTC health service provider together with any applicable terms and conditions;

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

   c) Reallocate a share of the net projected unused funding to the LHIN if the LHIN is projected to be overspent on its funding for the LTCH per diem rate;

   d) If there is net projected unused funding remaining after the reallocation, allocate to the LHIN by December 31 of each year a share of the unused funding in proportion to the number of LTCH beds that are licensed or approved and in operation in the LHIN's geographic area, other than (i) Beds in Abeyance and (ii) beds funded by the LHIN pursuant to paragraphs 18 and 21 of this Schedule, compared to the provincial total number of LTCH beds that are licensed or approved and in operation in the Province, other than Beds in Abeyance and beds funded by all the LHINs pursuant to paragraphs 18 and 21 of this Schedule to their respective Ministry LHIN Performance Agreements; and

   e) At its discretion, provide Supplementary Funding.

3. The **LHIN** will distribute and reconcile the funding provided under paragraph 2 of this Schedule, pursuant to the terms of a service accountability agreement that is consistent with and requires adherence to the Funding Policies and any additional terms and conditions. For greater certainty, the LHIN may not provide any more funding to LTC health service providers than is identified in paragraph 2 of this Schedule, except as provided in the Funding Policies and this Schedule.

4. If a LTC health service provider's beds are closed or transferred to another LHIN, or if a LTC health service provider's licence expires, is surrendered or is revoked under the LTCHA, the residual funding for the beds provided under subparagraph 2 (a) of this Schedule reverts to the **MOHLTC**.

Construction Funding Subsidy (CFS)

5. The **MOHLTC** will:

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

   b) Provide the CFS per diem to the LHIN.

6. The **LHIN** will provide the CFS per diem to LTC health service providers for each approved or licensed bed that is identified in paragraph 5 of this Schedule and operated in accordance with the MOHLTC's conditions of funding, applicable legislation or Development Agreement.

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

Assignment of LTC Service Agreement

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

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

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

11. Where the **MOHLTC**

a) has entered into a Development Agreement with a LTCH health service provider or a proposed LTCH health service provider (an "Operator");

b) has consented to the grant of a security interest to a Lender under the Development Agreement; and

c) has directed the LHIN to consent to the assignment of the Operator's rights under a service accountability agreement,

then the **LHIN**,

d) Shall deliver to the Lender a commitment, in the MOHLTC's standard form, to provide the LHIN's consent to the assignment of the Operator's rights under the service accountability agreement between the Operator and the LHIN;

e) Upon the grant of a licence to the Operator in respect of the Home, and for so long as a CFS is to be paid in respect of the Home, shall consent to the grant of a security interest in the service accountability agreement between the LHIN and the Operator in respect of the Home, provided that:

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

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

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

Beds in Abeyance

12. The **MOHLTC** will review and may approve Beds in Abeyance applications in accordance with the Beds in Abeyance policy and LTCH Protocol.

13. In the event that an application is approved, the **LHIN** may seek and the **MOHLTC** may grant permission to temporarily use the amount of funding available as a result of any approved Beds in Abeyance applications. If the MOHLTC approves the LHIN's request, the LHIN may use the funding in accordance with the approval, including any conditions that may attach to the approval.

Short-Stay Program Beds

14. The **MOHLTC** will:

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

inform approval of these beds in accordance with the LTCH Protocol;

b) Determine the minimum number of Convalescent Care Beds and Interim Beds in the Province;

c) In consultation with the LHIN, determine the LTC health service providers that will provide the Convalescent Care Beds and the Interim Beds and the number of those beds from the minimum number of beds determined in subparagraph (b) of this paragraph; and

d) Set other conditions for the operation of Convalescent Care Beds and Interim Beds.

