

## H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 1<sup>st</sup> day of April, 2011

B E T W E E N:

CENTRAL LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

STEVENSON MEMORIAL HOSPITAL (the "Hospital")

**WHEREAS** the LHIN and the Hospital (together the "Parties") entered into a two year hospital service accountability agreement that took effect April 1, 2008 (the "H-SAA");

**AND WHEREAS** pursuant to an amending agreement effective as of April 1, 2010 (the "1st Amending Agreement") the H-SAA was amended and extended effective April 1, 2010;

**AND WHEREAS** the LHIN and the Hospital have agreed to extend the H-SAA for a fourth year;

**NOW THEREFORE** in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree as follows:

**1.0 Definitions.** Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the H-SAA. References in this Agreement to the H-SAA mean the H-SAA as amended and extended by the 1<sup>st</sup> Amending Agreement.

**2.0 Amendments.**

2.1 Agreed Amendments. The Parties agree that the H-SAA shall be amended as set out in this Article 2.

2.2 Title and Headers. The Parties agree that the title of the H-SAA and the headers within the H-SAA shall be amended by deleting "2008-2011" and replacing it with "2008-2012."

2.3 Definitions.

(a) The following new definition will be added:

"Explanatory Indicator" means a measure of hospital performance for which no Performance Target is set.

(b) The definition for HAPS in Article 2.1 shall be deleted and replaced with:

“HAPS means the Board-approved hospital accountability planning submission provided by the Hospital to the LHIN for the Fiscal years 2008-2009, 2009-2010, 2010-2011 and 2011-2012;”

(c) The following new definition will be added:

“Accountability Agreement” means the Accountability Agreement in effect between the LHIN and the MOHLTC during a Fiscal Year.”

(d) The terms “Performance Indicator” and “Performance Indicators” shall be deleted and replaced with “Accountability Indicator” and “Accountability Indicators” respectively.

2.4 Term. The reference to “March 31, 2011” in Article 3.2 shall be deleted and replaced with “March 31, 2012”.

2.5 Remedies for Non-Compliance. The words “for Fiscal Year 2009/10” shall be deleted from Article 12.1(i)(a).

2.6 Schedules.

- (a) Schedule A shall be supplemented with the addition of Schedule A1 attached to this Agreement.
- (b) Schedules B and B1 shall be supplemented with the addition of Schedule B2 attached to this Agreement.
- (c) Schedules C and C1 shall be supplemented with the addition of Schedule C2 attached to this Agreement.
- (d) Schedules D and D1 shall be supplemented with the addition of Schedule D-2 attached to this Agreement.
- (e) Schedules E and E1 shall be supplemented with the addition of Schedule E2 attached to this Agreement.
- (f) Schedules F and F1 shall be supplemented with the addition of Schedule F2 attached to this Agreement.
- (g) Schedules G and G1 shall be supplemented with the addition of Schedule G2 attached to this Agreement.
- (h) Schedules H and H1 shall be supplemented with the addition of Schedule H2 attached to this Agreement.

2.7 Renegotiation of Schedules. The Parties agree that it is their intention to negotiate and to further amend the Schedules following the announcement of funding allocations by the MOHLTC.

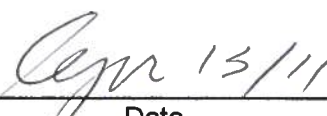
- 3.0 Effective Date.** The Parties agree that the amendments set out in Article 2 shall take effect on April 1, 2011. All other terms of the H-SAA, including but not limited to current funding levels and those provisions in Schedule A to H not amended by s. 2.6, above, shall remain in full force and effect.
- 4.0 Governing Law.** This Agreement and the rights, obligations and relations of the Parties will be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable therein.
- 5.0 Counterparts.** This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.
- 6.0 Entire Agreement.** This Agreement together with Schedules A1, B2, C2, D2, E2, F2, G2 and H2, constitutes the entire agreement between the Parties with respect to the subject matter contained in this Agreement and supersedes all prior oral or written representations and agreements.

