

AMENDING AGREEMENT

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

B E T W E E N:

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

[Deep River and District Hospital Corporation] (the "Hospital")

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

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

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

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

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

2.0 Amendments.

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

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

2.3 Definitions.

(a) The following new definition will be added:

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

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



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

(c) The terms "Performance Indicator" and "Performance Indicators" shall be deleted and replaced with "Accountability Indicator" and "Accountability Indicators" respectively.

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

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

2.6 Schedules.

- (a) Schedule A shall be supplemented with the addition of Schedule A-1 attached to this Agreement.
- (b) Schedules B and B-1 shall be supplemented with the addition of Schedule B-2 attached to this Agreement.
- (c) Schedules C and C-1 shall be supplemented with the addition of Schedule C-2 attached to this agreement.
- (d) Schedules D and D-1 shall be supplemented with the addition of Schedule D-2 attached to this agreement.
- (e) Schedules E and E-1 shall be supplemented with the addition of Schedule E-2 attached to this agreement.
- (f) Schedules F and F-1 shall be supplemented with the addition of Schedule F-2 attached to this agreement.
- (g) Schedules G and G-1 shall be supplemented with the addition of Schedule G-2 attached to this agreement.
- (h) Schedules H and H-1 shall be supplemented with the addition of Schedule H-2 attached to this agreement.

2.7 Renegotiation of Schedules. The Parties agree that it is their intention to negotiate and to further amend the Schedules following the announcement of funding allocations by the Ministry of Health and Long-Term Care.

3.0 **Effective Date**. The Parties agree that the amendments set out in Article 2 shall take effect on April 1, 2011. All other terms of the H-SAA, including but not limited to current funding levels and those provisions in Schedule A to H not amended by s. 2.6 above, shall remain in full force and effect.



- 4.0 Governing Law.** This Agreement and the rights, obligations and relations of the Parties will be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable therein.
- 5.0 Counterparts.** This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.
- 6.0 Entire Agreement.** This Agreement together with Schedules A-1, 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.

CHAMPLAIN LOCAL HEALTH INTEGRATION NETWORK

By:

Dr. Wilbert Keon, Chair

Date

And by:

Mr. Alex Munter, CEO

Date

Deep River and District Hospital Corporation

By:

[Signature]

Mr. Paul Fehrenbach, Chair

March 30/11

Date

And by:

[Signature]

Mr Larry Schruder, CEO

March 30/11

Date

[Handwritten initials]

ii) LHIN Target

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

(iii) Performance Corridor

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

and

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

8.0 REPORTING OBLIGATIONS

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

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

(a) Smoking Cessation Programs

The hospital will work towards a goal to ensure that the Ottawa Model of Smoking Cessation is provided to hospital and reaches 80% of inpatient smokers by March 31, 2013. The hospital will expand the Ottawa Model for Smoking Cessation program to improve baseline reach by 25% by March 31, 2012. [Reach = individuals screened as a percentage of the prevalence of inpatient smokers];

(b) Eastern Ontario Regional Laboratory Association (EORLA)

The Hospital acknowledges that the EORLA and its member hospitals, including the Hospital, have agreed to continue with a transitional management arrangement as an interim step to achieving the full implementation of the integrated, regional laboratory system. To this end the Hospital agrees that it will renew such agreements with EORLA and EORLA's member hospitals as are reasonably required to give effect to the transitional management arrangement.