15. The **LHIN** will:

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

b) Have the ability to set, in its discretion, a threshold for occupancy of Short-Stay Respite Beds that is higher than the minimum set by the MOHLTC pursuant to subparagraph14 (a) of this Schedule;

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

d) Advise and/or make a proposal to MOHLTC about matters referred to in subparagraph 14(c) of this Schedule;

e) Incorporate the conditions referred to in subparagraph 14(d) of this Schedule in service accountability agreements;

f) At its discretion, request that the MOHLTC approve the conversion of existing licensed or approved beds into Convalescent Care Beds additional to those identified in subparagraph14(b) of this Schedule in accordance with the LTCH Protocol; and

g) Provide from its allocation, all additional funding for the converted Convalescent Care Beds approved by the MOHLTC pursuant to subparagraph 15(f) of this Schedule to LTC health service providers in accordance with the Funding Policies, including the additional subsidy for Convalescent Care Beds and the resident co-payment portion of the base level-of-care per diem funding.

LHIN-Requested LTCH Beds

16. In paragraphs 17 and 18 of this Schedule "LHIN Requested LTCH Beds" means, subject to a determination under subparagraph 18(b) of this Schedule, a LTCH bed funded by the LHIN out of its allocation, other than its allocation for LTCHs:

a) That would increase the bed capacity of an existing LTCH licence issued under section 99, or an approval granted under section 130 of the LTCHA; or

b) In the case of a development or redevelopment, that is over and above the number of LTCH beds that the MOHLTC has approved a LTC health service provider for development or redevelopment.

17. The **LHIN** will:

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

b) In its request identify (i) the number of LHIN Requested LTCH Beds requested; (ii) the estimated amount of funding required to support the beds in accordance with the Funding Policies, including Supplementary Funding and funding that would be paid in accordance with paragraphs 3 and 6 of this Schedule; and (iii) where, subject to a determination under subparagraph 18(b) of this Schedule, the funding will be found within the LHIN's allocation, other than its allocation for LTCHs; and

c) Fund the LHIN Requested LTCH Beds in accordance with the Funding Policies and paragraphs 3 and 6 of this Schedule if the LHIN's request for LHIN Requested LTCH Beds is granted by the MOHLTC.

18. The **MOHLTC** will:

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

b) Determine the amount of funding, if any, that the MOHLTC may contribute;

c) Confirm the amount of the funding required to support the beds in accordance with the Funding Policies, including Supplementary Funding and funding that would be calculated pursuant to paragraphs 2 and 5 of this Schedule; and

d) Reallocate the confirmed funding from the sources identified by the LHIN to (i) the LHIN's allocation for LTCH beds for all funding to be paid in accordance with paragraphs 3 and 6 of this Schedule; and (ii) the MOHLTC's allocation for Supplementary Funding when the LHIN Requested LTCH Beds are available for occupancy.

LHIN-Requested Temporary LTCH Beds

19. In paragraphs 20 and 21 of this Schedule, "LHIN Requested Temporary LTCH Beds" means a LTCH bed for which the MOHLTC would issue a temporary licence in accordance with section 111 of the LTCHA or increase the bed capacity of a temporary licence in accordance with the LTCHA, on the condition that the LTCH bed will be funded by the LHIN out of the LHIN's allocation, which may include funding approved for temporary use under paragraph 13 of this Schedule.

20. The **LHIN** will:

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

b) In its request identify (i) the number of LHIN Requested Temporary LTCH Beds requested; (ii) the estimated amount of funding required to support the beds in accordance with the Funding Policies, including Supplementary Funding and funding that would be paid in accordance with paragraph 3 of this Schedule; and (iii) where the funding will be found within the LHIN's allocation; and

c) If the request is approved pursuant to paragraph 21 of this Schedule, provide the funding identified in subparagraph 21(b) of this Schedule for the LHIN Requested Temporary LTCH Beds in accordance with the Funding Policies for the term of the temporary licence issued by the MOHLTC, including any increases in this funding and Supplementary Funding after the date the temporary licence is issued by the MOHLTC for these beds.

21. The **MOHLTC** will:

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

b) Confirm the amount of funding required to support the beds in accordance with the Funding Policies, including Supplementary Funding and the funding paid in accordance with paragraph 3 of this Schedule.

SCHEDULE 4: FUNDING and ALLOCATIONS

Definitions

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

"Annual Balanced Budget" means that, in a fiscal year, the total revenues are greater than or equal to the total expenses. Further, for the LHIN, the meaning of annual balanced budget is also subject to Public Sector Accounting Board (PSAB) rules as well as any interpretations issued by the MOHLTC in financial management policies, directives or guidelines under paragraph 8 of this Schedule.

