Waterloo Wellington **LHIN**

BREIFING NOTE

January 31, 2018

For Decision

Board of Directors Item 13.3 - Service Accountability Agreements for Hospitals (H-SAA), Private Hospital (PH-SAA), Multi-Sector (M-SAA) and Long-Term Care Homes (L-SAA)

PURPOSE

To provide the WWLHIN Board of Directors with a recommendation to approve the proposed Agreement template changes, funding, service volumes and local obligations to complete the amending Hospital Service Accountability Agreements (H-SAA), Private Hospital Service Accountability Agreement (PH-SAA), Multi-Sector Service Accountability Agreements (M-SAA), and Long Term Care Home Service Accountability Agreements (L-SAA).

CORE CONTEXT

- In 2017-2018 the WWLHIN currently has H-SAAs (7), PH-SAA (1), M-SAAs (39) and L-SAAs (36) that expire on March 31, 2018.
- Through the requirements specified in the Local Health System Integration Act (LHSIA) and the Ministry-LHIN Accountability Agreement (L-LAA), LHINs must have a current Service Accountability Agreement (SAA) in place with each of their Health Service Providers (HSPs).
- The LHINs and Health Service Providers (HSP) cannot enter into new agreements for new funding until any funding is approved through the 2018-2019 spring provincial budgets. As additional funding is received by the LHIN, accountability agreements are amended through funding letters.
- Annual Planning Submissions (APS) are initially submitted to the LHIN by the 2nd week of November. The LHIN does not consider the submission in November to be final as changes usually occur post submission up to January 31st through the LHIN review process.
- The APS will inform the negotiation of the SAAs between the LHIN and the HSP.
- Final HSP Board approved APS are required to be submitted to the WWLHIN by each Health Service Provider by no later than January 31, 2018.
- At the time of initial APS submission, and in the absence of definitive ministry funding targets in 2018, HSPs will complete the 2018-2019 APS based on a planning assumption of a 0% base adjustment. This is a provincial and not a local LHIN requirement.
- An HSP must consider this planning assumption when developing its forecasts on service volume and indicator performance. If the HSP is considering a service target reduction to

meet the 0% guideline, they must initiate a discussion with their LHIN representative and submit a Service Delivery Change Form (SDCF).

- The LHINs will provide guidance to the HSP throughout the review process to assist the HSP in submitting their balanced budget.
- A number of Community sector HSP's submitted SDCFs with their 2018-2019 Annual Planning Submissions.
- Overall, through APS and SDCF reviews HSPs identified the pressures in 2018-2019 to be:
    - increased demand for Specialized Day Programs for seniors at risk,
    - avoiding wait lists for services,
    - reduction of some service volumes,
    - potential reduction of staffing
    - the uncertainty of the impact of Bill 148,
    - maintaining ALC rate
    - Increased operating costs
- The SDCFs approved for 2018-2019 included the re-allocation of existing resources between functional centers that will increase service capacity, improve community connections, and improve the patient experience.

RECOMMENDATION

THAT the Waterloo Wellington Local Health Integration Network Board of Directors approve the proposed H-SAA, PH-SAA, M-SAA and L-SAA Agreement template changes, with 2017-18 known funding, and service volumes for the period from April 1, 2018 to March 31, 2019;

AND

THAT the WW LHIN Board of Directors authorize the WWLHIN Board Chair and LHIN CEO to execute the Service Accountability Agreements on behalf of the WW LHIN Board of Directors provided that the execution versions of the Agreements are substantially similar to template changes identified in this Briefing Note.

BACKGROUND INFORMATION

Change to Service Accountability Agreements

In the fall of 2017, provincial LHIN CEO representatives, in partnership with Associations and LHIN Legal, reviewed each of the current SAAs (H-SAA, PH-SAA, L-SAA and M-SAA) and changed the language in the agreement templates to be in alignment with recent legislative changes necessitated by the Patients First Act.
The current Hospital service accountability agreement (the "current H-SAA") was entered into in 2008. A new 2018-2020 Agreement template replaces the Agreement the LHINs inherited from the Ministry.

The changes that have been made in the SAAs can be found in Appendix A.

An Additional Briefing Note providing information and seeking Board Approval of the 2018-2020 Hospital Agreement template can be found in Appendix H.

Implementation of Local Obligations

In addition to the general performance obligations set out in the accountability agreements, the WWLHIN has chosen to include eight (9) Local Obligations to be specific in the accountability agreements. Eight (8) WW LHIN Local Obligations were approved by the LHIN Board at the October 5, 2017 Board mtg. 1 additional obligation has been added to the M-SAA and H-SAA

In 2018-2019 Local Obligations are being included to:

- Advance system integration:
- Provide clarity about specific requirements that providers need to address on key areas of system focus;
- Make the SAAs more reflective of priorities and work underway in the local system; and
- Align accountabilities across sectors and support transparency.

