2008-2012 H-SAA AMENDING AGREEMENT # 2

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

B E T W E E N:

NORTH SIMCOE MUSKOKA LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

- AND -

GEORGIAN BAY GENERAL HOSPITAL (the "Hospital")

WHEREAS the LHIN and the Hospital entered into a hospital service accountability agreement that took effect April 1, 2008 and has been amended by agreements made as of April 1, 2010 and April 1, 2011 (the "H-SAA");

AND WHEREAS the Parties acknowledged, in the amending agreement made as of April 1, 2011, that further amendments would be required to the Schedules following the announcement of funding allocations by the Ministry of Health and Long-Term Care.

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.

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 Schedules.

(a) Schedule B-2 shall be deleted and replaced with Schedule B-2 attached to this Agreement.

(b) Schedules C-2 shall be deleted and replaced with Schedule C-2 attached to this Agreement.

(c) Schedules D-2 shall be deleted and replaced with Schedule D-2 attached to this Agreement.

(d) Schedules H-2 shall be deleted and replaced with Schedule H-2 attached to this Agreement.

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, those provisions in the Schedules not amended by s. 2.2, 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.

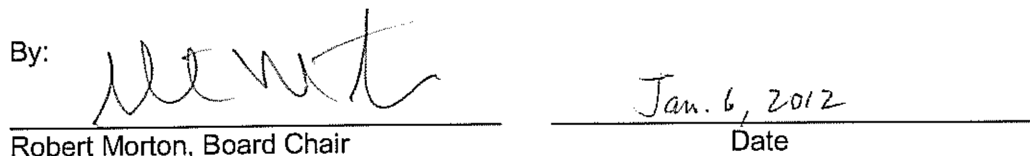
5.0 **Counterparts.** This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.

6.0 **Entire Agreement.** This Agreement together with Schedules B-2, C-2, D-2, and H-2, 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.

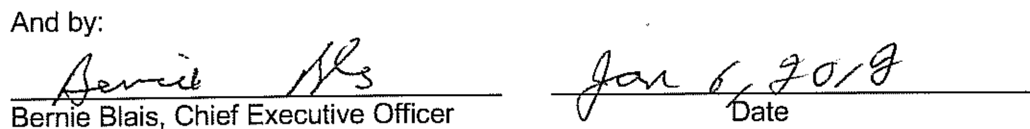
NORTH SIMCOE MUSKOKA LOCAL HEALTH INTEGRATION NETWORK

By:



Robert Morton, Board Chair — Date

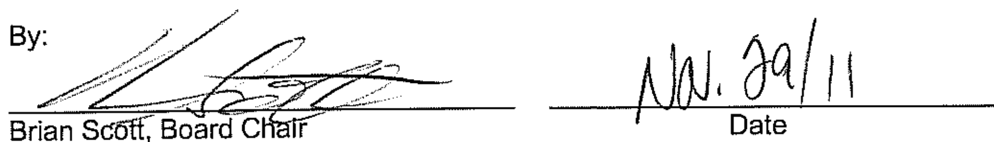
And by:



Bernie Blais, Chief Executive Officer — Date

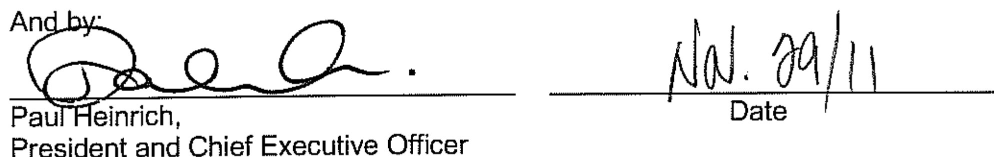
GEORGIAN BAY GENERAL HOSPITAL

By:



Brian Scott, Board Chair — Date

And by:



Paul Heinrich,
President and Chief Executive Officer — Date

Schedule B2
Performance Obligations for 11/12

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 90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients

a) <u>Definition</u>. 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 90th 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) <u>LHIN Target</u>

(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) <u>Performance Corridor</u>

(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 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients

a) <u>Definition</u>. 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 90th 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 90th 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 90th 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) <u>LHIN Target</u>

(i) For hospitals performing at the LHIN's Accountability Agreement target or better:
PerformanceTarget: 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) <u>Performance Corridor</u>

(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) **90th 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 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th 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 "90th 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 "90th 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) <u>LHIN Targets</u>

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) <u>Performance Corridors</u>

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) **90th Percentile Wait Times for Cardiac Bypass Surgery**

(i) Definition. 90th 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 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th 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) 90th 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 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th 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 "90th 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 "90th 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) 90th 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 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th 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 "90th 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 "90th 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) 90th 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 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait t 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 "90th 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 "90th 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) 90th 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 90th 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 "90th 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 "90th 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) 90th 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 90th 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 "90th 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 "90th 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.