The transitional management arrangement will be extended for the 2011/12 fiscal year and will provide that:



- i) the planning for and provision of laboratory services for the Hospital will be jointly managed by the Hospital's executive lead with laboratory portfolio responsibility and EORLA Senior Management;
- ii) the Hospital's laboratory medical director will be ultimately responsible/accountable for the provision of laboratory services to the Hospital and working with EORLA Senior Management, will be responsible for ensuring that the laboratory needs of the Hospital's clinical programs are met;
- iii) the Hospital's senior laboratory manager will report to both the Hospital's executive lead with laboratory portfolio responsibility and to EORLA's Senior Management. In this regard, the Hospital's senior laboratory manager will attend regularly scheduled EORLA operations meetings to participate in the planning for and lead the implementation of the delivery of laboratory services as part of the implementation of the integrated, regional laboratory system
- iv) all significant changes of the Hospitals laboratory services will be approved by the Hospital and EORLA on the advice of the Hospital's laboratory medical director as well as in consultation with Senior Management of both EORLA and Champlain Local Health Integration Network. Significant changes will involve EORLA's Discipline Specific Working Groups (DSWG)
- v) the Hospital is responsible for all laboratory operating and capital requirements, as well as all ancillary services currently provided in support of the Hospital laboratory. EORLA Senior Management will work with the Hospital executive lead for laboratory to manage service levels, quality and cost of the Hospital's laboratory activities
- vi) the Hospital laboratory cost increases related to factors such as volume increases, changes in clinical programs delivered in the Hospital, Hospital negotiated/determined compensation increases will be the responsibility of the Hospital.
- vii) this transitional management agreement will be in effect for the term of this HSAA or until the implementation of the EORLA model is defined and negotiated with the Hospital;
- viii) the EORLA Board of Directors will continue as the governing body of EORLA
- ix) the conditions of funding provided by the Ministry of Health and Long Term Care and Champlain LHIN to further support the establishment and operation of EORLA as a sustainable, regional hospital laboratory system be met. Accordingly, the hospital agrees to:
 1. Work with EORLA to finalize a Membership Agreement by March 31, 2012;
 2. Work with EORLA to finalize a Service Level Agreement for the purchase of the laboratory services by March 31, 2012;
 3. Work with EORLA in cooperation with The Province towards implementing the Ontario Laboratory Information System (OLIS) across all hospital sites;
 4. Work with EORLA to identify and protect actual laboratory expenditures for 2010/11. This amount plus inflationary increases or changes in funding associated with program changes/Post

Construction Operating Plans will be the baseline contribution to EORLA;

5. Work with EORLA to identify actual laboratory related capital expenditures for 2009/10 and 2010/11, planned capital expenditures for 2011/12 and an inventory of laboratory capital equipment/capital and operating equipment leases. This information is considered the basis for EORLA and the Hospitals developing a 5 year capital plan;
6. Work with EORLA to develop and implement a standard approach to laboratory testing and quality assurance throughout the Champlain LHIN; and
7. Work with EORLA and support the implementation roll-out of the "Regional Laboratory Information System (LIS) and Anatomic Pathology Information System (APIS) as per the signed 2010 Memorandum of Understanding" which describes how the parties intend to work together to move from the current utilization of locally-based LIS and APIS to an integrated regional LIS and APIS shared_services_solution.

(c) Regional Health Services Planning

Hospitals will participate in regional health services planning as requested by the LHIN. Hospitals will also implement LHIN-approved plans and will align their services with regional programs such as, but not limited to, Maternal Newborn, Palliative, EORLA, Diabetes and Eastern Counties

(d) Integrated Health Services Plan (IHSP)

All hospitals will ensure that their strategic plans are aligned with the LHIN's 2010/13 IHSP

(e) French Language Services (FLS)

If the Hospital is required to provide services to the public in French under the provision of the *French Language Services Act (1986)*, the Hospital will be required to submit a French language implementation report to the LHIN. If the Hospital is not required to provide services to the public in French under the provision of the *French Language Services Act (1986)*, it will be required to provide a report to the LHIN that outlines how the Hospital addresses the needs of its local Francophone community.