"Health System Funding Reform (HSFR) Funding" is comprised of HBAM Funding and QBP Funding.

"Health Based Allocation Model (HBAM)" is a population health-based funding methodology that uses population and clinical information to inform funding allocation.

"HBAM Funding" means the portion of funding allocated to a health service provider based on the results of HBAM allocation methodology.

"Multi-year funding targets" means the funding targets for more than one fiscal year.

"Non-HSFR Funding" is the portion of hospital and community care access centre funding net of HSFR Funding.

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

"Quality Based Procedures (QBP)" means the evidence-based funding determination that uses a 'price times volume' methodology to calculate the funding for a targeted set of specific patient groups/procedures.

"QBP Funding" means the portion of funding allocated to a health service provider as a result of QBP analyses using QBP allocation methodology as communicated to the LHINs by the Ministry from time to time.

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

Funding

2. The government's overall provincial LHIN funding allocations that have been updated from the 2013-14 Printed Estimates to include any additional funding to August 31, 2013 and any reallocations initiated by the LHINs are set out in the following tables, in this Schedule:

a) Table 1 – Statement of Overall LHIN Provincial 2013-14 Funding Allocation
b) Table 1a – Statement of Overall LHIN Provincial 2013-14 Funding Allocation for Hospitals and Community Care Access Centres
c) Table 3 – Statement of Overall LHIN Provincial 2013-14 Dedicated Service Funding

by Sector.

3. The **MOHLTC:**

a) Will provide to the LHIN on September 20, 2013 the 2013-14 funding allocation that has been updated from the 2013-14 Printed Estimates to include any additional funding to August 31, 2013 and any reallocations initiated by the LHIN, set out in the following tables in this Schedule:

(i) Table 2 – Statement of Individual LHIN 2013-14 Funding Allocation
(ii) Table 2a – Statement of Individual LHIN 2013-14 Funding Allocation for Hospitals and Community Care Access Centres
(iii) Table 3a – Statement of Individual LHIN 2013-14 Dedicated Service Funding by Sector;

b) As the LHIN makes funding allocation decisions at the sector level throughout the year, will revise the Health Service Provider Transfer Payment Allocation by Sector – Initiatives allocation in Table 2 in this Schedule to the appropriate sectors;

c) Will reconcile all funding provided to the LHIN under the Agreement on an annual basis;

d) Will recover funding from the LHIN if the MOHLTC has advised the LHIN that the particular funding is recoverable;

e) May set terms and conditions for any of the funding set out in the tables in this Schedule, including the type of funding, whether the funding is subject to annual adjustment, and whether and in what circumstances the funding may be recoverable from the LHIN by the MOHLTC;

f) Has determined that HSFR Funding set out in Tables 1a and 2a is subject to annual adjustment by the MOHLTC, and QBP Funding included in the HSFR Funding set out in Tables 1a and 2a in this Schedule is subject to annual adjustment and is recoverable by the MOHLTC; and

g) May require the LHIN to carry out certain initiatives.

4. The **LHIN**:

a) Will allocate the funds provided by the MOHLTC for 2013-15, in accordance with the LHSIA, the Agreement and any applicable terms and conditions of which the LHIN is advised by the MOHLTC, including those set out in paragraph 3 of this Schedule;

b) Will carry out MOHLTC-required initiatives that may include:

(i) Aboriginal Community Engagement, French Language Health Services, French Language Health Planning Entities, LHIN Shared Services Office, Diabetes Regional Coordination Centre Program, Emergency/Alternative Level of Care Performance Leads, Emergency Department LHIN Leads and Critical Care LHIN Leads, as set out in Table 2 in this Schedule under LHIN Operating Allocation – Initiatives; and

(ii) Aging At Home, Urgent Priorities Fund, ALC Investment, Behavioural Supports Ontario Project and funding for Community Investment Initiatives as set out in Table 2 in this Schedule under Health Service Provider Transfer Payment Allocation – Initiatives.

c) May, at its discretion, provide additional funding for the services for which Dedicated Service Funding is identified; and

d) May, only with prior approval from the MOHLTC, reallocate unused Dedicated Service Funding to another service. If the MOHLTC does not give approval, the LHIN shall return unused Dedicated Service Funding to the MOHLTC.