HSP Local Obligation work plans are to be HSP board approved and due April 1, 2018.

In addition, a separate obligation for health equity reporting will be included in 2018-2019 asking HSPs to report back March 31, 2019 on the specific steps taken and outcomes achieved to address health equity. In previous SAAs the health equity reporting was included as part of the French Language Services reporting but there have been mandated changes to the FLS reporting requirements which no longer allows for these two requirements and reports to be merged.

2018-19 WWLHIN Local Obligations are summarized in Appendix B

Hospital Service Accountability Agreements

Hospital Annual Planning Submissions were received in November 2017 and reviewed by LHIN staff. Initial meetings with each hospital occurred in early December to seek further clarity on components of their plans such as revenue assumptions, clinical service activity assumptions and other operational pressures. Ongoing conversations continue, to better understand the possible risks and pressures that may exist with the plans that were submitted. There were no Service Delivery Change Forms initially submitted by any of the hospitals in the 2018-2019 planning process.

Overall, based on a planning assumption of a 0% base adjustment, 5 out of 8 hospitals initially submitted a balanced budget for 2018-2019.

From initial review, hospitals are projecting relatively similar Clinical Activity and Patient Service volumes for 2018-2019. This does not mean that service volumes are not reduced, as service corridors are intended to allow for variations in volumes e.g. Emergency Department Weighted Cases Target = 2,926, but has a corridor of >= 2,633 and <= 3,219. For instance, ED service volumes could decrease from prior years and in some cases activity and patient service volumes have increased in hospitals due to 2017-2018 investments.

In general, if hospitals were to receive a 0% funding increase, all would have to make some significant operational changes in order to continue to balance their budgets and manage the increasing demand for services. An example of this might be planning a reduction in actual service delivery volumes while ensuring they remain above the lower corridor in the H-SAA.

Overall, hospitals in WWLHIN have not specifically identified strategies to deal with unknown operational pressures for 2018-2019. As in past years, no significant operational changes are identified and executed until more concrete funding details become available. The intent is to have the hospitals identify where they have pressures and how it would impact services the most, and where any new funding would be focused if it became available following announcement of the spring budget.

In Summary, given the fact that additional hospital funding for the next fiscal year is unknown at this point in time, the initial 2018-19 H-SAA schedules will be set to known 2017-2018 funding and current service volume targets or higher, as outlined in the Appendices. LHIN staff will set the initial 2018-19 global service volume targets at the 2017-2018 current target or increased target that was submitted by the hospital in their Hospital Annual Planning Submission (HAPS). These figures will be reviewed with the hospitals prior to creating the initial 2018-2019 H-SAA schedules.

The Chair of the WWLHIN Finance Committee and LHIN staff will meet with their hospital counterparts in January/February to ensure all parties have the same understanding of financial and performance details.

In addition, Ministry-LHIN Accountability Agreement (MLAA) Performance Targets and associated targets for each hospital will be maintained (e.g. wait times for procedures and diagnostics, ALC, readmissions).

A summary of 2017-2018 Allocation by Hospital is provided in Appendix C and an aggregate Hospital Service Volume by WWLHIN and by Hospital for 2018-2019 is provided in Appendix D.

Private Hospital Service Accountability Agreements

New funding has been introduced for the addition of three new inpatient beds in 2017-2018. There is ongoing work with Homewood Health Center to finalize the additional weighted cases to be added to their 2018-19 PH-SAA to reflect the permanent funding for these three new inpatient beds. A summary of service volumes and funding allocation is provided in Appendix E.

Multi-Sector Service Accountability Agreements

New investment in Community Services in 2017-2018 focused on one time funding to address wait list pressures in Dementia Community Programs, services to seniors at risk in rural communities, overnight respite in Kitchener and Guelph, and improving access to health care with additional rides to Day Programs. The WWLHIN also received additional based funding for opioid and structured psychotherapy and supportive housing to address key wait times for Mental Health & Addiction services.

A summary of total Multi-Sector Volumes as well as by Sub Sector (CSS, CMHA, and CHC) is provided in Appendix F. A summary of funding allocation by HSP is provided in Schedule G.

A LHIN staff review of the 2018-2019 Community Annual Planning Submissions (CAPS) and Service Delivery Change Form requests identified the following specific key pressures for Community HSPs in 2018-2019:

- Ensuring fair and equitable staff compensation
- Growing waitlists for services
- Increased demand for client fee subsidies and fewer sources of revenue from other funding bodies such as charitable organizations
- Affordable and accessible Transportation

Of the 22 agencies offering community support services, the majority are expressing funding pressures due to ongoing commitments to address salaries and benefits. Costs are attempted to be offset by donations and municipal tax base contributions. Additional revenue is also being generated by increasing user fees and co-payments for eligible expenditures. Additional volume and demand is also causing pressure for smaller agencies to respond to urgent referrals. Wait lists for key services such as acquired brain injury, supportive housing and dementia programs remain a concern.

