
Schedule B

Performance Obligations

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1.0 PERFORMANCE CORRIDORS FOR SERVICE VOLUMES IDENTIFIED IN SCHEDULE D

1.1 APPLICATION

The following Performance Corridors are to be applied to the Service Volumes set out in **Schedule D**. Performance Corridors have been stratified by Hospital size.

1.2 TOTAL ACUTE ACTIVITY, INCLUDING INPATIENT AND DAY SURGERY WEIGHTED CASES

The table below shows the Performance Corridor boundaries by Hospital size for inpatient and day surgery activity as measured by weighted cases.

Hospital Weighted Cases	Corridor Floor	Corridor Ceiling
≤ 500	75%	125%
501 – 1,000	85%	115%
1,001 – 5,000	90%	110%
5,001 – 10,000	92%	108%
10,001 – 15,000	94%	106%
15,001 – 25,000	95%	105%
25,001 – 40,000	96%	104%
> 40,000	97%	103%

Day Surgery Activity: Hospital day surgery cases are reported in the National Ambulatory Care Reporting System (NACRS) maintained by the Canadian Institute for Health Information (CIHI). The total number of cases is aggregated under the following functional centres:

Account	Description
71260*	Operating Rooms (OR)
71262*	Combined OR/ Post Anesthetic Recovery Rooms (PARR)
71265*	Post Anesthetic Recovery Rooms (PARR)
7134020	Day/Night Surgical/Procedural (OR/PARR Excluded)
7134025*	Day/Night Surgical/Procedural
7134055*	Endoscopy Day/Night

Inpatient surgery volumes reported under the 712* functional centres *and* in the Discharge Abstract Database (DAD), are excluded.

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1.3 MENTAL HEALTH INPATIENT DAYS

Mental Health Inpatient Days for designated mental health beds are reported in the Ontario Health Reporting System (OHRS) Management Information System (MIS) Standard under the following account codes:

Primary Account	Secondary Account	Description
7127625*	403*	Acute Mental Health
7127645*		Addiction Inpatient
7127650*		Child/Adolescent
7127655*		Forensic
7127690*		Psychiatric Crisis Unit
7127695*		Longer Term Psychiatry

Below are Performance Corridors for this indicator:

Mental Health Inpatient Days	Corridor Floor
≤ 5,000	85%
> 5,000 to ≤10,000	90%
> 10,000	94%

1.4 ELDERLY CAPITAL ASSISTANCE PROGRAM (ELDCAP) INPATIENT DAYS

ELDCAP Inpatient Days for designated ELDCAP beds are reported in the OHRS under the following account codes:

Primary Account	Secondary Account	Description
7129560	403*	ELDCAP

The Performance Corridor is between 98% and 102% for all hospitals.

1.5 REHABILITATION INPATIENT DAYS

Rehabilitation Inpatient Days for designated rehabilitation beds are reported in the OHRS under the following account codes:

Primary Account	Secondary Account	Description
71281*	403*	Rehabilitation Inpatient Days

Below are the Performance Corridors for this indicator.

Hospital Rehabilitation Inpatient Days	Corridor Floor
< 10,000	85%
10,001 – 20,000	90%
> 20,000	94%

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1.6 COMPLEX CONTINUING CARE RESOURCE UTILIZATION GROUP (RUG) WEIGHTED PATIENT DAYS

This indicator is based upon the CIHI Chronic Care Reporting System (CCRS)/Resource Utilization Group (RUG-III) weighted patient days (RWPDP).

Below are the Performance Corridors for CCC RUG Weighted Patient Days.

Hospital Complex Continuing Care RWPDP	Corridor Floor
≤ 20,000	85%
20,001 – 40,000	90%
40,001 – 100,000	92%
> 100,000	94%

1.7 AMBULATORY CARE VISITS

Ambulatory Care Visits are reported in the OHRS as Total Ambulatory Visits minus Emergency Department Visits (all scheduled, non-scheduled, inpatient (IP) and outpatient (OP) clinic visits, and visits in non- surgical Day / Night functional centres) under the following account codes:

Primary Account	Secondary Account	Description
7134* (excluding 7134025, 7134055), 712*, 7135*, 715*	450*, 5*, (excluding 50*, 511*, 512*, 513*, 514*, 518*, 519*, 521*)	Ambulatory Care Visits

Below are the Performance Corridors for this indicator.

Hospital Ambulatory Visits (excluding Emergency Department Visits)	Corridor Floor
≤ 30,000	75%
30,001 – 100,000	80%
100,001 – 200,000	85%
200,001 – 300,000	90%
300,001 – 400,000	92%
> 400,000	94%

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1.8 EMERGENCY DEPARTMENT VISITS

Emergency Department visits are reported in the OHRS as Emergency Visits (all scheduled, non-scheduled, IP and OP visits in Emergency functional centres).

Primary Account	Secondary Account	Description
71310*	450*, 5*, (excluding 50*, 511*, 512*, 513*, 514*, 518*, 519*, 521*)	Emergency Visits

Below are the Performance Corridors for this indicator:

Hospital Emergency Visits	Corridor Floor
≤ 30,000	85%
30,001 – 50,000	90%
50,001 – 100,000	93%
> 100,000	96%

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2.0 PERFORMANCE CORRIDORS FOR PERFORMANCE INDICATORS IDENTIFIED IN SCHEDULE D

2.1 APPLICATION

The following Performance Corridors are to be applied to the Performance Indicators set out in **Schedule D**.

