2008-13 H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (this "Agreement") is made as of the 30th day of June, 2012.

BE T W E E N:

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

AND

COLLINGWOOD GENERAL AND MARINE 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 have extended the H-SAA by agreement effective April 1, 2012;

AND WHEREAS the Parties wish to further amend the H-SAA;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree that the H-SAA shall be amended as follows:

1.0 Definitions. Except as otherwise defined in this Agreement below, 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 Amended Definitions. Effective April 1, 2012, the following terms shall have the following meanings:

"**Base Funding**" means the Base funding set out in Schedule C (as defined below).

"**Costs**" for the purposes of Section 4.0 below, means all costs for the Executive Office (as defined below) including office space, supplies, salaries and wages of the officers and staff of the Executive Office, conferences held for or by the Executive Office and travel expenses of the officers and staff of the Executive Office.

"**Executive Office**" means the office of the chief executive officer or equivalent, and the office of every member of senior management of the Hospital that reports directly to the chief executive officer or equivalent.

"**Explanatory Indicator**" means an indicator of Hospital performance that is complementary to one or more Accountability Indicators and used to support planning, negotiation or problem solving, but for which no Performance Target has been set.

"**HAPS**" means the Board-approved hospital annual planning submission provided by the Hospital to the LHIN for the Fiscal Years 2012-2013;

"**Indicator Technical Specifications**" and "**2012-13 H-SAA Indicator Technical Specifications**" means the document entitled "Hospital Service Accountability Agreement 2012-13: Indicator Technical Specifications March 2012" as it may be amended or replaced by the LHIN from time to time.

The definition of "**Performance Standard**" is amended by adding the words "and the Indicator Technical Specifications" after the last word "Schedules". As a result, "**Performance Standard**" means the acceptable range of performance for a Performance Indicator or Service Volume that results when a Performance Corridor is applied to a Performance Target (as described in the Schedules and the Indicator Technical Specifications).

"**Post-Construction Operating Plan (PCOP) Funding**" and "**PCOP Funding**" means annualized operating funding provided to support service expansions and other costs occurring in conjunction with completion of an approved capital project, as set out in Schedule C (2012 – 2013) (Hospital One-Year Funding Allocation) and further detailed in Schedule F (2012 – 2013) (Post-Construction Operating Plan Funding and Volume).

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

Schedule A (2012 – 2013) (Planning and Reporting);
Schedule C (2012 – 2013) (Hospital One-Year Funding Allocation)
Schedule D (2012 – 2013) (Service Volumes)
Schedule E (2012 – 2013) (Indicators)
Schedule E1 (2012 – 2013) (LHIN Specific Indicators and Targets) and
Schedule F (2012 – 2013) (Post-Construction Operating Plan Funding and Volume)

"**Schedule A**" means Schedule A (2012 – 2013) (Planning and Reporting).

"**Schedule C**" means Schedule C (2012 – 2013) (Hospital One-Year Funding Allocation).

2.3 Interpretation. This Agreement and the H-SAA shall be interpreted with reference to the Indicator Technical Specifications.

2.4 Term. This Agreement and the H-SAA will terminate on March 31, 2013.

2.5 Recovery of Funding. Section 5.6.1 (Recovery of Funding) (a) (Generally) of the H-SAA is amended by deleting (v) and adding the following as Section 5.6.1 (Recovery of Funding) (a.1) (Specific Programs):

(i) if the Performance Obligations set out in Schedule E (2012 – 2013) (Indicators) in respect of Critical Care Funding are not met, the LHIN will adjust the Critical Care Funding following the submission of in-year and year-end data;

(ii) if the Hospital does not meet a performance Obligation or Service Volume under its post-construction operating plan, as detailed in Schedule F or Schedule F (2012 – 2013), the LHIN may: adjust the applicable Post-Construction Operating Plan Funding to reflect

reported actual results and projected year-end activity; and perform final settlements following the submission of year-end data of Post Construction Operating Plan Funding;

(iii) if the Hospital does not meet a Performance Obligation or Service Volume set out in Schedule D for a service within Part III - Services and Strategies, the LHIN may: adjust the Funding for that service to reflect reported actuals and projected year-end activity; and, perform in-year reallocations and final settlements following the submission of year-end data of service; and,

(iv) if the Hospital does not meet a Performance Obligation or Service Volume as detailed in Schedule D for a Wait Time Service, the LHIN may: adjust the respective Wait Time Funding to reflect reported actuals and projected year-end activity; and perform in-year reallocations and final settlements following the submission of year-end data.

