MINISTRY LHIN ACCOUNTABILITY AGREEMENT ("MLAA") 2015-18

THE AGREEMENT (the "Agreement") effective as of April 1, 2017.

B E T W E E N :

Her Majesty the Queen in right of Ontario
as represented by the Minister of Health and Long-Term Care
("MOHLTC")

- and -

Toronto Central Local Health Integration Network ("LHIN")

WHEREAS the parties entered into an accountability agreement for fiscal years 2015-2018 pursuant to section 18 of the *Local Health System Integration Act, 2006* ("MLAA");

AND WHEREAS, after April 1, 2017, the Minister of Health and Long-Term Care may make an order pursuant to section 34.2 of LHSIA that would affect the LHIN and the CCAC in the LHIN;

AND WHEREAS the parties wish to amend the MLAA on the terms and conditions set out herein.

NOW THEREFORE in consideration of the mutual covenants and agreements contained in this Agreement and other good and valuable consideration (the receipt and sufficiency of which are hereby acknowledged by each of the parties), 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 MLAA.

1.1 "Transfer Date" means the effective date of the order of the Minister of Health and Long-Term Care that transfers all of the assets, liabilities, rights, obligations and employees of the Toronto Central Community Care Access Centre to the LHIN pursuant to section 34.2 of LHSIA.

2.0 Amendments.

2.1 The parties agree that the MLAA shall be amended as set out in this Article 2.

2.2 Effective April 1, 2017, the Agreement is amended by replacing it with the text of Appendix 1 that is not underscored.

2.3 Effective the Transfer Date, the Agreement is amended by replacing it with all the text of Appendix 1, including the text that is underscored.

2.4 Amendments set out in this Article 2 are made despite section 19 of the Agreement.

3.0 **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.

4.0 **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.

IN WITNESS WHEREOF the parties have executed this Agreement.

Her Majesty the Queen in right of Ontario,
as represented by the Minister of
Health and Long-Term Care:

Original signed by the Minister Dated April 4, 2017

_____
The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care

Toronto Central Local Health Integration Network

By:

Original signed by the Chair

_____
Dr. Vivek Goel, Chair

APPENDIX 1

MINISTRY-LHIN ACCOUNTABILITY AGREEMENT

APRIL 1, 2015 – MARCH 31, 2018

BETWEEN:

Her Majesty the Queen in right of Ontario, as represented by the Minister of Health and Long-Term Care ("MOHLTC")

- and -

Toronto Central Local Health Integration Network ("LHIN")

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MINISTRY-LHIN ACCOUNTABILITY AGREEMENT
APRIL 1, 2015 – MARCH 31, 2018

BETWEEN:

Her Majesty the Queen in right of Ontario, as represented by the Minister of Health and Long-Term Care ("MOHLTC")

- and -

Toronto Central Local Health Integration Network ("LHIN")

Introduction

The *Local Health System Integration Act, 2006* (LHSIA), the Memorandum of Understanding (MOU) and this MOHLTC-LHIN Agreement (Agreement) are the key elements of the accountability framework between the MOHLTC and the Local Health Integration Networks (LHINs). LHSIA requires that the Minister and each LHIN enter into an accountability agreement in respect of the local health system (section 18).

The purpose of the Agreement is to establish the respective performance obligations of the MOHLTC and LHINs relating to key operational and funding expectations that are not already addressed in LHSIA or the MOU.

The Agreement identifies the MOHLTC's strategic priorities for the health system and reflects the continued evolution of the LHIN model as well as the LHINs' maturity in managing the local health system. It recognizes that the MOHLTC and the LHINs have a joint responsibility to achieve better health outcomes for Ontarians and to effectively oversee the use of public funds in a fiscally sustainable manner. The Agreement acknowledges the MOHLTC's responsibility to apply appropriate scrutiny of fiscal management and health services delivery managed by the LHINs. The Agreement addresses the LHINs' expectations regarding promoting health equity and respecting the diversity of communities in the planning, design, delivery, and evaluation of services. The Agreement also outlines the LHINs' new operational and funding expectations with respect to the delivery and management of home and community care services.

The Agreement reflects the LHINs' critical role in advancing system transformation by building on the progress made to date under the *Excellent Care for All Act* (ECFAA) and Ontario's Action Plan for Health Care. The MOHLTC has defined the next phase of health care system transformation through Patients First: Action Plan for Health Care. The Action Plan is focused on creating a health care system that is patient-centred, accountable, transparent, and evidence-based through the following shared goals:

- **Access:** Improving System Integration and Access
- **Connect:** Modernizing Home and Community Care
- **Inform:** Increasing the Health and Wellness of Ontarians including Mental Health and Addictions in Ontario
- **Protect:** Ensuring Sustainability and Quality across the System

A number of key initiatives have been introduced to support the continued transformation of the health care system and achieve the vision set forth in the Patients First: Ontario's Action Plan for Health Care. The MOHLTC and LHINs will continue to work with Health Service Providers, and other providers, including public health, to enhance joint planning and coordination within and among providers and ensure alignment with current provincial strategies, including:

- **Health System Funding Reform (HSFR):** A funding strategy that features quality based funding to facilitate fiscal sustainability through high quality, evidence-based and patient-centred care.

- **The Primary Care Access Guarantee**: A provincial commitment that all Ontarians who want one will have a primary care provider, and that more Ontarians will able to see their primary care provider on the same or next day when sick, as well as on weekends and after-hours.

- **Health Links:** An innovative model to enhancing service delivery and coordinated care for individuals with complex care needs.

- **Patients First: Roadmap to Strengthen Home and Community Care:** A three-year plan to improve and expand home and community care in Ontario to achieve higher quality, more consistent, and better integrated care. In 2017-18, the MOHLTC and the LHINs will work together to implement approved components of the Roadmap.

- **Comprehensive Mental Health and Addictions Strategy**: A multi-year strategy to transform the mental health and addictions system so that all Ontarians have timely access to an integrated system of coordinated and effective promotion, prevention, early intervention, and community support and treatment programs.

- **Palliative Care**: Development of new, and expansion of, existing models of care to support the advancement of a continuum of high quality and patient-centred end-of-life care across the province.

- **LHIN Sub-Regions**: The definition and implementation of sub-regional structures within LHINs, including the establishment of clinical and operational leadership within sub-regions to drive local performance improvements.

To further support the transformation agenda, including the delivery of quality health services, and to address the demographic and fiscal challenges facing Ontario, the MOHLTC and the LHINs recognize that comprehensive health system capacity planning that includes both the MOHLTC and the LHINs is required.

Primary Purpose of the Agreement

1. The Agreement is an accountability agreement for the purposes of section 18 of the LHSIA. The Agreement outlines the mutual understanding between the MOHLTC and the LHIN of their respective performance obligations in the period from April 1, 2015 to March 31, 2018 covering the 2015-2016, 2016-2017, and 2017-2018 Fiscal Years. The MOHLTC and the LHIN may review the Agreement during its term to reflect the evolution of the LHIN's role and responsibility.

Principles

2. **Both parties** will carry out the responsibilities and obligations based on principles that reflect:

   a) Alignment with provincial priorities and strategies;
   b) Sustainability of the healthcare system by maximizing the efficient and effective use of public funds;
   c) Performance improvement;
   d) High-quality, patient-centred service delivery;
   e) Consistency;
   f) Consultation and collaboration among the MOHLTC, LHINs, Health Service Providers, other providers and applicable communities;
   g) Openness and transparency; and
   h) Innovation, creativity and flexibility.

Definitions

3. The following terms have the following meanings in the Agreement:

   "Agreement" means this Agreement, including any schedules, and any instrument which amends this Agreement.

   "Annual Business Plan" means the plan for spending the funding received by the LHIN from the MOHLTC.

   "BPSAA" means the *Broader Public Sector Accountability Act, 2010*.

   "Community" in section 5 of Schedule 1 has the meaning set out in subsection 16(2) of the LHSIA.

   "CCAC" means Community Care Access Centre.

   "Consolidation Report" means a report that includes the LHIN's revenues and expenditures for LHIN operations and transfer payments to Health Service Providers, and balance sheet accounts for the LHIN.

   "**Dedicated Service Funding**" means, in respect of a specific service, the funding that must be used by the LHIN to fund the provision of the specific service.

   "Digital Health" means the coordinated and integrated use of electronic systems, information and communication technologies to facilitate the collection, exchange and management of personal health information in order to improve the quality, access, productivity and sustainability of the healthcare system. Key application areas of Digital Health in Ontario include, but are not limited to:

- Electronic health information systems (e.g., electronic medical records, hospital information systems, electronic referral and scheduling systems, digital imaging and archiving systems, chronic disease management systems, laboratory information systems, drug information and ePrescribing systems)
- Electronic health information access systems (e.g., provider portals, consumer Digital Health)
- Underlying enabling systems (e.g., client/provider/user registries, health information access layer)
- Remote healthcare delivery systems (e.g., telemedicine services)

"eHealth Ontario" means the government agency responsible to the Minister of Health and Long-Term Care which is a corporation without share capital created and continued in Ontario Regulation 43/02 made under the *Development Corporations Act*.

"Fiscal Year" means the period from April 1 to March 31.

"Health Based Allocation Model (HBAM)" is a population health-based funding methodology that uses population and clinical information to inform funding allocation.

"Health Service Provider (HSP)" has the meaning set out in section 2 of the LHSIA.

"Memorandum of Understanding" and "MOU" means the Memorandum of Understanding entered into between the MOHLTC and the LHIN, signed in 2017 as amended or replaced from time to time.

"Quality Based Procedures (QBP)" means the evidence-based funding determination that uses a 'price times volume' methodology to calculate the funding for a targeted set of specific patient groups/procedures.

"Regular and Consolidation Report" means a report that includes a statement of the LHIN's revenues, actual expenditures, forecasted expenditures for LHIN operations, transfer payments, an explanation of variances as required between the forecasted expenditures and revenues, and the identification of any financial and performance risks.

"Schedule" means any one of and "Schedules" means any two or more of the schedules appended to the Agreement, including the following:

1. General;
2. Local Health System Program Specific Management;
3. Long-Term Care Homes Program Specific Management;
4. Funding and Allocations;
5. Local Health System Performance;
6. Integrated Reporting; and
7. LHIN Delivered Services.

"Service Accountability Agreement (SAA)" means the service accountability agreement that the LHIN and a HSP are required to enter into under subsection 20 (1) of the LHSIA.

"**Sub-region**" means planning zones within each LHIN that will serve as the focal point

for local engagement, health care planning, performance measurement and integration.

"**Year-end**" means the end of a Fiscal Year.