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

**CENTRAL LOCAL HEALTH INTEGRATION NETWORK**

By:

  
 \_\_\_\_\_  
 Ken Morrison, Board Chair

  
 \_\_\_\_\_  
 Date

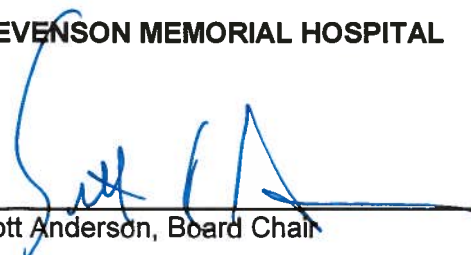
And by:


  
 \_\_\_\_\_  
 Kim Baker, CEO

  
 \_\_\_\_\_  
 Date

**STEVENSON MEMORIAL HOSPITAL**

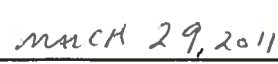
By:

  
 \_\_\_\_\_  
 Scott Anderson, Board Chair

  
 \_\_\_\_\_  
 Date

And by:

  
 \_\_\_\_\_  
 Gary Ryan, CEO

  
 \_\_\_\_\_  
 Date

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# Schedule A1

## Planning and Funding Timetable

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### OBLIGATIONS

<b>Part I - Funding Obligations</b>	<b>Party</b>	<b>Timing</b>
Announcement of hospital-specific 2011-12 base funding allocation	LHIN	The later of June 30, 2011 or 21 Days after confirmation from the MOHLTC

<b>Part II - Planning Obligations</b>	<b>Party</b>	<b>Timing</b>
Sign 1 year extension to the 2008-11 Hospital Service Accountability Agreement	Hospital/LHIN	No later than March 31, 2011
Announcement of multi-year planning targets for 2012-15 Hospital Service Accountability Agreement negotiations*	LHIN	Contingent upon MOHLTC announcement and direction
Publication of the Hospital Accountability Planning Submission Guidelines for 2012-15*	LHIN	Fiscal quarter following MOHLTC direction regarding new multi-year agreements
Indicator Refresh (including detailed hospital calculations)*	LHIN (in conjunction with MOHLTC)	Contingent upon announcement and timing of multi-year planning targets
Submission of Hospital Accountability Planning Submission for 2012-15 *	Hospital	Contingent upon announcement and timing of multi-year planning targets and provincial 2012-15 HAPS /Hospital Service Accountability Agreement process
Sign 2012-15 Hospital Service Accountability Agreement *	Hospital/LHIN	No later than March 31, 2012

\* Intended process based on timely announcement of multi-year planning targets from the MOHLTC. Actual process may change to adapt to timing and duration of the planning targets actually announced by the MOHLTC.

**1.0 PERFORMANCE CORRIDORS FOR SERVICE VOLUMES AND ACCOUNTABILITY INDICATORS**

1.1 The provisions of Article 1 of Schedule B apply in Fiscal Year 11/12 with all references to Schedule D being read as referring to Schedule D2.

**2.0 PERFORMANCE CORRIDORS FOR ACCOUNTABILITY INDICATORS**

2.1 The provisions of Article 2 of Schedule B, as amended by B1, apply in Fiscal Year 11/12 subject to the following amendments:

(a) New sub articles 2.7, 2.8 and 2.9 shall be added as set out below;

**2.7 90<sup>th</sup> Percentile Emergency Room (ER) Length of Stay for Admitted Patients**

a) Definition. The total emergency room (ER) length of stay (LOS) where 9 out of 10 admitted patients completed their visits. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ER.

Steps:

- 1: Calculate ER LOS in hours for each patient.
- 2: Apply inclusion and exclusion criteria.
- 3: Sort the cases by ER LOS from shortest to highest.
- 4: The 90<sup>th</sup> percentile is the case where 9 out of 10 admitted patients have completed their visits.