2.6 Funding. Section 6.1.1 (Funding) of the H-SAA is amended by deleting (ii) and replacing it with:

"(ii) used in accordance with the Schedules".

2.7 Balanced Budget. Section 6.1.3 (Balanced Budget) of the H-SAA is amended by deleting "Schedule B" at the end of the Section and replacing it with "Schedule E1 (2012 – 2013) LHIN Specific Indicators and Targets".

2.8 Hospital Services. Section 6.2 (Hospital Services) of the H-SAA is amended by adding the words "and the Indicator Technical Specifications" after the word "Schedule" in (i) and (ii).

2.9 Planning Cycle. Section 7.1 (Planning Cycle) of the H-SAA is amended by replacing the words "the planning cycle in Part II of *Schedule A* ("Planning Cycle") for Fiscal Years 2010/11 and 2011/12" with the words "the timing requirements of Schedule A (2012 – 2013) Planning and Reporting".

2.10 Timely Response. Section 7.6.1 (Timely Response) of the H-SAA is amended by deleting both occurrences of "Schedule B" and replacing these with "Schedule A (2012 – 2013) Planning and Reporting".

2.11 Specific Reporting Obligations. Section 8.2 (Specific Reporting Obligations) of the H-SAA is amended by deleting "Schedule B" and replacing it with "Schedule A (2012 – 2013) Planning and Reporting".

2.12 Planning Cycle. Section 12.1 (Planning Cycle) of the H-SAA is amended by replacing "Schedule A" in (i) with "Schedule A (2012 – 2013) Planning and Reporting".

2.13 Executive Office Reduction. The Hospital shall reduce the Costs of its Executive Office by ten percent (10%) over fiscal years 2011/12 and 2012/13. Entities that have a year end of March 31 should use their 2010/11 budget as a baseline, and entities that have a year end of December 31 should use their 2010 budget as a baseline.

3.0 Effective Date. The Parties agree that the amendments set out in Article 2 shall take effect on April 1, 2012. All other terms of the H-SAA 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 A (2012 – 2013) (Planning and Reporting), C (2012 – 2013) (Hospital One-Year Funding Allocation), D (2012 – 2013) (Service Volumes), E (2012 – 2013) (Indicators), Schedule E1 (LHIN Specific Indicators and Targets) and F (2012 – 2013) (Post-Construction Operating Plan Funding and Volume) constitute 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: _____ October 4, 2012

Robert Morton, Board Chair — Date

And by:

_____ October 4, 2012

~~Bernie Blais, Chief Executive Officer~~ Jill Tettmann, Interim CEO — Date

COLLINGWOOD GENERAL AND MARINE HOSPITAL

By: _____ September 27, 2012

Shiela Metras, Board Chair — Date
I have authority to bind the Hospital.

And by:

Linda L. Davis September 27, 2012

Linda Davis, — Date
President and Chief Executive Officer
I have authority to bind the Hospital.

Reporting Obligations

Schedule A:

Part I – Planning
Since the MOHLTC was unable to release the amount of Hospital funding for the 2012 – 2013 fiscal year before March 31, 2012, it was not possible for the LHIN and the Hospital to enter into an H-SAA for the 2012 – 2013 fiscal year by March 31, 2012. In the circumstances, the following steps were taken at the following times: ▪ The 2008-12 H-SAA was extended to June 30, 2012. ▪ The HAPS Submission process was launched on April 17th, 2012, with the HAPS due May 29th. ▪ On execution of an amending agreement, the 2008-12 H-SAA will be amended and extended for a one year term, effective April 1, 2012 through March 31, 2013.