Long-Term Care Homes

5. The funding allocations in Tables 1 and 2 for LTCHs are only estimates that are subject to adjustment in accordance with the Funding Policies as defined in Schedule 3, including adjustments for reconciliation, Beds in Abeyance, and Construction Funding Subsidy per diem.

Annual Balanced Budget Requirements

6. The **LHIN** will:

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

b) Achieve an Annual Balanced Budget for its operations; and

c) Require health service providers who receive LHIN funding through transfer payments to achieve an Annual Balanced Budget.

Multi-Year Funding Requirements

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 this schedule and the Multi-Year Funding Framework. Multi-year funding targets are to be used for planning purposes only and may be revised upward or downward at the discretion of the MOHLTC.

Financial Management Polices and Guidelines

8. The **MOHLTC** may develop and issue to the LHIN policies, directives and guidelines related to financial management.

9. The **LHIN** will comply with all applicable legislation, including the Financial Administration Act; any MOHLTC policies, directives and guidelines issued to the LHIN related to financial management; and government financial management policies, guidelines, and directives, including the following:

a) Multi-Year Funding Framework;

b) Parameters for Financial Health Framework;
c) Fiscal Prudence through Contingency Planning Policy; and
d) Parameters for In-Year and Year-End Reallocations Policy.

Accounting Standards

10. The **MOHLTC**:

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

b) May review the documentation described in paragraph 11 of this Schedule during regular business hours and upon twenty-four hours' notice to the LHIN.

11. The **LHIN** will:

a) Prepare its financial reports and statements on its Operating and health service provider Transfer Payment Budgets, including its Annual Business Plan, based on the Public Sector Accounting Board (PSAB) standards, subject to interpretations and modifications issued under paragraph 10 of this Schedule.

b) Maintain documentation to support all financial statements and related payment instructions, including funding approval letters to health service providers and service accountability agreements signed between the LHIN and its health service providers.

Table 1: Statement of Overall LHIN Provincial 2013-14 Funding Allocation		
	2013-14 Funding Allocation (000s)	**2014-15 Funding Allocation (000s)**
Total LHIN Operating Allocation	**24,971,536.5**	**TBD**
Total Health Service Provider (HSP) Transfer Payment Allocation	24,881,083.6	TBD
Operation of LHIN	63,920.2	TBD
Initiatives	26,532.7	TBD
E-Health	.0	TBD
Total Health Service Provider Transfer Payment Allocation by Sector		
Operations of Hospitals	16,403,556.6	TBD
Grants to compensate for Municipal Taxation - Public Hospitals	3,739.6	TBD
Long Term Care Homes	3,421,313.5	TBD
Community Care Access Centres	2,215,870.7	TBD
Community Support Services	429,803.4	TBD
Acquired Brain Injury	47,326.2	TBD
Assisted Living Services in Supportive Housing	236,922.4	TBD
Community Health Centres	362,422.7	TBD
Community Mental Health	688,095.4	TBD
Addictions Program	174,462.5	TBD
Specialty Psychiatric Hospitals	608,035.4	TBD
Grants to Compensate for Municipal Taxation - Psychiatric Hospitals	126.3	TBD
Initiatives	289,408.9	TBD

Table 1a: Statement of Overall LHIN Provincial 2013-14 Funding Allocation for Hospitals and Community Care Access Centres		
	2013-14 Funding Allocation (000s) [1]	**2014-15 Funding Allocation (000s) [1]**
Hospitals	**16,403,556.5**	**TBD**
Health System Funding Reform (HSFR)	6,268,996.7	TBD
Includes One-time Mitigation Funding	43,935.7	TBD
Non-HSFR	10,134,559.8	TBD
Community Care Access Centre	**2,215,870.7**	**TBD**
Health System Funding Reform (HSFR)	599,997.7	TBD
Includes One-time Mitigation Funding	3,335.3	TBD
Non-HSFR	1,615,873.0	TBD

[1] The amounts in this table are included in Table 1 under the respective sectors.

