2008-13 H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (this "Agreement") is made as of the 30th day of June, 2012.

BETWEEN:

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

AND

TIMMINS AND DISTRICT HOSPITAL (the "Hospital")

WHEREAS the LHIN and the Hospital entered into a hospital service accountability agreement that took effect April 1, 2008 and has been amended by agreements made as of April 1, 2010 and April 1, 2011 (the "H-SAA");

AND WHEREAS the Parties have extended the H-SAA by agreement effective April 1, 2012;

AND WHEREAS the Parties wish to further amend the H-SAA;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree that the H-SAA shall be amended as follows:

1.0 Definitions. Except as otherwise defined in this Agreement below, all terms shall have the meaning ascribed to them in the H-SAA.

2.0 Amendments.

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

2.2 Amended Definitions. Effective April 1, 2012, the following terms shall have the following meanings:

"**Base Funding**" means the Base funding set out in Schedule C (as defined below).

"**Costs**" for the purposes of Section 4.0 below, means all costs for the Executive Office (as defined below) including office space, supplies, salaries and wages of the officers and staff of the Executive Office, conferences held for or by the Executive Office and travel expenses of the officers and staff of the Executive Office.

"**Executive Office**" means the office of the chief executive officer or equivalent, and the office of every member of senior management of the Hospital that reports directly to the chief executive officer or equivalent.

"**Explanatory Indicator**" means an indicator of Hospital performance that is complementary to one or more Accountability Indicators and used to support planning, negotiation or problem solving, but for which no Performance Target has been set.

"**HAPS**" means the Board-approved hospital annual planning submission provided by the Hospital to the

LHIN for the Fiscal Years 2012-2013;

"**Indicator Technical Specifications**" and "**2012 -13 H-SAA Indicator Technical Specifications**" means the document entitled "Hospital Service Accountability Agreement 2012-13: Indicator Technical Specifications March 2012" as it may be amended or replaced from time to time.

The definition of "**Performance Standard**" is amended by adding the words "and the Indicator Technical Specifications" after the last word "Schedules". As a result, "**Performance Standard**" means the acceptable range of performance for a Performance Indicator or Service Volume that results when a Performance Corridor is applied to a Performance Target (as described in the Schedules and the Indicator Technical Specifications).

"**Post-Construction Operating Plan (PCOP) Funding**" and "**PCOP Funding**" means annualized operating funding provided to support service expansions and other costs occurring in conjunction with completion of an approved capital project, as set out in Schedule C (2012 – 2013) (Hospital One-Year Funding Allocation) and further detailed in Schedule F (2012 – 2013) (Post-Construction Operating Plan Funding and Volume).

"**Schedule**" means any one of, and "**Schedules**" means any two or more as the context requires, of the Schedules appended to this Agreement, including the following:

Schedule A (2012 – 2013) (Planning and Reporting);
Schedule C (2012 – 2013) (Hospital One-Year Funding Allocation)
Schedule D (2012 – 2013) (Service Volumes)
Schedule E (2012 – 2013) (Indicators)
Schedule E1 (2012 – 2013) (LHIN Specific Indicators and Targets) and
Schedule F (2012 – 2013) (Post-Construction Operating Plan Funding and Volume)

"**Schedule A**" means Schedule A (2012 – 2013) (Planning and Reporting).

"**Schedule C**" means Schedule C (2012 – 2013) (Hospital One-Year Funding Allocation).

2.3 Interpretation. This Agreement and the H-SAA shall be interpreted with reference to the Indicator Technical Specifications.

2.4 Term. This Agreement and the H-SAA will terminate on March 31, 2013.

2.5 Recovery of Funding. Section 5.6.1 (Recovery of Funding) (a) (Generally) of the H-SAA is amended by deleting (v) and adding the following as Section 5.6.1(Recovery of Funding) (a.1) (Specific Programs):

(i) if the Performance Obligations set out in Schedule E (2012 – 2013) (Indicators) in respect of Critical Care Funding are not met, the LHIN will adjust the Critical Care Funding following the submission of in-year and year-end data;