Excludes:

1. ER visits where Registration Date/Time and Triage Date/Time are both missing;
2. ER visits where Left ER Date/Time and Disposition Date/Time are both missing;
3. ER visits where patients are over the age of 125 on earlier of triage or registration date;
4. Negative ER LOS (earlier of registration or triage after date/time patient left ER);
5. Duplicate records within the same functional centre where all data elements have the same values, except Abstract ID number;
6. Non-Admitted Patients (Disposition Codes 01 – 05 and 08 – 15); and
7. Admitted Patients (Disposition Codes 06 and 07) with missing patient left ER Date/Time.

b) LHIN Target

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Target: maintain or improve current performance*
- (ii) For hospitals performing above the LHIN's Accountability Agreement target:

*Performance Target:* To be negotiated locally taking into consideration contribution to the MLPA target

c) Performance Corridor

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Corridor:* equal to or less than the LHIN's Accountability Agreement target
- (ii) For hospitals performing above the LHIN's Accountability Agreement target:  
*Performance Corridor:* 10%

2.8 **90<sup>th</sup> Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients**

- a) Definition. The total emergency room (ER) length of stay (LOS) where 9 out of 10 non-admitted complex (Canadian Triage and Acuity Scale (CTAS) levels I, II and III) patients completed their visits. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves ER.

Steps

1. Calculate ER LOS in hours for each patient.
2. Apply inclusion and exclusion criteria.
3. Sort the cases by ER LOS from shortest to highest.
4. The 90<sup>th</sup> percentile is the case where 9 out of 10 non-admitted patients have completed their visits.

Excludes:

1. ER visits where Registration Date/Time and Triage Date/Time are both missing;
2. ER visits where Left ER Date/Time and Disposition Date/Time are both missing;
3. ER visits where patients are over the age of 125 on earlier of triage or registration date;
4. Negative ER LOS (earlier of registration or triage after date/time patient left ER);
5. Duplicate records within the same functional centre where all data elements have the same values;
6. ER visits identified as the patient has left ER without being seen (Disposition Codes 02 and 03);
7. Admitted Patients (Disposition Codes 06 and 07);
8. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with assigned CTAS IV and V;
9. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with missing CTAS; and
10. Transferred Patients (Disposition Codes 08 and 09) with missing patient left ER Date/Time.

b) LHIN Targets

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Target:* maintain or improve current performance
- (ii) For hospitals performing above the LHIN's Accountability Agreement target with Pay for Results Funding:  
*Performance Target:* To be negotiated locally taking into consideration contribution to the LHIN's Accountability Agreement target

c) Performance Corridors

- (i) For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Corridor:* equal to or less than the LHIN's Accountability Agreement target
- (ii) For hospitals performing above the LHIN's Accountability Agreement target:  
*Performance Corridor:* 10%

**2.9 90<sup>th</sup> Percentile ER Length of Stay for Non-admitted Minor Uncomplicated (CTAS IV-V) Patients**

- a) Definition. The total emergency room (ER) length of stay (LOS) where 9 out of 10 non-admitted minor/uncomplicated (Canadian Triage and Acuity Scale (CTAS) levels IV and V) patients completed their visits. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ER.

Steps

1. Calculate ER LOS in hours for each patient.
2. Apply inclusion and exclusion criteria.
3. Sort the cases by ER LOS from shortest to highest.
4. The 90<sup>th</sup> percentile is the case where 9 out of 10 non-admitted patients have completed their visits.

Excludes:

1. ER visits where Registration Date/Time and Triage Date/Time are both missing;
2. ER visits where Left ER Date/Time and Disposition Date/Time are both missing;
3. ER visits where patients are over the age of 125 on earlier of triage or registration date;
4. Negative ER LOS (earlier of registration or triage after date/time patient left ER);
5. Duplicate records within the same functional centre where all data elements have the same values;
6. ER visits identified as the patient has left ER without being seen (Disposition Codes 02 and 03);
7. Admitted Patients (Disposition Codes 06 and 07);

8. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with assigned CTAS I, II and III;
9. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with missing CTAS; and
10. Transferred Patients (Disposition Codes 08 and 09) with missing patient left ER Date/Time.