Table 2: Statement of Individual LHIN 2013-14 Funding Allocation		
	2013-14 Funding Allocation (000s)	**2014-15 Funding Allocation (000s)**
Total LHIN Operating Allocation	**1,448,260.9**	**TBD**
Total Health Service Provider (HSP) Transfer Payment Allocation	1,440,977.6	TBD
Operation of LHIN	4,752.8	TBD
Initiatives	2,530.5	TBD
E-Health		TBD
Total Health Service Provider Transfer Payment Allocation by Sector		
Operations of Hospitals	948,201.2	TBD
Grants to compensate for Municipal Taxation – Public Hospitals	240.3	TBD
Long Term Care Homes	210,355.3	TBD
Community Care Access Centres	118,647.1	TBD
Community Support Services	27,675.1	TBD
Acquired Brain Injury	2,664.8	TBD
Assisted Living Services in Supportive Housing	18,366.3	TBD
Community Health Centres	19,237.0	TBD
Community Mental Health	54,211.4	TBD
Addictions Program	21,108.0	TBD
Specialty Psychiatric Hospitals		TBD
Grants to Compensate for Municipal Taxation - Psychiatric Hospitals		TBD
Initiatives	20,271.1	TBD

Table 2a: Statement of Individual 2013-14 Funding Allocation for Hospitals and Community Care Access Centres		
	2013-14 Funding Allocation (000s) [1]	**2014-15 Funding Allocation (000s) [1]**
Hospitals	**948,201.2**	**TBD**
Health System Funding Reform (HSFR)	305,578.0	TBD
Includes One-time Mitigation Funding	8,803.2	TBD
Non-HSFR	642,623.2	TBD
Community Care Access Centre	**118,647.1**	**TBD**
Health System Funding Reform (HSFR)	32,682.5	TBD
Includes One-time Mitigation Funding	-	TBD
Non-HSFR	85,964.6	TBD

[1] The amounts in this table are included in Table 1 under the respective sectors.

Table 3: Statement of Overall LHIN Provincial 2013-14 Dedicated Service Funding by Sector	
	2013-14 Dedicated Service Funding Allocation
Hospitals	
Post Construction Operating Plan	TBD
Community Health Centres	
Uninsured Persons Services	$4,075,382
Mental Health	
Consumer Survivor Initiatives	$12,000,355
Addictions	
Problem Gambling Treatment Services	$11,083,282
Community Care Access Centres	
School Health Professional and Personal Support Services	$84,091,615
Other	
Compensation Under Specified Initiatives / Agreements [(1)]	$85,191,853

[1] Includes CHC physician salaries and psychiatric sessional fees for community and hospital-based agencies.

Table 3a: Statement of Individual LHIN 2013-14 Dedicated Service Funding by Sector	
	2013-14 Dedicated Service Funding Allocation
Hospitals	
Post Construction Operating Plan	TBD
Community Health Centres	
Uninsured Persons Services	$0
Mental Health	
Consumer Survivor Initiatives	$1,030,968
Addictions	
Problem Gambling Treatment Services	$942,932
Community Care Access Centres	
School Health Professional and Personal Support Services	$3,813,802
Other	
Compensation Under Specified Initiatives / Agreements [(1)]	$4,590,872

[1] Includes CHC physician salaries and psychiatric sessional fees for community and hospital-based agencies.

SCHEDULE 5: LOCAL HEALTH SYSTEM PERFORMANCE

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 the 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 LHSIA and the *Commitment to the Future of Medicare Act, 2004* 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 performance indicators set out in Tables 1, 2 and 3;

   b) Provide the LHIN with calculated results for the performance indicators by the release dates set out in Schedule 6, and supporting performance information as requested by the LHIN, such as the performance of health service providers; and

   c) Provide the LHIN with technical documentation for the performance indicators set out in Tables 1, 2 and 3, including the methodology, inclusions and exclusions.