(ii) if the Hospital does not meet a performance Obligation or Service Volume under its post-construction operating plan, as detailed in Schedule F or Schedule F (2012 – 2013), the LHIN may: adjust the applicable Post-Construction Operating Plan Funding to reflect reported actual results and projected year-end activity; and perform final settlements following the submission of year-end data of Post Construction Operating Plan Funding;

(iii) if the Hospital does not meet a Performance Obligation or Service Volume set out in Schedule D for a service within Part III - Services and Strategies, the LHIN may: adjust the Funding for that service to

reflect reported actuals and projected year-end activity; and, perform in-year reallocations and final settlements following the submission of year-end data of service; and,

(iv) if the Hospital does not meet a Performance Obligation or Service Volume as detailed in Schedule D for a Wait Time Service, the LHIN may: adjust the respective Wait Time Funding to reflect reported actuals and projected year-end activity; and perform in-year reallocations and final settlements following the submission of year-end data.

2.6 Funding. Section 6.1.1 (Funding) of the H-SAA is amended by deleting (ii) and replacing it with:

"(ii) used in accordance with the Schedules".

2.7 Balanced Budget. Section 6.1.3 (Balanced Budget) of the H-SAA is amended by deleting "Schedule B" at the end of the Section and replacing it with "Schedule E1 (2012 – 2013) LHIN Specific Indicators and Targets".

2.8 Hospital Services. Section 6.2 (Hospital Services) of the H-SAA is amended by adding the words "and the Indicator Technical Specifications" after the word "Schedule" in (i) and (ii).

2.9 Planning Cycle. Section 7.1 (Planning Cycle) of the H-SAA is amended by replacing the words "the planning cycle in Part II of *Schedule A* ("Planning Cycle") for Fiscal Years 2010/11 and 2011/12" with the words "the timing requirements of Schedule A (2012 – 2013) Planning and Reporting".

2.10 Timely Response. Section 7.6.1 (Timely Response) of the H-SAA is amended by deleting both occurrences of "Schedule B" and replacing these with "Schedule A (2012 – 2013) Planning and Reporting".

2.11 Specific Reporting Obligations. Section 8.2 (Specific Reporting Obligations) of the H-SAA is amended by deleting "Schedule B" and replacing it with "Schedule A (2012 – 2013) Planning and Reporting".

2.12 Planning Cycle. Section 12.1 (Planning Cycle) of the H-SAA is amended by replacing "Schedule A" in (i) with "Schedule A (2012 – 2013) Planning and Reporting".

3.0 Effective Date. The Parties agree that the amendments set out in Article 2 shall take effect on April 1, 2012. All other terms of the H-SAA shall remain in full force and effect.

4.0 Executive Office Reduction. The Hospital shall reduce the Costs of its Executive Office by ten percent (10%) over fiscal years 2011/12 and 2012/13. Entities that have a year end of March 31 should use their 2010/2011 budget as a baseline, and entities that have a year end of December 31 should use their 2010 budget as a baseline.

5.0 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.

6.0 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.

7.0 Entire Agreement. This Agreement together with Schedules A (2012 – 2013) (Planning and Reporting), C (2012 – 2013) (Hospital One-Year Funding Allocation), D (2012 – 2013) (Service Volumes), E (2012 – 2013) (Indicators), Schedule E1 (LHIN Specific Indicators and Targets) and F (2012 – 2013) (Post-Construction Operating Plan Funding and Volume) constitute the entire agreement between the

Parties with respect to the subject matter contained in this Agreement and supersedes all prior oral or written representations and agreements.

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

NORTH EAST LOCAL HEALTH INTEGRATION NETWORK

By:

_____

Elaine Pitcher, Chair of the Board of Directors

And by:

_____

Louise Paquette, Chief Executive Officer

TIMMINS AND DISTRICT HOSPITAL

By:

Leon Laforest, Board Chair

I have authority to bind the Hospital.

And by:

Roger Walker, President and Chief Executive Officer

I have authority to bind the Hospital.

Schedule A–Reporting Obligations

Part I – Planning
Since the MOHLTC was unable to release the amount of Hospital funding for the 2012 – 2013 fiscal year before March 31, 2012, it was not possible for the LHIN and the Hospital to enter into an H-SAA for the 2012 – 2013 fiscal year by March 31, 2012. In the circumstances, the following steps were taken at the following times: ▪ The 2008-12 H-SAA was extended to June 30, 2012. ▪ The HAPS Submission process was launched on April 17th, 2012, with the HAPS due May 29th. ▪ On execution of an amending agreement, the 2008-12 H-SAA will be amended and extended for a one year term, effective April 1, 2012 through March 31, 2013.