2.2 READMISSIONS TO OWN FACILITY FOR SELECTED CMGs

- (a) Definition: The number of patients readmitted to own facility for unplanned inpatient care. This is compared to the number of expected unplanned readmissions using data from all Ontario facilities and accounting for the likelihood of return to the same facility (varies by facility).

Readmissions
to Own Facility for Selected CMGs =

Observed number of patients discharged with specified CMGs, readmitted to own acute care facility for any unplanned inpatient care, within 30 days of discharge for the index hospitalization.

The following CMGs were identified for inclusion in this Performance Indicator:

Eligible Conditions & CMGs for Calculation of Readmission Indicator*	
CMG	CMG Description
Stroke: Age: >=45	
13	Specific Cerebrovascular Disorders Except Transient Ischemic Attacks
COPD: Age>=45	
140	Chronic Obstructive Pulmonary Disease (COPD)
142	Chronic Bronchitis
Pneumonia: All ages	
143	Simple Pneumonia and Pleurisy
AMI: Age >=45	
205	AMI without Cardiac Cath with Congestive Heart Failure
206	AMI without Cardiac Cath with Ventricular Tachycardia
207	AMI without Cardiac Cath with Angina
208	AMI without Cardiac cath without Specified Cardiac Conditions
CHF: Age>=45	
222	Heart Failure
Diabetes: All ages	
483	Diabetes
GI: All ages	
281	GI Hemorrhage
285	Complicated Ulcer
286	Uncomplicated Ulcer
289	Inflammatory Bowel Disease

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Eligible Conditions & CMGs for Calculation of Readmission Indicator*	
CMG	CMG Description
290	GI Obstruction
294	Esophagitis, Gastroenteritis and Misc. Digestive Disease
297	Other GI Diagnoses
323	Cirrhosis and Alcoholic Hepatitis
325	Pancreas Disease (except Malignancy)
326	Liver Diseases (except Cirrhosis or Cancer)
329	Biliary Tract Diseases
Cardiac CMGs	
Cardiac: Age	
212	Unstable Angina without Cardiac Cath with Specific Cardiac Conditions
213	Unstable Angina without Cardiac Cath without Specific Cardiac Conditions
237	Arrhythmia
235	Angina Pectoris
242	Chest Pain

*Specified CMGs are subject to change if CMG+ is implemented in Ontario.

Readmissions are limited to unplanned readmissions to own hospital within thirty (30) days of index hospitalization discharge date (excluding deaths, patient sign-outs against medical advice and transfers). Discharge date of index hospitalization should occur within the calendar year.

(b) **LHIN Target: Expected number** of readmissions *times* historical “own hospital” readmission proportion The Expected Number Readmissions equals the sum of all predicted probabilities for unplanned readmission to any Ontario acute care hospital *times* the proportion of readmissions that return to the same facility (differs for different facilities). It is adjusted for patient factors such as CMG, age, sex and prior hospitalizations. Look-up tables are provided in WERS to assist in the calculation of this indicator.

(c) **Performance Corridor:** The Performance Corridor is the upper control limit on the amount by which the Hospital’s readmission rate exceeds the expected rate. The width of this corridor is related to the Hospital’s annual number eligible cases. The width is three times the standard deviation of the Hospital’s expected readmission rate divided by the square root of the Hospital’s number of eligible cases.

Hospital-specific corridors are available on the Web Enabled Reporting System (WERS).

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2.3 PERCENTAGE OF CHRONIC PATIENTS WITH NEW STAGE 2 OR GREATER SKIN ULCERS (CHRONIC CARE DESIGNATED ACTIVITY ONLY)

(a) Definition: Percentage of Patients with New Stage 2 or Greater Skin Ulcers can be interpreted as an estimate of the percentage of ulcer-free CCC patients who developed stage 2 or greater skin ulcers (of any kind) over a typical 90-day period. Lower values are expected to reflect better performance. This indicator is risk adjusted.

Count of target assessments, across all quarters of a fiscal year that meet both the numerator and denominator criteria. An RAI-MDS target assessment is counted if patient is recorded as having one or more skin ulcers at stage 2 or higher [any of the following MDS items have a value greater than 0: M1b "Number of Stage 2 skin Ulcers;" M1c "Number of Stage 3 Skin Ulcers; M1d "Number of Stage 4 Skin Ulcers.

% Chronic Patients with New Stage 2 or > Skin Ulcers =

All RAI-MDS target assessments in the fiscal year that do not meet the exclusion criteria.

Exclusions:

Target assessments that meet any of the following conditions are excluded: 1. Patient who already had one or more skin ulcers of stage 2 or greater on the most recent prior MDS assessment; 2. Missing data for MDS items M1b, M1c or M1d on the target assessment or on the most recent prior one.

(b) LHIN Target: The indicator target is the weighted average of the risk adjusted rate (most recently 6.1%).