4. The **LHIN** will:

   a) Work to achieve the LHIN's performance targets for the performance indicators set out in Tables 1, 2 and 3;

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

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

Table 1: Performance Indicators			
▪ Objective: To enhance person-centred care ▪ Expected Outcome: Persons will experience improved access to healthcare services identified below in alignment with best practices.			
INDICATOR	**Provincial target**	**LHIN Baseline 2013-14**	**LHIN Target 2013-14**
90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients	8 hours	29.12 hours	25.00 hours
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	8 hours	6.50 hours	6.50 hours
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4 hours	4.13 hours	4.00 hours
Percent of Priority IV Cases Completed Within Access Target for Cancer Surgery *	Priority IV: 84 days	92%	90%
Percent of Priority IV Cases Completed Within Access Target for Cardiac By-Pass Procedures *	Priority IV: 90 days	93.8%	90%
Percent of Priority IV Cased Completed Within Access Target for Cataract Surgery *	Priority IV: 182 days	98%	90%
Percent of Priority IV Cases Completed Within Access Targets for Hip Replacement *	Priority IV: 182 days	77%	85%
Percent of Priority IV Cases Completed Within Access Target for Knee Replacement *	Priority IV : 182 days	61%	75%
Percent of Priority IV Cases Completed Within Access Target for MRI Scan *	Priority IV : 28 days	68%	80%
Percent of Priority IV Cases Completed Within Access Target for Diagnostic CT Scan *	Priority IV : 28 days	75%	83%

* The reporting for these indicators has been revised starting 2013/14. Previous Agreements included the 90th percentile wait time for these surgical and diagnostic imaging services.

Table 2: Performance Indicators			
▪ Objective: To improve system integration and enhance coordination of care while ensuring better transitions to various care settings. ▪ Expected Outcome: Persons will be able to navigate the healthcare system and receive the care they need, when and where they need it.			
INDICATOR	**Provincial target**	**LHIN Baseline 2013-14**	**LHIN Target 2013-14**
Percentage of Alternate Level of Care (ALC) Days	9.46%	22.33%	22.00%
90th Percentile Wait Time from Community for CCAC In-Home Services – Application from Community Setting to first CCAC Service (excluding case management)	To be determined (TBD)	59 days	48 days
Wait Time from When CCAC Receives Application to Long Term Care Home to When Assessment for Eligibility is Completed *	TBD		

* New indicator for 2013/14. The MOHLTC and the LHINs will monitor performance in 2013/14 and work together to refine quality and consistency of data. Targets will be established starting 2014/15.

Table 3: Performance Indicators			
▪ Objective: To implement evidence based practice to drive quality and value and improve health outcomes ▪ Expected Outcome: Persons will receive quality inpatient care and coordinated post-discharge care, leading to reduced readmission rates that may improve survival, quality of life and other outcomes without increasing cost.			
INDICATOR	**Provincial target**	**LHIN Baseline 2013-14**	**LHIN Target 2013-14**
Readmissions within 30 days for Selected CMGs	TBD	16.96%	15.00%
Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions *	TBD	17.20%	16.50%
Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions *	TBD	27.20%	25.00%

* The methodology for these indicators has been revised starting 2013/14. Results may not be comparable to the previous Agreement.

SCHEDULE 6: INTEGRATED REPORTING

General Obligations

1. The MOHLTC and the LHIN will report to each other as set out in Table 1.

2. The **MOHLTC** will:

   a) Provide any necessary training, instructions, materials, data, templates, forms, and guidelines to the LHIN to assist with the completion of the reports listed in Table 1; and

   b) As required, develop reporting requirements relating to government priorities and notify the LHIN of the requirements.

3. **Both parties** will:

   a) Work together to ensure a timely flow of information, including financial records, to fulfill the reporting requirements of both parties; and

   b) 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.