Part II – Reporting	Party	Timing
Hospitals submit MIS trial balance and supplemental reporting as necessary	Hospital	30 days after the end of each quarter beginning with the 2nd quarter
Year end MIS trial balance and supplemental report	Hospital	60 days following the end of the fiscal year
Audited Financial Statements	Hospital	60 days following the end of the fiscal year
French Language Services Report as applicable	Hospital	60 days following the end of the fiscal year
Attestation of compliance with tasks required by CritiCall as per the Agreement between the assigned CritiCall Transfer Payment Agency and the MOHLTC	Hospital	60 days following the end of the fiscal year
Hospital to provide compliance attestations as required by Applicable Law	Hospital	In accordance with obligations
Such other reporting as may be required by the LHIN from time to time (Note 1)	Hospital	As directed by the LHIN

Note 1: Request for reporting as per LHIN authority as set out in the Local Health System Integration Act

Hospital One-Year Funding Allocation

Hospital: COLLINGWOOD GENERAL & MARINE HOSPITAL
Facility #: 640

Schedule C: (2012-2013)

	Vol	Rate	ALLOCATIONS Base	ALLOCATIONS One-Time
Operating Base Funding			$0	$0
Base Funding (Note 1)			$31,025,039	$0
PCOP (Reference Schedule F)			$0	$0
Incremental Funding Adjustment			$0	$0
Other Funding				
Funding adjustment 1 - Indirect WTS Costs			$83,033	$0
Funding adjustment 2 - HSFR Funding Impact (Incremental 2012/13 hip/knee Indirect Cost			$8,509	$0
Funding adjustment 3 - HSFR Funding Impact (Post Mitigation HBAM)			$225,080	$0
Funding adjustment 4 - Starch Volume Expanders			$9,600	$0
Funding adjustment 5 - General Surgery (Cholecystectomy Surgery)			$0	$15,840
Funding Adjustment 6 ( )			$0	$0
Other Items			$0	$0
Prior Years' Payments			$0	$0
Services: Schedule D				
Cardiac catherization			$0	$0
Cardiac surgery			$0	$0
Organ Transplantation			$0	$0
Strategies: Schedule D				
Endovascular aortic aneurysm repair			$0	$0
Electrophysiology studies EPS/ablation			$0	$0
Percutaneous coronary intervention (PCI)			$0	$0
Implantable cardiac defibrillators (ICD)			$0	$0
Newborn screening program			$0	$0
Specialized Hospital Services: Schedule D	Vol	Rate		
Magnetic Resonance Imaging			$0	$0
Provincial Regional Genetic Services 2			$0	$0
Permanent Cardiac Pacemaker Services			$0	$0
Provincial Resources				
Stem Cell Transplant			$0	$0
Adult Interventional Cardiology for Congenital Heart Defects			$0	$0
Cardiac Laser Lead Removals			$0	$0
Pulmonary Thromboendarterectomy Services			$0	$0
Thoracoabdominal Aortic Aneurysm Repairs (TAA)			$0	$0
Other Results (Wait Time Strategy):				
Selected Cardiac Services			$0	$0
Hip Replacements - Revisions	1	$8,796	$0	$8,796
Knee Replacements - Revisions	1	$8,796	$0	$8,796
Magnetic Resonance Imaging (MRI)			$0	$0
Computed Tomography (CT)	71	$250	$0	$17,750
Quality-Based Procedures: Schedule D Planning Allocation	Vol	Rate		
Primary Hips	40	$7,071	$304,861	$0
Primary knee	65	$6,254	$446,601	$0
Cataract			$0	$0
Inpatient rehab for primary hip			$0	$0
Inpatient rehab for primary knee			$0	$0
Chronic Kidney Disease - per Ont.Renal Net. Funding Allocation			$522,916	$0
Subtotal			**$32,625,639**	**$51,182**
Total Base and One-time Hospital Funding			**$32,676,821**	

Note 1: Includes lines previously in Schedules G and H (Cardiac Rehabilitation, Visudyne Therapy, Regional Trauma, Regional and district Stroke Centres, Sexual Assault/Domestic Violence Treatment Centres, HIV Outpatient clinics). See HAPS Guidelines for additional information.