Accountability Framework

4. **Both parties** will fulfill their performance obligations in accordance with the terms of the Agreement.

5. **Both parties** will collaborate and cooperate to:

   a) Facilitate the achievement of the requirements of the Agreement;
   b) Promote financial sustainability and efficient utilization of financial resources;
   c) Develop clear and achievable service and financial performance obligations and identify risks to performance;
   d) Advance evidence-based, high quality, patient-centred care;
   e) Establish clear lines of communication and responsibility; and
   f) Work diligently to resolve issues in a proactive and timely manner.

6. The **LHIN** is responsible for managing its operational and financial performance as a Crown agency, the performance of the local health system, the delivery and management of home and community care services, and collaborating with the MOHLTC and with providers to support provincial goals, as set out in the Agreement and using its authority under law. The **MOHLTC** is responsible for collaborating with the LHIN to achieve those ends. The **MOHLTC** and the **LHIN** recognize that issues may arise in the local health system that will require joint MOHLTC-LHIN problem-solving, decision making and action.

7. The **MOHLTC** has established provincial priorities and strategies for the health system through the Minister's mandate letter to the LHIN for the 2017/18 Fiscal in accordance with the Premier's mandate letter to the Minister for the 2017/18 Fiscal Year and will communicate supporting initiatives to the LHIN.

8. The **LHIN** will work with the MOHLTC, local clinical leaders, HSPs and other providers in the local health system to achieve and accelerate provincial and LHIN Sub-region priorities and strategies.

9. **Both parties** will follow a proactive and responsive approach to performance improvement based on the following principles:

   a) Prudent financial management of public healthcare resources;
   b) Better access to high quality, patient-centred services;
   c) Strengthened transitions in care across the entire patient journey;
   d) Ongoing performance improvement;
   e) An orientation to problem-solving; and
   f) Focus on relative risk of non-performance.

10. Where matters arise that could significantly affect either the LHIN's or MOHLTC's ability to perform their obligations under the Agreement, they shall provide written notice to the other party as soon as reasonably possible (a "Performance Factor"). Notice shall include a

description of any remedial action the party has taken or plans to take to remedy the issue. Receipt of notice will be acknowledged within five business days of the date of the notice.

11. **Both parties** agree to meet and discuss the Performance Factor within one calendar month of the date of the notice. During the meeting, using the principles set out in paragraph 5 above, the parties will discuss:

    a) The causes of the Performance Factor;
    b) The impact of the Performance Factor and whether it poses a “low”, “moderate” or “high” risk to achieving the obligations of the Agreement;
    c) The steps in the performance improvement process to be taken to mitigate the impact of the Performance Factor; and
    d) Whether revisions or amendments to a party’s performance obligations are required.

12. Where a LHIN Performance Factor is not mutually resolved, the Minister will determine the remedies to improve performance, depending on the extent, exposure or level of risk.

13. The **MOHLTC** will consult the LHIN in developing guidelines to determine parameters and process for escalating interventions initiated by the MOHLTC.

Next MOHLTC LHIN Agreement

14. **Both Parties** will enter into a new agreement under section 18 of the LHSIA to be effective at the end of the Agreement. If the new agreement is not signed by the Parties by April 1, 2018, the Agreement will continue in force until the new agreement is signed. Both Parties will make their best efforts to sign a new agreement as soon as they are able.

General

15. Any amendment to the Agreement will only be effective if it is in writing and signed by the authorized representative(s) of each party.

16. The **LHIN** will not assign any duty, right or interest under the Agreement without the written consent of the MOHLTC.

17. If a due date for materials falls on a weekend or on a holiday recognized by the MOHLTC, the materials are due on the next business day.

18. The **LHIN** will inform the MOHLTC as soon as reasonably possible when a due date for materials will not be met.

19. Each Schedule applies to the 2015-18 Fiscal Years, unless stated otherwise in a Schedule. Some of the performance obligations in a Schedule may apply only to one Fiscal Year, as stated in that Schedule.

20. Each party will communicate with each other about matters pertaining to the Agreement through the following persons:

To the MOHLTC:
Ministry of Health and Long-Term Care,
Health System Accountability and Performance Division
Hepburn Block, 5th Floor
80 Grosvenor Street,
Toronto, ON M7A 1R3

Attention:
Assistant Deputy Minister,
Health System Accountability and Performance

Fax: (416) 212-1859
Telephone: (416) 212-1134
E-mail: tim.hadwen@ontario.ca

With a copy to:
Director, Local Health Integration Network (LHIN) Liaison Branch
80 Grosvenor St.
5th Floor, Hepburn Block
Toronto, ON M7A 1R3

Fax: (416) 326-9734
Telephone: (416) 314-1864
E-mail: jane.sager@ontario.ca

To the LHIN:
Toronto Central Local Health Integration Network
425 Bloor St. E., Suite 201
Toronto ON M4W 3R4

Attention: Chair

Fax: (416) 921-0117
Telephone: (416) 921-7453
E-mail: Vivek.Goel@lhins.on.ca

With a copy to:
Toronto Central Local Health Integration Network
425 Bloor St. E., Suite 201
Toronto ON M4W 3R4

Attention: CEO

Fax: (416) 921-0117
Telephone: (416) 921-7453
E-mail: Susan.Fitzpatrick@lhins.on.ca

Her Majesty the Queen in right of Ontario, as represented by the Minister of Health and Long-*Term Care:*

_____

Minister of Health and Long-Term Care

Toronto Central Local Health Integration Network

By:

_____

Chair

SCHEDULE 1: GENERAL

Definitions

1. In this Schedule, the following terms have the following meanings:

"Active Offer" means the clear and proactive offer of service in French to individuals, from the first point of contact, without placing the responsibility of requesting services in French on the individual.

"Digital Health Board (DHB)" is a board that provides advice to the MOHLTC on the development of the new Digital Health Strategy, and, once approved, will monitor its implementation. DHB is chaired by the Deputy Minister of Health and Long-Term Care, and membership includes the LHIN Chief Executive Officers that represent each of the three LHIN Clusters.

"CHRIS" means the Client Health and Related Information System.

"Enabling Technologies for Integration (ETI)/Project Management Offices (PMO) LHIN Cluster" is funding to LHIN Clusters to enable the required governance, oversight and support of local, regional and provincial initiatives.

"FIPPA" means the *Freedom of Information and Protection of Privacy Act, 1990*.

"LHIN Cluster" is a grouping of LHINs for the purpose of advancing Digital Health initiatives through regional coordination aligned with the MOHLTC's provincial priorities. The LHIN Clusters provide governance, oversight, and support to ensure the successful adoption of local, regional, and provincial Digital Health initiatives.

"PHIPA" means the *Personal Health Information Protection Act, 2004*.

Provincial Priorities and Strategies

2. **Both parties** will:

a) Work together to develop a collaborative process to support current and future health system capacity planning so that decisions about local service provision will advance provincial priorities and strategies;

b) Work together to support implementation of broader government priorities and strategies through collaboration with other ministries; and

c) Work with Health Quality Ontario (HQO), local clinical leaders, HSPs and other providers to advance the quality agenda and align quality improvement efforts across sectors and the local health care system.

Provincial Health Agencies

3. The **MOHLTC** will work with the MOHLTC's provincial health agencies and networks to ensure that they work with the LHINs to support the fulfillment of provincial priorities and strategies.

4. The **LHIN** will work with the MOHLTC's provincial health agencies, provincial health networks, and the patient ombudsman, as applicable, to support the fulfillment of provincial priorities and strategies.

Community Engagement

5. The **LHIN** will fulfill its community engagement requirements in accordance with the LHIN Community Engagement Guidelines to ensure greater clarity and transparency of process.

6. **Both parties will** work together to engage patients, families, and caregivers across the province collaboratively and meaningfully, and, where possible, align provincial patient engagement activities and local community engagement efforts.

French Language Services (FLS)

7. The **MOHLTC** will:

   a) Ensure that provincial priorities and strategic directions for the health system foster the provision of health services in a way that meets the requirements of the *French Language Services Act*; and

   b) Outline system-wide expectations and accountabilities regarding the provision of FLS.

8. The **LHIN** will:

   a) Promote health equity, including equitable health outcomes, to reduce or eliminate health disparities and inequities, to recognize the impact of social determinants of health, and to respect the diversity of communities;

   b) Collaborate with the French Language Health Planning Entity in the planning and integration of FLS, as required; and

   c) Hold HSPs accountable for the provision of FLS and reporting as per the SAAs;

9. **Both parties** will:

   a) Comply with the requirements of the *French Language Services Act;*
   b) Work with health system partners and the Office of Francophone Affairs (OFA) to follow the designation process of HSPs; and

   c) Promote the concept of "Active Offer" across the health system.

Digital Health

10. The **MOHLTC** will:

    a) Set directions for Digital Health through the DHB;

    b) Work with eHealth Ontario and others to establish technical and information management standards related to Digital Health and implementation / compliance timeframes for the interoperability of the health system in Ontario, including standards related to content, architecture, technology, privacy and security; and

    c) Review annual LHIN Cluster Digital Health plans as submitted for funding through the ETI/PMO program by the LHINs.

11. The **LHIN** will:

    a) Ensure that Digital Health investment decisions are appropriately endorsed by DHB and align with the new Digital Health Strategy;

    b) Champion provincial directions set by the MOHLTC for Digital Health and related priorities;

    c) Assist its respective LHIN Cluster to prepare an annual LHIN Cluster Digital Health plan that aligns with the provincial Digital Health priorities for 2017-18, to be submitted to the MOHLTC for review; and

    d) Include Digital Health commitments in SAAs requiring HSPs to:

        (i) Assist the LHIN to implement provincial Digital Health priorities for 2017-18;

        (ii) Comply with any technical and information management standards, including those related to data, architecture, technology, privacy and security, set for HSPs by the MOHLTC or the LHIN within the timeframes set by the MOHLTC or the LHIN, as the case may be;

        (iii) Implement and use the approved provincial Digital Health solutions identified in the LHIN Cluster Digital Health plan;

        (iv) Implement technology solutions that are compatible or interoperable with the provincial blueprint and with the LHIN Cluster Digital Health plan; and

        (v) Include, in their annual planning submissions, plans for achieving Digital Health priority initiatives.

12. **Both parties** will work together, and in conjunction with eHealth Ontario, and the Ontario Telemedicine Network, and other partners as appropriate, to:

    a) Participate in forums for the discussion of Digital Health issues at a provincial level to identify options to support the roll out of Digital Health initiatives and related Digital Health issues including local health system needs, challenges, and opportunities and Digital Health standards, definitions, and architectural frameworks; and

b) Inform one another of significant issues or initiatives that contribute to or have an impact on provincial or local Digital Health issues, strategies or work plans.