The most significant risk for community support services with a 0% base funding increase is the impact of increased minimum wage expectations in 2018 and in 2019. It is expected that additional funding may be required to recruit and retain staffing to ensure services are not affected.

In 2018-2019 the WW LHIN will be adding a new M-SAA with the Region of Waterloo and the City of Guelph to support Community Paramedicine Services. The WWLHIN will also add a new M-SAA with The County of Wellington for Supportive Housing. These new three new Agreements are as a result of transferring 2017-2018 funding and services from an existing HSP to better align with the intent of the delivery of service. In addition, more Mental Health and Addiction Supportive Housing units and community support services are anticipated to be delivered in partnership with municipalities in Waterloo and Wellington in 2018-2019.

If new base funding is received by the Ministry of Health and Long Term Care in 2018-2019, it is expected that new funding will be targeted to dementia community programs. Planning is underway with the LHIN staff, providers and the ministry to address those patients who at most risk and need continuous respite support before they require long term care services. Additional integration efforts are underway to link behaviour support services across sectors to ensure continuity of care and seamless transitions between hospital and home.

Based on a 0% base funding increase and no reduction in service volumes for 2018-2019 CSS (Community Support Services), CMHA (Community Mental Health and Addiction) , and CHC (Community Health Centres) M-SAAs will be created using the known 2017-2018 funding and service volume targets or higher.

Long Term Care Home Service Accountability Agreements

In 2018-2019 the 4110 beds in 36 Long Term Care Homes remain unchanged from 2017-2018 in the WWLHIN. The current 2016-2019 L-SAAs will be amended with a new Agreement template along with schedules, until March 31, 2019.

The April 1, 2017 opening base allocation for our 36 LTC homes was $195,988,116. In 2017-2018 there were base funding increases totalling $4,856,356, bringing the opening allocation for April 1, 2018 up to $200,844,472.

NEXT STEPS

Upon LHIN Board approval of the proposed Agreement template changes, and 2017-2018 funding, and service volumes for the period from April 1, 2018 to March 31, 2019, LHIN staff will create and deliver the proposed Service Accountability Agreements along with attached schedules to all HSPs.

HSPs are required to obtain signed approval of their Agreement and schedules from their Board and return to the LHIN by March 1st 2018. The LHIN CEO and Board Chair will them sign back the SAAs on behalf of the WWLHIN and agreements between the WWLHIN and HSPs will be executed by March 31st 2018 to allow funding to be provided to these organizations effective April 1, 2018.

The proposed Service Volumes identified in the tables below are subject to adjustments. LHIN staff will continue to review HSP Board approved Annual Planning Submissions up to the January 31, 2018. Prior to any execution of the new Agreements on April 1, 2018, WWLHIN staff will provide the LHIN CEO and Board Chair with any significant changes to the proposed allocations.

After April 1, 2018, WWLHIN staff will bring any new proposed base funding and volume adjustments to the Board and will provide the Finance and Audit Committee and/or Board with updates on overall funding on a quarterly basis.

APPENDIX A

Impacted SAA	Significant Changes from 2017-2018	Rationale for Changes
H-SAA, L-SAA, M-SAA	Background section has been updated.	To ensure consistency across all the agreements.
H-SAA, L-SAA, M-SAA	Various terms and definitions have been updated.	To reflect legislative changes (e.g. CFMA to LHSIA) and ensure consistency across agreements and provincial priorities (e.g. e-Health to Digital Health)
L-SAA	Add: FLS designation information to Schedule A	To identify which LTCHs have capacity to support FLS residents.
L-SAA	Removed reference to the use of the Funding. Added reference to any directive or provincial standard issued by the Minister under LHSIA. Also added deeming provision with regard to section 20 of LHSIA.	Clarified relevance of LHSIA to this section. The procedural requirements of section 20 (notice, negotiation, etc.) are deemed to have been met in respect of any terms or conditions added pursuant to this section 4.5.
L-SAA	Updated requirements for effective date of amendments to manuals, guidelines or policies in Schedule D.	Updated so that any amendments are effective in accordance with the terms of the amendment.
L-SAA, M-SAA	Added reference to HSP mechanisms to engage families and patients in planning. Also clarified that HSPs will report on community engagement and integration activities using any template provided by the LHIN.	Update includes reference to geographic sub-regions, and clarified approach to reporting.
L-SAA, M-SAA	Updated section pertaining to personal health information and LHSIA. Also updated section on reporting related to Health Quality Ontario.	Clarified LHINs' right to collect personal health information for purposes that relate to their new mandate to provide home and community care and do long-term care home placements. Also clarified expectations for HSPs regarding quality improvement.