Reference to Schedules D and F means (2012 - 2013) unless otherwise stated

Service Volumes

Hospital: COLLINGWOOD GENERAL & MARINE HOSPITAL
Facility #: 640

Schedule D: (2012-2013)

Part I- GLOBAL VOLUMES Refer to 2012-13 H-SAA Indicator Technical Specification Document for further Details	Measurement Unit	2012/13 Performance Standard	2012/13 Performance Target
Emergency Department Weighted Cases	Weighted Cases	>= 1174 and <= 1434	1,304
Complex Continuing Care	Weighted Patient Days		
Total Acute Inpatient	Weighted Cases	>= 4140 and <= 5060	4,600
Day Surgery	Weighted Visits	>= 553 and <= 748	650
Mental Health Inpatient	Weighted Patient Days		
Rehab Inpatient	Weighted Cases		
Elderly Capital Assistance Program (ELDCAP)	Inpatient Days		
Ambulatory Care	Visits	16,800	22,400

Part II- WAIT TIME VOLUMES (Formerly Schedule H) Note 1	Measurement Unit	2012/13 Base	2012/13 Incremental
Cardiac Surgery -CABG	Cases	0	0
Cardiac Surgery -Other Open Heart	Cases	0	0
Cardiac Surgery -Valve	Cases	0	0
Cardiac Surgery -Valve/CABG	Cases	0	0
Paediatric Surgery	Cases	0	0
General Surgery	Cases	41	15
Hip Replacement - Revisions	Cases	0	1
Knee Replacements - Revisions	Cases	0	1
Magnetic Resonance Imaging (MRI)	Total Hours	0	0
Computed Tomography (CT)	Total Hours	2,000	71

Part III- Services & Strategies (Formerly Schedule G)	Measurement Unit	2012/13 Base	2012/13 Incremental
Catherization	Cases	0	0
Angioplasty	Cases	0	0
Other Cardiac (Note 2)	Cases	0	0
Organ Transplantation (Note 3)	Cases	0	0
Neurosurgery (Note 4)	Cases	0	0
Bariatric Surgery	TBD	0	0

Part IV- Quality Based Procedures (formerly in wait times program Schedule H) Note 5	Measurement Unit	
Primary hip	Volumes	40
Primary knee	Volumes	65
Cataract	Volumes	0
Inpatient rehab for primary hip	Volumes	0
Inpatient rehab for primary knee	Volumes	0
Chronic Kidney Disease (as per Ontario Renal Network Allocation Schedule)	Volumes	0

Note 1- Reflect wait time procedure volumes, both base and incremental at 2011/2012 levels unless otherwise directed by your LHIN.

Note 2- Cardiac Services are LHIN managed (Protected Services) including: Implantable Cardic Defibrilators (ICD), electrophysiology studies (EPS), Ablations, Ablations with advance mapping, Pacemakers, Drug Eluting Stents (DES), Cardiac surgery (CABG, valve, other open heart, valve+CABG), Angioplasty, and Cardiac Catheterization.

Note3- Organ Transplantation - Funding for living donation (kidney & liver) is 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.

Note4- includes neuromodulation, coil embolization, and emergency neurosurgery cases.

Note 5- Under Health system Funding Reform (HSFR), for each quality-based procedure, the volumes are determined as a single figure for the year. Previously, under Wait Time program they were identified as base and incremental.