8.2 The following reporting obligations are added to Article 8 of Schedule B:

(a) **French Language Services.** If the Hospital is required to provide services to the public in French under the provisions of the *French Language Services Act*, the Hospital will be required to submit a French language implementation report to the LHIN. If the Hospital is not required to provide services to the public in French under the provisions of the *French Language Service Act*, it will be required to provide a report to the LHIN that outlines how the Hospital addresses the needs of its local Francophone community."

9.0 LHIN SPECIFIC PERFORMANCE OBLIGATIONS

9.1 Except where specifically limited to a given year, the obligations set out in Article 9 of Schedule B, as amended by B1, apply to Fiscal Year 11/12. Without limiting the foregoing, waivers or conditional waivers for 08/09, 09/10 and 10/11 do not apply to 11/12.

9.2

(a)

i. The hospitals will be required to report on the obligations and expectations listed in Table 1 and the indicators listed in Table 2. Non-acute hospitals will report only on relevant indicators

Table 1

LHIN Specific Performance Obligation	Definition
Risk Management Plans	HSP Boards must ensure that an established and documented Risk Management Process is in place such that risks are identified and reported to the LHIN when there is a moderate or serious risk of impact on the achievement of the Accountability Agreements.
Client Experience	HSP's will provide the LHIN with a summary of the satisfaction survey results required under section 5 of the Excellent Care for all Act. The summary will include overall client satisfaction and overall satisfaction of employees and others working for the HSP.
Falls Prevention and Reduction Program	HSPs will ensure that a falls prevention and reduction program is established for at-risk clients. The program will be aligned with the LHIN-wide Integrated Regional Falls Program. Minimum requirements of this program will include: • The identification of individuals at risk for falls • The collection of information about the number of clients experiencing falls, falls resulting in harm, falls resulting in ER visits, and falls resulting in inpatient admissions • A strategy to reduce the number of falls resulting in harm
Wound Care	HSPs will ensure that risk identification and prevention activities to address Wound Care in alignment with the NSM LHIN Guidelines for Wound Care and that data is collected and reported to the LHIN.
Reporting of Clinical Data Submissions to CIHI and MOHLTC	HSPs will ensure that all clinical data submission timelines for CIHI submission are adhered to.

LHIN Specific Performance Expectation	Definition

LHIN Specific Performance Expectation	Definition
Care Connections Participation	HSPs are expected to collaborate with system partners and Local Leadership Councils to implement the 12 Areas of Focus for Care Connections. HSPs will ensure Senior Management or delegate representation at all meetings for Care Connections oversight structures as agreed to between the HSP and the LHIN, and other meetings that may be scheduled from time to time as appropriate. Georgian Bay General Hospital is the Lead Organization and Coordinating Council Chair for Complex and Chronic Health Needs.

Table 2

LHIN Specific Indicator	Definition
Total ALC Days (as reported by NSM LHIN Hospitals)	Total number of inpatient days designated as ALC in a given time period Includes: 1. Data from acute care hospitals, including those with psychiatric beds (AP hospitals) and without psychiatric beds (AT hospitals) 2. Individuals designated as ALC Excludes: 1. Newborns and stillborns 2. Records with missing or invalid "Discharge Date"
Average (mean) length of stay for ALC patients	Total number of inpatient days designated as ALC in a given time period divided by the total number of discharges designated ALC Includes: 1. Data from acute care hospitals, including those with psychiatric beds (AP hospitals) and without psychiatric beds (AT hospitals) 2. Individuals designated as ALC Excludes: 1. Newborns and stillborns 2. Records with missing or invalid "Discharge Date"
Proportion of Diabetics getting HbA1c testing	The percentage of ambulatory care diabetic patients age 18 and older who have received hemoglobin A1C (HbA1C) tests within the appropriate guideline period. Includes: • Number of unique patients age >18 registered with Hospital Diabetic Education Centers Excludes: • women with gestational diabetes
Proportion of Diabetics getting LDL testing	The percentage of ambulatory care diabetic patients age 18 and older who have received a lipoprotein-cholesterol LDL-C test within the appropriate guideline period. Includes: • Number of unique patients age >18 registered with Hospital Diabetic Education Centers Excludes: • women with gestational diabetes