Impacted SAA	Significant Changes from 2017-2018	Rationale for Changes
L-SAA, M-SAA	Added new section - 3.5 (M-SAA)/3.6 (L-SAA) French Language Services	New section about French Language Services that sets out the roles, responsibilities and obligations of HSPs depending on whether they are Identified, Designated or neither. The LHIN will provide the Ministry's Guide to the HSP.
L-SAA, M-SAA	Added new section - 3.6(M-SAA)/3.5(L-SAA) Minister's Mandate Letter language	New section about the Minister's Mandate Letter. The LHIN will share the Mandate Letter with the HSP and LHINs and may add local obligations to Schedule E to advance priorities in the Mandate Letter.
M-SAA	Added reference the pro-rating of funds	Clarifies that if the SAA is signed part way through the year, the funding in Schedule B will be pro-rated (i.e. paid for only the part of the year that the SAA is in effect).
M-SAA	Added reference to Funding Increases	Process around the LHIN allocating additional funds to an HSP.
M-SAA	Added description section to Conditions of Funding	Clarified that all funding is subject to Applicable Law and Applicable Policy including Health System Funding Reform.

APPENDIX B

No.	Contract Type	Obligation Description	Target and Reporting Requirements
1.	H-SAA PH-SAA	Carry-over from 2017-2018. Hospitals will provide admission, discharge and emergency department notifications and summaries, preferably in electronic format, to primary care within 48 hours of discharge in order to improve patient follow-up with a family doctor after leaving hospital.	100% on target Quarterly reporting, as part of Agreement.
2.	H-SAA PH-SAA	Carry-over from 2017-2018. Hospitals will provide the provide the client, community-based health care provider/ primary care provider, and community pharmacy (as appropriate) with a BPMDP (Best Possible Medication Discharge Plan) complete patient medication list upon discharge.	100% on target Quarterly reporting, as part of Agreement.
3.	H-SAA PH-SAA M-SAA	Carry-over from 2017-2018. Hospitals will participate in System Coordinated Access (SCA) for the following streams: Diabetes, Orthopaedics/ Musculoskeletal (MSK), Mental Health and Addictions (MHA), Chronic Disease Prevention and Management (CDPM), Diagnostic Imaging (DI), Specialized Geriatric Services (SGS), and cataract surgery, with clinical teams being part of the design and development of the system.[1]	Hospital sign-off on SCA system stream projects as per overall SCA program timelines for WWLHIN. Notification through the WWLHIN SCA program.
4.	H-SAA PH-SAA M-SAA	Carry-over from 2017-2018. All Health Service Providers (HSPs) have a process to identify individuals	Define percentage of complex residents per sub-region care community.

[1] http://systemcoordinatedaccess.ca/

No.	Contract Type	Obligation Description	Target and Reporting Requirements
		who meet the Health Links definition/ criteria and/or who would benefit from a coordinated care approach. HSPs will initiate, participate in and share coordinated care plans. It is expected that HSPs will update and communicate changes to care plans as a patient's condition and situation changes.	Determine baseline current state of number of Coordinated Care Plans per sub-region care community. Quarterly reporting via the Health Links sub-region care community Steering Committee.
5.	H-SAA PH-SAA	Carry-over from 2017-2018. Hospitals seeking to implement a new Hospital Information System will use the Principles of Digital Health Strategy 2.0, Digital Health Investment and Sustainment Board, Hospital Information System (HIS) Renewal, HIS Clustering Guidebook for Hospitals and LHINs, and the EHR Connectivity Strategy to guide their decisions.	Obligation as per MOHLTC Digital Health policy. Notification per HSP.
6.	H-SAA PH-SAA	Carry-over from 2017-2018. Hospitals will adopt the principles and practices of senior friendly care and senior friendly hospitals (SFH) through the adoption of SFH principles, patient experience feedback, and participate in local planning related to senior services.	Each hospital to identify a set of performance indicators that highlight areas of focus, potentially including the following: - % of hospital patients (65 and over) receiving assessments of Activities of Daily Living functions with validated tool at both admission and discharge (acute only). -% of hospital patients (65 and over) receiving delirium screening with a validated tool at admission and discharge. -Incidence of delirium patients (65 and over) acquired over the course of hospital admission. Quarterly reporting, through the Health Links sub-region care