Hospital Performance Indicators*

Hospital: COLLINGWOOD GENERAL & MARINE HOSPITAL
Facility #: 640

Schedule E: (2012-2013)

Accountability Indicators	Measurement Unit	2012/13 Performance Standard	2012/13 Performance Target
Part I - PERSON EXPERIENCE: Access, Effective, Safe, Person-Centered			
90th Percentile ER LOS for Admitted Patients	Hours	26.6 - 29.3	26.6
90th Percentile ER LOS for Non-admitted Complex (CTAS I-III) Patients	Hours	6.3 - 6.8	6.3
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated (CTAS IV-V) Patients	Hours	3.9 - 4.0	3.9
90th Percentile Wait Times for Cancer Surgery	Days		
90th Percentile Wait Times for Cardiac Bypass Surgery	Days		
90th Percentile Wait Times for Cataract Surgery	Days		
90th Percentile Wait Times for Joint Replacement (Hip)	Days	182 to 200	182
90th Percentile Wait Times for Joint Replacement (Knee)	Days	182 to 200	182
90th Percentile Wait Times for Diagnostic MRI Scan	Days		
90th Percentile Wait Times for Diagnostic CT Scan	Days	28 to 31	28
Cases of Ventilator-associated Pneumonia	Cases/Days		0
Central Line Infection Rate	Cases/Days		0
Rate of Hospital Acquired Cases of Clostridium Difficile Infections	Cases/Days		0
Rate of Hospital Acquired Cases of Vancomycin Resistant Enterococcus Bacteremia	Cases/Days		0
Rate of Hospital Acquired Cases of Methicillin Resistant Staphylococcus Aureus Bacteremia	Cases/Days		0
Part II - ORGANIZATIONAL HEALTH: Efficient, Appropriately Resourced, Employee Experience, Governance			
Current Ratio (Consolidated)	Ratio	0.228 - 0.252	0.24
Total Margin (Consolidated)	Percentage	>= -5.7%	(5.7%)
Part III - SYSTEM PERSPECTIVE: Integration, Community Engagement, eHealth			
Percentage ALC Days (closed cases)	Percentage	0.0%	15.4%
Part IV - LHIN Specific Indicators and Performance targets, see Schedule E1 (2012-2013)			

Explanatory Indicators	Measurement Unit
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
Hospital Standardized Mortality Ratio	Percentage
Readmission within 30 days for Selected CMGs	Ratio
Total Margin (Hospital Sector Only)	Percentage
Percentage Full Time Nurses	Percentage
Percentage Paid Sick Time	Percentage
Percentage Paid Overtime	Percentage
Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions	Visits
Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions	Visits

***Refer to 2012-13 H-SAA Indicator Technical Specification document for further details.**

Hospital: Collingwood General and Marine Hospital
Facility #: 640

1.0 LHIN-Specific Indicators, Performance Targets and Standards

1.1 PERFORMANCE OBLIGATIONS

Care Connections Participation

Health Service Providers are required to collaborate with system partners to support the development of an integrated system of health services that provides person-centred, timely, equitable access, high quality, evidence-based services in an efficient, effective and sustainable manner (referred to as "Care Connections").

HOSPITAL SPECIFIC: As a lead organization accountable for the achievement of agreed upon deliverables associated with the SURGERY COORDINATING COUNCIL as part of the Care Connections vision, the Hospital will ensure that:

- The CEO (or a LHIN-approved Senior Executive delegate) is assigned to act as Chair of the Coordinating Council for the above initiative
- Participate and collaborate as a member of an oversight council ("referred to as the "Leadership Council") to implement such recommendations as are agreed to by the Leadership Council.
- The hospital understands that as a partner in the local health system, it has an ongoing obligation to participate in the work and initiatives of the Enabling Councils (Communications, ICT/eHealth, Integrated Health Human Resources, Transportation, System Navigation and Governance), to the extent that it is able without impacting its capacity to meet its other obligations under this agreement. Such initiatives include, but are not limited to:

    - Identification of enabling Council project leads and/or project champions
    - Participation in regional/provincial planning and implementation groups
    - Specific obligations as may be specified as a condition of participation in enabling Council initiatives (Project Charter)