Table 1: MOHLTC and LHIN Reporting Obligations (2013/14)

Due Date	Description of Item
2013/2014	
APRIL	
April 16, 2013	MOHLTC will provide to the LHIN a Year End Report confirming the expenditures and revenue related to its transfer payments as of March 31 of the preceding fiscal year
April 30, 2013	MOHLTC will provide to the LHIN the forms for the Year-end Consolidation Report
April 30, 2013	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
April 30, 2013	The LHIN will submit to the MOHLTC an Attestation as required under the *Broader Public Sector Accountability Act* (*BPSAA*)
MAY	
May 13, 2013	MOHLTC will provide the LHIN with the most recent quarter of data for indicators in Schedule 5: Local Health System Performance
May 14, 2013	MOHLTC will provide to the LHIN a Year End Report with updated expenditures and revenue related to its transfer payments as of March 31 of the preceding fiscal year
May 17, 2013	The MOHLTC will provide to the LHIN for planning and reporting purposes the initial preliminary allocation for 2013-14
May 31, 2013	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 the Agreement applies
JUNE	
June 3, 2013	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
On or about the 7th working day (date may vary on IFIS GL close as advised by the MOHLTC)	MOHLTC will make the expenditure and revenue report available to the LHIN in APTS for the LHIN's review
June 28, 2013	The LHIN will submit to the MOHLTC Q1 Regular and Consolidation Report using the forms provided by the MOHLTC
June 28, 2013	The LHIN will submit to the MOHLTC an Annual Report for the previous fiscal year in accordance with MOHLTC requirements
June 28, 2013	The LHIN will submit to the MOHLTC a Board approved report on consultant use for the previous fiscal year using the template provided in the Minister's Directive under the *BPSAA*

Due Date	Description of Item
JULY	
July 31,2013	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
July 31,2013	The LHIN will submit to the MOHLTC an Attestation as required under the *BPSAA*
AUGUST	
August 12, 2013	The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 5: Local Health System Management
August 15, 2013	The MOHLTC will provide the preliminary approved allocation for the current fiscal year, as of July 31, 2013
August 30, 2013	MOHLTC will provide to the LHIN the forms and information requirements for the Multi-year Consolidation Report
SEPTEMBER	
September 3, 2013	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
On or about the 7th working day (date may vary on IFIS GL close as advised by the MOHLTC)	The MOHLTC will make the expenditure and revenue report available to the LHIN in APTS for the LHIN's review
September 30, 2013	The LHIN will submit to the MOHLTC Q2 Regular and Consolidation Report using the forms provided by the MOHLTC
September 30, 2013	The MOHLTC will provide to the LHIN the forms and information requirements for the 2014/15 Annual Business Plan
OCTOBER	
October 31, 2013 (or date necessary to meet central agency reporting requirements as advised by the MOHLTC)	The LHIN will submit to the MOHLTC a Multi-year Consolidation Report using the form provided by the MOHLTC
By October 31, 2013	The LHIN will submit to the MOHLTC an Attestation as required under the *BPSAA*
October 31, 2013	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
NOVEMBER	
November 12, 2013	MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 5: Local Health System Management
DECEMBER	
December 2, 2013	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC

Due Date	Description of Item
On or about the 7th working day (date may vary on IFIS GL close as advised by the MOHLTC)	The MOHLTC will make the expenditure and revenue report available to the LHIN in APTS for the LHIN's review
December 31, 2013	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, 2014	MOHLTC will provide the LHIN with year-end instructions (including templates)
By January 31, 2014	The LHIN will submit to the MOHLTC an Attestation required under the *BPSAA*
January 31, 2014	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
FEBRUARY	
February 10, 2014	MOHLTC will provide the LHIN with most recent quarter of performance data for indicators in Schedule 5: Local Health System Performance
February 14, 2014	MOHLTC will provide to the LHIN the forms and requirements for the Annual Report (non-financial content)
February 28, 2014	The LHIN will submit to the MOHLTC a Draft 2014/15 Annual Business Plan using the forms provided by the MOHLTC
MARCH	
March 3, 2014	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
March 28, 2014	MOHLTC will provide to the LHIN the forms for the Annual Report (financial content)
2014/2015	
APRIL	
April 15, 2014	MOHLTC will provide to the LHIN a Year End Report confirming the expenditures and revenue related to its transfer payments as of March 31 of the preceding fiscal year
April 15, 2014	The LHIN will submit to the MOHLTC Year End Reallocation Report on actual expenditures related to in-year reallocations as of March 31 of the preceding fiscal year
April 30, 2014	MOHLTC will provide to the LHIN the forms for the Year-end Consolidation Report
By April 30, 2014	The LHIN will submit to the MOHLTC an Attestation as required under the *BPSAA*
April 30, 2014	The LHIN will submit to the MOHLTC a Expense Report using the forms provided by the MOHLTC