b) LHIN Target

- (i) For hospitals performing at the LHIN’s Accountability Agreement target or better:  
*Performance Target:* maintain or improve current performance
- (ii) For hospitals performing above the LHIN’s Accountability Agreement target:  
*Performance Target:* To be negotiated locally taking into consideration contribution to the LHIN’s Accountability Agreement target

c) Performance Corridor

- (i) For hospitals performing at the LHIN’s Accountability Agreement target or better:  
*Performance Corridor:* less than or equal to the LHIN’s Accountability Agreement target
- (ii) For hospitals performing above the LHIN’s Accountability Agreement target with Pay for Results Funding:  
*Performance Corridor:* 10%

and

- (b) All references to Schedule D1 shall be read as referring to Schedule D2.

**3.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO NURSING ENHANCEMENT/CONVERSION**

3.1 The provisions of Article 3 of Schedule B, as amended by B1 apply in Fiscal Year 11/12 subject to the following amendments:

- (a) subsection 3.1 and 3.2(b) shall be deleted; and
- (b) all references to Schedule D1 shall be read as referring to Schedule D2.

**4.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO CRITICAL CARE**

4.1 The provisions of Article 4 of Schedule B, as amended by B1, apply in Fiscal Year 11/12 subject to the following amendments:

- (a) references to “2010/11” shall be read as referring to “2011/12”; and
- (b) all references to Schedule E1 shall be read as referring to Schedule E2.

**5.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO POST CONSTRUCTION OPERATING PLAN FUNDING AND VOLUME**

5.1 The provisions of Article 5 of Schedule B, as amended by B1, apply in Fiscal Year 11/12, subject to the following amendments:



- (a) references to Schedule F1 shall be read as referring to Schedule F2; and
- (b) references to “2010/11” shall be read as referring to 2011/12.

**6.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO PROTECTED SERVICES**

6.1 The Performance Obligations set out in Article 6 of Schedule B, as amended by B1, apply in Fiscal Year 11/12, subject to the following amendments:

- (a) All references to Schedule D1 or Schedule G1 shall be read as referring to Schedules D2 and G2 respectively; and
- (b) All references to “2010/11” shall be read as referring to “2011/12”

**7.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO WAIT TIME SERVICES**

7.1 The Performance Obligations set out in Article 7 of Schedule B, as amended by B1 apply to Fiscal Year 11/12 subject to the following amendments.

- (a) Sub article 7.2 shall be amended with the addition of the following eight new sub paragraphs (c)-(i):

**(c) 90<sup>th</sup> Percentile Wait Times for Cancer Surgery**

- (i) Definition. This indicator measures the time between a patient’s and surgeon’s decision to proceed with surgery, and the time the procedure is conducted. The 90<sup>th</sup> percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90<sup>th</sup> percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the “90<sup>th</sup> percentile patient”. If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the “90<sup>th</sup> percentile patient” is the indicator value

Excludes:

1. Procedures no longer required;
2. Diagnostic, palliative and reconstructive cancer procedures;
3. Procedures on skin - carcinoma, skin-melanoma, and lymphomas;
4. Procedures assigned as priority level 1;
5. Wait list entries identified by hospitals as data entry errors; and
6. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients’ wait days. These are considered data entry errors.

(ii) LHIN Targets

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Target:* maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Target:* Accountability Agreement target or better

(iii) Performance Corridors

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Corridor:* less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Corridor:* 10%

(d) **90<sup>th</sup> Percentile Wait Times for Cardiac Bypass Surgery**

- (i) Definition. 90<sup>th</sup> percentile wait times for cardiac bypass surgery. This indicator measures the time between a patients' acceptance for bypass surgery, and the time the procedure is conducted. The 90<sup>th</sup> percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90<sup>th</sup> percentile wait time is an actual wait time of a patient and is not estimated. Waiting periods are counted from the date a patient was accepted for bypass surgery by the cardiac service or cardiac surgeon.

Includes: Elective patients who have been accepted for bypass surgery who are Ontario residents.