Risk Management

HSP Boards must ensure that an established and documented Risk Management Process is in place such that significant and major risks are identified and reported promptly to the LHIN and in a manner prescribed by the LHIN. Reporting to the LHIN is required (but is not limited to) when the risk is likely to:

- Impair the achievement of a North Simcoe Muskoka Local Health Integration Network (NSM LHIN) strategic goal, objective or key local priority;
- Result in not achieving a balanced budget;
- Create significant damage to a Health Service Provider's reputation or damage to the NSM LHIN's reputation; or,
- Require intervention in Health Service Provider operations by the NSM LHIN Board of Directors and/or an external body.

- Impact on the achievement of the obligations identified in this Accountability Agreement.

HQO-associated reporting to the LHIN

Pursuant to the *Excellent Care For All Act, 2010*, the hospital will prepare a Quality Improvement Plan (QIP) for submission to Health Quality Ontario (HQO) in a form prescribed by HQO on timelines established by that agency. In addition to meeting this statutory obligation, the hospital agrees:

(i) To provide the LHIN with a draft version of their QIP 30 days prior to its submission to HQO.

(ii) To receive and provide LHIN comments to the hospital's quality committee for consideration when finalizing the plan and in the development of the subsequent year's plan.

(iii) To be prepared to discuss at quarterly performance meetings with the LHIN, the hospital's progress on achieving the targets identified in the QIP

(iv) To submit to the LHIN, 30 days prior to its submission to HQO, its annual report on the achievement of its QIP targets.

.

Client Experience

Hospitals will provide the LHIN with an annual summary of the satisfaction survey results required under section 5 of the Excellent Care for All Act. Acknowledging that client surveys must be conducted each fiscal year while employee/staff satisfaction must be conducted every two fiscal years, the summary will include the most recent fiscal year results of the client and employee satisfaction surveys as follows:

- Total number of patients/family members surveyed for Client Satisfaction
- Total number of patients/family members indicating that the overall care provided was positive
- Total number of staff members surveyed for Staff Satisfaction
- Total number of Staff members indicating Positive Satisfaction

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,
    - The number of falls resulting in harm,
    - The number of falls resulting in ER visits (for those hospitals with ERs), and
    - The number of falls resulting in inpatient admissions (for those hospitals with ERs)
- 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 North Simcoe Muskoka LHIN Guidelines for Wound Care and that data is collected and reported to the LHIN.

1.2 PERFORMANCE INDICATOR REPORTING

INDICATOR TO BE REPORTED	Description	Type	NOTES	Collingwood General and Marine Hospital
Wound Care - Pressure Ulcers Incidence	Total number of discharges in which a new pressure ulcer (stage 2 to 4) occurred.	Accountability	Requirement under Wound Strategy Monitoring as agreed to by LHIN Leadership Council (Proposed 10% reduction)	√
ALC Days	Total number of ALC days	Accountability	Supplements Accountability indicator for Percentage of ALC Days by requiring a reduction of the raw number of ALC days in hospital (Proposed 20% reduction)	√
2-Day ALC Designations	Total number of discharges designated ALC within 2 days of Admission	Accountability	Supplements Accountability indicator for Percentage of ALC Days by requiring a reduction in the number of patients designated ALC within 2 days (Proposed 20% reduction)	√
Total numbers of Falls while in-hospital	Obtained from internal Incident/ occurrence reporting	Explanatory	As part of the Falls Prevention and Reduction Program	√

Hospital Local Reporting Obligations

Schedule E1:

INDICATOR TO BE REPORTED	Description	Type	NOTES	Collingwood General and Marine Hospital
Total numbers of Falls resulting in harm while in hospital (Severity of Harm Scale)	Obtained from internal Incident/ occurrence reporting	Accountability	As part of the Falls Prevention and Reduction Program (MAINTAIN or improve from previous year) – Note: Target to be aligned with HQO Quality Improvement plans *Note: Harm is defined as "temporary or permanent impairment of physical or psychological body function or structure" (Categories 2-6 on the SEVERITY OF HARM SCALE:* ***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)*	√
Fall-related ER Visits	Total numbers of clients visiting a hospital ER due to a fall (W00-W19)	Explanatory	As part of the Falls Prevention and Reduction Program	√