LHIN Specific Indicator	Definition
Proportion of Diabetics getting Retinal Exams	The percentage of ambulatory care diabetic patients age 18 and older who have received retinal eye exams within the appropriate guideline period Includes: • Number of unique patients age >18 registered with Hospital Diabetic Education Centers Excludes: • women with gestational diabetes
Proportion of Diabetics with Diabetes in Control (HbA1c <=7)	The percentage of ambulatory diabetic patients age 18 and older who have received hemoglobin A1C (HbA1C) test with a measurement value of less than or equal to 7.0%. Includes: • Number of unique patients age >18 registered with Hospital Diabetic Education Centers Excludes: • women with gestational diabetes
Total number of Falls among clients (patients)	A count of the total number of occurrences of falls among those clients presenting at the Emergency Room.
Total numbers of Falls resulting in harm (Severity of Harm Scale)	Number of harmful falls that take place in hospital each month that are categorized as a 2, 3, 4, 5, or 6 on the severity of harm scale which ranges from "Temporary Harm" to "Death". Includes: • Category 1 = No Harm to the patient/client. May require temporary monitoring to ensure no harm has occurred. • Category 2 = Temporary harm to the patient/client and required intervention. • Category 3 = Temporary harm to the patient/resident and required initial or prolonged hospitalization • Category 4 = Permanent consequences to the patient/client • Category 5 = Intervention necessary to sustain life • Category 6 = Death
Total numbers of clients visiting a hospital ER due to a fall in the last 90 days	Total numbers of clients visiting a hospital ER due to a fall in the last 90 days.
Total numbers of clients being admitted to a hospital following a fall in the last 90 days	Total numbers of clients being admitted to a hospital following a fall in the last 90 days.
Pressure Ulcer Prevalence	Total number of inpatients with a new pressure ulcer (stage 2 or higher)

ii. The hospitals will be required to report to the LHIN according to the schedule in Table 3.

Table 3

LHIN Specific Performance Obligation	Frequency of reporting	Due Dates
Risk Management Plans	Annual (once) – any change to be reported to the LHIN	July 31, 2011
Client Experience	Annual	June 30, 2012
Falls Prevention and Reduction Program	Quarterly	July 31, 2011 October 31, 2011 January 31, 2012 April 30, 2012
Wound Care	Quarterly	
Reporting of Clinical Data Submissions to CIHI and MOHLTC	Quarterly	
LHIN Specific Indicators		
Total ALC Days (as reported by NSM LHIN) Hospitals	Quarterly	July 31, 2011 October 31, 2011 January 31, 2012 April 30, 2012
Reduction in Average (mean) length of stay for ALC patients	Quarterly	
Proportion of Diabetics getting HbA1c testing	Quarterly	
Proportion of Diabetics getting LDL testing	Quarterly	
Proportion of Diabetics getting Retinal Exams	Quarterly	
Proportion of Diabetics with Diabetes in Control (HbA1c <=7)	Quarterly	
Total numbers of Falls among clients (patients)	Quarterly	
Total numbers of Falls resulting in harm (Severity of Harm Scale)	Quarterly	
Total numbers of clients visiting a hospital ER due to a fall in the last 90 days	Quarterly	
Total numbers of clients being admitted to a hospital following a fall in the last 90 days	Quarterly	
Pressure Ulcer Prevalence	Quarterly	

iii. Georgian Bay General Hospital Targets and Corridors are listed in Table 4. Each hospital agrees on their individual target for the reduction in total ALC days.

Table 4

LHIN Specific Indicator	Performance Target	Corridor and Reporting Variance
Total ALC Days* Hospital = GEORGIAN BAY GENERAL HOSP	Reduction of a minimum 180 ALC days per fiscal year from FY 2010/11 totals	Quarterly reductions of 45 ALC days per quarter +/- 10 ALC days
Average (mean) length of stay for ALC patients	Year 1 - Explanatory Indicator	
Proportion of Diabetics getting HbA1c testing	Year 1 - Explanatory Indicator	Hospitals with Diabetes Education Centers (DECs)
Proportion of Diabetics getting LDL testing	Year 1 - Explanatory Indicator	Hospitals with Diabetes Education Centers (DECs)
Proportion of Diabetics getting Retinal Exams	Year 1 - Explanatory Indicator	Hospitals with Diabetes Education Centers (DECs)
Proportion of Diabetics with Diabetes in Control (HbA1c <=7)	Year 1 - Explanatory Indicator	Hospitals with Diabetes Education Centers (DECs)
Total numbers of Falls among clients	Year 1 - Explanatory Indicator	
Total numbers of Falls resulting in harm (Severity of Harm Scale)	Year 1 - Explanatory Indicator	
Total numbers of clients visiting a hospital ER due to a fall in the last 90 days	Year 1 - Explanatory Indicator	
Total numbers of clients being admitted to a hospital following a fall in the last 90 days	Year 1 - Explanatory Indicator	
Pressure Ulcer Prevalence	15.0% reduction	

(b) Reporting in a template agreed by LHIN and hospitals will be submitted to the LHIN according to the schedule in section 9.3 (a) (ii).

