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:

HAMILTON NIAGARA HALDIMAND BRANT
LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

NORFOLK 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 E-2 shall be deleted and replaced with Schedule E-2 attached to this Agreement.

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

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

(g) 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, E-2, F-2, G-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.

HAMILTON NIAGARA HALDIMAND BRANT LOCAL HEALTH INTEGRATION NETWORK

By:

Michael Shea, Board Chair — Date: Nov. 4, 2011

And by:

Donna Cripps, Chief Executive Officer — Date: Nov. 4, 2011

NORFOLK GENERAL HOSPITAL

By:

Peter Hellyer, Board Chair — Date: Oct 26/2011

And by:

Kelly Isfan, President and Chief Executive Officer — Date: October 24 2011

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) 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 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) 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 90th 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 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) LHIN Target

(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) 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) **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) 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) **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) <u>LHIN Target</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: the LHIN's Accountability Agreement target or better

(iii) <u>Performance Corridor</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%

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 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 The following provisions are added to Article 9 of Schedule B

(a) **ACUTE ALTERNATIVE LEVEL OF CARE (ALC)**

Definition:
Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.

Indicator Calculation:

$$\frac{\text{Total number of acute inpatient days designated as ALC in a given time period}}{\text{Total number of acute inpatient days in a given time period}} \times 100$$

Hospitals are required to report on this indicator quarterly using the Quarterly Report on WERS

Exclusion Criteria
Newborns, stillborns and records with missing or invalid discharge dates are not included

LHIN Target:
Hospitals are to reduce their acute ALC rate to 11% or less by March 31 2012

(b) **HOSPITAL STANDARDIZED MORTALITY RATIO (HSMR) INDICATOR**

Definition:
The ratio of the actual number of acute in-hospital deaths to the expected number of in-hospital deaths for conditions accounting for 80% of in-patient mortality as reported by the Canadian Institute for Health Information (CIHI).

Hospitals are required to report on these indicators quarterly using the Quarterly Report on WERS. Reports are sent to hospitals by CIHI quarterly.

LHIN Target:
HSMR will be lower than reported previously or in line with the provincial average. Hospitals are expected to review practice if there is a rise in monitoring indicators.

Multi-site hospitals must report by site

CIHI Reported HSMR
• HSMR
• Medical HSMR
• Surgical HSMR
• ICU-Related HSMR
• HSMR excl transfers

(c) **HNHB LHIN CLINICAL SERVICE PLAN (CSP)**

Implement and provide leadership for year 1 & 2 of the CSP objectives as appropriate for your organization. Implementation of CSP initiatives should be a standing item for semi-annual reporting to the hospital's Board of Directors

LHIN Target

Provide the LHIN with the hospital's semi-annual report to the Board on HNHB LHIN Clinical Service Plan implementation status.

(d) **ALTERNATE LEVEL OF CARE (ALC) DESIGNATION GREATER THAN OR EQUAL TO FORTY (40) DAYS**

All patients who have been designated as waiting for an ALC for forty (40) days or more must undergo an intensive case management review, and in conjunction with the Hamilton Niagara Haldimand Brant Community Care Access Centre (CCAC) develop a discharge plan that is to be included in the patient's chart. The discharge plan must be reviewed and updated on a weekly basis.

(e) **SUPPORT THE LHIN TO REDUCE THE ALC RATE THROUGH INCREASED COLLABORATION**

The Hospital will work with the HNHB CCAC to develop appropriate agreements that will support the CCAC to proactively identify hospital patients who will need community support to return home from hospital.