Information Management

13. The **MOHLTC** will:

a) Develop, maintain and support health data standards; communicate health data reporting requirements and standards to the LHIN and HSPs; advise/inform the LHIN and HSPs of reporting and data quality issues; and inform the LHINs and HSPs of reporting timelines;

b) Consult with the LHIN to identify LHIN data/information requirements that support data infrastructure for LHIN operational needs, and prepare data sharing agreements and / or amendments to existing agreements as required; work with LHINs toward a shared understanding of privacy rules and obligations compliant with PHIPA and FIPPA;

c) Receive data and information from HSPs on behalf of the LHIN and provide the LHIN with timely access to the appropriate data to support health system needs; and

d) Invite LHIN input into the Health System Information Management Strategy, to provide advice on information management policies and processes, data architecture, and system development to provide relevant evidence-based analyses and plans to improve the health services of Ontarians within the LHIN's geographic area.

14. The **LHIN** will:

a) Submit personal health information and data related to the delivery and management of the LHIN Delivered Services in paragraphs 1, 2 and 3 of Table 1 to Schedule 7 of this Agreement through CHRIS;

b) Require HSPs to submit data and information as communicated by the MOHLTC under clause 13(a) of this Schedule to the MOHLTC, Canadian Institute for Health Information, or other third party;

c) Identify LHIN data / information requirements to support the LHIN analysis at the local level, and work collaboratively with the MOHLTC to develop appropriate data access methodology, consistent data analysis and reporting;

d) Work with HSPs to improve data quality and timeliness as necessary;

e) Provide input to ensure LHIN Information Management needs and interests are integrated into the Digital Health Strategy, the Open Data, initiative, and Health System Information Management Strategy, and establish enabling governance structures to ensure ongoing feedback; and

f) Work with Health Shared Services Ontario (HSSO) and use the LHIN Delivered

Services delivery platforms managed by that agency, which include the CHRIS, the Health Partner Gateway (HPG), and assessment tools to support efficient and effective delivery of LHIN Delivered Services, as defined in Schedule 7 to this Agreement.

15. **Both parties** will avoid duplicating data and information management infrastructure and processes, determine and prioritize data and information products, and streamline reporting requirements and timelines for the LHIN and HSPs.

Health Service Provider Compliance Protocols

16. The **MOHLTC** will:

    a) Retain its compliance, inspection and enforcement authorities under legislation; and

    b) Inform the LHIN as soon as reasonably possible on matters related to compliance, inspection and enforcement in long-term care homes (LTCHs) and otherwise through a mutually agreeable reporting schedule.

17. The **LHIN** will:

    a) Exercise its legislative and contractual authorities as necessary or as required under law, including conducting or requiring audits and reviews of HSPs; and

    b) Inform the MOHLTC as soon as reasonably possible:

        i) Of non-compliance by an HSP with an assigned agreement, a SAA or legislation that has not been resolved to the LHIN's satisfaction; or

        ii) Of an HSP that is licensed or approved to operate a LTCH,

            a) That is experiencing financial issues;

            b) Where the LHIN is aware that there is risk to resident health and / or safety in a LTCH; or

            c) Where the results of an audit or review conducted or required by a LHIN identify problems.

Capital

18. **Both parties** will work together during the term of the Agreement to review and revise capital planning and delivery model(s) as appropriate.

General Performance Obligations

19. The **MOHLTC** will provide the LHIN with, and develop as appropriate, those provincial standards (such as operational, financial or service standards and policies, operating

manuals and program eligibility), directives and guidelines that apply to the LHIN or to HSPs, including providing the LHIN with relevant program manuals.

20. The **LHIN** will:

    a) Require HSPs to provide services funded by the LHIN in accordance with provincial standards, directives and guidelines provided pursuant to paragraph 19 of this Schedule;

    b) Manage the performance of HSPs. Where HSPs' performance do not meet expectations, the LHIN will identify and implement measures to support HSPs' improved performance; and

    c) Provide certificates of compliance, or attestations as the case may be, to the MOHLTC in form and substance as required by the MOHLTC.

21. **Both parties** will work together to ensure that government priorities and implementation of provincial strategies are reflected in HSP planning submission templates, SAAs and schedules with HSP and other providers.

Review and Update

22. **Both Parties** agree to review and update the Schedules annually, as necessary to better reflect the Primary Purpose, within 120 days of the date a budget motion is approved by the Ontario Legislature for the Fiscal Year.

23. **Both Parties** agree to work together to review the accountability agreements with HSPs with a view to reducing or consolidating accountability agreements where possible.

SCHEDULE 2: LOCAL HEALTH SYSTEM PROGRAM-SPECIFIC MANAGEMENT

Definitions

1. In this schedule, the following term has the following meaning:

   "Quality Improvement Plan (QIP)" is an organization-owned document that established a plan for quality improvement over the coming year. QIPs are designed to be a lever for change on system-wide priority quality issues as well as key issues that are important within each organization. Further, QIPs are a public commitment to meet quality improvement goals. By developing the plan, the organization outlines how they will address improving the quality of care it provides to its patients, residents or clients. QIPs include reporting of indicators to measure important areas for quality improvement, and to reflect organizations' specific quality improvement goals and opportunities.

Provincial Programs

2. The **MOHLTC** and the **LHIN** will establish a coordinated and effective system for the management of provincial programs.

3. The **MOHLTC** will:

   a) Identify provincial programs, determine any terms and conditions, including Dedicated Service Funding, related to these provincial programs and communicate these to the LHIN; and

   b) Establish:

      (i) Roles and responsibilities related to provincial program delivery; and

      (ii) Performance management, monitoring and evaluation processes.

4. The **LHIN** will fulfill requirements as may be identified by the MOHLTC under paragraph 3 of this Schedule and work with other LHINs to coordinate provincial program service delivery.

Other Programs

5. If the **MOHLTC** establishes expectations and requirements for any other programs, it will advise the LHIN.

6. The **LHIN** will require HSPs that provide the specific program to provide program services in accordance with the expectations and requirements established by the MOHLTC.

Devolution

7. The **MOHLTC**:

   a) Will determine the devolution of province-wide programs to the LHINs;

   b) Will consult with LHINs before identifying a Lead LHIN; and

   c) May specify the terms and conditions applicable to the funding and administration of the province-wide program after its devolution.

8. The **LHIN** will:

   a) Administer the devolved program in accordance with the "Agreement Concerning the Devolution of Provincial Programs", also known as the Lead LHIN Model Agreement and any terms and conditions specified by the MOHLTC; and

   b) Confirm any proposed changes to the Lead LHIN Model Agreement with the MOHLTC prior to implementation.

Primary Care

9. The **MOHLTC** will:

   a) Develop strategic priorities and standards for the primary health care sector, as well as performance expectations, and communicate these to the LHIN on a regular basis, to support the achievement of the Primary Care Access Guarantee;

   b) Approve the Sub-regions within each LHIN to serve as the focal point for local primary care planning and performance monitoring to improve accessibility and coordination of primary care services;

   c) Consult, collaborate and share information with the LHIN in respect of primary care capacity, health human resources, practice models and service delivery;

   d) Consult, collaborate and share information with the LHIN in respect of primary care access, including working in partnership to address access gaps where possible and feasible; and

   e) Ensure appropriate provincial supports are in place for Health Care Connect.

10. The **LHIN** will:

   a) Engage with primary care providers, patients, and clinical leaders to assist in furthering Sub-region and provincial health system priorities and to help inform opportunities for improvement;

   b) Develop local strategies, based on the needs identified through planning and engagement activities, to address both the unique local priorities of each Sub-region as well as key provincial priorities;

c) Undertake primary care service capacity assessment across all Sub-regions and use this information to identify service gaps and implement local strategies to address these gaps;

d) Work with the MOHLTC to enhance primary care capacity to sustain and improve primary care delivery; and

e) Work with the MOHLTC on primary care access planning and performance monitoring, through identifying current and future primary care access challenges, to ensure access to quality primary care services.

Health Links

11. The **MOHLTC** will:

a) Provide direction regarding the evolution of the Health Links model and alignment with Sub-regions;

b) Work with LHINs in monitoring the performance of Health Links across the province to achieve a reasonable state of maturity before aligning them geographically and functionally with Sub-regions; and

c) Lead the development of provincial communications including key messages.

12. The **LHIN** will**:**

a) Lead and support the implementation of Health Links to facilitate integrated health care service delivery within the Sub-regions and work with the MOHLTC on the evolution of the Health Links model within the Sub-regions;

b) Monitor the performance of Health Links and report to the MOHLTC as required; and

c) Lead communications within the LHIN sub-regions and conduct stakeholder engagement as required.

13. **Both parties** will:

a) Work together to develop system-wide tools and promote their uptake to support Health Links; and

b) Work together to lead sustainability planning of Health Links and operationalize within the LHIN and Sub-regions.

Quality Improvement Plans

14. The **LHIN** will work collaboratively with HQO to develop and disseminate the required templates, and will provide guidance and accompanying supports to its HSPs in the development of Quality Improvement Plans;

15. The **LHIN** will require each LTCH, and Community Health Centre (CHC), as well as every other inter-professional team-based primary care organization (including Family Health Teams, Nurse Practitioner-Led Clinics, and Aboriginal Health Access Centres) with which the LHIN has an SAA, to submit a Quality Improvement Plan to HQO that is aligned with their SAA and supports local health system priorities.

Mental Health and Addictions

16. The **MOHLTC** will:

a) For forensic mental health services, determine and advise the LHIN of:

(i) The number and type of forensic mental health inpatient beds, alternative care pathway services, outpatient services, the forensic case management initiatives, and the Transitional Rehabilitation Housing Programs' numbers and models;

(ii) The designated hospitals that provide forensic mental health services; and

(iii) The required service levels for subclauses 16 a) (i) and (ii) in this Schedule.

b) Determine and advise the LHIN of the type (adult or pediatric, inpatient, residential, day treatment or outpatient) and quantity of specialty eating disorder services, where applicable; and

c) Determine and advise the LHIN of the type and quantity of problem gambling treatment and prevention services.