No.	Contract Type	Obligation Description	Target and Reporting Requirements
			community Steering Committee.
7.	M-SAA	New for 2018-2019. Wait times for all funded services are publicly posted with the regional access centre at Canadian Mental Health Association Waterloo Wellington (CMHAWW) Here 24/7. Each provider to reduce, or eliminate duplication of referral, intake and assessment through to placement of service through integration and optimization of business processes with the regional access centre. Providers use provincially adopted staged screening and assessment tools through Centre for Addiction and Mental Health (CAMH) Provincial System Support Program.[2]	As per Explanatory Indicators as per 2017-18 M-SAA: - Repeat Unplanned Emergency Visits within 30 days for Mental Health conditions - Repeat Unplanned Emergency Visits within 30 days for Substance Abuse conditions - Average Number of Days Waited from Referral/Application to Initial Assessment Complete -Average number of days waited from Initial Assessment Complete to Service Initiation Submit integration and optimization plan for centralization of referral, intake and service placement processes with regional access centre. Quarterly report, as part of contract.
8.	H-SAA PH-SAA M-SAA L-SAA	New for 2018-2019. HSPs will implement the Quality Standards as released by Health Quality Ontario (HQO).[3]	Gap analysis of services in meeting the Quality Standards and work plan in achieving the standard. Annual plan and status report.
9.	H-SAA, M-SAA	**NEW.** That the Health Service Provider use the funding provided by this agreement and report on HSP performance in achieving the objectives and targets in the WWLHIN Annual Business Plan, MLAA, and Minister's mandate letter and this SAA.	Reporting Mechanism still to be determined by LHIN.

[2] http://www.camh.ca/en/hospital/about_camh/provincial_systems_support_program/Pages/default.aspx

[3] http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards

Waterloo Wellington **LHIN**

APPENDIX C

2017-18 Hospital Funding Allocation						
Hospital	**Global Base & One-Time**	**Wait Time Strategy - Base**	**HBAM**	**QBP**	**Total**	**EDP4R (based on 17/18)**
Cambridge Memorial Hospital	$ 54,636,144	$ 695,180	$ 28,748,195	$ 12,670,046	$ 96,749,565	$ 1,140,700
Grand River Hospital	$ 125,955,724	$ 1,648,521	$ 79,385,223	$ 20,501,455	$ 227,490,923	$ 1,313,000
Groves Memorial Community Hospital	$ 18,099,000	$ 135,949	$ -	$ -	$ 18,234,949	$ -
Guelph General Hospital	$ 56,490,505	$ 1,423,396	$ 36,886,808	$ 17,226,752	$ 112,027,461	$ 1,994,700
North Wellington Health Care	$ 16,782,281	$ -	$ -	$ -	$ 16,782,281	$ -
St. Joseph's Health Centre, Guelph	$ 11,123,571	$ -	$ 7,413,360	$ -	$ 18,536,931	$ -
St. Mary's General Hospital	$ 73,349,522	$ 433,283	$ 42,286,730	$ 10,856,865	$ 126,926,400	$ 1,025,300
Total	**$ 356,436,747**	**$ 4,336,329**	**$ 194,720,316**	**$ 61,255,118**	**$ 616,748,510**	**$ 5,473,700**

The funding outlined above reflects the known 2017-2018 funding (one-time and base). The schedules that will be created and sent to HSPs for April 1, 2018 will reflect these known funding amounts.

APPENDIX D

Hospital Service Volumes Summary - Aggregate

Service	2017/18 H-SAA Target at start of FY	2018/19 Proposed H-SAA Target as of Dec 31, 2017
Total Acute Activity including Inpatient (Weighted Cases)	82,177	82,965
Emergency (Weighted Cases)	15,924	16,157
Ambulatory Care (Visits)	514,620	516,220
Complex Continuing Care (Weighted Patient Days)	65,885	65,914
Inpatient Mental Health (Weighted Patient Days)	140,268	142,976
Inpatient Rehabilitation (Weighted Cases)	1,174	1,300
Ambulatory - MH Community Services (Visits)	9,500	9,500
Total Service Units	**829,548**	**835,032**

Hospital Service Volumes Summary - Cambridge Memorial Hospital

Hospital	2017/18 H-SAA Target at start of FY	2018/19 Proposed H-SAA Target as of Dec 31, 2017
Total Acute Activity including Inpatient (Weighted Cases)	12,703	12,703
Emergency (Weighted Cases)	2,926	2,926
Ambulatory Care (Visits)	84,293	84,293
Inpatient Mental Health (Weighted Patient Days)	7,446	8,192
Inpatient Rehabilitation (Weighted Cases)	261	310
Total Service Units	**107,629**	**108,424**

Hospital Service Volumes Summary - Grand River Hospital

Hospital	2017/18 H-SAA Target at start of FY	2018/19 Proposed H-SAA Target as of Dec 31, 2017
Total Acute Activity including Inpatient (Weighted Cases)	26,344	26,344
Emergency (Weighted Cases)	3,882	3,882
Ambulatory Care (Visits)	240,585	240,585
Complex Continuing Care (Weighted Patient Days)	43,000	43,000
Inpatient Mental Health (Weighted Patient Days)	44,274	46,236
Inpatient Rehabilitation (Weighted Cases)	478	555
Total Service Units	**358,563**	**360,602**