Hospital Multi-Year Funding Allocation

Schedule C2 2011/12 - October 2011

Hospital Norfolk General Hospital

Fac # 804

	2011/12 Allocation	
	Base	One-Time
Operating Base Funding	$32,737,900	
Multi-Year Funding Incremental Adjustment	540,100	
Other Funding		
Funding adjustment 1 (General Surgery)		$27,600
Funding adjustment 2 (AAH - Slow Stream Rehab)		565,497
Funding adjustment 3 (Chronic Care)		3,200
Funding adjustment 4 (Critical Care Nurses Training)		18,000
Funding Adjustment 5 ( )		
Funding Adjustment 6 ( )		
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)		$12,000
Total Additional Base and One Time Funding	$540,100	$626,297
Total Allocation	$33,904,297	

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 - October 2011

Hospital Norfolk General Hospital

Fac # 804

	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	16.80	15.1-18.5
90th Percentile ER LOS for Non-admitted Complex Patients	Hours	7.50	≤ 7.5
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated Patients	Hours	4.50	≤ 4.5
Explanatory Indicators			
Emergency Department Activity	Weighted Cases		
Emergency Department Visits	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	0.24	0.22-0.26
Total Margin (Consolidated)	Percentage	0%	≥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	Visits		
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	6,150	>5658
Complex Continuing Care	RUG Weighted Patient Days	4,500	>3825
Mental Health	Inpatient Days	0	0
ELDCAP	Inpatient Days	0	0
Rehabilitation	Inpatient Days	0	0
Ambulatory Care***	Visits	17,500	>13125

* 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*)

Note:
1) LHIN Specific - there is no corridor for ER LOS indicator for the non admitted complex and minor uncomplicated indicators
2) Targets for the admitted ER LOS indicator was calculated based on ER LOS data for the period January - December 2010. A weighted methodology was applied to arrive at a target for each hospital that represented the highest end of a 10% corridor. For hospitals with targets that are less than 8 hours the corridor is < 8 hours.

Critical Care Funding

Schedule E2 2011/12 - October 2011

Hospital Norfolk General 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- October 2011

Hospital Norfolk General 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 - October 2011

Hospital Norfolk General Hospital

Fac # 804

	Units of Service	2011/12 Performance Target	2011/12 Performance Standard
Stable Priority Services			
Chronic Kidney Disease	Weighted Units	NA	NA
Cardiac catherization	Procedures	NA	NA
Cardiac surgery	Weighted Cases	NA	NA
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	NA	NA
Specialized Hospital Services			
Cardiac Rehabilitation	Number of patients treated	NA	NA
Visudyne Therapy	Number of insured Visudyne vials administered	NA	NA
Total Hip and Knee Joint Replacements (Non-WTS)	Number of Implant Devices	NA	NA
Magnetic Resonance Imaging	Hours of operation	NA	NA
Regional Trauma	Cases	NA	NA
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

Schedule H2 2011/12 - October 2011

Hospital Norfolk General Hospital

Fac # 804

	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)	NA	NA	NA	NA
Cataract Surgeries (Total Procedures)	457	NA	457	0
Magnetic Resonance Imaging (MRI) (Total Hours)	NA	NA	NA	NA
Computed Tomography (CT) (Total Hours)	1,976	125	1,976	48

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
90th Percentile Wait Times for Cancer Surgery	Days	NA	NA
90th Percentile Wait Times for Cardiac Surgery	Days	NA	NA
90th Percentile Wait Times for Cataract Surgery	Days	120	≤120
90th Percentile Wait Times for Hip Replacement Surgery	Days	NA	NA
90th Percentile Wait Times for Knee Replacement Surgery	Days	NA	NA
90th Percentile Wait Times for MRI Scan	Days	NA	NA
90th Percentile Wait Times for CT Scan	Days	25	≤ 25

* 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.

Note:

1) The target identified for the wait time indicators is the LHIN's 2010-11 MLPA target or the 90th percentile wait time your organization reported for the period April - December 2010 if your reported wait time for this period is lower than the LHIN's MLPA target. (Exception cardiac surgery target is the LHIN's 2010-11 MLPA target)

2) LHIN Specific corridor for wait time services where the current performance is less than or equal to the LHIN MLPA target is to maintain or improve current wait time target for that service.