Part II – Reporting	Party	Timing
Hospitals submit MIS trial balance and supplemental reporting as necessary	Hospital	30 days after the end of each quarter beginning with the 2nd quarter
Year end MIS trial balance and supplemental report	Hospital	60 days following the end of the fiscal year
Audited Financial Statements	Hospital	60 days following the end of the fiscal year
French Language Services Report as applicable	Hospital	60 days following the end of the fiscal year
Attestation of compliance with tasks required by CritiCall as per the Agreement between the assigned CritiCall Transfer Payment Agency and the MOHLTC	Hospital	60 days following the end of the fiscal year
Hospital to provide compliance attestations as required by Applicable Law	Hospital	In accordance with obligations
Such other reporting as may be required by the LHIN from time to time (Note 1)	Hospital	As directed by the LHIN

Note 1: Request for reporting as per LHIN authority as set out in the Local Health System Integration Act

Hospital One-Year Funding Allocation

Hospital: Timmins and District Hospital
Facility #: 907

Schedule C: (2012-2013)

			ALLOCATIONS	
			Base	One-Time
Operating Base Funding			$63,782,881	$0
Base Funding (Note 1)			$0	$0
PCOP (Reference Schedule F)			$133,000	$0
Incremental Funding Adjustment			$0	$0
Other Funding				
Funding adjustment 1 (Starch Volume Expanders)			$10,000	$0
Funding adjustment 2 (ALC Investments (Base))			$400,000	$0
Funding adjustment 3 (2012-13 Additional Mitigation Funding)			$0	$555,400
Funding adjustment 4 (2012-13 Impact HBAM Funding)			($438,200)	$0
Funding Adjustment 5 (Total Indirect Cost from 11/12 Wait Times)			$0	$20,900
Funding Adjustment 6 (Emergency Department (ED) Pay-for-Results)			$0	$768,000
Funding Adjustment 7 ( )			$0	$0
Funding Adjustment 8 ( )			$0	$0
Funding Adjustment 9 ( )			$0	$0
Funding Adjustment 10 ( )			$0	$0
Other Items			$0	$0
Prior Years' Payments			$0	$0
Services: Schedule D				
Cardiac catherization			$0	$0
Cardiac surgery			$0	$0
Organ Transplantation			$0	$0
Strategies: Schedule D				
Endovascular aortic aneurysm repair			$0	$0
Electrophysiology studies EPS/ablation			$0	$0
Percutaneous coronary intervention (PCI)			$0	$0
Implantable cardiac defibrillators (ICD)			$0	$0
Newborn screening program			$0	$0
Specialized Hospital Services: Schedule D	**Vol**	**Rate**		
Magnetic Resonance Imaging			$0	$0
Provincial Regional Genetic Services 2			$0	$0
Permanent Cardiac Pacemaker Services			$0	$0
Provincial Resources				
Stem Cell Transplant			$0	$0
Adult Interventional Cardiology for Congenital Heart Defects			$0	$0
Cardiac Laser Lead Removals			$0	$0
Pulmonary Thromboendarterectomy Services			$0	$0
Thoracoabdominal Aortic Aneurysm Repairs (TAA)			$0	$0
Other Results (Wait Time Strategy):				
Selected Cardiac Services			$0	$0
Hip and Knee Replacements - Revisions			$0	$0
Paediatric Surgery	14	$1,063	$0	$14,900
MRI OBSP High Risk	53	$260	$0	$13,800
Magnetic Resonance Imaging (MRI)	4,000	$260	$0	$1,040,000
Computed Tomography (CT)	242	$250	$0	$60,500
Quality-Based Procedures: Schedule D Planning Allocation	**Vol**	**Rate**		
Primary Hips	24	$7,071	($139,974)	$169,701
Primary knee	82	$6,254	($398,209)	$457,940
Cataract	582	$497	($225,230)	$367,981
Inpatient rehab for primary hip			$0	$0
Inpatient rehab for primary knee	3	$4,872	($18,803)	$47,949
Chronic Kidney Disease - per Ont.Renal Net. Funding Allocation			($833,500)	$912,515
Subtotal			**$62,271,965**	**$4,429,586**
Total Base and One-time Hospital Funding			**$66,701,551**	

Note 1: Includes lines previously in Schedules G and H (Cardiac Rehabilitation, Visudyne Therapy, Regional Trauma, Regional and district Stroke Centres, Sexual Assault/Domestic Violence Treatment Centres, HIV Outpatient clinics). See HAPS Guidelines for additional information.