Due Date	Description of Item
MAY	
May 12, 2014	The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 5: Local Health System Performance
May 13, 2014	MOHLTC will provide to the LHIN a Year End Report with updated expenditures and revenue related to its transfer payments as of March 31, of the preceding fiscal year
May 16, 2014	The MOHLTC will provide to the LHIN for planning and reporting purposes the initial preliminary allocation for 2014-15
May 30, 2014 (or date necessary to meet central agency reporting requirements as advised by the MOHLTC)	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 the Agreement applies
JUNE	
June 2, 2014	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
On or about the 7th working day (date may vary on IFIS GL close as advised by the MOHLTC)	The MOHLTC will make the expenditure and revenue report available to the LHIN in APTS for the LHIN's review
June 30, 2014	The LHIN will submit to the MOHLTC Q1 Regular and Consolidation Report using the forms provided by the MOHLTC
June 30, 2014	The LHIN will submit to the MOHLTC an Annual Report for the previous fiscal year in accordance with MOHLTC requirements
June 30, 2014	The LHIN will submit to the MOHLTC a Board approved report on consultant use for the previous fiscal year using the template provided in the Minister's Directive under the *BPSAA*
JULY	
July 31,2014	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
July 31,2014	The LHIN will submit to the MOHLTC an Attestation as required under the *BPSAA*
AUGUST	
August 12, 2014	The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 5: Local Health System Management
August 15, 2014	The MOHLTC will provide the preliminary approved allocation for the current fiscal year, as of July 31, 2014
August 29, 2014	MOHLTC will provide to the LHIN the forms and information requirements for the Multi-year Consolidation Report

Due Date	Description of Item
SEPTEMBER	
September 2, 2014	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
On or about the 7th working day (date may vary on IFIS GL close as advised by the MOHLTC)	The MOHLTC will make the expenditure and revenue report available to the LHIN in APTS for the LHIN's review
September 30, 2014	The LHIN will submit to the MOHLTC Q2 Regular and Consolidation Report using the forms provided by the MOHLTC
September 30, 2014	The MOHLTC will provide to the LHIN the forms and information requirements for the 2014/15 Annual Business Plan
OCTOBER	
October 31, 2014 (or date necessary to meet central agency reporting requirements as advised by the MOHLTC)	The LHIN will submit to the MOHLTC a Multi-year Consolidation Report using the form provided by the MOHLTC
By October 31, 2014	The LHIN will submit to the MOHLTC an Attestation as required under the *BPSAA*
October 31, 2014	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
NOVEMBER	
November 12, 2014	MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 5: Local Health System Management
DECEMBER	
December 3, 2014	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
On or about the 7th working day (date may vary on IFIS GL close as advised by the MOHLTC)	The MOHLTC will make the expenditure and revenue report available to the LHIN in APTS for the LHIN's review
December 31, 2014	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 30, 2015	MOHLTC will provide the LHIN with year-end instructions (including templates)
By January 30, 2015	The LHIN will submit to the MOHLTC an Attestation required under the *BPSAA*

Due Date	Description of Item
January 30, 2015	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
FEBRUARY	
February 10, 2015	MOHLTC will provide the LHIN with most recent quarter of performance data for indicators in Schedule 5: Local Health System Performance
February 13, 2015	MOHLTC will provide to the LHIN the forms and requirements for the Annual Report (non-financial content)
February 28, 2015	The LHIN will submit to the MOHLTC a Draft 2015/16 Annual Business Plan using the forms provided by the MOHLTC
MARCH	
March 3, 2015	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
March 27, 2015	MOHLTC will provide to the LHIN the forms for the Annual Report (financial content)