(f) Cultural/Linguistic Dimension

HSPs will support the development and implementation of a Champlain LHIN Plan to capture information on the Francophone and Aboriginal clients/patients

(g) Information Systems

- i) The Hospital will work as part of the initiative to establish a standard for an Emergency Department Information System for the Champlain LHIN Hospitals. In addition, it will agree to abide by the standard when developing plans to implement, update, or replace its Emergency Department Information System. The standard will include a strategy to address those hospitals that have chosen to adopt either a "best of breed" or an integrated solution;
- ii) The hospital understands that as a partner in the health care system, it has an obligation to participate in e-Health initiatives. Hospitals

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;

iii) 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 eHealth Strategic Plans. In so doing, they will identify those areas, projects, or initiatives where collaboration is targeted. In addition, the hospital agrees that, prior to making a material investment in information systems or information technology; the hospital will share the product specifications and identified need with the LHIN E-Health Lead. The LHIN E-Health Lead will evaluate the submission to ensure that the purchase is aligned with any strategic IT/ IS plans, or with the identified best practice standards within the LHIN. The LHIN E-Health Lead will advise the hospital of his opinion on how the submission supports a LHIN-wide IT/ IS approach within 30 days and include in that opinion any recommendations which would strengthen the integration of IT/ IS connectivity within the LHIN. Should the hospital disagree with these recommendations, the hospital is required to advise its LHIN specialist and provide their rationale for proceeding as originally planned. The LHIN consultant will review the submission, and may agree with the hospital, or refer the question to the LHIN senior directors for direction. Further dispute resolution will be subject to the terms of this agreement. Any recommendations, in the opinion of the LHIN E-Health Lead, that support electronic data interchange compatibility and supports users' ease of use are to be incorporated into the hospital's purchase and implementation plans. Finally, the hospital's procurement person or department will affirm that collaboration has been sought prior to allowing any material investment in information systems or information technology to proceed

(h) Senior Friendly

Hospitals will utilize findings of the Senior Friendly self-assessment to develop quality improvement plans in line with best practices

(i) Alternative Level of Care (ALC)

i) Each hospital will report quarterly to the LHIN the number of ALC patients referred to CCAC for assessment and discharge planning, excluding those clients waiting for rehabilitation services, complex continuing care and palliative care not at home. The target for 2011-12 is 100%.

ii) For hospitals whose percentage of ALC days are above the LHIN's MLPA target, the hospital will develop a plan in conjunction with the LHIN to achieve the region's MLPA goal of % ALC days. The Champlain LHIN MLPA target will be provided on an annual basis

(j) Diabetes

All HSPs who offer chronic self-management programs will register such with the Living Health Champlain Program at

<http://www.livinghealthy Champlain.ca/main.aspx?lang=en&nongraphical=false>

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.



Performance Indicators

Schedule D2 2011/12

Hospital **Deep River and District Hospital**

Fac # **#648**

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
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PERSON EXPERIENCE: Access, Safe, Effective, Person-Centred

Accountability Indicators

90th Percentile ER LOS for Admitted Patients	Hours	28.00	<=28
90th Percentile ER LOS for Non-admitted Complex Patients	Hours	8.00	<=8
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated Patients	Hours	4.80	<=4.80

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	0.80	.8 to 2.0
Total Margin (Consolidated)	Percentage	0.00	0

Explanatory Indicators

Total Margin (Hospital Sector Only)	Percentage		
Percentage Full Time Nurses	Percentage		
Percentage Paid Sick Time	Percentage		
Percentage Paid Overtime	Percentage		

SYSTEM INTEGRATION: Integration, Community Engagement, eHealth

Explanatory Indicators

Percentage ALC Days	Days		
Repeat Unplanned Emergency Visits within 30 days for Mental Health Conditions	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	475	356-594
Complex Continuing Care	RUG Weighted Patient Days		
Mental Health	Inpatient Days		
ELDCAP	Inpatient Days		
Rehabilitation	Inpatient Days		
Ambulatory Care***	Visits	250	>188

* Global volumes based on CIHI Case mix Group (CMG) methodology and RW weights.

**Volume Performance Indicators under Global Volumes vary in application based on hospital type.

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