17. The **LHIN** will:

a) Fund the provision by HSPs of a combination of community mental health and addiction services for the local health system, including services for people who have been in conflict with the criminal justice system;

b) Fund the provision by HSPs of the following services:

(i) Forensic mental health services that include forensic mental health inpatient beds, forensic alternative care pathway services, outpatient services,case management initiatives, and the Transitional Rehabilitation Housing Programs at the service levels as described in clause 16(a) of this Schedule;

(ii) Specialty eating disorder services as advised by the MOHLTC under clause 16(b) of this Schedule; and

(iii) Problem gambling treatment and prevention services as advised by the MOHLTC under clause 16(c) of this Schedule.

c) Require HSPs, designated as psychiatric facilities under the *Mental Health Act*, to

provide the essential mental health services in accordance with the specific designation for that site and discuss any material changes to the service delivery models or service levels with the MOHLTC; and

d) Not make any changes to types or levels of, or amount of, service as specified by the MOHLTC under paragraph 16 of this Schedule without MOHLTC approval.

Supportive Housing

18. The **MOHLTC** will advise the LHIN of:

a) The number of buildings and housing units in respect of which operating and rent subsidies, or rent supplements are paid to support the provision of housing for persons with longer-term care needs (including the frail elderly, and those with acquired brain injuries, physical disabilities, HIV/AIDs) or serious mental illness and / or problematic substance use;

b) The names of the specific agencies that receive such payments; and

c) The required service levels for support within housing for such persons who occupy such buildings or housing units, as set out in clause 18(a) of this Schedule.

19. The **LHIN** will:

a) Fund HSPs for the provision of support within housing in accordance with the required service levels as advised by the MOHLTC under clause 18(c) of this Schedule;

b) Consult and obtain MOHLTC approval in writing prior to decreasing service levels for support within housing for such persons who occupy such buildings or housing units described in clause 18(a) of this Schedule; and

c) Collaborate, where possible, with Consolidated Municipal Service Managers "CMSM"s) and / or District Social Services Administration Boards ("DSSAB"s) (as applicable in the area of the LHIN) to co-ordinate LHIN funded services with social and affordable housing funded by the CMSM and / or the DSSAB.

20. **Both parties** will work together to revise the required service levels for such persons who occupy such buildings or housing units set out in clause 18(a) of this Schedule as appropriate**.**

Quality Based Procedures (QBP)

21. **Both parties** will work together to develop the QBP volume allocation methodology.

22. The **MOHLTC** will set appropriate volumes at the provincial and LHIN level.

23. The **LHIN** will work with their HSPs to:

a) Finalize HSP-level allocations to align capacity with the demand for service across the LHIN and to optimize performance;

b) Implement service delivery models that support patient needs and adhere to clinical guidelines; and

c) Support the adoption of evidence-based best practices recommended in new or existing QBP Clinical Handbooks and/or HQO's Quality Standards.

SCHEDULE 3: LONG-TERM CARE HOMES PROGRAM SPECIFIC MANAGEMENT

Definitions

1. Definitions below apply to Schedule 3: Long-Term Care Homes and Schedule 4: Funding and Allocations:

"Acknowledgement and Consent Agreement" means an agreement entered into between the MOHLTC, the operator of a LTCH, and one or more lenders or secured parties, by which the MOHLTC consented to, or agreed to request a consent to, any of the following: (a) a mortgage of real property associated with the LTCH, (b) an assignment of a Development Agreement with the MOHLTC, and / or (c) an assignment of a service agreement.

"Beds in Abeyance" means LTCH beds licensed or approved by the MOHLTC, for which the LTC Health Service Provider has obtained written permission from the Director, Licensing and Policy Branch, in accordance with the LTCHA for the beds not to be available for occupancy.

"Construction Funding Subsidy per diem" or **"CFS per diem"** means any per diem funding paid pursuant to a Development Agreement.

"Convalescent Care Beds" means those short-stay beds, licensed or approved under the LTCHA, that are part of a short-stay convalescent care program for which residents may be eligible for admission in accordance with regulations under the LTCHA.

"Development Agreement" means an agreement between the MOHLTC and a LTC Health Service Provider, or a proposed LTC Health Service Provider, to develop, upgrade, retrofit or redevelop LTCH beds.

"Funding Policies" means the funding and financial management policies determined by the MOHLTC for LTCHs as the same may be amended from time to time. Funding Policies establish the rates, and amounts and envelopes of all funding provided to LTC Health Service Providers by the MOHLTC or the LHIN, including Supplementary Funding. Funding Policies also establish the applicable conditions for funding, the funding reconciliation rules, and the form, manner and content and date for submission of reports.

"Interim Beds" means those short-stay beds that are licensed or approved under the LTCHA and that fall within the definition of "interim bed" in accordance with regulations under the LTCHA.

"**Licensed Bed Capacity**" means a LTCH Health Service Provider's total number of LTCH beds licensed or approved under the LTCHA.

"LTCH" means long-term care home.

"LTCH Protocol" means the document titled "Long-Term Care Homes Protocol" as prepared and amended by the MOHLTC.

"LTCH Redevelopment" means any MOHLTC program or initiative to support the redevelopment or renewal of existing LTCH capacity, and includes the Enhanced Long-Term Care Home Renewal Strategy.

"LTCHA" means the *Long-Term Care Homes Act, 2007* and regulations thereunder.

"LTC Health Service Provider" means a Health Service Provider that is a licensee within the meaning of subsection 2(1) of the LTCHA.

"Supplementary Funding" means funding for LTCH beds provided directly by the MOHLTC to LTC Health Service Provider s in accordance with applicable Funding Policies and pursuant to a funding agreement between MOHLTC and the LTC Health Service Provider.

"Service agreement" means the agreement pursuant to which funding is provided to a LTC Health Service Provider and includes a SAA.

"Short-Stay Respite Beds" means those short-stay beds, licensed or approved under the LTCHA, that are part of a short-stay respite care program for which residents may be eligible for admission in accordance with regulations under the LTCHA.

Funding

2. The **MOHLTC** will:

   a) Determine and provide to the LHIN, the amount of funding that a LHIN may provide to a LTC Health Service Provider together with any applicable terms and conditions;

   b) Determine any net projected unused funding for all LHINs that, as of September 30 in each Fiscal Year, has not or is projected not to be used by LTC Health Service Providers;

   c) Reallocate a share of the net projected unused funding to the LHIN if the LHIN is projected to be overspent on its funding for the LTCH per diem rate;

   d) If there is net projected unused funding remaining after the reallocation, allocate to the LHIN by December 31 of each year a share of the unused funding in proportion to the number of LTCH beds that are licensed or approved and in operation in the LHIN's geographic area, other than (i) Beds in Abeyance and (ii) beds funded by the LHIN pursuant to paragraphs 20 and 23 of this Schedule, compared to the provincial total number of LTCH beds that are licensed or approved and in operation in the Province, other than Beds in Abeyance and beds funded by all the LHINs pursuant to paragraphs 20 and 23 of this Schedule to their respective MOHLTC-LHIN Performance Agreements; and

   e) At its discretion, provide Supplementary Funding.

3. The **LHIN** will distribute and reconcile the funding provided under paragraph 2 of this Schedule, pursuant to the terms of an SAA that is consistent with and requires adherence to the Funding Policies and any additional terms and conditions. For greater certainty, the LHIN may not provide any more funding to LTC Health Service Providers than is identified in paragraph 2 of this Schedule, except as provided in the Funding Policies and this Schedule.

4. If a LTC Health Service Provider's Licensed Bed Capacity changes because one or more beds are closed or transferred to another LHIN, or the licence expires, is surrendered or is revoked under the LTCHA, the LHIN may seek, except where the beds are transferred to another LHIN, and the MOHLTC may approve use of some or all of the funding available as a result of the change on terms and conditions determined by the MOHLTC.

Construction Funding Subsidy (CFS)

5. The **MOHLTC** will:

   a) Determine the CFS per diem and the LTC Health Service Providers in the geographic area of the LHIN that will receive the per diem, including any conditions on the funding and the number of beds for which the LTC health service provider will receive the CFS per diem; and

   b) Provide the CFS per diem to the LHIN.

6. The **LHIN** will provide the CFS per diem to LTC Health Service Providers for each approved or licensed bed that is identified in paragraph 5 of this Schedule and operated in accordance with the MOHLTC's conditions of funding, applicable legislation or Development Agreement.

7. Every SAA entered into between the LHIN and the LTC Health Service Provider during the term of the Agreement and in the future will contain an obligation on the **LHIN** to provide the CFS per diem to the LTC Health Service Provider for the length of time set out in the particular Development Agreement for the particular beds.

Long-Term Care Home Redevelopment

8. **Both parties** will work together to establish a coordinated and effective system for the implementation of LTCH Redevelopment.

9. The **MOHLTC** will:

   a) Identify and develop policies and processes surrounding LTCH Redevelopment including determination of any terms and conditions of funding and a process for the scheduling of redevelopment projects, and communicate these to the LHIN; and

   b) Establish:

(i) MOHLTC, LHIN and LTC Health Service Provider roles and responsibilities related to LTCH Redevelopment;

(ii) Areas requiring LHIN input; and

(iii) Performance management, monitoring and evaluation processes.

10. The **LHIN** will:

a) Fulfill requirements as may be identified under paragraph 9 of this Schedule, and work with other LHINs to coordinate implementation of LTCH Redevelopment; and

b) Provide input related to LTCH Redevelopment as requested by the MOHLTC related to:

(i) Scheduling of redevelopment projects including identification of LHIN-level LTCH bed capacity and current or predictable demand for LTCH beds;

(ii) Location of redevelopment projects;

(iii) Identification of linkages to LHIN program priorities and local health service needs;

(iv) The MOHLTC's policies and processes relating to LTCH Redevelopment; and

(v) Any other requirements identified by MOHLTC.

Assignment of LTC Service Agreement

11. Where the MOHLTC has entered into an Acknowledgement and Consent Agreement with a LTC Health Service Provider and one or more lenders of the LTC Health Service Provider (Lender) prior to the proclamation of the LTCHA, the **LHIN** will treat the MOHLTC's consent to assign the service agreement under the Acknowledgement and Consent Agreement as if MOHLTC had provided the consent on behalf of the LHIN.

12. Where an Acknowledgement and Consent Agreement or a Development Agreement between the MOHLTC and the LTC Health Service Provider provides that the MOHLTC will request the LHIN to consent to an assignment of the service agreement, to the Lender or person designated by the Lender, the **LHIN** will consent to the assignment of the service agreement to that person where the MOHLTC so requests, and the consent shall be subject to terms and conditions similar to those of the Acknowledgement and Consent Agreement or the Development Agreement as the case may be.

13. In addition, the **LHIN** will not unreasonably withhold consent requested from a Lender, or from a receiver or receiver and manager appointed by a Lender or by a court order, to assign its or the LTC Health Service Provider's right, title and interest in the service agreement or any part thereof or interest therein to another party, subject to all applicable legislative requirements.