(c) Performance Corridor: The corridor is the upper control limit for this rate. This is three times the standard deviation associated with the average risk-adjusted rate divided by the square root of the Hospital's eligible number of cases. The indicator should not exceed the target by more than this upper control limit.

Hospital-specific corridors available on the Web-Enabled Reporting System.

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2.4 CURRENT RATIO

- (a) Definition: The number of times a Hospital's short-term obligations can be paid using the Hospital's short-term assets.

$$\text{Current Ratio} = \frac{\text{Current Assets}}{\text{Current Liabilities}} = \frac{\text{Current Assets - credits in current asset accounts excluding bad debt + debits in current liability accounts}}{\text{Current Liabilities, excluding deferred contributions - debits in current liability accounts + credits in current asset accounts (excluding bad debt)}}$$

This performance indicator should be calculated using consolidated corporate balance sheet (all fund types and sector codes). Treatment of credits and debits for assets and liabilities is applied at the HAPS account roll-up level.

- (b) LHIN Target: 0.8 – 2.0
- (c) Performance Corridor: If outside LHIN Target, a Performance Corridor of plus or minus 10% of the Negotiated Target would be applied. For example, if the Negotiated Target is 0.7, the Performance Corridor would have a lower limit of 0.63 (0.7 * 90%) and an upper limit of 0.77 (0.7 * 110%).
- (d) Calculating the Current Ratio

- (i) Account Contents of Numerator: i.e. current assets - credits in current asset accounts excluding bad debt + debits in current liability accounts:

Primary Accounts	Secondary Accounts
1* (excluding credit balances in all 1* accounts except for bad debt [1*355]) + debit balances in 4* accounts	Not applicable

Clarification of treatment of Bad Debt: Balances in Bad Debt accounts 1*355 are kept in numerator whether negative or positive.

- (ii) Account Contents of Denominator: i.e. Current Liabilities, excluding deferred contributions - debits in current liability accounts + credits in current asset accounts (excluding bad debt):

Primary Accounts	Secondary Accounts
4* (excluding 4*8 and excluding debit balances in 4* accounts) + credit balances in 1* accounts (excluding bad debts 1*355)	Not applicable

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Excluded Deferred Contributions	
Account	Description
4* 8 00	Deferred Contributions - Current Detailed accounts required
4* 8 40	Deferred Donations - Current New Reporting Level
4* 8 42	Def. Donations - Current - Land, Building & Building Service Equipment
4* 8 44	Def. Donations - Current – Equipment
4* 8 46	Def. Donations – Current – Operations
4* 8 50	Deferred Provincial Grants - Current New Reporting Level
4* 8 52	Def. Provincial Grants - Current - Land, Building & Building Service Equipment
4* 8 54	Def. Provincial Grants - Current – Equipment
4* 8 56	Def. Provincial Grants - Current - Operations
4* 8 60	Deferred Research Grant - Current New Reporting Level
4* 8 62	Def. Research Grants - Current - Land, Building & Building Service Equipment
4* 8 64	Def. Research Grants - Current – Equipment
4* 8 66	Def. Research Grants - Current - Operations
4* 8 70	Def. Donation Contributed – Current
4* 8 72	Def. Donation Contributed - Current - Land, Building & Building Service Equipment
4* 8 74	Def. Donation Contributed - Current - Equipment
4* 8 76	Def. Donation Contributed - Current - Operations

2.5 TOTAL MARGIN

- (a) **Definition:** The percent by which total revenues exceed or fall short of total expenses, excluding the impact of facility amortization, in a given year.

$$\text{Total Margin} = \frac{\text{Total Surplus / Deficit}}{\text{Total Revenues}} \times \frac{\text{Total Corporate Revenues (excluding Interdepartmental Recoveries and Facility-related Deferred Revenues) minus Total Corporate Expenses (excluding Interdepartmental Expenses and Facility-related Amortization Expenses)}}{\text{Total Corporate Revenues (excluding interdepartmental Recoveries and Facility-related Deferred Revenues)}}$$

Total margin is calculated before facility-related amortized expenses and revenues. Inter-departmental recoveries and expenses are also excluded. The Total Margin indicator should be calculated using the consolidated corporate income statements (all fund types and sector codes)

- (b) **LHIN Target:** : 0% unless the LHIN has granted a waiver. The LHIN waiver will form part of the Agreement pursuant to section 6.1.3. (c). The negotiated Performance Target as agreed in the waiver will be included in Schedule D and the conditions that may be granted by the LHIN are to be included in this section of Schedule B.

- (c) **Performance Corridor:** No negative variance is acceptable from the Negotiated Target.

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- (d) Calculating the Total Margin
- (i) Account Contents of Numerator (i.e. Total Corporate Revenues (excluding Interdepartmental Recoveries and Facility-related Deferred Revenues) – Total Corporate Expenses (excluding Interdepartmental Expenses and Facility-related Amortization Expenses))

Primary Accounts	Secondary Accounts
7* + 8*	1* to 9* (excluding 12171, 12195, 12196, 12197, 122*, 13002, 13102, 14102, 15102, 15103, 45100, 62800, 69571, 69700, 72000, 95020, 95040, 95060, 95065, 955*)

Note: Because revenues are reported as credits (negative values) and expenses as debits (positive values) in the MIS Trial Balance, the straight sum of the above revenue and expense accounts will net to the surplus/deficit.