Excludes: Time spent investigating heart disease before a patient is accepted for a procedure. For example, the time it takes for a patient to have a heart catheterization procedure before being referred to a heart surgeon is not part of the waiting time shown for heart surgery.

(ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Target:* maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding

*Performance Target:* the LHIN's Accountability Agreement target or better

**(iii) Performance Corridor**

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Corridor:* less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Corridor:* 10%

**(e) 90<sup>th</sup> Percentile Wait Times for Cataract Surgery**

- (i) **Definition.** This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90<sup>th</sup> percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90<sup>th</sup> percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90<sup>th</sup> percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90<sup>th</sup> percentile patient" is the indicator value.

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors; and
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

**(ii) LHIN Target**

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Target:* maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Target:* The LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Corridor*: less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Corridor*: 10%

(f) **90<sup>th</sup> Percentile Wait Times for Joint Replacement (Hip)**

- (i) Definition. This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90<sup>th</sup> percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90<sup>th</sup> percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom.)
3. Count the total number of cases and multiply by 0.90 to get the "90<sup>th</sup> percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90<sup>th</sup> percentile patient" is the indicator value.

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors; and
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

(ii) LHIN Target.

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Target*: maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Target*: the LHIN's Accountability Agreement target or better

- (iii) Performance Corridor
  1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Corridor*: less than or equal to Accountability Agreement target
  2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Corridor*: 10%

(g) **90<sup>th</sup> Percentile Wait Times for Joint Replacement (Knee)**

- (i) Definition. This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90<sup>th</sup> percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90<sup>th</sup> percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90<sup>th</sup> percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90<sup>th</sup> percentile patient" is the indicator value

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors; and
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

- (ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*PerformanceTarget*: maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Target*: the LHIN's Accountability Agreement target or better

- (iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Corridor*: less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding  
*Performance Corridor*: 10%

**(h) 90<sup>th</sup> Percentile Wait Times for Diagnostic Magnetic Resonance Imaging (MRI) Scan**

- (i) Definition. This indicator measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted. This interval is typically referred to as 'intent to treat'. The 90<sup>th</sup> percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90<sup>th</sup> percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90<sup>th</sup> percentile patient" is the indicator value

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors;
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors; and
5. As of January 1, 2008, diagnostic imaging cases classified as specified date procedures (timed procedures).

(ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Target*: maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Target*: the LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Corridor*: less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Corridor*: 10%

(i) **90<sup>th</sup> Percentile Wait Times for Diagnostic Computed Tomography (CT) Scan**

- (i) **Definition.** This indicator measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted. This interval is typically referred to as 'intent to treat'. The 90<sup>th</sup> percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90<sup>th</sup> percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90<sup>th</sup> percentile patient" is the indicator value

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors;
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors; and
5. As of January 1, 2008, diagnostic imaging cases classified as specified date procedures (timed procedures).

ii) **LHIN Target**

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Target*: maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:

*Performance Target:* the LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:  
*Performance Corridor:* less than or equal to the LHIN's Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:  
*Performance Corridor:* 10%

and

- (b) All references to Schedules A, G, or H being read as referring to Schedules A1, G2 or H2 respectively.

**8.0 REPORTING OBLIGATIONS**

8.1 The reporting obligations set out in Article 8 of Schedule B, as amended by B1, apply to Fiscal Year 11/12.

**9.0 LHIN SPECIFIC PERFORMANCE OBLIGATIONS**

9.1 The obligations set out in Article 9 of Schedule B1, are replaced by the following provisions which apply to Fiscal Year 2011/12. Without limiting the foregoing, waivers or conditional waivers for 08/09, 09/10 and 10/11 do not apply to 11/12.

9.2 Balanced Budget Requirement

- (a) The Hospital shall continue the implementation of non-clinical operational efficiencies identified by the Hospital.
- (b) The LHIN shall review the performance obligations of the Hospital Service Accountability Agreement within a reasonable timeframe of the LHIN issuing to the hospital its specific allocation.