14. Where the **MOHLTC**

a) Has entered into a Development Agreement with a LTCH Health Service Provider or a proposed LTCH Health Service Provider (an "Operator");

b) Has consented to the grant of a security interest to a Lender under the Development Agreement; and

c) Has directed the LHIN to consent to the assignment of the Operator's rights under a SAA,

then the **LHIN,**

d) Shall deliver to the Lender a commitment, in the MOHLTC's standard form, to provide the LHIN's consent to the assignment of the Operator's rights under the SAA between the Operator and the LHIN;

e) Upon the grant of a licence to the Operator in respect of the Home, and for so long as a CFS is to be paid in respect of the Home, shall consent to the grant of a security interest in the SAA between the LHIN and the Operator in respect of the Home, provided that:

(i) The security interest in the SAA may only be exercised together with the exercise of a security interest in the licence for the beds; and

(ii) The security interest is subject to all applicable statutory requirements and restrictions, including section 107 of the LTCHA and sections 2(2), 19 and 20 of the LHSIA; and

f) Shall amend section 15.8 of the SAA in respect of the Home to remove the following sentence: "No assignment or subcontract shall relieve the HSP from its obligations under the Agreement or impose any liability upon the LHIN to any assignee or subcontractor."

Beds in Abeyance

15. The **MOHLTC** will review and may approve Beds in Abeyance applications in accordance with the Beds in Abeyance policy and LTCH Protocol.

16. In the event that an application is approved, the **LHIN** may seek and the **MOHLTC** may grant permission to temporarily use the amount of funding available as a result of any approved Beds in Abeyance applications. If the MOHLTC approves the LHIN's request, the LHIN may use the funding in accordance with the approval, including any conditions that may attach to the approval.

Short-Stay Program Beds

17. The **MOHLTC** will:

a) Determine the minimum threshold for occupancy for Short-Stay Respite Beds to

inform approval of these beds in accordance with the LTCH Protocol;

b) Determine the minimum number of Convalescent Care Beds and Interim Beds in the Province;

c) In consultation with the LHIN, determine the LTC Health Service Providers that will provide the Convalescent Care Beds and the Interim Beds and the number of those beds from the minimum number of beds determined in clause (b) of this paragraph; and

d) Set other conditions for the operation of Convalescent Care Beds and Interim Beds.

18. The **LHIN** will:

a) Take action as appropriate to improve the utilization of Short-Stay Respite Beds;

b) Have the ability to set, in its discretion, a threshold for occupancy of Short-Stay Respite Beds that is higher than the minimum set by the MOHLTC pursuant to clause 17(a) of this Schedule;

c) Determine which LTC Health Service Providers will provide Short-Stay Respite Beds within the existing licensed or approved beds of each home and the number of such beds;

d) Advise and / or make a proposal to MOHLTC about matters referred to in clause 17(c) of this Schedule;

e) Incorporate the conditions referred to in clause 17(d) of this Schedule in SAAs;

f) At its discretion, request that the MOHLTC approve the conversion of existing licensed or approved beds into Convalescent Care Beds additional to those identified in clause 17(b) of this Schedule in accordance with the LTCH Protocol; and

g) Provide from its allocation, all additional funding for the converted Convalescent Care Beds approved by the MOHLTC pursuant to clause 18(f) of this Schedule to LTC Health Service Providers in accordance with the Funding Policies, including the additional subsidy for Convalescent Care Beds and the resident co-payment portion of the base level-of-care per diem funding.

LHIN-Requested LTCH Beds

19. In paragraphs 20 and 21 of this Schedule “LHIN Requested LTCH Beds” means, subject to a determination under clause 21(b) of this Schedule, a LTCH bed funded by the LHIN out of its allocation, other than its allocation for LTCHs:

a) That would increase the bed capacity of an existing LTCH licence issued under section 99, or an approval granted under section 130 of the LTCHA; or

b) In the case of a development or redevelopment, that is over and above the number of LTCH beds that the MOHLTC has approved a LTC Health Service Provider for development or redevelopment.

20. The **LHIN** will:

a) At its discretion, request LHIN Requested LTCH Beds;

b) In its request identify (i) the number of LHIN Requested LTCH Beds requested; (ii) the estimated amount of funding required to support the beds in accordance with the Funding Policies, including Supplementary Funding and funding that would be paid in accordance with paragraphs 3 and 6 of this Schedule; and (iii) where, subject to a determination under clause 21(b) of this Schedule, the funding will be found within the LHIN's allocation, other than its allocation for LTCHs; and

c) Fund the LHIN Requested LTCH Beds in accordance with the Funding Policies and paragraphs 3 and 6 of this Schedule if the LHIN's request for LHIN Requested LTCH Beds is granted by the MOHLTC.

21. The **MOHLTC** will:

a) Consider the LHIN's request for LHIN Requested LTCH Beds and decide whether to grant the request.

b) Determine the amount of funding, if any, that the MOHLTC may contribute;

c) Confirm the amount of the funding required to support the beds in accordance with the Funding Policies, including Supplementary Funding and funding that would be calculated pursuant to paragraphs 2 and 5 of this Schedule; and

d) Reallocate the confirmed funding from the sources identified by the LHIN to (i) the LHIN's allocation for LTCH beds for all funding to be paid in accordance with paragraphs 3 and 6 of this Schedule; and (ii) the MOHLTC's allocation for Supplementary Funding when the LHIN Requested LTCH Beds are available for occupancy.

LHIN-Requested Temporary LTCH Beds

22. In paragraphs 23 and 24 of this Schedule, "LHIN Requested Temporary LTCH Beds" means a LTCH bed for which the MOHLTC would issue a temporary license in accordance with section 111 of the LTCHA or increase the bed capacity of a temporary licence in accordance with the LTCHA, on the condition that the LTCH bed will be funded by the LHIN out of the LHIN's allocation, which may include funding approved for temporary use under paragraph 16 of this Schedule.

23. The **LHIN** will:

a) At its discretion, make a request for LHIN Requested Temporary LTCH Beds for a term of no longer than 5 years;

b) In its request identify (i) the number of LHIN Requested Temporary LTCH Beds requested; (ii) the estimated amount of funding required to support the beds in accordance with the Funding Policies, including Supplementary Funding and funding that would be paid in accordance with paragraph 3 of this Schedule; and (iii) where the funding will be found within the LHIN's allocation; and

c) If the request is approved pursuant to paragraph 24 of this Schedule, provide the funding identified in clause 24(b) of this Schedule for the LHIN Requested Temporary LTCH Beds in accordance with the Funding Policies for the term of the temporary licence issued by the MOHLTC, including any increases in this funding and Supplementary Funding after the date the temporary licence is issued by the MOHLTC for these beds.

24. The **MOHLTC** will:

a) Consider the LHIN's request for LHIN Requested Temporary LTCH Beds and decide whether to grant the request; and

b) Confirm the amount of funding required to support the beds in accordance with the Funding Policies, including Supplementary Funding and the funding paid in accordance with paragraph 3 of this Schedule.

SCHEDULE 4: FUNDING and ALLOCATIONS

Definitions

1. In this Schedule, the following terms have the following meanings:

"Annual Balanced Budget" means that, in a Fiscal Year, the total revenues are greater than or equal to the total expenses. Further, for the LHIN, the meaning of annual balanced budget is also subject to Public Sector Accounting Board (PSAB) rules as well as any interpretations issued by the MOHLTC in financial management policies, directives or guidelines under paragraph 8 of this Schedule.

"Health System Funding Reform (HSFR) Funding" is comprised of HBAM Funding and QBP Funding.

"HBAM Funding" means the portion of funding allocated to an HSP based on the results of HBAM allocation methodology as communicated to the LHINs by the MOHLTC from time to time.

"Multi-year funding targets" means the funding targets for more than one Fiscal Year.

"Non-HSFR Funding" is the portion of hospital and Community Care Access Centre/ LHIN Delivered Services funding net of HSFR Funding.

"LHIN's Operating Allocation" means the allocation for the LHIN's corporate operations.

"Quality Based Procedure (QBP) Funding" means the portion of funding allocated to an HSP as a result of QBP allocation methodology as communicated to the LHINs by the MOHLTC from time to time.

"Health Service Provider (HSP) Transfer Payment Allocation" means the budget for the LHIN's funding of HSPs.

Funding

2. The government's overall provincial LHIN funding allocations to the date February 28, 2017 are set out in the following tables, in this Schedule:

   a) Table 1 – Statement of Overall LHIN Provincial 2017-18 Funding Allocation
   b) Table 1a – Statement of Overall LHIN Provincial 2017-18 Funding Allocation for Hospitals and Community Care Access Centres/ LHIN Delivered Services
   c) Table 3 – Statement of Overall LHIN Provincial 2017-18 Dedicated Service Funding by Sector.

3. The **MOHLTC:**

   a) Will provide to the LHIN the 2017-18 funding allocation to the date February 28, 2017 set out in the following tables in this Schedule:

(i) Table 2 – Statement of Individual LHIN 2017-18 Funding Allocation
(ii) Table 2a – Statement of Individual LHIN 2017-18 Funding Allocation for Hospitals and Community Care Access Centres/LHIN Delivered Services)
(iii) Table 3a – Statement of Individual LHIN 2017-18 Dedicated Service Funding by Sector;

b) Will revise Table 2, 2a and 3a to reflect government funding allocation decisions at the sector level throughout the year;

c) Will revise the HSP Transfer Payment Allocation by Sector – Initiatives allocation in Table 2 in this Schedule to the appropriate sectors, as the LHIN makes funding allocation decisions at the sector level throughout the year;

d) Will reconcile all funding provided to the LHIN under the Agreement on an annual basis;

e) Will recover funding from the LHIN if the MOHLTC has advised the LHIN that the particular funding is recoverable;

f) May set terms and conditions for any of the funding set out in the tables in this Schedule, including the type of funding, whether the funding is subject to annual adjustment, and whether and in what circumstances the funding may be recoverable from the LHIN by the MOHLTC;

g) Has determined that HSFR Funding set out in Tables 1a and 2a is subject to annual adjustment by the MOHLTC, and QBP Funding included in the HSFR Funding set out in Tables 1a and 2a in this Schedule is subject to annual adjustment and is recoverable by the MOHLTC; and

h) May require the LHIN to carry out certain initiatives, activities and/or specific actions as determined by MOHLTC.