- (ii) Account Contents of Denominator (i.e. Total Corporate Revenues (excluding Interdepartmental Recoveries and Facility-related Deferred Revenues))

Primary Accounts	Secondary Accounts
7* + 8*	1* (excluding 12171, 12195, 12196, 12197, 122*, 13002, 13102, 14102, 15102, 15103)

2.6 PERCENTAGE OF FULL-TIME NURSES

- (a) Definition: The percentage of Management and Operational Support (MOS), Unit Producing Personnel (UPP) and Nurse Practitioner (NP) earned hours (including worked and benefit hours) provided by full-time nurses of all employment status for provincial sector code 1*.

$$\% \text{ Full-Time Nurses} = \frac{\text{MOS, UPP and NP Earned Hours for Professional \& Regulated Full-Time RNs, RPNs, Nurse Managers, CNS, Nurse Educators and Nurse Practitioners}}{\text{MOS, UPP and NP Earned Hours for Professional and Regulated RNs, RPNs, Nurse Managers, CNS, Nurse Educators and Nurse Practitioners of all Employment Status}}$$

- (b) LHIN Target: Minimum of 70%
- (c) Performance Corridors:
- (i) For Academic and Community Hospitals the Performance Corridor is the Performance Target minus 1% (lower limit only).
- (ii) For Small Hospitals, as defined by the JPPC, the Performance Corridor is the Performance Target minus 3% (lower limit only).

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(d) Calculating the Percentage of Full-time Nurses:

- (i) Account contents of Numerator (i.e. MOS, UPP and NP Earned Hours for Full-Time Nurses)

Primary Accounts	Secondary Accounts
711*, 712*, 713*, 714*, 715*, 717*, 718*, 719*	See table below

Nursing Account Codes	Description
631 11 1*	Earned Hours Details MOS RN Full-Time
631 11 3*	Earned Hours Details MOS RN Part-Time - Temporary Full-Time
631 11 4*	Earned Hours Details MOS RN Part-Time - Job Share
631 11 6*	Earned Hours Details MOS RN Casual - Temporary Full-Time
631 12 1*	Earned Hours Details MOS RPN Full-Time
631 12 3*	Earned Hours Details MOS RPN Part-Time - Temporary Full-Time
631 12 4*	Earned Hours Details MOS RPN Part-Time - Job Share
631 12 6*	Earned Hours Details MOS RPN Casual -Temporary Full-Time
631 13 1*	Earned Hours Details MOS Nurse Manager Full-Time
631 13 3*	Earned Hours Details MOS Nurse Manager Part Time - Temporary Full-Time
631 13 4*	Earned Hours Details MOS Nurse Manager Part Time - Job Share
631 13 6*	Earned Hours Details MOS Nurse Manager Casual - Temporary Full time
631 14 1*	Earned Hours Details MOS Clinical Nurse Specialist Full-Time
631 14 3*	Earned Hours Details MOS Clinical Nurse Specialist Part-Time - Temporary Full-Time
631 14 4*	Earned Hours Details MOS Clinical Nurse Specialist Part-Time - Job Share
631 14 6*	Earned Hours Details MOS Clinical Nurse Specialist Casual - Temporary Full-Time
631 15 1*	Earned Hours Details MOS Nurse Educator Full-Time
631 15 3*	Earned Hours Details MOS Nurse Educator Part-Time - Temporary Full-Time
631 15 4*	Earned Hours Details MOS Nurse Educator Part-Time - Job Share
631 15 6*	Earned Hours Details MOS Nurse Educator Casual - Temporary Full-Time
631 16 1*	Earned Hours Details MOS Nurse Practitioner Full-Time
631 16 3*	Earned Hours Details MOS Nurse Practitioner Part-Time - Temporary Full-Time
631 16 4*	Earned Hours Details MOS Nurse Practitioner Part-Time - Job Share
631 16 6*	Earned Hours Details MOS Nurse Practitioner Casual - Temporary Full-Time
635 11 1*	Earned Hours Details UPP RN Full-Time
635 11 3*	Earned Hours Details UPP RN Part-Time - Temporary Full-Time
635 11 4*	Earned Hours Details UPP RN Part-Time - Job Share
635 11 6*	Earned Hours Details UPP RN Casual - Temporary Full-Time
635 12 1*	Earned Hours Details UPP RPN Full Time
635 12 3*	Earned Hours Details UPP RPN Part Time - Temporary Full Time
635 12 4*	Earned Hours Details UPP RPN Part-Time - Job Share
635 12 6*	Earned Hours Details UPP RPN Casual - Temporary Full-Time
635 13 1*	Earned Hours Details UPP Nurse Manager Full-Time
635 13 3*	Earned Hours Details UPP Nurse Manager Part Time - Temporary Full-