Reference to Schedules D and F means (2012 - 2013) unless otherwise stated

Service Volumes

Hospital: Timmins and District Hospital
Facility #: 907

Schedule D: (2012-2013)

Part I- GLOBAL VOLUMES Refer to 2012-13 H-SAA Indicator Technical Specification Document for further Details	Measurement Unit	2012/13 Performance Standard	2012/13 Performance Target
Emergency Department Weighted Cases	Weighted Cases	>= 1492 and <= 1824	1,658
Complex Continuing Care	Weighted Patient Days	>= 7357	8,655
Total Acute Inpatient	Weighted Cases	>= 5428 and <= 6372	5,900
Day Surgery	Weighted Visits	>= 615 and <= 833	724
Mental Health Inpatient	Weighted Patient Days	>= 6091	7,166
Rehab Inpatient	Weighted Cases	>= 146 and <= 244	195
Elderly Capital Assistance Program (ELDCAP)	Inpatient Days		
Ambulatory Care	Visits	30,240	37,800

Part II- WAIT TIME VOLUMES (Formerly Schedule H) Note 1	Measurement Unit	2012/13 Base	2012/13 Incremental
Cardiac Surgery -CABG	Cases		
Cardiac Surgery -Other Open Heart	Cases		
Cardiac Surgery -Valve	Cases		
Cardiac Surgery -Valve/CABG	Cases		
Cancer Surgery	Cases	186	0
Paediatric Surgery	Cases	301	14
General Surgery	Cases	201	0
Hip and Knee Replacement - Revisions	Cases	0	0
Magnetic Resonance Imaging (MRI)	Total Hours	3,120	4,000
Computed Tomography (CT)	Total Hours	2,375	242

Part III- Services & Strategies (Formerly Schedule G)	Measurement Unit	2012/13 Base	2012/13 Incremental
Catherization	Cases		
Angioplasty	Cases		
Other Cardiac (Note 2)	Cases		
Organ Transplantation (Note 3)	Cases		
Neurosurgery (Note 4)	Cases		
Bariatric Surgery	TBD		

Part IV- Quality Based Procedures (formerly in wait times program Schedule H) Note 5	Measurement Unit	
Primary hip	Volumes	24
Primary knee	Volumes	82
Cataract	Volumes	582
Inpatient rehab for primary hip	Volumes	0
Inpatient rehab for primary knee	Volumes	3
Chronic Kidney Disease (as per Ontario Renal Network Allocation Schedule)	Volumes	Note 6

Note 1- Reflect wait time procedure volumes, both base and incremental at 2011/2012 levels unless otherwise directed by your LHIN.

Note 2- Cardiac Services are LHIN managed (Protected Services) including: Implantable Cardic Defibrilators (ICD), electrophysiology studies (EPS), Ablations, Ablations with advance mapping, Pacemakers, Drug Eluting Stents (DES), Cardiac surgery (CABG, valve, other open heart, valve+CABG), Angioplasty, and Cardiac Cathetherization.

Note3- Organ Transplantation - Funding for living donation (kidney & liver) is included as part of organ transplantation funding. Hospitals are funded retrospectively for deceased donor management activity, reported and validated by the Trillium Gift of Life Network.

Note4- includes neuromodulation, coil embolization, and emergency neurosurgery cases.

Note 5- Under Health system Funding Reform (HSFR), for each quality-based procedure, the volumes are determined as a single figure for the year. Previously, under Wait Time program they were identified as base and incremental.

Note 6- See the Ontario Renal Network 2012-13 CKD Service Volumes and Funding Amounts found in schedule A of the package sent directly to your hospital via Cancer Care Ontario.