4. The **LHIN**:

a) Will allocate the funds provided by the MOHLTC for 2017-18, in accordance with the LHSIA, the Agreement and any applicable terms and conditions of which the LHIN is advised by the MOHLTC, including those set out in paragraph 3 of this Schedule;

b) Will carry out MOHLTC-required initiatives, activities, and/or specific actions;

c) Will ensure no approval is granted regarding the carry-forward of unspent funding from one Fiscal Year to the next;

d) May, at its discretion, provide additional funding for the services for which Dedicated Service Funding is identified;

e) May, only with prior approval from the MOHLTC, reallocate unused Dedicated Service Funding to another service. If the MOHLTC does not give approval, the LHIN shall return unused Dedicated Service Funding to the MOHLTC;

f) i) May, only with prior approval from the MOHLTC, reallocate funds from the LHIN's HSP Transfer Payment Allocation to the LHIN's Operating Allocation; and

ii) May, only with prior approval from the MOHTLC, reallocate funds from the CCAC/LHIN Delivered Services Allocation to any other funding allocation as set out in Table 2 to the Schedule; and

g) Will assist / coordinate with the MOHLTC, as needed, to i) obtain HSP's financial information; ii) recover funds, if any, after settlement has been approved.

Long-Term Care Homes

5. The funding allocations in Tables 1 and 2 for LTCHs are only estimates that are subject to adjustment in accordance with the Funding Policies as defined in Schedule 3, including adjustments for reconciliation, Beds in Abeyance, and Construction Funding Subsidy per diem.

Annual Balanced Budget Requirements

6. The **LHIN** will:

a) Plan for and achieve an Annual Balanced Budget for its operations; and

b) Require HSPs who receive LHIN funding through transfer payments to plan for and achieve an Annual Balanced Budget.

Multi-Year Funding Requirements

7. The **LHIN** will plan and manage LHIN forecasted expenses for the LHIN's Operating and Transfer Payment Budgets within the multi-year funding targets set out in this schedule and the Multi-Year Funding Framework. Multi-year funding targets are to be used for planning purposes only and may be revised upward or downward at the discretion of the MOHLTC.

Financial Management Polices and Guidelines

8. The **MOHLTC** may develop and give to the LHIN policies, directives and guidelines related to financial accountability and management.

9. The **LHIN** will comply with all applicable legislation, including the Financial Administration Act; any MOHLTC policies, directives and guidelines issued to the LHIN related to financial accountability and management; the TB/MBC and Ministry of Finance Directives listed in Appendix 1 of the MOU, including the Transfer Payment Accountability Directive, the Cash Management Directive, the Procurement Directive, the Travel, Meal and Hospitality Expenses Directive, and any other government financial management policies, guidelines, and directives.

Accounting Standards

10. The **MOHLTC**:

    a) Will issue interpretations and modifications relating to PSAB standards, based on advice from the Office of the Provincial Controller; and

    b) May review the documentation described in paragraph 11 of this Schedule during regular business hours and upon twenty-four hours' notice to the LHIN.

11. The **LHIN** will:

    a) Prepare its financial reports and statements on its Operating and HSP Transfer Payment Budgets, including its Annual Business Plan, based on the PSAB standards, subject to interpretations and modifications issued under paragraph 10 of this Schedule.

    b) Maintain documentation to support all financial statements and related payment instructions, including funding approval letters to HSPs and SAAs signed between the LHIN and its HSPs.

Table 1: Statement of Overall LHIN Provincial 2017-18 Funding Allocation	
	2017/18 Funding Allocation (000s)
Total LHIN Operating Allocation	**25,858,997.1**
Total Health Service Provider (HSP) Transfer Payment Allocation	25,769,096.2
Operation of LHIN	57,241.9
Initiatives	25,519.0
Digital Health	7,140.0
Total HSP Transfer Payment Allocation by Sector	
Operations of Hospitals	16,449,520.9
Grants to Compensate for Municipal Taxation - Public Hospitals	0.0
Long Term Care Homes	3,671,483.9
Community Care Access Centres/LHIN Delivered Services	2,654,670.7
Community Support Services	571,328.4
Acquired Brain Injury	57,417.7
Assisted Living Services in Supportive Housing	317,922.3
Community Health Centres	391,174.3
Community Mental Health	813,422.6
Addictions Program	196,638.5
Specialty Psychiatric Hospitals	645,516.8
Grants to Compensate for Municipal Taxation - Psychiatric Hospitals	0.0
Initiatives	0.0

Notes

1. Amounts are as of February 28th, 2017, and are subject to change, based on further amendments.

2. Effective April 1st, Community Care Access Centre (CCAC) includes transfer of Ontario Association of CCAC members' fees and legal fees to the Health Shared Services Ontario (HSSO) effective April 1st, 2017 and the total of an 8% reduction as part of the LHIN/CCAC integration efficiencies.

3. Effective April 1st, Operation of LHINs includes transfer of LHIN Shared Services and LHIN Collaborative to HSSO.

4. Effective on the Transfer of LHINs, Community Care Access Centre will be renamed as the LHIN Delivered Services as defined in Schedule 7, table 1, paragraphs 1-3.

Table 1a: Statement of Overall LHIN Provincial 2016-17 Funding Allocation for Hospitals and Community Care Access Centres/LHIN Delivered Services	
	2017-18 Funding Allocation (000's) (1)
Hospitals	**TBD**
Health System Funding Reform (HSFR)	TBD
Includes One-time Mitigation Funding	TBD
Non-HSFR[2]	TBD
Community Care Access Centre/LHIN Delivered Services	**TBD**
Health System Funding Reform (HSFR)	TBD
Includes One-time Mitigation Funding	TBD
Non-HSFR	TBD

1. The amounts in this table are included in Table 1 under the respective sectors.
2. The Non-HSFR figures are draft as some 2015-16 accruals are still in the approval process.

Table 2: Statement of Individual LHIN 2017-18 Funding Allocation	
	2017/18 Funding Allocation (000s)
Total LHIN Operating Allocation	**4,844,533.9**
Total Health Service Provider (HSP) Transfer Payment Allocation	4,836,066.0
Operation of LHIN	4,436.4
Initiatives	4,031.4
Digital Health	0.0
Total HSP Transfer Payment Allocation by Sector	
Operations of Hospitals	3,599,361.9
Grants to Compensate for Municipal Taxation - Public Hospitals	0.0
Long Term Care Homes	281,033.0
Community Care Access Centres/LHIN Delivered Services	248,018.6
Community Support Services	103,146.8
Acquired Brain Injury	3,091.8
Assisted Living Services in Supportive Housing	60,492.3
Community Health Centres	94,931.7
Community Mental Health	141,011.2
Addictions Program	37,673.3
Specialty Psychiatric Hospitals	267,305.4
Grants to Compensate for Municipal Taxation - Psychiatric Hospitals	0.0
Initiatives	0.0

Notes

1. Amounts are as of February 28th, 2017, and are subject to change, based on further amendments.

2. Effective April 1st, Community Care Access Centre (CCAC) includes transfer of Ontario Association of CCAC members' fees and legal fees to the Health Shared Services Ontario (HSSO) effective April 1st, 2017 and the total of an 8% reduction as part of the LHIN/CCAC integration efficiencies.

3. Effective April 1st, Operation of LHINs includes transfer of LHIN Shared Services and LHIN Collaborative to HSSO.

4. Effective on the Transfer of LHINs, Community Care Access Centre will be renamed as the LHIN Delivered Services as defined in Schedule 7, table 1, paragraphs 1-3.

Table 2a: Statement of Individual 2016-17 Funding Allocation for Hospitals and Community Care Access Centres/LHIN Delivered Services	
	2017-18 Funding Allocation (000's) (1)
Hospitals	**TBD**
Health System Funding Reform (HSFR)	TBD
Includes One-time Mitigation Funding	TBD
Non-HSFR[2]	TBD
Community Care Access Centre/LHIN Delivered Services	**TBD**
Health System Funding Reform (HSFR)	TBD
Includes One-time Mitigation Funding	TBD
Non-HSFR	TBD

1. The amounts in this table are included in Table 1 under the respective sectors.
2. The Non-HSFR figures are draft as some 2015-16 accruals are still in the approval process.

Table 3: Statement of Overall LHIN Provincial 2017-18 Dedicated Service Funding by Sector	
	2017-18 Dedicated Service Funding Allocation
Hospitals	
Post Construction Operating Plan [1]	TBD
Community Health Centres	
Uninsured Persons Services	$4,413,197
CHC Physician Salaries and Benefits	$83,402,573
Mental Health	
Consumer Survivor Initiatives	TBD
Addictions	
Problem Gambling Treatment Services	TBD
Community Care Access Centres/LHIN Delivered Services	
School Health Professional and Personal Support Services	$84,091,615
Other	
Psychiatric Sessional Fees for Community and Hospital-based Agencies [2]	$40,946,894

[1] Total Planned Estimated Dedicated Funding to March 31, 2018.

[2] Combined total of psychiatric sessional fees for mental health and addictions.

Table 3a: Statement of Individual LHIN Provincial 2017-18 Dedicated Service Funding by Sector	
	2017-18 Dedicated Service Funding Allocation
Hospitals	
Post Construction Operating Plan [1]	TBD
Community Health Centres	
Uninsured Persons Services	$2,253,357
CHC Physician Salaries and Benefits	$19,288,723
Mental Health	
Consumer Survivor Initiatives	TBD
Addictions	
Problem Gambling Treatment Services	TBD
Community Care Access Centres/LHIN Delivered Services	
School Health Professional and Personal Support Services	$5,216,756
Other	
Psychiatric Sessional Fees for Community and Hospital-based Agencies [2]	$7,387,868

[1] Total Planned Estimated Dedicated Funding to March 31, 2018.

[2] Combined total of psychiatric sessional fees for mental health and addictions.

SCHEDULE 5: LOCAL HEALTH SYSTEM PERFORMANCE

Definitions

1. In this Schedule, the following terms have the following meanings:

"Developmental indicator" means a measure of local health system performance that requires development due to factors such as the need for methodological refinement, testing, consultation, or analysis of reliability, feasibility and/or data quality.

"HIG" means HBAM Inpatient Grouper.

"**LHIN target**" means a planned result for an indicator against which actual results can be compared.

"**Monitoring indicator**" means a measure of local health system performance that the MOHLTC and the LHINs will monitor against provincial results or established provincial targets where set.

"**Performance indicator**" means a measure of local health system performance for which a LHIN target will be set.

"**Provincial target**" means an optimal performance result for an indicator, which may be based on expert consensus, performance achieved in other jurisdictions, or provincial expectations.

General Obligations

2. Under the LHSIA and the *Commitment to the Future of Medicare Act*, *2004* the **LHIN** will measure and plan to improve performance at the local level through,
   a) SAAs with HSPs; and
   b) Agreements with subcontractors providing LHIN Delivered Services.

3. **Both parties** will undertake an annual review of the indicators and the respective indicator categories. As part of this review, indicators may be moved between the performance, monitoring, and developmental categories, as appropriate.