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Nursing Account Codes	Description
	Time
635 13 4*	Earned Hours Details UPP Nurse Manager Part Time - Job Share
635 13 6*	Earned Hours Details UPP Nurse Manager Casual - Temporary Full-Time
635 14 1*	Earned Hours Details UPP Clinical Nurse Specialist Full-Time
635 14 3*	Earned Hours Details UPP Clinical Nurse Specialist Part Time - Temporary Full-Time
635 14 4*	Earned Hours Details UPP Clinical Nurse Specialist Part Time - Job Share
635 14 6*	Earned Hours Details UPP Clinical Nurse Specialist Casual Temporary Full-Time
635 15 1*	Earned Hours Details UPP Nurse Educator Full-Time
635 15 3*	Earned Hours Details UPP Nurse Educator Part-Time - Temporary Full-Time
635 15 4*	Earned Hours Details UPP Nurse Educator Part-Time Job Share
635 15 6*	Earned Hours Details UPP Nurse Educator Casual Temporary Full-Time
635 16 1*	Earned Hours Details UPP Nurse Practitioner Full-Time
635 16 3*	Earned Hours Details UPP Nurse Practitioner Part-Time - Temporary Full-Time
635 16 4*	Earned Hours Details UPP Nurse Practitioner Part-Time Job Share
635 16 6*	Earned Hours Details UPP Nurse Practitioner Casual Temporary Full-Time
638 11 1*	Earned Hours Details NP RN Full-Time
638 11 3*	Earned Hours Details NP RN Part-Time - Temporary Full-Time
638 11 4*	Earned Hours Details NP RN Part-Time - Job Share
638 11 6*	Earned Hours Details NP RN Casual - Temporary Full-Time
638 16 1*	Earned Hours Details NP Nurse Practitioner Full-Time
638 16 3*	Earned Hours Details NP Nurse Practitioner Part-Time - Temporary Full-Time
638 16 4*	Earned Hours Details NP Nurse Practitioner Part-Time - Job Share
638 16 6*	Earned Hours Details NP Nurse Practitioner Casual - Temporary Full-Time

(ii) Account Contents of Denominator (i.e. MOS, UPP and NP Earned Hours for Nurses of all Employment Status)

Primary Accounts	Secondary Accounts
711*, 712*, 713*, 714*, 715*, 717*, 718* and 719*	See table below

Account	Description
631 ** **	Earned Hours Details MOS
635 ** **	Earned Hours Details UPP
638 ** **	Earned Hours Details NP

Where ** the 4th and 5th position is equal to all nursing occupational class codes, with a value of:

4th and 5th digits	Occupational Class
11	RN
12	RPN
13	Nurse Manager
14	Clinical Nurse Specialist
15	Nurse Educator
16	Nurse Practitioner

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Where ** the 6th and 7th position is equal to employment status, type of earned hrs (worked + benefit) with a value of :

6th digit	Employment status
1	Full-Time
2	Part-Time Regular
3	Part-Time Temporary Full-Time
4	Part-Time Job Share
5	Casual Regular
6	Casual-Temporary Full-Time
9	Purchased Service

7th digit	Type of Earned hours
1	wkd-overtime
2	wkd-other
3	ben-sick
4	ben-vacation
5	ben-education
6	ben-orientation
7	ben-other

**3.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO NURSING
ENHANCEMENT/CONVERSION**

3.1 MEASUREMENT OF FULL-TIME NURSING PERFORMANCE INDICATOR

For the purposes of measuring the Performance Indicator respecting full-time employed nurses set out in Schedule D, the percentage of nursing staff working on a full-time basis shall be calculated as described above under “Percent Full-Time Nurses.”

The term “nursing staff” means registered nurses/nurse practitioners and registered practical nurses working at the Hospital who are registered with the College of Nurses of Ontario.

3.2 REPORTING AND ANNUAL NURSING STAFF PLANS

- (a) The Hospital shall report to the LHIN at the end of each fiscal year to confirm that the hiring of the nursing staff positions set out on the Hospital’s report entitled “Reporting for Full-Time Nursing Fund” has been achieved;
- (b) The Hospital Annual Planning Submission (HAPS), will include a plan to achieve the Performance Target respecting full-time nursing staff (the “Nursing Plan”). The Nursing Plan may include staff reductions if:
 - (i) such reductions are achieved through voluntary attritions or management of vacancies; or
 - (ii) the Hospital demonstrates that:
 - (a) It has considered measures to maintain the employment of nursing staff and to improve efficiency in administrative and clinical areas; and
 - (a) It has discussed any reductions proposed in the HAPS with its chief nursing executive and has engaged its nursing staff in its decisions about such matters, such as discussions with its nursing council, all with a view to maintaining the stability of nursing employment.
 - (c) The Hospital shall implement the Nursing Plan approved by the LHIN.
 - (d) The percentage of full-time nurses in the Nursing Plan approved by the LHIN shall be the Performance Target for the % Full-Time Performance Indicator as outlined in Schedule D of this Agreement.