Hospital Service Volumes Summary - Groves Community Memorial Hospital

Hospital	2017/18 H-SAA Target at start of FY	2018/19 Proposed H-SAA Target as of Dec 31, 2017
Total Acute Activity including Inpatient (Weighted Cases)	2,290	2,360
Emergency (Weighted Cases)	1,000	1,100
Ambulatory Care (Visits)	11,000	12,600
Complex Continuing Care (Weighted Patient Days)	2,221	2,250
Total Service Units	**16,511**	**18,310**

Hospital Service Volumes Summary - Guelph General Hospital

Hospital	2017/18 H-SAA Target at start of FY	2018/19 Proposed H-SAA Target as of Dec 31, 2017
Total Acute Activity including Inpatient (Weighted Cases)	18,782	18,782
Emergency (Weighted Cases)	4,086	4,086
Ambulatory Care (Visits)	67,976	67,976
Total Service Units	**90,844**	**90,844**

Hospital Service Volumes Summary - North Wellington Health Care

Hospital	2017/18 H-SAA Target at start of FY	2018/19 Proposed H-SAA Target as of Dec 31, 2017
Total Acute Activity including Inpatient (Weighted Cases)	1,408	1,440
Emergency (Weighted Cases)	880	950
Ambulatory Care (Visits)	13,500	13,500
Total Service Units	**15,788**	**15,890**

Hospital Service Volumes Summary - St. Joseph's Health Care, Guelph

Hospital	2017/18 H-SAA Target at start of FY	2018/19 Proposed H-SAA Target as of Dec 31, 2017
Ambulatory Care (Visits)	4,000	4,000
Complex Continuing Care (Weighted Patient Days)	20,664	20,664
Inpatient Rehabilitation (Weighted Cases)	435	435
Total Service Units	**25,099**	**25,099**

Hospital Service Volumes Summary - St. Mary's General Hospital

Hospital	2017/18 H-SAA Target at start of FY	2018/19 Proposed H-SAA Target as of Dec 31, 2017
Total Acute Activity including Inpatient (Weighted Cases)	20,650	21,336
Emergency (Weighted Cases)	3,150	3,213
Ambulatory Care (Visits)	93,266	93,266
Total Service Units	**117,066**	**117,815**

WW LHIN Hospital Base Allocation Summary

Hospital	2017/18 H-SAA Base Allocation at start of FY	2018/19 Proposed H-SAA Base Allocation as of Dec 31, 2017
Cambridge Memorial Hospital	$ 88,568,860	$ 94,667,305
Grand River Hospital	$ 219,728,758	$ 225,398,608
Groves Memorial Community Hospital	$ 17,769,249	$ 18,091,949
Guelph General Hospital	$ 107,805,310	$ 109,406,491
North Wellington Health Care	$ 15,958,095	$ 16,214,381
St. Joseph's Health Centre, Guelph	$ 18,694,330	$ 18,049,181
St. Mary's General Hospital	$ 121,389,195	$ 125,858,350
Total	**$ 589,913,797**	**$ 607,686,265**

APPENDIX E

Private Hospital Service Volumes and Funding Summary- Homewood Health Center Inc.

Hospital	2017/18 H-SAA Target at start of FY	2018/19 Proposed H-SAA Target as of Dec 31, 2017
Visits	4,000	4,000
Group Visits	5,500	5,500
Inpatient Mental Health (Weighted Patient Days)	87,663	88,548
Total Service Volumes	**97,163**	**98,048**
Total Funding	**32,161,350**	**32,290,573**

APPENDIX F

Total Multi- Sector Service Volume Summary

Service	2017/18 M-SAA Target at start of FY	2018/19 Proposed M-SAA Target as of Dec 31, 2017
Attendance Days Face-to-Face	858,216	860,714
Group Participant Attendances	59,133	79,624
Group Sessions	9,353	11,625
Hours of Care	157,111	157,111
Individuals Served by Functional Centre	86,368	89,979
Inpatient/Resident Days	221,403	221,403
Meal Delivered-Combined	143,000	143,000
Not Uniquely Identified Service Recipient Interactions	22,534	34,234
Service Provider Group Interactions	680	680
Service Provider Interactions	216,603	275,614
Visits	475,548	475,548
Total Service Volumes	**2,249,949**	**2,360,430**

Community Support Services Service Volume Summary

Service	2017/18 M-SAA Target at start of FY	2018/19 Proposed M-SAA Target as of Dec 31, 2017
Attendance Days Face-to-Face	843,702	843,702
Group Participant Attendances	10,600	13,100
Group Sessions	1,165	1,465
Hours of Care	145,903	145,903
Individuals Served by Functional Centre	29,647	32,486
Inpatient/Resident Days	63,111	63,111
Meal Delivered-Combined	143,000	143,000
Not Uniquely Identified Service Recipient Interactions	6,740	6,740
Visits	200,972	200,972
Total Service Volumes	**1,444,840**	**1,450,479**

Total volumes increased in year due to one-time investments to support seniors living in the community. Investments allowed for 8 more Seniors Outreach workers to provide housekeeping, light care support and transportation to at risk seniors, in both urban and rural areas. Additional one time funding helped more residents attend community dementia programs provided for more overnight respite to assist with caregiver burden, and support services for people with Alzheimer disease and other similar conditions. Community Support workers work

closely with LHIN Home and Community Care teams to enable seniors to live at home longer, delaying admission to placement to long term care home.