Hospital Performance Indicators*

Hospital: Timmins and District Hospital
Facility #: 907

Schedule E: (2012-2013)

Accountability Indicators	Measurement Unit	2012/13 Performance Standard	2012/13 Performance Target
Part I - PERSON EXPERIENCE: Access, Effective, Safe, Person-Centered			
90th Percentile ER LOS for Admitted Patients	Hours	17.4 to 19.1	17.4
90th Percentile ER LOS for Non-admitted Complex (CTAS I-III) Patients	Hours	5.4 to 5.9	5.4
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated (CTAS IV-V) Patients	Hours	4 to 4.4	4.0
90th Percentile Wait Times for Cancer Surgery	Days	35 to 39	35
90th Percentile Wait Times for Cardiac Bypass Surgery	Days		
90th Percentile Wait Times for Cataract Surgery	Days	155 to 171	155
90th Percentile Wait Times for Joint Replacement (Hip)	Days	300 to 330	300
90th Percentile Wait Times for Joint Replacement (Knee)	Days	300 to 330	300
90th Percentile Wait Times for Diagnostic MRI Scan	Days	65 to 72	65
90th Percentile Wait Times for Diagnostic CT Scan	Days	21 to 23	21
Cases of Ventilator-associated Pneumonia	Cases/Days	0	0
Central Line Infection Rate	Cases/Days	0	0
Rate of Hospital Acquired Cases of Clostridium Difficile Infections	Cases/Days	0 to 0	0.17
Rate of Hospital Acquired Cases of Vancomycin Resistant Enterococcus Bacteremia	Cases/Days	TBD	TBD
Rate of Hospital Acquired Cases of Methicillin Resistant Staphylococcus Aureus Bacteremia	Cases/Days	TBD	TBD
Part II - ORGANIZATIONAL HEALTH: Efficient, Appropriately Resourced, Employee Experience, Governance			
Current Ratio (Consolidated)	Ratio	0.245 - 0.271	0.26
Total Margin (Consolidated)	Percentage	>= 0%	0.0%
Part III - SYSTEM PERSPECTIVE: Integration, Community Engagement, eHealth			
Percentage ALC Days (closed cases)	Percentage	up to 18.7%	17.0%

Explanatory Indicators	Measurement Unit
30-day Readmission of Patients with Stroke or Transient Ischemic Attack (TIA) to Acute Care for All Diagnoses	Percentage
Percent of stroke patients discharged to rehabilitation.	Percentage
Percent of Stroke Patients Managed on a Designated Stroke Unit.	Percentage
Hospital Standardized Mortality Ratio	Percentage
Readmission within 30 days for Selected CMGs	Ratio
Total Margin (Hospital Sector Only)	Percentage
Percentage Full Time Nurses	Percentage
Percentage Paid Sick Time	Percentage
Percentage Paid Overtime	Percentage
Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions	Visits
Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions	Visits

Part IV - LHIN Specific Indicators and Performance targets, see Schedule E1 (2012-2013)

***Refer to 2012-13 H-SAA Indicator Technical Specification document for further details.**

Hospital Local Reporting Obligations

Hospital:	**Timmins and District Hospital**
Facility #:	**907**

Schedule E1:

E1.1 French Language Service Report

Information reported in the FLS Report submitted in Q4 of 2011-2012 will serve to verify if the 2011-2012 target for the FLS Equity Index has been reached and to identify the new baseline for the FLS Equity Index for the 2012-2013 service accountability agreement. The baseline index and target will be communicated to the HSP during Q2 of 2012-2013.

For monitoring purposes, the HSP will complete an FLS Report in Q4 of 2012-2013 in the manner prescribed by the NE LHIN. However, if the HSP is consistently showing a baseline FLS Equity Index of 1 or above, the HSP will not be required to complete a FLS Report in Q4 of 2012-2013.

FLS Planning

Based on the results of the FLS Report submitted by the HSP, as described above, the NE LHIN may also require the HSP to complete an FLS Implementation Plan as a planning tool to assist the HSP in meeting its target, or may require the HSP to complete an FLS Designation Plan if the HSP is deemed ready for designation under the *French Language Services Act (FLSA)*.1 This requirement would be communicated to the HSP during Q2 of 2012-2013.