**4.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO CRITICAL CARE
SCHEDULE E**

The following are the Performance Obligations regarding critical care as set out in Schedule E:

4.1 APPLICATION

The following accountability conditions apply to all hospitals that provide Level 3 or Level 2 critical care services:

- (a) Submission of accurate and timely data to the Critical Care Information System and participating in data accuracy audits as requested by MOHLTC or the LHIN.
- (b) Submission of a change request form to the MOHLTC and LHIN within 30 days of any changes to the hospital's critical care capacity (as defined through Ontario's Critical Care Strategy).
- (c) Ensure hospital senior leadership and ICU leaders review and assess CCIS data and implications with the Critical Care LHIN Leader on a quarterly basis as part of on going efforts to improve patient access and patient safety.
- (d) Cooperate with MOHLTC, LHIN and the Critical Care LHIN Leader to identify and implement at least one performance improvement initiative for critical care within the year.
- (e) Coordinate/report all inter-hospitals transfer of critically ill patients through CritiCall.
- (f) Cooperate with LHIN hospitals and CritiCall to establish a CritiCall on-call schedule for medical/surgical critical care patients and track adherence to this on-call schedule.
- (g) Cooperate with CritiCall, LHIN hospitals and other hospitals to support the establishment of CritiCall on-call schedules for other ICU-related specialty services (e.g. neurosurgical critical care, cardiac care, trauma and paediatrics).

4.2 CRITICAL CARE BEDS

Accountability conditions associated with funding for critical care beds in 2008/09 and 2009/10 will be provided to the Hospital if funding is provided.

4.3 CRITICAL CARE FUNDING

The following additional conditions apply to critical care, if critical care funding was received in 2007/08:

- (a) The ICU beds put into operation since 2004/05 as a result of critical care funding should continue to be allocated in addition to pre-existing Medical-Surgical ICU capacity;

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- (b) These beds shall generally serve the needs of patients with multi-system organ failure and critically ill patients from the emergency room and presenting through CritiCall shall receive priority for these beds;
- (c) In respect to CritiCall, the Hospital shall follow the ICU bed availability rotation plan as established by the teaching Hospital ICU leadership, namely, Mount Sinai Hospital, St. Michael's Hospital, University Health Network, and Sunnybrook Health Sciences Centre; and
- (d) The Hospital shall alter its internal priorities on such occasions as necessary in order to maintain access to CritiCall and to keep its emergency department open.

4.4 FINANCIAL SETTLEMENT AND RECOVERY FOR CRITICAL CARE

If the Performance Obligations set out above are not met, the LHIN will adjust the Critical Care Funding following the submission of in-year and year-end data.

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

5.1 POST CONSTRUCTION OPERATING PLAN (PCOP) FUNDING

PCOP funding is additional operating funding provided to support service expansions and other costs occurring in conjunction with completion of an approved capital project. The LHIN is providing operating funding in 2008/09 and 2009/10 to support the expansion of services that occurred in conjunction with the completion of capital projects detailed in Schedule F. Funding for either of 2008/09 and 2009/10 will be based on LHIN review of expected services increases expressed in Hospital's PCOP. Schedule F provides the expected service volumes for funding provided. All funding should be considered as annualized for those meeting volume expectations subject to section 5.2. Additionally, service expansion volumes have been adjusted from the PCOP in line with LHIN funding available.

5.2 FINANCIAL SETTLEMENT AND RECOVERY FOR POST-CONSTRUCTION OPERATING PLANS

If the Hospital does not meet a Performance Obligation or Service Volume under its post-construction operating plan, as detailed in Schedule F, the LHIN may do the following:

- (a) adjust the applicable Post-Construction Operating Plan Funding to reflect reported actual results and projected year-end activity; and
- (b) perform final settlements following the submission of year-end data of Post-Construction Operating Plan Funding.

**6.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO PROTECTED SERVICES
SCHEDULE G**

6.1 DEFINITIONS:

For the purposes of this Agreement, *Protected Services* refers to the following services:

Stable Priority Services. Priority Services refers to services designated for life-threatening conditions that typically require highly skilled human resources, specialized infrastructure, that are not yet fully diffused, are rapidly growing, and for which access to the services by residents in different regions of the province is at issue. Priority Services are detailed in Schedule G. Priority Services are a time-limited designation.

Specialized Hospital Services. Specialized Hospital Services are services that were funded on the basis of volumes in 2004-2005 or earlier and are now funded through the Hospitals' base allocation. The Specialized Hospital Services are detailed in Schedule G.

Provincial Strategies/Projects. The Provincial Strategies/Projects are detailed in Schedule G.

In addition to the Performance Obligations for Protected Services set out below, the Hospital will meet the Service Volumes set out in Schedule G or D for each Protected Service program for which the Hospital receives funding.

6.2 PERFORMANCE OBLIGATIONS FOR PROTECTED SERVICES

- (a) Where the Hospital provided any of the Protected Services in the 2007/08 fiscal year, and where these services will continue to be protected in 2008/09 and 09/10 the Hospital will provide, in the 2008/09 and 09/10 fiscal year, at least the service level that the Hospital provided in the 2007/08 fiscal year. This excludes additional volumes that may have been allocated in-year on a one-time basis or services that may have been transferred to another Hospital.
- (b) Changes to Protected Services are acceptable as long as the needs of patients are addressed, established service levels are maintained, and any planned program changes are discussed with, and approved in advance by the LHIN.
- (c) Hospitals shall maintain the established regional or provincial service catchment area to ensure continued access where local provision of Protected Services are not otherwise available.
- (d) In respect of those Protected Services that are not measured with an activity level or unit of service as set out in Schedule G, the Hospital shall use the funding for those Protected Services for their intended purpose.

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Performance Obligations

- (e) The Hospital shall plan for Specialized Hospital Services as part of its Base Funding and provide the volumes as detailed in Schedule G.

