2008-13 H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (this "Agreement") is made as of April 1st, 2012.

BETWEEN:

TORONTO CENTRAL LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

UNIVERSITY HEALTH NETWORK (the "Hospital")

WHEREAS the LHIN and the Hospital (together the "Parties") 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".

2.13 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.

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 Governing Law. This Agreement and the rights, obligations and relations of the Parties will be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable therein.

5.0 Counterparts. This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.

6.0 Entire Agreement. This Agreement together with Schedules A (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.

TORONTO CENTRAL LOCAL HEALTH INTEGRATION NETWORK

By:

Angela Ferrante, Chair

And by:

Camille Orridge, CEO

UNIVERSITY HEALTH NETWORK

By:

John Mulvihill, Chair, I have authority to bind the Hospital.

And by:

Robert Bell, 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

Schedule C (2012-2013)

Hospital: University Health Network	**2012/13 Planning Assumption***	
Fac #: 947	Base	One-Time
Operating Base Funding		
HSFR allocation (Note 1)	936,009,028	
TC LHIN UPF adjustment	(1,271,156)	
Total Operating Funding	**934,737,872**	
PCOP (Reference Schedule F)		
Other Funding		
Funding adjustment 1 (Transfer Toronto Rehabilitation)	115,145,133	
Funding adjustment 2 (Enhance Care Program from CCAC)	1,471,879	
Funding adjustment 3 (ED P4R Q3 premium) PYE in 2011-12	487,000	
Funding adjustment 4 (Telemedicine)	386,349	
Funding Adjustment 5 ( )		
Other Items		
Prior Years' Payments		
Services: Schedule D		
Cardiac catherization		
Cardiac surgery		
Organ Transplantation		
Strategies: Schedule D		
Organ Transplantation		
Endovascular aortic aneurysm repair		
Electrophysiology studies EPS/ablation		
Percutaneous coronary intervention (PCI)		
Implantable cardiac defibrillators (ICD)		
Newborn screening program		
Specialized Hospital Services: Schedule D		
Magnetic Resonance Imaging		
Provincial Regional Genetic Services 2		
Permanent Cardiac Pacemaker Services		
Provincial Resources		
Stem Cell Transplant		
Adult Interventional Cardiology for Congenital Heart Defects		
Cardiac Laser Lead Removals		
Pulmonary Thromboendarterectomy Services		
Thoracoabdominal Aortic Aneurysm Repairs (TAA)		
Other Results (Wait Time Strategy):		
Selected Cardiac Services		
Hip Replacements - Revisions		
Knee Replacements - Revisions		
Magnetic Resonance Imaging (MRI)		
Computed Tomography (CT)		
Quality-Based Procedures: Schedule D Planning Allocation Assumption (rate x volume)		
Primary Hips		
Primary knee		
Cataract		
Inpatient rehab for primary hip		
Inpatient rehab for primary knee		
Chronic Kidney Disease - as per Ontario Renal Network Funding Allocation		
Additional Base and One Time Funding	117,490,361	0
Total Allocation	1,052,228,233	

Note 1 - From previously circulated HSFR spreadsheet from MOH; includes Global, HBAM & QBP Funds

* to be confirmed by TC LHIN Funding Letter

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

Service Volumes

Schedule D (2012 - 2013)

Hospital University Health Network

Facility # 947

	Measurement Unit	2012/13 Performance Target	2012/13 Performance Standard
Part I - GLOBAL VOLUMES Refer to 2012-13 H-SAA Indicator Technical Specification Document for further details			
Emergency Department	Weighted Cases	5,350	>4,815
Complex Continuing Care	Weighted Patient Days	73,268	>69,604
Total Inpatient Acute	Weighted Cases	69,992	>62,993
Day Surgery	Weighted Visits	5,336	>4,802
Inpatient Mental Health	Weighted Patient Days	11,685	>10,517
Inpatient Rehabilitation	Weighted Cases	2,814	>2,500
Elderly Capital Assistance Program (ELDCAP)	Inpatient Days		
Ambulatory Care	Visits	984,987	>935,738

		2012/13 Base	2012/13 Incremental
Part II - WAIT TIME VOLUMES (Formerly Schedule H) (Note 1)			
Cardiac Surgery -CABG	Cases		
Cardiac Surgery -Other Open Heart	Cases		
Cardiac Surgery -Valve	Cases		
Cardiac Surgery -Valve/CABG	Cases		
Paediatric Surgery	Cases		
General Surgery	Cases		
Hip & Knee Replacement - Revisions	Cases	89	26
Magnetic Resonance Imaging (MRI)	Total Hours	13,520	17,949
Computed Tomography (CT)	Total Hours	17500	732

		2012/13 Performance Target	2012/13 Performance Standard
Part III - Services & Strategies(Formerly Shedule G)			
Catherization	Cases		
Angioplasty	Cases		
Other Cardiac (Note 2)	Cases		
Organ Transplantation (Note 3)	Cases		
Neurosurgery (Note 4)	Cases		
Bariatric Surgery	Cases	300	
Regional Trauma	Cases		

		2012/13 Volume
Part IV - Quality Based Procedures (Formerly in Wait Times program Schedule H) (Note 5)		
Primary hip	Volumes	TBD
Primary knee	Volumes	TBD
Cataract	Volumes	36
Inpatient rehab for primary hip	Volumes	161
Inpatient rehab for primary knee	Volumes	225
Chronic Kidney Disease (as per Ontario Renal Network Allocation Schedule)	Volumes	

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 Catheterization.