1 *Designation under the FLSA is a legal process and an official recognition of a HSP's ability to provide quality FLS.*

E1.2 Percent of Complex Continuing Care Residents and Elderly Capital Assistance Program (ELDCAP) Patients who have fallen in the past 30 days (Percent-Measurement) (Explanatory Indicator)

Hospital will collaborate with the NE LHIN and Health Quality Ontario (HQO) to develop and implement a quality improvement plan (QIP) to address change in their local system. QIPs should address percent of patient/resident falls in Complex Continuing Care facilities and/or the Elderly Capital Assistance Program (ELDCAP) beds with the goal of reducing falls below 10%. The NE LHIN will work with the hospitals towards establishing 2013/14 targets for falls for the purpose of becoming a performance indicator for 2013/14. Hospital will submit their final QIP draft to the NE LHIN for review on or before March 1st of each year, prior to submission to HQO.

Calculation: Data to calculate this indicator can be found by accessing CIHI's CCRS eReporting tool.

Target: TBD

Hospital Local Reporting Obligations

Hospital:	**Timmins and District Hospital**
Facility #:	**907**

Schedule E1:

E1.3 Hand Hygiene compliance before patient contact (Percent-Measurement) (Explanatory Indicator)
Hospital will collaborate with the NE LHIN and Health Quality Ontario (HQO) to develop and implement a quality improvement plan (QIP) to address change in their local system. QIPs should address Hand Hygiene before patient contact above 82%. The NE LHIN will work with the hospitals towards establishing 2013/14 targets for Hand Hygiene for the purpose of becoming a performance indicator for 2013/14. Hospital will submit their final QIP draft to the NE LHIN for review on or before March 1st of each year, prior to submission to HQO.
Calculation: Number of times that hand hygiene was performed before patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100

Target: 80%

E1.4 Senior Friendly Hospital Strategy
Hospital will actively promote the hospital experience and health outcomes of seniors by developing and implementing improvement plans in support of the provincial senior friendly hospital strategy. Plans should have a particular focus on seniors' care in the priority areas of delirium and functional decline and should integrate with new or existing quality improvement activities outlined in the hospital's quality improvement plan. The deadline for senior friendly hospital improvement plan completion is September 30, 2012.

E1.5 eHealth: Interoperability of Ontario's Health System.
The MOHLTC has agreed to set, in consultation with the LHIN and others, as appropriate, technical standards related to eHealth and the interoperability of Ontario's health system. It is expected that the LHINs will consult the hospital sector when setting these standards. The Hospital agrees to comply with any standards set by Ontario Health Informatics Standards Council that are approved for use, provided that said compliance does not commit the hospital to significant costs which could result in an operating deficit for the hospital.
The hospital agrees to participate in the development of the regional eHealth Strategic Plan [Plan] and subsequent iterations of the Plan. The hospital will ensure that their Information Technology/Information Management (IT/IM) activities will be aligned with and contribute to the advancement of regional and provincial eHealth strategic/tactical plans.

E1.6 eHealth: Participation in eHealth Initiatives.
The hospital understands that as a partner in the health care system, it has an obligation to participate in eHealth initiatives. Hospitals participation is defined as including, but not limited to, the identification of project leads/champions, participation in regional/provincial planning and implementation groups.

Hospital Local Reporting Obligations

Hospital:	**Timmins and District Hospital**
Facility #:	**907**

Schedule E1:

E1.7 eHealth: ALC Resource Matching & Referral (RM&R).
The Resource Matching and Referral (RM&R) project is a key eHealth initiative in the NE LHIN. It is designed to help improve the flow of clients through the health care system by assisting health service provider agencies locate and match appropriate and available services to client needs. The hospital agrees to actively participate in the Provincial ALC Resource Matching and Referral (RM&R) Initiative and to support cluster and regional-based project principles and implementation initiatives.