Community Mental Health & Addictions Service Volume Summary

Service	2017/18 M-SAA Target at start of FY	2018/19 Proposed M-SAA Target as of Dec 31, 2017
Attendance Days Face-to-Face	14,514	17,012
Group Participant Attendances	32,739	43,445
Group Sessions	7,003	7,891
Hours of Care	11,208	11,208
Individuals Served by Functional Centre	26,095	26,867
Inpatient/Resident Days	158,292	164,100
Not Uniquely Identified Service Recipient Interactions	15,794	27,494
Service Provider Interactions	177,193	177,193
Visits	205,099	210,189
Total Service Volumes	**647,937**	**685,399**

Increases in service delivery for Mental Health and Addictions are most significantly attributable to increased base investments, including Opioid Strategy dollars.

Community Health Centres Service Volume Summary

Service	2017/18 M-SAA Target at start of FY	2018/19 Proposed M-SAA Target as of Dec 31, 2017
Group Participant Attendances	15,794	23,079
Group Sessions	1,185	2,269
Individuals Served by Functional Centre	30,626	30,626
Service Provider Group Interactions	680	680
Service Provider Interactions	39,410	98,421
Visits	69,477	69,477
Total Service Volumes	**157,172**	**224,552**

WWLHIN Community Health Centres are working diligently to provide innovative models of care to an increasing complex and vulnerable population. This includes supporting the rapid access addiction clinics, refugee and immigrant health, increasing primary care and other clinical outreach capacity, and various upstream population health interventions including addressing social determinants of health.

All CHCs have proposed balanced budgets for 2018/19. Across the CHC sector, service delivery targets are either maintained or increased. Increased volumes are being accepted by

the LHIN. Service volume reduction requests required a Service Delivery Change Form request. Sector-wide decreases proposed in individuals served and visits are skewed by Kitchener Downtown CHC. This HSP is currently under a performance improvement plan. Kitchener Downtown CHC will be asked to submit a SDCF in 2018-19 to address reduced target volumes. Some shifts are due to functional center reporting changes and reclassifications to more accurately reflect the services being delivered.

Waterloo Wellington **LHIN**

APPENDIX G

Community Health Service Provider Funding Allocations	Closing Base Allocation March 31, 2017	Opening Allocation April 1, 2018*
Community Health Centres		
Guelph Community Health Centre	5,193,197	5,364,097
Kitchener Downtown Community Health Centre	4,285,567	4,447,667
Langs Farm Village Association	8,170,952	8,447,852
Woolwich Community Health Care Centre	4,742,810	4,880,910
Total Community Health Centres	**22,392,526**	**23,140,526**
Community Mental Health and Addictions		
Cambridge Memorial Hospital (CMHA)	3,014,681	3,014,682
Canadian Mental Health Association - Waterloo Wellington Dufferin	22,310,012	23,201,012
Carizon Family and Community Services	95,225	95,225
Dunara Homes for Recovery Inc.	497,196	497,196
Family Counselling and Support Services for Guelph-Wellington	44,350	44,350
Grand River Hospital (CMHA)	5,764,682	5,764,682
Homewood Health Centre Inc. (CMHA)	4,673,885	4,673,886
House of Friendship	2,282,267	2,893,268
Ray of Hope Inc.	1,558,011	1,558,012
St. Mary's General Hospital (CMHA)	1,023,835	1,023,835
Stonehenge Therapeutic Community Inc.	2,739,836	2,823,836
The Portage Program for Drug Dependencies Inc.	1,125,465	1,125,465
Thresholds Homes and Supports	8,692,769	8,692,769
Total Community Mental Health and Addictions	**53,822,214**	**55,408,218**
Community Support Services		
Alzheimer Society of Waterloo Wellington	473,905	473,905
Centre for Sight Enhancement, University of Waterloo	173,482	173,482
Community Care Concepts of Woolwich, Wellesley and Wilmot	982,908	982,908
Community Support Connections - Meals on Wheels and More	2,581,545	2,581,545
Corporation of the City of Kitchener	499,428	499,428
East Wellington Community Services	183,061	183,061
Fairview Mennonite Home	295,401	295,401
Guelph Independent Living	3,132,389	3,132,389
Hospice of Waterloo Region	1,182,645	1,211,745
Hospice Wellington	135,807	158,910
Independent Living Centre of Waterloo Region	6,559,180	6,559,180
K-W Seniors Day Program, Incorporated	447,008	447,008
K-W Working Centre for the Unemployed	730,052	852,904
Lutheran Homes Kitchener Waterloo - Trinity Village Outreach	222,233	222,233
Regional Municipality of Waterloo - Sunnyside Home	2,866,364	2,866,364
St. Joseph's Health Centre (CSS)	4,527,891	4,522,891
The Canadian National Institute for the Blind - Waterloo/Wellington District	338,868	458,068
The Corporation of the City of Cambridge	785,819	785,819
The Corporation of the City of Waterloo - Adult Recreation Centre	604,876	604,876
The Corporation of the Township of Mapleton	179,300	179,300
Traverse Independence Not-For-Profit	4,831,645	4,831,645
Victorian Order of Nurses for Canada – Ontario Branch – WWD Site	1,630,170	1,630,170
Total Community Support Services	**33,363,977**	**33,653,232**
Total Community HSP Funding	**109,578,717**	**112,201,976**