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.

Indicators*

Hospital University Health Network

Schedule E (2012 - 2013)

Facility # 947

Accountability Indicators	Measurement Unit	2012/13 Performance Target	2012/13 Performance Standard
Part I - PERSON EXPERIENCE: Access, Effective, Safe, Person-Centered			
90th Percentile ER LOS for Admitted Patients	Hours	23.00	<25.3
90th Percentile ER LOS for Non-admitted Complex (CTAS I-III) Patients	Hours	7.85	<8.64
90th Percentile ER LOS for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	Hours	4.50	<4.95
90th Percentile Wait Times for Cancer Surgery	Days	68.00	<71.4
90th Percentile Wait Times for Cardiac Bypass Surgery	Days	32.00	<35.2
90th Percentile Wait Times for Cataract Surgery	Days	110.00	<121
90th Percentile Wait Times for Joint Replacement (Hip)	Days	123.00	<135
90th Percentile Wait Times for Joint Replacement (Knee)	Days	110.00	<121
90th Percentile Wait Times for Diagnostic MRI Scan	Days	99.00	<109
90th Percentile Wait Times for Diagnostic CT Scan	Days	35.00	<38.5
Rate of Ventilator-Associated Pneumonia	Cases/1000 Days	0.00	<2.43
Central Line Infection Rate	Cases/1000 Days	0.00	<1.0
Rate of Hospital Acquired Cases of Clostridium Difficile Infections	Cases/1000 Days	0.00	<0.89
Rate of Hospital Acquired Cases of Vancomycin Resistant Enterococcus Bacteremia	Cases/1000 Days	0.00	<0.25
Rate of Hospital Acquired Cases of Methicillin Resistant Staphylococcus Aureus Bacteremia	Cases/1000 Days	0.00	<0.25
Current Ratio (Consolidated)	Ratio	0.80	0.7-2.0
Total Margin (Consolidated)	Percentage	0.00%	0.00%
Part III - SYSTEM PERSPECTIVE: Integration, Community Engagement, eHealth			
Percentage ALC Days (closed cases) - Acute	Days	9.46%	<10.41%
Number of open ALC cases - CCC	Days	20	<25
Number of open ALC cases - Rehab	Days	20	<25

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 Inpatient Rehabilitation Following an Acute Stroke Hospitalization	Percentage
Percent of Stroke Patients Admitted to a Stroke Unit During Their Inpatient Stay	Percentage
Hospital Standardized Mortality Ratio	Percentage
Readmissions Within 30 Days for Selected CMGs	Ratio
Total Margin (Hospital Sector Only)	Percentage
Percentage of Full-Time Nurses	Percentage
Percentage of Paid Sick Time (Full-Time)	Percentage
Percentage of 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 for further details.

LHIN-Specific Indicators

Schedule E1 (2012 - 2013)

Hospital University Health Network

TC LHIN will review all obligations on an annual basis and update as necessary based on strategic priorities of the LHIN. TC LHIN obligations include:

1. Actively participate in applicable initiatives endorsed by the Hospital Sector Table and approved by TC LHIN. This can include integration activities and value and affordability initiatives.

2. Adopt eHealth system tools that are endorsed at the Hospital Sector Table and approved by TC LHIN.

3. Continue to actively participate in the LHIN's Resource Matching and Referral (RM&R) Initiative and support the TC CCAC in their role as RM&R business lead

4. French Language Services
Reporting requirement for identified agencies:
Complete/Update and submit to the LHIN through its FLS Coordinator a French Language Services (FLS) Implementation Plan for 2012/13.
   a. Draft by September 30, 2012
   b. Final by December 31, 2012

The FLS Implementation Plan must include yearly targets in each of the key results areas with specific deadlines. These targets will be negotiated and commonly-agreed upon with the LHIN by December 31, 2012.

Report twice a year on the progress of their FLS Implementation Plan to the LHIN through its FLS Coordinator.
   a. March 31, 2013
   b. September 30, 2013
   c. March 31, 2014
   d. September 30, 2014

5. TCLHIN Hospital Quality Indicators
Hospitals will comply with reporting requirements associated with the applicable TCLHIN Quality Indicators.

6. Senior Friendly Hospital Initiative
Hospitals will actively promote the hospital experience and health outcomes of seniors by developing and implementing Improvement Plans that support the Provincial Senior Friendly Hospital Strategy. Senior friendly hospital improvement efforts should have a particular focus on seniors' care in the priority areas of delirium and functional decline and should be integrated in the hospital's Quality Improvement Plan (QIP).

7. Actively participate with the TCLHIN in the collection of health equity data.