9.3. Accountability Indicators

Targets for Accountability Indicators set out in sub-articles 2.1 (a) and 7.1 (a) of Schedule B2 will be set to "TBD". During the first quarter of Fiscal 2011/12, the Hospitals and LHIN will work to set actual targets for these indicators.

9.4. E-health

- (a) In support of the Provincial e-Health Strategy, the Hospital will consider the technical standards approved by the Ontario Health Informatics Standards Council (OHISC) for all new technology investments to ensure interoperability within clinical systems.
- (b) The Hospital will participate in the development of the e-Health Strategic Plan and subsequent iterations of the Plan, and will work with the LHIN to align Information Technology/Information Management activities (IT/IM) with the strategy.



9.5. Health Equity and Community Engagement

The Hospital will provide the LHIN an annual Health Equity and an annual Community Engagement Plan by September 30, 2011. The Hospital will collaborate with the LHIN to determine the content of the plans, including the application of community engagement guidelines.

9.6. Quality

Hospitals will comply with all requirements as set out in the *Excellent Care for All Act, 2010*.

9.7. Peer Accountability, Integration and Long-Term Solutions to Advance the Local Health System

The Hospital will continue to work collaboratively with other Hospitals, other health service providers and with the Central LHIN to advance the strategic direction of the local health system as outlined in the Integrated Health Service Plan.

9.8. Capital Initiatives

When planning for capital initiatives, the Hospital will comply with the requirements outlined in the Ministry Capital Planning Manual as may be updated or amended from time to time.

9.9. Ontario Renal Network

The Hospital will collaborate with the Ontario Renal Network and comply with their requirements related to dialysis services and funding.

9.10. Compliance

The Hospital will report, in its quarterly risk reporting submission to the LHIN, the status of its compliance with each of the Schedule B requirements.

# Hospital Multi-Year Funding Allocation

Schedule C2 2011/12

Hospital	Fac #	2011/12 Planning Allocation	
		Base	One-Time
ALLISTON Stevenson Memorial	596		
<b>Operating Base Funding</b>		\$ 18,238,100	
<b>Multi-Year Funding Incremental Adjustment</b>			
<b>Other Funding</b>			
Funding adjustment 1 (Wait Time Strategy - General Surgery)			\$ 74,200
Funding adjustment 2 (Wait Time Strategy - Pediatric Surgery)			\$ 20,200
Funding adjustment 3 ( )			
Funding adjustment 4 ( )			
Funding Adjustment 5 ( Incontinence Supplies )			
Funding Adjustment 6 ( )			
Other Items			
Prior Years' Payments			
<b>Critical Care Strategies Schedule E</b>			
<b>PCOP: Schedule F</b>			
PCOP			
<b>Stable Priority Services: Schedule G</b>			
Chronic Kidney Disease			
Cardiac catheterization			
Cardiac surgery			
<b>Provincial Strategies: Schedule G</b>			
Organ Transplantation			
Endovascular aortic aneurysm repair			
Electrophysiology studies EPS/ablation			
Percutaneous coronary intervention (PCI)			
Implantable cardiac defibrillators (ICD)			
Daily nocturnal home hemodialysis			
Provincial peritoneal dialysis initiative			
Newborn screening program			
<b>Specialized Hospital Services: Schedule G</b>			
Cardiac Rehabilitation			
Visudyne Therapy			
Total Hip and Knee Joint Replacements (Non-WTS)			
Magnetic Resonance Imaging			
Regional Trauma			
Regional & District Stroke Centres			
Sexual Assault/Domestic Violence Treatment Centres			
Provincial Regional Genetic Services			
HIV Outpatient Clinics			
Hemophilic Ambulatory Clinics			
Permanent Cardiac Pacemaker Services			
<b>Provincial Resources</b>			
Bone Marrow Transplant			
Adult Interventional Cardiology for Congenital Heart Defects			
Cardiac Laser Lead Removals			
Pulmonary Thromboendarterectomy Services			
Thoracoabdominal Aortic Aneurysm Repairs (TAA)			
<b>Health Results (Wait Time Strategy): Schedule H</b>			
<b>Selected Cardiac Services</b>			
Total Hip and Knee Joint Replacements		\$ -	
Cataract Surgeries		\$ -	
Magnetic Resonance Imaging (MRI)		\$ -	
Computed Tomography (CT)		\$ 64,800	
<b>Total Additional Base and One Time Funding</b>		\$ -	\$ 159,200
<b>Total Allocation</b>		\$ 18,238,100	\$ 159,200