(c) The LHIN may ask for supplementary reporting as and when the LHIN will deem required.

(d) The LHIN may ask for more details and/or supporting documents as and when the LHIN will deem required.

* Please refer to the NSM LHIN ALC Background document for details

Hospital Multi-Year Funding Allocation

Schedule C2 2011/12

Hospital Georgian Bay General Hospital	**2011/12 Approved Allocations**	
Fac # 726	Base	One-Time
Operating Base Funding	40,265,200	
Multi-Year Funding Incremental Adjustment	632,500	
Other Funding		
Funding adjustment - High Growth	194,200	
Funding adjustment - ER Pay for Results		682,700
Funding adjustment - LHIN-wide Complex Continuing Care (CCC)		241,750
Funding adjustment - Chronic Care Co-Payment		7,200
Funding adjustment - Critical Care Nurse Training Funds		18,000
Funding adjustment - OTN Telemedicine Nurse	26,569	
Other Items		
Prior Years' Payments		
Critical Care Stategies Schedule E		
PCOP: Schedule F		
PCOP		
Stable Priority Services: Schedule G		
Chronic Kidney Disease		
Cardiac catherization		
Cardiac surgery		
Provincial Strategies: Schedule G		
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		
Specialized Hospital Services: Schedule G		
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		
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)		
Health Results (Wait Time Strategy): Schedule H		
Selected Cardiac Services		
Total Hip and Knee Joint Replacements		
Cataract Surgeries		
Magnetic Resonance Imaging (MRI)		
Computed Tomography (CT)		25,000
Total Additional Base and One Time Funding	**853,269**	**974,650**
Total Allocation	**42,093,119**	

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: Georgian Bay General Hospital

Fac #: 726

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
PERSON EXPERIENCE: Access, Safe, Effective, Person-Centred			
Accountability Indicators			
90th Percentile ER LOS for Admitted Patients	Hours	13.90	<23.0
90th Percentile ER LOS for Non-admitted Complex Patients	Hours	5.20	<6.8
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated Patients	Hours	2.90	<4.0
Explanatory Indicators			
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		
ORGANIZATIONAL HEALTH: Efficient, Appropriately Resourced, Employee Experience, Governance			
Accountability Indicators			
Current Ratio (consolidated)	Ratio	0.47	>4.0
Total Margin (Conslidated)	Percentage	0.00	0
Explanatory Indicators			
Total Margin (Hospital Sector Only)	Percentage		
Percentage Full Time Nurses	Percentage		
Percentage Paid Sick Time	Percentage		
Percentage Paid Overtime	Percentage		
SYSTEM INTEGRATION: Integration, Community Engagement, eHealth			
Explanatory Indicators			
Percentage ALC Days	Days		
Repeat Unplanned Emergency Visits within 30 days for Mental Health Conditions	Vists		
Repeat Unplanned Emergency Visits within 30 days for Substance Abuse Conditions	Visits		
GLOBAL VOLUMES			
Accountability Indicators			
Total Acute Activity, incl. Inpatient and Day Surgery*	Weighted Cases	4,200	3,780 - 4,620
Complex Continuing Care	RUG Weighted Patient Days	8,900	>7,565
Mental Health	Inpatient Days		
ELDCAP	Inpatient Days		
Rehabilitation	Inpatient Days	4,600	>3,910
Ambulatory Care***	Visits	17,700	>13,275

* Global volumes based on CIHI Case mix Group (CMG)+ methodology and RIW weights.
**Volume Performance Indicators under Global Volumes vary in application based on hospital type.

***Ambulatory Care includes OHRS Primary account codes 7134* (excluding 7134055), 712*, 7135*,715* OHRS secondary statistical account codes:447*,450*,5* (excluding 50*,511*,512*,513*,514*,518*,519*,521*)

Wait Time Services

Schedule H2 2011/12

Hospital Georgian Bay General Hospital

Fac # 726

	2010/11 Funded		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)				
Cataract Surgeries (Total Procedures)				
Magnetic Resonance Imaging (MRI) (Total Hours)				
Computed Tomography (CT) (Total Hours)	1,950	0	1,950	100

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
90th Percentile Wait Times for Cancer Surgery	Days		
90th Percentile Wait Times for Cardiac Surgery	Days		
90th Percentile Wait Times for Cataract Surgery	Days		
90th Percentile Wait Times for Hip Replacement Surgery	Days		
90th Percentile Wait Times for Knee Replacement Surgery	Days		
90th Percentile Wait Times for MRI Scan	Days		
90th Percentile Wait Times for CT Scan	Days	28	10%***

* 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.

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