6.3 FINANCIAL SETTLEMENT AND RECOVERY FOR PROTECTED SERVICES

If the Hospital does not meet a Performance Obligation or Service Volume as detailed in Schedule G for a Protected Service, the LHIN may do the following:

- (a) Adjust the respective Protected Services Funding to reflect reported actuals and projected year-end activity; and,
- (b) Perform in-year reallocations and final settlements following the submission of year-end data of Protected Services Funding.

**7.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO WAIT TIME SERVICES
SCHEDULE H**

7.1 PERFORMANCE OBLIGATIONS WITH RESPECT TO WAIT TIME SERVICES

- (a) *Cardiac Revascularization*: For the purposes of monitoring volumes performed, all selected Cardiac procedures will be performed in accordance with the terms and conditions of Section 6, and monitored as set out in Schedule G.
- (b) *Cancer Surgery*: Where the Hospital receives funding from Cancer Care Ontario, the Hospital will enter into a Cancer Surgery and/or Chemotherapy Agreement with Cancer Care Ontario.
- (c) *Cataract Surgery, Total Hip and Knee Joint Replacements, Magnetic Resonance Imaging (MRI) and Computed Tomography (CT)*: If the Hospital receives Wait Time Funding, the Hospital agrees to provide the surgical volume levels and/or MRI hours as indicated in Schedule H and comply with the following conditions:
 - (i) The Hospital will complete all base volumes/hours as detailed in Schedule H by the end of each fiscal year;
 - (ii) Incremental surgery volumes for cataracts, total hip and knee joint replacements, MRI and/or CT hours of operation will be completed by the end of each fiscal year;
 - (iii) The Hospital will report the base and incremental volumes/hours via the LHIN's quarterly performance reports;
 - (iv) For greater clarity, the Hospital agrees that the delivery of these additional volumes/hours will not impede on its performance in delivering other Hospital services under the Agreement;
 - (v) The Hospital will begin to develop surgical access management processes by creating a centralized wait list within the Hospital for those services funded as part of the Wait Time Strategy by the end of the fiscal year.
 - (vi) For MRI and/or CT, the Hospital agrees to report the number of MRI and/or CT inpatients via the LHIN's regular reporting system.
 - (vii) The Hospital will demonstrate compliance with the funding conditions outlined in appendix A of the funding agreement.

Schedule B Performance Obligations

7.2 WAIT TIME REPORTING PERFORMANCE OBLIGATIONS

- (a) The Hospital will participate in a province-wide Wait Time Information System.
- (b) Pursuant to LHIN Administrative Letters respecting Wait Time funding, the Hospital will provide the minimum wait time data requirements for the Wait Time services (cardiac, cancer, cataract, total hip and knee joint replacements, MRI and CT) to the Wait Time Information Office on a monthly basis.

7.3 FINANCIAL SETTLEMENT AND RECOVERY FOR WAIT TIME SERVICES

If the Hospital does not meet a Performance Obligation or Service Volume as detailed in Schedule H for a Wait Time Service, the LHIN may do the following:

- (a) Adjust the respective Wait Time Funding to reflect reported actuals and projected year-end activity; and
- (b) Perform in-year reallocations and final settlements following the submission of year-end data.

8. REPORTING OBLIGATIONS

8.1 REPORTING

A table consolidating the Hospital's and LHIN reporting obligations are attached as Appendix 1 to this **Schedule B**.

8.2 REPORTING TIMELINES

In accordance with *section 7.6.1* of this Agreement, where no timeline is set out in this **Schedule B** or elsewhere in this Agreement, the LHIN will respond to a report or submission from the Hospital not later than 30 days after the report or submission has been received.

9. LHIN SPECIFIC PERFORMANCE OBLIGATIONS

9.1 OPTIMAL USE OF COMPLEX CONTINUING CARE AND REHABILITATION

- The LHIN is determining the optimal use of CCC and Rehabilitation beds to relieve pressures on acute care and provide specialized care for medically complex patients. This is a top priority for 2008/09.

Schedule B

Performance Obligations

9.2 OPERATIONAL AND SERVICE REVIEWS

- The Hospital is currently undergoing internal and externally-led operational and service reviews, including peer reviews. After completion of the reviews, the LHIN will work with the Hospital to identify potential opportunities for savings, and good practices that can be shared with peers.

9.3 SPASTICITY SERVICES

- The LHIN supports spasticity services as a mechanism to improve patients' independence.
- To ensure there is no duplication between the proposals from Toronto Rehabilitation Institute (TRI) and the Hospital, the LHIN will be expecting a coordinated strategy and implementation plan which will include identification of the different populations and geographies best served by each organization within the LHIN.
- The LHIN has set aside base funding for implementation of the approved plan. The LHIN anticipates submission of the coordinated plan by May 2008, with an expected implementation date of July 2008. Funds will be released once the coordinated plan is approved.

9.4 TUBERCULOSIS PROGRAM

- The LHIN recognizes the importance of the Hospital's Tuberculosis Program in providing necessary care to a growing number of disadvantaged and marginalized patients in Toronto.
- The Hospital will submit a Business Case with a supporting Presentation to the LHIN by April 2008.