E1.8 eHealth: Consultation with LHIN eHealth Lead to Align Technology.
The hospital understands that under legislation they are required to look for integration opportunities with other health service providers. The hospital agrees that it will incorporate opportunities to collaborate / integrate IT services with other health service providers into their IT/eHealth Strategic Plans. To assist in the identification of integration opportunities the hospital agrees to have representation and participate on the NE LHIN Information Technology/eHealth Integration and Alignment Council (NE LHIN IAC). NE LHIN IAC is a forum where NE LHIN hospitals will share information on existing and future implementations of IT/eHealth initiatives and provide strategic advice on the development and implementation of these initiatives for their hospital partner organizations. Therefore the hospital also agrees, as part of its procurement process, to include a NE LHIN IAC review of the hospital's projects and proposed procurements sited in the hospital's IT/eHealth strategic plan/project list.

E1.9 Commitment to Integration
The HSP Board of Directors and management previously passed Board motions that committed the HSP to support the principles of integration as per the section 24 of the Local Health System Integration Act, 2006 (LHSIA) as a means of improving the health system in northern Ontario.
On an annual basis the HSP is committed to completing the following:
1) An organizational self-assessment tool of gaps, issues and pressures in the delivery of health care services (tool to be provided by the LHIN)

Hospital Local Reporting Obligations

Hospital:	**Timmins and District Hospital**
Facility #:	**907**

Schedule E1:

E1.10 Hospital Improvement Plan
The hospital will continue to implement the Hospital Improvement Plan to achieve a balanced operating position by September 30, 2012

E1.11 General Surgery
The hospital will actively participate in the development of a model for the delivery of general surgery, which will streamline general surgery in hospitals in the Cochrane Hub by December 2012.

E1.12 Shared Back Office Plan
The hospital will work with the Cochrane Hub hospitals to complete a shared back office plan by March 31, 2013. This plan will include, but will not be limited to, information technology, help desk and common practices.

E1.13 ALC Long Stay Patients
Working with the HUB hospitals and community health service providers, provide to the NE LHIN by January 31, 2013, a recommended target for ALC long stay patients in acute care beds (i.e., ALC LOS >30 days) to be achieved by March 31, 2013. Contribute to monthly progress updates to the NE LHIN to be prepared jointly by the NE CCAC and the HUB hospitals. Further discussion is required with the NE LHIN regarding post-acute long stay patients.

Post-Construction Operating Plan Funding and Volume

Hospital: Timmins and District Hospital
Facility #: 907

Schedule F: (2012-2013)

	2012/13							
		2012/13 Received from LHIN			2012/13 Hospital Plan		
	Total Approved Volume	Funding Rate	2012/13 Additional Volumes	Funding[1]	Additional Volumes	New Beds	Funding
Inpatient Acute - Medicine/Surgery	0	$0	0	$0	0	0	$0
Inpatient Acute -Obstetrics	0	$0	0	$0	0	0	$0
Inpatient Acute - ICU	0	$0	0	$0	0	0	$0
Inpatient Rehabilitation General	0	$0	0	$0	0	0	$0
Inpatient Complex Continuing Care	0	$0	0	$0	0	0	$0
Inpatient Acute - Mental Health	0	$0	0	$0	0	0	$0
Day Surgery	0	$0	0	$0	0	0	$0
Endoscopy (cases)	0	$0	0	$0	0	0	$0
Emergency	0	$0	0	$0	0	0	$0
Amb Care - Acute Mental Health	0	$0	0	$0	0	0	$0
Amb Care - Diabetes	0	$0	0	$0	0	0	$0
Amb Care - Palliative	0	$0	0	$0	0	0	$0
Clinic - Med/Surg	0	$0	0	$0	0	0	$0
Clinic - Metabolic	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Other - ( )	0	$0	0	$0	0	0	$0
Facility Costs		$0	0	$133,000	0	0	$0
Amortization		$0	0	$0		**0**	**$0**
Total Funding				**$133,000[2]**			**TBD**

Note 1 - Terms and conditions of PCOP funding are determined by the Ministry of Health and Long Term care (MOHLTC). Incremental volumes required to be achieved by the Hospital as set out above are in addition to PCOP volumes provided in previous years. The MOHLTC may adjust funded volumes upon reconcilation.

Note 2 - This amount must be the same as PCOP (Operating Base Funding) on Schedule C (2012 - 2013).

Once negotiated, an amendment (Schedule F1 (2012 - 2013) will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in any other Schedule.