Specific Obligations

4. The **MOHLTC** will**:**

   a. Calculate the results for the indicators set out in Tables 1, 2 and 3 to this Schedule,

   b. Provide the LHIN with calculated results for the indicators by the release dates set out in Schedule 6, and supporting performance information as requested by the LHIN, such as the performance of HSPs;

   c. Provide the LHIN with technical documentation for the indicators set out in Tables 1, 2 and 3 to this Schedule, including the methodology, inclusions and exclusions; and

d. Identify, as necessary, those monitoring indicators where LHINs will be expected to report on performance as part of their quarterly reporting process.

5. The **LHIN** will:

a. Demonstrate progress towards achieving the LHIN's performance targets for the performance indicators set out in Table 1 to this Schedule by the end of the term of this agreement;

b. Report quarterly on the performance of the local health system on all performance indicators;

c. Report on the performance of the local health system on all performance and monitoring indicators in the LHIN Annual Report; and

d. Report on the performance of monitoring indicators as requested by the MOHLTC.

The LHIN will demonstrate progress towards achieving the LHIN's performance targets for the performance indicators set out in Table 1 to this Schedule by the end of the term of this agreement

Table 1: Performance Indicators ***Definition:*** *Measures of local health system performance for which a LHIN target will be set*		
Indicator	**Provincial target**	**LHIN Target**
Home and Community • *Reduce wait time for home care (improve access)* • *More days at home (including end of life care)*		
Percentage of Home Care Clients with Complex Needs who received their Personal Support Visit within 5 Days of the date that they were authorized for Personal Support Services	5 days	95%
Percentage of Home Care Clients who received their nursing visit within 5 days of the date they were authorized for Nursing Services	5 days	95%
90th Percentile Wait Time from community for Home-Care Services: Application from community setting to first Home Care service (excluding case management)*	21 days	21 days
90th Percentile Wait time from Hospital Discharge to Service Initiation for Home and Community Care**	TBD	TBD
System Integration and Access • *Provide care in the most appropriate setting* • *Improve coordinated care* • *Reduce wait times (specialists, surgeries)*		
90th Percentile Emergency Department (ED) Length of Stay for Complex Patients	8 hours	8 hours
90th Percentile ED Length of Stay for Minor/Uncomplicated Patients	4 hours	4 hours
Percent of Priority 2, 3 and 4 Cases Completed Within Access Targets for Hip Replacement	Priority 2: 42 days Priority 3: 84 days Priority 4: 182 days	90%
Percent of Priority 2, 3 and 4 Cases Completed Within Access Target for Knee Replacement	Priority 2: 42 days Priority 3: 84 days Priority 4: 182 days	90%
Percentage of Alternate Level of Care (ALC) Days	9.46%	9.46%
ALC Rate	12.7%	12.7%

*The target is subject to change as a result of the ongoing work in the area of home and community care
**The target may be subject to change as it will be under development for the 2017/18 Fiscal Year

The LHIN will demonstrate progress towards achieving the LHIN's performance targets for the performance indicators set out in Table 1 to this Schedule by the end of the term of this agreement

Table 1: Performance Indicators ***Definition:*** *Measures of local health system performance for which a LHIN target will be set*		
Indicator	**Provincial target**	**LHIN Target**
Health and Wellness of Ontarians - Mental Health • *Reduce any unnecessary health care provider visits* • *Improve coordination of care for mental health patients*		
Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions***	16.3%	16.3%
Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions***	22.4%	22.4%
Sustainability and Quality • *Improve patient satisfaction* • *Reduce unnecessary readmissions*		
Readmissions within 30 days for Selected HIG Conditions	15.5%	15.5%

***The target is subject to change as a result of the ongoing work in the area of mental health and addictions.

Table 2: Monitoring Indicators ***Definition:*** *Measures of local health system performance that the MOHLTC and the LHINs will monitor against provincial results or established provincial targets where set.*	
Indicator	**Provincial target**
System Integration and Access • *Provide care in the most appropriate setting* • *Improve coordinated care* • *Reduce wait times (specialists, surgeries)*	
Percent of Priority 2, 3 and 4 Cases Completed Within Access Target for Cataract Surgery	Priority 2: 42 days Priority 3: 84 days Priority 4: 182 days
Percent of Priority 2 and 3 Cases Completed Within Access Target for MRI Scan	Priority 2: 2 days Priority 3: 2-10 days
Percent of Priority 2 and 3 Cases Completed Within Access Target for CT Scan	Priority 2: 2 days Priority 3: 2-10 days
Wait times from Application to Eligibility Determination for Long-Term Care Home Placement: From community setting, and from acute-care setting	Not applicable

Table 2: Monitoring Indicators ***Definition:*** *Measures of local health system performance that the MOHLTC and the LHINs will monitor against provincial results or established provincial targets where set*	
Indicator	**Provincial target**
Percent of Acute Care Patients who have had a follow-up with a physician within 7 days of discharge	Not applicable
Rate of emergency visits for conditions best managed elsewhere	Not applicable
Hospitalization rate for ambulatory care sensitive conditions	Not applicable

Table 3: Developmental Indicators ***Definition:*** *Measures of local health system performance that require development due to factors such as the need for methodological refinement, testing, consultation, or analysis of reliability, feasibility and/or data quality.*
Indicator
Home and Community Care • *Reduce wait time for home care (improve access)* • *More days at home (including end of life care)*
Percent of Palliative Care Patients discharged from hospital with home support
Sustainability and Quality • *Improve patient satisfaction* • *Reduce unnecessary readmissions*
Overall Satisfaction with Health Care in the Community

SCHEDULE 6: INTEGRATED REPORTING

General Obligations

1. The MOHLTC and the LHIN will report to each other as set out in Tables 1 and 2 to this Schedule.

2. The **MOHLTC** will:

   a) Provide any necessary training, instructions, materials, data, templates, forms, and guidelines to the LHIN to assist with the completion of the reports listed in Tables 1 and 2 to this Schedule; and

   b) As required, develop reporting requirements relating to government priorities and notify the LHIN of the requirements.

3. The **LHIN** will:

   a) Provide to the MOHLTC the reports set out in Table 2 if the LHIN's respective CCAC has not already provided the reports because the CCAC was dissolved by a Minister's Order under sections 34.2 and 34.5 of LHSIA.

   b) Provide to the MOHLTC the annual report for the 2016-17 and 2017-18 Fiscal Years of the dissolved CCAC for which the annual report has not already been provided by the CCAC.

4. **Both parties** will:

   a) Work together to ensure a timely flow and exchange of information, including financial records, to fulfill the reporting requirements of both parties; and

   b) Finalize the 2017/18 Annual Business Plan within 120 days of the date a budget motion is approved by the Ontario Legislature for the Fiscal Year as part of the annual review set out in section 22 of Schedule 1: General.

   c) Finalize the 2018/19 Annual Business Plan within the timelines required by the Management Board of Cabinet's Agencies and Appointments Directive, July 2016.

Table 1: MOHLTC and LHIN Reporting Obligations

Due Date	Description of Item
2017/2018	
APRIL	
April 14, 2017	MOHLTC will make the preliminary Year-End expenditure and revenue report available to the LHIN in APTS for the LHIN's review.
April 28, 2017	MOHLTC will provide to the LHIN the forms for the Year-End Consolidation Report
By April 28, 2017	The LHIN will submit to the MOHLTC an Expense Report using the forms provided by the MOHLTC
MAY	
May 12, 2017	The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 5: Local Health System Performance
May 15, 2017	MOHLTC will make the updated Year-End expenditure and revenue report available to the LHIN in APTS for the LHIN's review
May 15, 2017	The LHIN will submit to the MOHLTC an update to the comprehensive risk assessment using the forms provided by the MOHLTC as required by the Agency and Appointments Directive, July 2016.
May 19, 2017 (or a date necessary to meet central agency reporting requirements)	The LHIN will submit to the MOHLTC the year-end Consolidation Report using forms provided by the MOHLTC and the draft Audited Financial Statement if the signed statements are not ready by the due date of each Fiscal Year to which the Agreement applies
May 31, 2017	The MOHLTC will provide to the LHIN for planning and reporting purposes the initial preliminary allocation for 2017-18
JUNE	
June 9, 2017	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
On or about the 7th working day (date may vary on IFIS GL close as advised by the MOHLTC)	The MOHLTC will make the expenditure and revenue report available to the LHIN in APTS for the LHIN's review
June 30, 2017 (or a date necessary to meet central agency reporting requirements)	The LHIN will submit to the MOHLTC an Attestation required under the Agency and Appointments Directive and the BPSAA.
June 30, 2017	The LHIN will submit to the MOHLTC Q1 Regular and Consolidation Report using the forms provided by the MOHLTC

Due Date	Description of Item
June 30, 2017	The LHIN will submit to the MOHLTC a Board approved report on consultant use for the previous Fiscal Year using the template provided in the Minister's Directive under the *BPSAA*
JULY	
July 31, 2017	The LHIN will submit to the MOHLTC an Annual Report for the previous Fiscal Year in accordance with MOHLTC requirements
July 31, 2017	The LHIN will submit to the MOHLTC a summary report of their local hospitals' reports on consultant use for the previous Fiscal Year using the forms provided by the MOHLTC
By July 31, 2017	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
AUGUST	
August 14, 2017	The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 5: Local Health System Management
August 15, 2017	The MOHLTC will provide the preliminary approved allocation for the current Fiscal Year, as of July 31, 2017
August 15, 2017	The LHIN will submit to the MOHLTC a comprehensive risk assessment using the forms provided by the MOHLTC as required by the Agency and Appointments Directive.
August 30, 2017	MOHLTC will provide to the LHIN the forms and information requirements for the Multi-year Consolidation Report
SEPTEMBER	
September 11, 2017	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
On or about the 7th working day (date may vary on IFIS GL close as advised by the MOHLTC)	The MOHLTC will make the expenditure and revenue report available to the LHIN in APTS for the LHIN's review
September 29, 2017	The LHIN will submit to the MOHLTC Q2 Regular and Consolidation Report using the forms provided by the MOHLTC
September 29, 2017	The MOHLTC will provide to the LHIN the forms and information requirements for the 2018-19 Annual Business Plan.
OCTOBER	
By October 1, 2017	The MOHLTC will provide the LHIN with the Minister's Mandate Letter to the LHIN for the 2018/19 Fiscal Year.
October 31, 2017 (or date necessary to meet central agency reporting requirements as advised by the MOHLTC)	The LHIN will submit to the MOHLTC a Multi-year Consolidation Report using the form provided by the MOHLTC

Due Date	Description of Item
By October 31, 2017	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
NOVEMBER	
November 14, 2017	MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 5: Local Health System Management
November 15, 2017	The LHIN will submit to the MOHLTC an update to the comprehensive risk assessment using the forms provided by the MOHLTC as required by the Agency and Appointments Directive.
DECEMBER	
On or about the 7th working day (date may vary on IFIS GL close as advised by the MOHLTC)	The MOHLTC will make the expenditure and revenue report available to the LHIN in APTS for the LHIN's review
By December 8, 2017	The LHIN in conjunction with other LHINs will submit to the MOHLTC a summary of the annual board evaluation process for the period April 1, 2016 to March 31, 2017.
December 12, 2017	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
December 29, 2017	LHIN will submit to the MOHLTC Q3 Regular and Consolidation Report including final year-end forecast using the forms provided by the MOHLTC
By December 31, 2017	The LHIN will submit to the MOHLTC a Draft 2018-19 Annual Business Plan using the forms provided by the MOHLTC.
JANUARY	
January 31, 2018	MOHLTC will provide the LHIN with year-end instructions (including templates)
By January 30, 2018	The LHIN will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
FEBRUARY	
February 14, 2018	MOHLTC will provide the LHIN with most recent quarter of performance data for indicators in Schedule 5: Local Health System Performance
February 15, 2018	MOHLTC will provide to the LHIN the forms and requirements for the Annual Report (non-financial content)
February 15, 2018	The LHIN will submit to the MOHLTC a comprehensive risk assessment using the forms provided by the MOHLTC as required by the Agency and Appointments Directive, July 2016.

