

**HOSPITAL SERVICE ACCOUNTABILITY
AMENDING AGREEMENT #2**

THE AMENDING AGREEMENT effective as of the 1st day of April, 2011

B E T W E E N:

NORTH WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

- and -

MANITOUWADGE GENERAL HOSPITAL (the "HSP")

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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 WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

MANITOUWADGE 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.

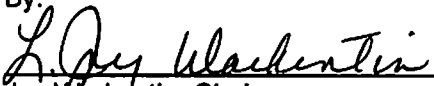
- (a) Schedules B-2 shall be deleted and replaced with Schedule B2 attached to this Agreement
- (b) Schedules C-2 shall be deleted and replaced with Schedule C2 attached to this Agreement.
- (c) Schedules D-2 shall be deleted and replaced with Schedule D2 attached to this Agreement.

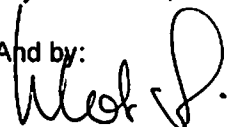
3.0 Effective Date. The Parties agree that the amendments set out in Article 2 shall take effect on April 1, 2011. All other terms of the H-SAA, those provisions in the Schedules not amended by s. 2.2, above, shall remain in full force and effect.

- 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 B2, C2 and D2 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.

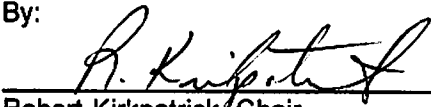
IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

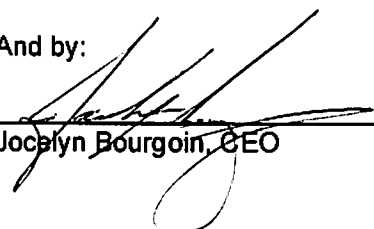
NORTH WEST LOCAL HEALTH INTEGRATION NETWORK

By:  November 16, 2011
 Joy Warkentin, Chair Date

And by:  November 16, 2011
 Laura Kokocinski, CEO Date

MANITOUWADGE GENERAL HOSPITAL

By:  OCTOBER 25, 2011
 Robert Kirkpatrick, Chair Date

And by:  OCTOBER 25, 2011
 Jocelyn Bourgoin, CEO Date

Amended 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 Emergency Room (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 Emergency Room (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:
Performance Target: maintain or improve current performance
- (ii) For hospitals performing above the LHIN's Accountability Agreement target:
Performance Target: To be negotiated locally taking into consideration contribution to the LHIN's Accountability Agreement target

c) Performance Corridor

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

and

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

3.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO NURSING ENHANCEMENT/CONVERSION

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

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

4.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO CRITICAL CARE

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

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

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

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

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

6.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO PROTECTED SERVICES

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

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

7.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO WAIT TIME SERVICES

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

- (a) Sub article 7.2 shall be amended with the addition of the following seven 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 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: 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%

(d) 90th Percentile Wait Times for Cardiac Bypass Surgery

- (i) Definition. 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 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%

(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.

9.0 LHM 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 Subsection 9.2(c), (d) & (e) of Schedule B-1 shall be deleted.
- 9.3 The following provisions are added to Article 9 of Schedule B
- (a) The Hospital will implement the strategies identified in the Hospital Improvement Plan (HIP) submitted by the Hospital to the North West LHM on September 28, 2011.
 - (b) To minimize risks to the North West health system, the HSP will develop a disaster plan that includes the North West LHM in that plan.
 - (c) To contribute to an improved health system, the HSP will align their strategic and operating activities with, and proactively adopt the North West LHM's "Home First" philosophy. As requested by the North West LHM, the HSP will collaborate with stakeholders with planning, implementation and reporting related to adoption of the Home First philosophy.
 - (d) To improve access to the North West LHM health system, the HSP will participate in the development and implementation of the North West LHM's Diversity Planning Framework and related performance indicators.
 - (e) To improve access and patient flow within the North West health system, the HSP will actively participate in (and implement) the Seniors Friendly Hospital Initiative.
 - (f) To contribute to an improved health system throughout the North West LHM, the HSP will address chronic disease prevention and management in its' strategic and operating plans.
 - (g) The HSP will submit the Quality Improvement Plan (QIP) produced under the *Excellent Care For All Act* (ECFAA) to the North West LHM annually (which will include local performance indicators such as client experience, etc).
 - (h) The HSP will participate in and contribute to the development and implementation of a single harmonized North West LHM eHealth Strategic Plan and subsequent iterations of that plan.
 - (i) The HSP will ensure that any Information Technology/Information System implementations material to provincial (eHealth Ontario) and local (North West LHM) eHealth Strategic and Tactical Plans will be aligned with and contribute to the advancement of these plans.
 - (j) To improve ALC pressures, to improve client flow for Long Term Care placement into Eldcap units, and to align with the North West LHM's Long-Term Care Home Service Accountability Agreements (L-SAAs), the HSP will work with the North West LTC Homes, North West CCAC and the North West LHM to:
 - i. Establish and/or confirm definitions and data sources for monitoring indicators included in the current L-SAAs (see chart below);

- ii. Establish reasonable targeted timelines for monitoring indicators included in the current L-SAAs (see chart below); and
- iii. Establish a mutual date to begin tracking (all monitoring indicators) included in the current L-SAAs (see chart below).