9.5 REVIEW OF FUNDING MECHANISMS AND CO-PAYMENT POLICIES

- Through discussions with the hospitals, issues were raised around the funding mechanisms and co-payment policies in complex continuing care and rehabilitation facilities. In response, the LHIN will review these issues and will hold a roundtable with hospitals in April 2008.
- The LHIN will develop a case to be brought forward to the LHIN CEO meeting in July 2008, and subsequently to the MOHLTC in September 2008.

9.6 BALANCED BUDGET AND HAA REFRESH

- For 2008/09 the LHIN expects the Hospital to maintain services at 2007/08 levels and to consult the LHIN prior to the implementation of any changes to these services.
- While the attached Schedule D reflects a deficit for 2008-09 and 2009-10, the Hospital agrees that it has an obligation to plan for and achieve a balanced budget in 2009-10, subject to:
 - For 2008/09 the Hospital has planned for a total margin of less than 1% and the LHIN is satisfied that the financial health of the hospital will sustain operations and meet performance targets.
 - Recognizing that the Hospital was unable to present a plan for a balanced budget for 2009/10 as required by the 2008/09 HAPS, the Hospital agrees that it will provide a plan for a balanced budget for 2009/10 no later than September 30, 2008. The plan may include a discussion on service volumes and organizational changes. The LHIN shall monitor the Hospital's performance monthly.

Schedule B
Performance Obligations

- The Hospital and the LHIN will conduct a refresh, including indicators and schedules by January 31, 2009.

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

HOSPITAL CALENDARIZED REPORTING CHART 2008 - 10				
Due Date	Description of Item	From	To	Submission Process/Tool
MAY				
May 31	Hospitals' year end trial balance, year end consolidation reports, and audited financial statements (if available) or draft financial statements.	Hospital	LHIN	MIS Trial Balance, WERS, Electronic File Transfer to Ministry
May 31	All Clinical Submissions (Q4 2007/08; 2008/09)	Hospital	CIHI	Electronic File Transfer to CIHI
JUNE				
June - within first 5 working days	Hospitals provide LHINs with a statement indicating they are on target to achieve a balanced budget and to meet performance targets. It may include an action plan to address any in-year pressures. This report supports LHIN Q1 reporting. Year end Supplementary Form reports.	Hospital	LHIN	Format to be provided by LHIN, WERS
June 15	Hospitals to provide information to support LHIN's Annual Service Plan submission to Ministry. The information identifies opportunities and risks to transform the health delivery system.	Hospital	LHIN	Format to be provided by LHIN
June 30	Board approved Audited Financial statements.	Hospital	LHIN	e-mail or hard copy
June 30	Hospital Annual Planning Submission Guide to Hospitals	LHIN	Hospital	Guide distributed by LHIN
JULY				
July 31	Hospitals submit Q1 report (Note: This is a new requirement. In past, Hospital did not submit a Q1 Report)	Hospital	LHIN	MIS Trial balance
AUGUST				
August – within first 5 working days	Q1 Supplementary Form reports.	Hospital	LHIN	WERS
SEPTEMBER				
September – within first 5 working days	Hospitals provide LHINs with a statement indicating they are on target to achieve a balanced budget and to meet performance targets. It may include an action plan to address any in-year pressures. This will support LHIN Q2 reporting	Hospital	LHIN	Format to be provided by LHIN
September 30	All Clinical Submissions (Q1 2008/09; 2009/10)	Hospital	CIHI	Electronic File Transfer to CIHI
OCTOBER				
October 31	Hospitals submit Q2 reports (Note: It is important for the hospital to accurately predict year-end volumes for cataracts, total hips and knee joint replacements, MRI and/or CT hours of operations to facilitate in-year reallocation of cases.)	Hospitals	LHIN	WERS, MIS Trial balance

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

HOSPITAL CALENDARIZED REPORTING CHART 2008 - 10				
Due Date	Description of Item	From	To	Submission Process/Tool
NOVEMBER				
November – within first 5 working days	Q2 Supplementary Form reports.	Hospital	LHIN	WERS
November 30	All clinical Submissions (Q2 2008/09, 2009/10)	Hospital	CIHI	Electronic File Transfer to CIHI
DECEMBER				
December – within first 5 working days	Hospitals provide LHINs with a statement indicating they are on target to achieve a balanced budget and to meet performance targets. It may include an action plan to address any in-year pressures This information supports LHIN Q3 reporting. The LHIN Q3 will be the most detailed to enable LHINs to reallocate funds within HSPs and to outline plans to meet performance targets.	Hospital	LHIN	Format to be provided by LHIN
JANUARY				
January 31	Hospitals submit Q3 reports	Hospital	LHIN	WERS, MIS Trial balance
FEBRUARY				
February – within first 5 working days	Q3 Supplementary Form reports.	Hospital	LHIN	WERS
February 28	All Clinical Submissions (Q3 2008/09; 2009/10)	Hospital	CIHI	Electronic File Transfer to CIHI
MARCH				
March – within first 5 working days	Hospitals provide LHINs with a statement indicating they are on target to achieve a balanced budget and performance targets. This report supports LHIN Q4 – LHINs are required to confirm year end financial position and achievement of non-financial targets.	Hospital	LHIN	Format to be provided by LHIN