Due Date	Description of Item
February 28, 2018	The LHIN will submit to the MOHLTC an Attestation required under the *BPSAA* and the Agency and Appointments Directive
MARCH	
By March 1, 2018	For approval by the Minister, the LHIN will submit to the MOHLTC a Final 2018-19 Annual Business Plan, using the forms provided by the MOHLTC
March 14, 2018	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC

Table 2: LHIN Reporting Obligations for LHIN Delivered Services

Only those requirements listed below that relate to LHIN Delivered Services in Schedule 7 will be applicable when reporting for the remainder of the Fiscal Year after the CCAC has been dissolved.

OHRS/MIS Trial Balance Submission (through OHFS)	
2016-17	**Due Dates (Must pass 3c Edits)**
2016-17 Q4	May 31, 2017
2017-18	**Due Dates (Must pass 3c Edits)**
2017-18 Q1	*Not required 2017-18*
2017-18 Q2	October 31, 2017
2017-18 Q3	January 31, 2018
2017-18 Q4	May 31, 2018
Supplementary Reporting - Quarterly Report (through SRI)	
2016-2017	**Due five (5) business days following Trial Balance Submission Due Date**
2016-17 Q4	June 7, 2017 – Supplementary Reporting Due
2017-2018	**Due five (5) business days following Trial Balance Submission Due Date**
2017-18 Q2	November 7, 2017
2017-18 Q3	February 7, 2018
2017-18 Q4	June 7, 2018 – Supplementary Reporting Due
Annual Reconciliation Report (ARR) through SRI and paper copy submission **(LHINs must submit a paper copy ARR submission to the MOHLTC; soft copy to be provided through SRI)**	
Fiscal Year	**Due Date**
2016-17 (If the ARR has not already been provided by the CCAC)	June 30, 2017
2017-18: 1) For part of the Fiscal Year for the dissolved CCAC if ARR has not already been provided by the CCAC. 2) For the remainder of the Fiscal Year following the dissolution of the CCAC.	June 30, 2018
Board-Approved Audited Financial Statements (AFS) **(LHINs must submit a paper copy of Board-Approved Audited Financial Statements to the MOHLTC; soft copy to be uploaded to SRI)**	
Fiscal Year	**Due Date**
2016-17 (If the AFS has not already been provided by the CCAC)	June 30, 2017
2017-18 For the part of the Fiscal Year of the dissolved CCAC if the AFS has not already been provided by the CCAC.	June 30, 2018

SCHEDULE 7: LHIN DELIVERED SERVICES

Definitions

1. The following terms have the following meaning in this schedule:

   "HCCSA" means the *Home Care and Community Services Act, 1994* and the regulations thereunder.

   "LTCHA" means the *Long-Term Care Homes Act, 2007* and the regulations thereunder.

   "LHIN Delivered Services" means the services described in Table 1.

2. The **MOHLTC** has set out the indicators for the LHIN Delivered Services in Schedule 5 of this Agreement.

3.

   a) The **LHIN** will deliver the LHIN Delivered Services in accordance with, and otherwise comply with,
      (i) This Agreement;
      (ii) All applicable laws; and
      (iii) The directives, guidelines, standards, policies or other documents identified in Tables 2 and 3 of this Schedule.

   b) The **LHIN** will comply with all other directives, guidelines, standards, policies or other documents that apply to LHIN Delivered Services.

   c) The **MOHTLC** will endeavor to promptly inform the LHIN of amendments, additions to or new directive, guidelines, standards, policies or other documents that apply to LHIN Delivered Services.

   d) Subject to a) (i), (ii), and (iii), the LHIN will not:

      (i) Reduce, stop, or cease to provide; or
      (ii) Transfer to an HSP the requirement to provide,

      any LHIN Delivered Service for which the LHIN has been funded to provide directly or through a subcontracted service provider, except:
         I. With notice to the MOHLTC, and
         II. If required by MOHLTC, the prior written consent of the MOHLTC.

   For clarity, nothing in this provision restricts the LHIN's authority or power to determine appropriate types of volumes of LHIN Delivered Services to be provided to any individual, nor does this provision limit the power or authority of the LHIN in respect of staffing or personnel matters including determining the individuals who will provide the LHIN Delivered Services on behalf of the LHIN

Directives, Guidelines, Standards and Policies

4. The **MOHLTC** will:

a) Give to the LHIN a copy of the directives, guidelines, standards, policies, or any other documents identified in Tables 2 and 3 of this Schedule, as well any other directives, guidelines, standards, policies or other documents that apply to LHIN Delivered Services;

b) Give notice of any amendments to the directives, guidelines, standards, policies or other documents identified in Tables 2 and 3 of this Schedule, as well any other directives, guidelines, standards, policies or other documents that apply to LHIN Delivered Services. Amendments will be effective on the first day of April following the receipt of the notice or on such other date as may be advised by the MOHLTC.

Funding

5. The **MOHLTC** will:

a) Determine and provide to the LHIN the amount of funding as set out in Schedule 4 that a LHIN may use for the provision of the LHIN Delivered Services.

6. The **LHIN** will:

a) Use the funding amount provided by the MOHLTC to provide the LHIN Delivered Services.

Subcontracting the Provision of Services

7. The **LHIN** may:

a) Subject to the provisions of the HCCSA, the LTCHA and this Agreement, contract only the provision of the LHIN Delivered Services in paragraph 1 of Table 1. The LHIN acknowledges that actions taken or not taken by the subcontractor, and the LHIN Delivered Services provided by the subcontractor, are deemed actions taken or not taken by the LHIN, and services provided by the LHIN.

b) When entering into a contract the LHIN agrees that the terms of the subcontract will enable the LHIN to meet its obligations under this Agreement.

c) Nothing contained in this Agreement or a subcontract will create a contractual relationship between any subcontractor or its directors, officers, employees, agents, partners, affiliates or volunteers and the MOHLTC.

Quality Improvement Plans

8. The **MOHLTC** will work with HQO and the LHINs to support the development of the LHIN's LHIN Delivered Services Quality Improvement Plan by providing the required templates, guidance and accompanying supports.

9. The **LHIN** will carry out the 2017/18 Quality Improvement Plan prepared and submitted by its respective Community Care Access Centre for 2017/18.

Table 1 Definition of Services

Services means:
1. The professional services and personal support services, and certain homemaking services and community support services, that the Minister has approved the LHIN to provide under section 28.1 of HCCSA;
2. Placement coordination under the LTCHA;
3. Managing the placement of persons into supportive housing programs, complex continuing care and rehabilitation beds in hospitals, and other programs and places where community services are provided under HCCSA;
4. Providing information to the public about, and making referrals to, health and social services;
5. The Health Care Connect program;
6. Other services set out in agreements (e.g. administrative support services to approved agencies under HCCSA).

Table 2
List of Directives, Guidelines, Standards, Policies and other documents

• Personal Support Services Wage Enhancement Directive, 2014
• Community Financial Policy, 2015
• Policy Guideline for CCAC and CSS Collaborative Home and Community-Based Care Coordination, 2014
• Policy Guideline Relating to the Delivery of Personal Support Services by CCACs and CSS Agencies, 2014
• Ministry of Health and Long-Term Care Directive for Quality Improvement Plans in Ontario's Community Care Access Centres, 2013
• Ontario Healthcare Reporting Standards – OHRS/MIS - most current version available to applicable year
• Ministry of Health and Long-Term Care Client Services Procurement Policy for CCACs, 2007
• Ministry of Health and Long-Term Care Client Services Procurement Procedures for CCACs, 2007
• Contract Management Guidelines for CCACs, September 2012
• Interim Contract Management Guidelines for CCACs for School Health Support Services, February 18, 2009 Memorandum from the ADM, Health System Strategy Division to CCAC Board Chairs and CCAC Executive Directors
• Guideline for Community Health Service Providers Audits and Reviews, August 2012
• Assisted Living Services for High Risk Seniors Policy, 2011
• Rapid Response Nursing Program (2011)
• Nurse Practitioner Integrated Palliative Home Care Program (2011)
• Mental Health Nursing Policy Guidelines
• Accreditation Policies for CCACs

Table 3
List of Directives, Guidelines, Standards, Policies and other documents for the Provision of Community Support Services

• Personal Support Services Wage Enhancement Directive, 2014
• Community Financial Policy, 2015
• Policy Guideline for CCAC and CSS Collaborative Home and Community-Based Care Coordination, 2014
• Policy Guideline Relating to the Delivery of Personal Support Services by CCACs and CSS Agencies, 2014
• Protocol for the Approval of Agencies under the Home Care and Community Services Act, 2012
• Assisted Living Services for High Risk Seniors Policy, 2011 (ALS-HRS)
• Community Support Services Complaints Policy (2004)
• Assisted Living Services in Supportive Housing Policy and Implementation Guidelines (1994)
• Attendant Outreach Service Policy Guidelines and Operational Standards (1996)
• Screening of Personal Support Workers (2003)
• Ontario Healthcare Reporting Standards – OHRS/MIS – most current version available to applicable year
• Guideline for Community Health Service Providers Audits and Reviews, August 2012