By May 31st following each fiscal year of this agreement, the HSP will report their activity for the immediately preceding fiscal year ending March 31st, related to the monitoring indicators described below.

	Monitoring Indicator Description	Targeted Timelines
1	# of clients accepted or declined by the LTC Home/Eldcap unit for the waitlist, outside the timelines set out in the Act and Regulations	To be determined
2	# of times when the LTC Home/Eldcap unit notifies the CCAC of a bed vacancy, outside the timelines set out in the Act and Regulations	To be determined
3	# of times when the LTC Home/Eldcap unit notifies the CCAC of their decision to accept or decline a client for placement, outside the targeted timelines established for the North West LHIN, upon receiving the client name from the CCAC	To be determined
4	# of times when the LTC Home/Eldcap unit admits a client from hospital, outside the targeted timelines established for the North West LHIN, starting from the time the Home accepts the client	To be determined
5	# of times when the LTC Home/Eldcap unit admits a client from community, outside of the targeted timelines established for the North West LHIN, starting from the time the LTC Home/Eldcap unit accepts the client	To be determined
6	Average number of days a bed available for occupancy remains unoccupied after the date on which the LTC Home/Eldcap unit has indicated it will be ready for occupancy	Not applicable
7	# of times the LTC Home/Eldcap unit refuses to admit an authorized or matched admission	Not applicable

Note – This Schedule B2 was amended October 21, 2011 to remove and/or amend the 2011/12 balanced budget waiver clause(s) in Section 9.3.

Hospital Multi-Year Funding Allocation

Amended Sch C2 2011/12

Hospital	2011/12 Funding Allocation (Note 1)	
	Base	One-Time
Manitouwadge General Hospital		
Fac # 719		
Operating Base Funding	4,492,000	0
Multi-Year Funding Incremental Adjustment	65,400	
Other Funding		
Excellent Care For All Act Implementation Funding		16,100
Grant in Lieu of taxes		1,350
Small Hospital Funding adjustment	19,000	
Nursing Positions to support telemedicine (1.0 RN FTE)	53,138	
Funding Adjustment 5 (Incontinence Supplies)		
Funding Adjustment 6 ()		
Other Items		
Prior Years' Payments		
Critical Care Strategies Schedule E		
PCOP: Schedule F		
PCOP		
Stable Priority Services: Schedule G		
Chronic Kidney Disease		
Cardiac catheterization		
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		
Hemophilic 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)		
Total Additional Base and One Time Funding	137,538	17,450
Total Allocation	4,629,538	17,450

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.

Note 1 - Amended Sept 23, 2011 for base funding increase for 1.0 FTE RN nursing resources to support telemedicine (\$53,138 annualized to \$85,021)
 Amended October 21, 2011 for base funding adjustments (\$65,400 + \$19,000 small hospital increase)

Performance Indicators

Amended Sch D2 2011/12

Hospital Manitowadge General Hospital

Fac # 719

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
PERSON EXPERIENCE: Access, Safe, Effective, Person-Centred		(Note 1)	(Note 1)
Accountability Indicators			
90th Percentile ER LOS for Admitted Patients	Hours	12.9	14.2
90th Percentile ER LOS for Non-admitted Complex Patients	Hours	8.9	9.8
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated Patients	Hours	3.2	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	2.29	0.80 - 2.00
Total Margin (Consolidated)	Percentage	1.93%	0.00%
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			
Accountability Indicators			
Percentage ALC Days	Percentage	25.9%	<25.9%
Repeat Unplanned Emergency Visits within 30 days for Mental Health Conditions	Percentage	17.0%	<17.0%
Repeat Unplanned Emergency Visits within 30 days for Substance Abuse Conditions	Percentage	27.1%	<27.1%
Readmission Rates within 30 Days for Selected CMGs - the Hospital will contribute to the achievement of the North West LHIN target of:	Percentage	12.8%	< 12.8%
GLOBAL VOLUMES			
Accountability Indicators			
Total Acute Activity, incl. Inpatient and Day Surgery*	Weighted Cases	280	210.00 - 350.00
Complex Continuing Care	RUG Weighted Patient Days	0	> 0.00
Mental Health	Inpatient Days	0	> 0.00
ELDCAP	Inpatient Days	3,253	> 3,188
Rehabilitation	Inpatient Days	0	> 0.00
Ambulatory Care***	Visits	0	> 0.00

* 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 - Amended October 21, 2011 to reflect approved changes submitted in HAPS, inclusion of hospital specific targets for ER LOS targets, and inclusion of NW LHIN specific targets for Readmission rates for CMGs