Waterloo Wellington **LHIN**

APPENDIX H

HOSPITAL SERVICE ACCOUNTABILITY AGREEMENT (H-SAA)

Purpose: **To seek approval of the New 2018-20 H-SAA Template Agreement**

To: Waterloo Wellington LHIN Board

Date: January 31, 2018

Action: **FOR APPROVAL**

RECOMMENDATIONS

- **Approval of the recommended 2018-20 H-SAA Template Agreement**

BACKGROUND

Co-chaired by a LHIN CEO and a hospital CEO as representative of the Ontario Hospital Association (the "OHA"), the Hospital Service Accountability Agreement (H-SAA) Steering Committee (Committee) was established to provide advice to the LHIN CEO Council on matters related to the H-SAA. Specifically, the Committee supports the development of the H-SAA template, facilitates the annual H-SAA schedules refresh processes through the Planning and Schedules and Indicators Work Groups, and addresses any issues that may arise throughout the life of the agreement.

UPDATES TO THE H-SAA

Indicators and Schedules: As this year was a year of significant transition for the LHINs, the activities of the Indicator, and Planning and Schedules Work Groups were minimized. As such, only material changes were made to the indicators and other schedules. Changes to the schedules were made mainly to align the indicators with the recommendations from the Ministry's Performance and Data Work Stream and to update dates where required.

Template Agreement: The current hospital service accountability agreement (the "current H-SAA") was entered into in 2008 as a result of a third-party facilitation. Although from an accountability perspective, it is an improvement over the previous hospital accountability agreement template that the LHINs inherited from the Ministry, it is deficient in a number of critical ways. Specifically, it leaves LHINs non-compliant with some of their fundamental obligations. For instance, the current H-SAA does not impose on hospitals all of the obligations that LHINs are required, by the Ministry-LHIN

Accountability Agreement (the "MLAA"), to flow-through to all funded HSPs. Likewise, the current H-SAA does not include appropriate mechanisms and provisions to enable the LHINs to meet the requirements of the Transfer Payment Accountability Directive ("TPAD").

The OHA, the body that negotiates with the LHINs on behalf of all hospitals, is of the view that because of the significant statutory framework in which hospitals operate, including the degree to which the Minister retains power over hospitals, hospital service accountability agreements should not be as prescriptive and interventionist as the service accountability agreements for the community sector (the "M-SAA"), which is the LHINs' baseline service accountability template agreement. The OHA has argued strenuously, over many years, that the current H-SAA is perfectly adequate or requires very little, if any, amendment.

We are not of the same view as the OHA as regards the adequacy of the current H-SAA. However, we recognize that hospitals have stringent regulatory obligations, as well as sophisticated governance structures and safeguards, which among other features, make their risk profiles very different from that of the typical community service provider with an M-SAA. As a result, we have not insisted on the same terms as the M-SAA. Instead, we worked with the OHA to review in detail every provision of the current H-SAA, with the M-SAA as our frame of reference, and amended the current H-SAA as necessary to enable LHINs to be compliant with their MLAA, TPAD, and other obligations. The outcome is the new H-SAA that is currently being brought forward for approval.

Aside improvement in compliance, the new H-SAA significantly increases accountability of hospitals for the funding they receive, and provides LHINs with substantially more and better tools to fulfill their duties as transfer payment funder, system planner and integrator.

RECOMMENDATIONS

It is recommended that the Waterloo Wellington LHIN Board approve the 2018-20 H-SAA template agreement.

NEXT STEPS

Once 2/3 of the LHIN Boards have approved the template agreement, LHINs will distribute the 2018-20 H-SAA template and associated schedules to the hospitals for review, consultation and subsequent approval by their Boards. Efforts will be made to have signed copies of the 2018-19 H-SAA template returned to the LHINs for final sign off by March 31, 2018.