Hospital Local Reporting Obligations

Schedule E1:

INDICATOR TO BE REPORTED	Description	Type	NOTES	Collingwood General and Marine Hospital
Fall-related Hospital Admissions	Total numbers of clients admitted as in inpatient due to a fall (W00-W19)	Explanatory	As part of the Falls Prevention and Reduction Program	√
Total # of Clients Surveyed	Total number of patients/family members surveyed for Client Satisfaction	Explanatory	Forms denominator for Client Experience indicator	√
Clients rating Care as Positive	Total number of patients/family members indicating that the overall care provided was positive	Explanatory	Forms numerator for Client Experience indicator (Positive rating to be defined in collaboration with hospital)	√
Total # of Staff Surveyed	Total number of staff members surveyed for Staff Satisfaction	Explanatory	Forms denominator for Staff Experience indicator	√
Staff rating Organization as Positive	Total number of Staff members indicating Positive Satisfaction	Explanatory	Forms numerator for Staff Experience indicator (Positive rating to be defined in collaboration with hospital)	√

2.0 REPORTING OBLIGATIONS

2.1 The reporting obligations set out in Schedule A - Reporting Obligations, Part 2 - Reporting apply to Fiscal Year 2012/13.

2.2 The following reporting obligations are added to Schedule A – Reporting Obligations, Part 2 - Reporting:

French Language Services

(a) 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.

As such, the hospital identified by the LHIN to provide service in both Official Languages in a designated area under the *French Language Services Act* must implement a plan to do so in order to work towards the designation under the *Act*, and agree to:

(i) Continue the implementation of French Language Services Planning and Implementation with the eventual completion of a FLS Designation plan

(ii) Actively participate in activities designed to support the implementation of their FLS plan, including working with the LHIN to complete the French Language Services Planning and Implementation plan.

(iii) Strike a FLS working group to facilitate the implementation of their FLS plan

(iv) Report to the LHIN on their progress with respect to their FLS plan annually:

- in a format to be provided by the LHIN (2011/12 Q4), or
- in SRI (2012/13 reporting template format on hold pending provincial review).

(b) 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."

2.3 The following e-health compliance requirements are added to Schedule A – Reporting Obligations, Part 2 - Reporting:

E-health:

(a) In support of the Provincial e-Health strategy the Hospital will strive to comply with any technical and information management standards, including those related to architecture, technology, privacy and security, set for the health service providers by the MOHLTC or the LHIN with the timeframes set by the MOHLTC or the LHIN as the case may be. The expectation is that any compliance requirements will be rolled out reasonably and in a manner consistent with the hospital's service mandate. In addition, the level of available resources will be considered in any required implementations.

eHealth-related discussions will take place at the North Simcoe Muskoka LHIN ICT / eHealth Steering Committee and each hospital is required to appoint the most senior staff responsible for eHealth decision-making as a committee member. This committee will make recommendations to the NSM LHIN Leadership Council with respect to:

- *ICT/eHealth Framework,*
- *e-Health Guiding Principles,*
- *Decision-Making Framework, and*
- *development and maintenance of an ICT/eHealth Operational Oversight structure*

(b) The hospital understands that as a partner in the health care system, it has an obligation to participate in e-Health initiatives. Hospital participation is defined as including, but not limited to, the identification of project leads/ champions, participation in regional/ provincial planning and implementation groups, as well as any specific obligations that may be specified in e-Health initiatives.

(c) The hospital understands that under legislation they are required to look for integration opportunities with other health service providers. The hospital agrees that it will incorporate opportunities to collaborate / integrate IT services with other health service providers into their e-Health Strategic Plans. In so doing, they will identify those areas, projects, or initiatives where collaboration is targeted.