Allocations not provided in this schedule for 2011/12 will be provided to hospitals in subsequent planning cycles. Hospitals should assume, for planning purposes, funding for similar volumes (as in 2010/11) for Priority Services in out-years.

**Performance Indicators**

Schedule D2 2011/12

Hospital **ALLISTON Stevenson Memorial**

Fac # **596**

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
<b>PERSON EXPERIENCE: Access, Safe, Effective, Person-Centred</b>			
<b>Accountability Indicators</b>			
90th Percentile ER LOS for Admitted Patients	Hours	TBD	TBD
90th Percentile ER LOS for Non-admitted Complex Patients	Hours	TBD	TBD
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated Patients	Hours	TBD	TBD
<b>Explanatory Indicators</b>			
Emergency Department Activity	Weighted Cases		
Emergency Department Vists	Visits		
30-day readmission of patients with stroke or transient ischemic attack (TIA) to acute care for all diagnoses	Percentage		
Percent of stroke patients discharged to rehabilitation	Percentage		
Percent of stroke patients managed on a designated stroke unit	Percentage		
Wait Time Volumes (Per Schedule H2)	Cases		
Rehabilitation Separations	Separations		
<b>ORGANIZATIONAL HEALTH: Efficient, Appropriately Resourced, Employee Experience, Governance</b>			
<b>Accountability Indicators</b>			
Current Ratio (consolidated)	Ratio	0.80	0.80 - 2.0
Total Margin (Consolidated)	Percentage	0.00%	0.00%
<b>Explanatory Indicators</b>			
Total Margin (Hospital Sector Only)	Percentage		
Percentage Full Time Nurses	Percentage		
Percentage Paid Sick Time	Percentage		
Percentage Paid Overtime	Percentage		
<b>SYSTEM INTEGRATION: Integration, Community Engagement, eHealth</b>			
<b>Explanatory Indicators</b>			
Percentage ALC Days	Days		
Repeat Unplanned Emergency Visits within 30 days for Mental Health Conditions	Visits		
Repeat Unplanned Emergency Visits within 30 days for Substance Abuse Conditions	Visits		
<b>GLOBAL VOLUMES</b>			
<b>Accountability Indicators</b>			
Total Acute Activity, Incl. Inpatient and Day Surgery*	Weighted Cases	2,215	1,993 - 2,436
Complex Continuing Care	RUG Weighted Patient Days	0	0
Mental Health	Inpatient Days	0	0
ELDCAP	Inpatient Days	0	0
Rehabilitation	Inpatient Days	0	0
Ambulatory Care***	Visits	23,430	> 17,573

\* Global volumes based on CIPHI Case mix Group (CMG)\* methodology and RW weights.  
 \*\*Volume Performance Indicators under Global Volumes vary in application based on hospital type.  
 \*\*\*Ambulatory Care includes OHRG Primary account codes 7134\* (excluding 7134956), 712\*, 7135\*, 715\* OHRG secondary statistical account codes: 447\*, 450\*, 5\* (excluding 511\*, 512\*, 513\*, 514\*, 516\*, 518\*, 521\*).