(d) In addition, the hospital agrees that, prior to making a material investment in information systems or information technology; the hospital will share the identified need with the ICT / eHealth Council who will review the proposal and make recommendations including highlighting any potential concerns.

(e) The LHIN e-Health Council will evaluate the submission to ensure that the proposed procurement is aligned with the hospital e-Health and/or e-Health Ontario strategic IT/ IS plans, or with the identified best practice standards.

(f) The NSM LHIN ICT e-Health Council will provide feedback and recommendations to the hospital with respect to the submission within 30 days and include in that opinion any recommendations which would strengthen the plan, including but not limited to opportunities for collaboration.

3.0 LHIN SPECIFIC PERFORMANCE OBLIGATIONS

3.1 Except where specifically limited to a given year, the obligations set out in Article 2 of Schedule E1 apply to Fiscal Year 12/13. Without limiting the foregoing, waivers or conditional waivers for 08/09, 09/10, 10/11 and 11/12 do not apply to 12/13.

3.2 The following provisions are added to Article 2 of Schedule E1

(a) The Hospital has advised the LHIN that it anticipates incurring a deficit of no more than $2.7M by March 31, 2013. The Hospital agrees that it will not exceed $2.7M.

(b) Subject to (a) the LHIN will waive the requirements of Article 6.1.3 Balanced Budget of the H-SAA from April 1, 2012 to March 31, 2013 provided that:

(i) the Hospital develops an improvement plan (the "HIP") that will enable the Hospital to achieve a balanced operating position no later than March 31, 2014;

(ii) the hospital board approved HIP is delivered to the LHIN within 6 weeks of the formal notice of the Hospital's 2012/13 funding allocation;

(iii) the HIP is acceptable to the LHIN;

(iv) the Hospital implements the HIP as directed by the LHIN; and

(v) the Hospital will report at any time if it is determined that their projected deficit for 2012/13 is greater than $2.7M. The report will contain explanations for the variance and recovery plan.

Post-Construction Operating Plan Funding and Volume

Hospital: COLLINGWOOD GENERAL & MARINE HOSPITAL
Facility #: 640

Schedule F: (2012-2013)

	2012/13							
		2012/13 Received from LHIN			2012/13 Hospital Plan		
	Total Approved Volume	Funding Rate	2012/13 Additional Volumes	Funding[1]	Additional Volumes	New Beds	Funding
Inpatient Acute - Medicine/Surgery	0	$0	0	$0	0	0	$0
Inpatient Acute -Obstetrics	0	$0	0	$0	0	0	$0
Inpatient Acute - ICU	0	$0	0	$0	0	0	$0
Inpatient Rehabilitation General	0	$0	0	$0	0	0	$0
Inpatient Complex Continuing Care	0	$0	0	$0	0	0	$0
Inpatient Acute - Mental Health	0	$0	0	$0	0	0	$0
Day Surgery	0	$0	0	$0	0	0	$0
Endoscopy (cases)	0	$0	0	$0	0	0	$0
Emergency	0	$0	0	$0	0	0	$0
Amb Care - Acute Mental Health	0	$0	0	$0	0	0	$0
Amb Care - Diabetes	0	$0	0	$0	0	0	$0
Amb Care - Palliative	0	$0	0	$0	0	0	$0
Clinic - Med/Surg	0	$0	0	$0	0	0	$0
Clinic - Metabolic	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Facility Costs		$0	0	$0	0	0	$0
Amortization		$0	0	$0		0	$0
Total Funding				**$0** [2]			**$0**

Note 1 - Terms and conditions of PCOP funding are determined by the Ministry of Health and Long Term care (MOHLTC). Incremental volumes required to be achieved by the Hospital as set out above are in addition to PCOP volumes provided in previous years. The MOHLTC may adjust funded volumes upon reconcilation.

Note 2 - This amount must be the same as PCOP (Operating Base Funding) on Schedule C (2012 - 2013).

Once negotiated, an amendment (Schedule F1 (2012 - 2013) will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in any other Schedule.