## Critical Care Funding

Schedule E2 2011/12

Hospital

*This section has been intentionally left blank*

*Once negotiated, an amendment will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in Schedule B, B1 or B2. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement*

# Post-Construction Operating Plan Funding and Volume

Schedule F2 2011/12

Hospital

*TBD. This section has been intentionally left blank*

*Once negotiated, an amendment (Sch F2.1) will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in Schedule B, B1 or B2. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement*

# Protected Services

Schedule G2 2011/12

Hospital

Fac #

Units of Service	2011/12 Interim Performance Target	2011/12 Performance Standard
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**Stable Priority Services**

Chronic Kidney Disease	Weighted Units	<input type="text" value="TBD"/>	<input type="text" value="TBD"/>
Cardiac catheterization	Procedures	<input type="text" value="TBD"/>	<input type="text" value="TBD"/>
Cardiac surgery	Weighted Cases	<input type="text" value="TBD"/>	<input type="text" value="TBD"/>

**Provincial Strategies**

Organ Transplantation* Endovascular aortic aneurysm repair Electrophysiology studies EPS/ablation Percutaneous coronary intervention (PCI) Implantable cardiac defibrillators (ICD) Daily nocturnal home hemodialysis Provincial peritoneal dialysis initiative Newborn screening program	Cases	<input type="text" value="TBD"/>	<input type="text" value="TBD"/>
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**Specialized Hospital Services**

Cardiac Rehabilitation	Number of patients treated	<input type="text" value="TBD"/>	<input type="text" value="TBD"/>
Visudyne Therapy	Number of insured Visudyne vials administered	<input type="text" value="TBD"/>	<input type="text" value="TBD"/>
Total Hip and Knee Joint Replacements (Non-WTS)	Number of Implant Devices	<input type="text" value="TBD"/>	<input type="text" value="TBD"/>
Magnetic Resonance Imaging	Hours of operation	<input type="text" value="TBD"/>	<input type="text" value="TBD"/>
Regional Trauma	Cases	<input type="text" value="TBD"/>	<input type="text" value="TBD"/>

- Regional & District Stroke Centres
- Sexual Assault/Domestic Violence Treatment Centres
- Provincial Regional Genetic Services
- HIV Outpatient Clinics
- Hemophiliac Ambulatory Clinics
- Permanent Cardiac Pacemaker Services

**Provincial Resources**

- Bone Marrow Transplant
- Adult Interventional Cardiology for Congenital Heart Defects
- Cardiac Laser Lead Removals
- Pulmonary Thromboendarterectomy Services
- Thoracoabdominal Aortic Aneurysm Repairs (TAA)

\* Organ Transplantation - Funding for living donation (kidney & liver) included as part of organ transplantation funding. Hospitals are funded retrospectively for deceased donor management activity, reported and validated by the Trillium Gift of Life Network.

Note: Additional accountabilities assigned in Schedule B, B1, B2

Funding and volumes for these services should be planned for based on 2010/11 approved allocations. Amendments, pursuant to section 5.2 of this Agreement, may be made during the quarterly submission process.

**Wait Time Services**

Hospital **ALLISTON Stevenson Memorial**

Fac #	598		2010/11 Funded +		Assumed Not Approved 2011/12 Funded +	
	Base Volumes	Incremental Volumes*	Base Volumes	Incremental Volumes **		
Selected Cardiac Services	Refer to Schedule G for Cardiac Service Volumes and Targets					
Total Hip and Knee Joint Replacements (Total Implantations)	0	0	0	0		
Cataract Surgeries (Total Procedures)	117	0	117	0		
Magnetic Resonance Imaging (MRI) (Total Hours)	0	0	0	0		
Computed Tomography (CT) (Total Hours)	0	341	1,308	259		

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
90th Percentile Wait Times for Cancer Surgery	Days	TBD	TBD
90th Percentile Wait Times for Cardiac Surgery	Days	TBD	TBD
90th Percentile Wait Times for Cataract Surgery	Days	TBD	TBD
90th Percentile Wait Times for Hip Replacement Surgery	Days	TBD	TBD
90th Percentile Wait Times for Knee Replacement Surgery	Days	TBD	TBD
90th Percentile Wait Times for MRI Scan	Days	TBD	TBD
90th Percentile Wait Times for CT Scan	Days	TBD	TBD

\* The 2010/11 Funded volumes are as a reference only  
 \*\* Once negotiated, an amendment will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in Schedule B,B1, B2. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement.  
 + Exclude LHIN-funded one-time volumes