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2008-16 H-SAA AMENDING AGREEMENT- SCHEDULE C.3

THIS AMENDING AGREEMENT

(the "Agreement") is made as of the 1st day of April, 2015

B E T W E E N:

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

AND

KINGSTON GENERAL HOSPITAL
(the "Hospital")

IN WITNESS WHEREOF the Parties have agreed to Schedule C.3 on the dates set out below.

SOUTH EAST LOCAL HEALTH INTEGRATION NETWORK

By: _____ _____
Donna Segal, Chair Date

And by: _____ _____
Paul Huras, CEO Date

KINGSTON GENERAL HOSPITAL

By: _____ _____
Scott Carson, Chair Date

And by: _____ _____
Leslee J. Thompson, President & CEO Date

Facility #:	693
Hospital Name:	Kingston General Hospital
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2015-2016 Schedule C3: LHIN Local Indicators and Obligations

Reporting

Reporting

The hospital will provide the LHIN with the following information:

a) A copy of the quarterly report and year-end financial statements, as approved by the hospital's board of directors, within 30 days of board approval. The statement should include a narrative summary of all significant financial assumptions and changes in operating conditions that contributed to the results. This obligation does not include the submission of year-end financial audit information, except as noted in section B (below).

b) A duly signed copy of the hospitals complete audited annual financial statements, by June 30th of each year.

c) As part of quarterly performance meetings, the hospital will provide the LHIN with status updates of activities related to all approved activities and projects.

Community and Stakeholder Engagement

Report on activities: The hospital will submit, on an annual basis to the LHIN, a report on all community and stakeholder engagement activities and Health Equity Impact Assessments (HEIA) completed for changes in clinical programming including an increase, decrease or cessation of clinical programs.

Participation in Initiatives

The hospital understands that as a partner in the local health system, it has an ongoing obligation to participate in Initiatives (Including Enabling Technologies), to the extent that it is able without impacting its capacity to meet its other obligations including this agreement. Such initiatives include, but are not limited to:

a) Identification of Enabling Technologies project leads and/or project champions.

b) Participation in regional/provincial planning and implementation groups.

c) Specific obligations as may be specified as a condition of participation in Enabling Technologies initiatives.

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

Participation in Initiatives (Continued)

Priority LHIN and Provincial initiatives currently identified include:

a) Regional Hospital Integration System (HIS)
- This initiative includes the possible implementation of a common hospital information system across the LHIN and shared support services for IT. An example of how the implementation of a common HIS can help will include the building of a regional iEHR along with providing one access point for provincial interfaces (OLIS, Drugs, EMPI, etc.) and the provincial Health Integration Access Layer.
- This project is currently on hold at the direction of the Ministry. When the initiative resumes the LHIN is committed to reviewing the implementation timing of this initiative on a hospital by hospital basis.

b) Ontario Lab Information System (OLIS)
- As a province-wide, integrated repository of tests and results, OLIS will contribute to fundamental improvements in patient care by providing practitioners with timely access to laboratory results that is needed at the time of clinical decision making. OLIS is a cornerstone information system that connects hospitals, community laboratories, public health laboratories and practitioners to facilitate the secure electronic exchange of laboratory test orders and results.

c) Clinical Document Repository (CDR)
- The CDR is a regional repository of the key patient records that are most commonly shared among healthcare providers across the continuum of care for those patients. This is a key component in the development of an electronic health record for citizens of Eastern Ontario. The initial scope of the CDR is to enable sharing of electronic clinical documents from the hospitals directly with primary care physicians in their EMRs.

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

Participation in Initiatives (Continued)

d) Connecting Northern and Eastern Ontario (cNEO)

"**Connecting Northern and Eastern Ontario** is a program funded by eHealth Ontario that will give clinicians secure and timely access to electronic patient health information in northern and eastern Ontario. This will be done by 'connecting' health service providers through the integration of health care systems.

The cNEO program is implementing electronic health record (EHR) services for an estimated 18,000+ clinicians across northern and eastern Ontario – with a targeted completion by fall 2016. Clinicians (from hospital, primary and/or community care) will be able to access their patients' electronic health information, such as lab reports, diagnostic imaging reports, discharge summaries and medications, in a seamless manner using their clinical viewer (portal) which is accessible via the Web (and/or their electronic medical record); or if in a hospital setting via their hospital information system.

The cNEO program is aligned with *Ontario's eHealth Blueprint* and standards and supports the government's commitment of providing electronic health records for all Ontarians. *Ontario's eHealth Blueprint* is a roadmap that outlines the principles, values, technology architecture and privacy and security practices required to establish and maintain electronic health records for all of Ontario's 13 million residents. cNEO is working closely with eHealth Ontario, the Local Health Integration Networks (South East, Champlain, North West and North East) and stakeholders in northern and eastern Ontario to ensure the success of the program."

e) Resource Matching and Referral (RM&R)

- The ALC RM&R project is a Provincial project, with a cluster delivery approach, supported by the Ministry of Health and Long-Term Care (MOHLTC) to streamline and standardize the provincial patient referral pathway and information. ALC RM&R will enhance the ability for clients to receive the right care at the right time, improving transitions of care by bringing together health care providers from across the province to standardize four patient referral processes.

f) Integrated Assessment Record (IAR)

- The Integrated Assessment Record (IAR) is an application that allows authorized users to view multiple community based assessments for a single patient. HSPs and community care workers use the IAR to view assessment information from different source organizations through a single clinical viewer.

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

Participation in Initiatives (Continued)

g) High Risk Screening Tool (AUA –iCART)

- The utilization of a high risk screen tool on individual 75+, flags health service providers this client requires a focused attention to prevent unnecessary non- acute hospital admissions, prolonged hospitalization, and designation of ALC. Clients identified as being "at risk", whether outpatient based or client sent home, the high screen score is referred utilization of an integrated community assessment tool- Assessment Urgency Algorithm (AUA) for frail, high risk patients with support provided by the ICART referral team (CCAC and Community Support Services) to minimize the risk for these clients as they travel from ER to the community or ER to inpatient unit to home and receive supportive services.

h) ED CCAC Notification system

- These initiatives include the transfer of information from hospitals to the CCAC CHRIS system and vice versa. design and implement an ED Notification System that will securely integrate CCAC and hospital patient information and admission systems to:
  - Inform CCAC Case Managers, or other staff, when a patient on CCAC services presents to the hospital ED.
  - Inform hospital ED clinicians and staff that a patient is receiving, or has recently received, support from the CCAC.

i) South East Health Integrated Information Portal (SHIIP)

- SHIIP's primary focus is to identify patients with complex needs, allowing primary care physicians to gain secure and verified access to patient information in real time. This initiative will leverage existing assets in IT and IM (i.e. CDR) to assist the Health Links initiative and coordination of patient care by way of a coordinated care plan.
- All SELHIN hospitals will be requested to act as data contributors to the SHIIP portal and recommend improvements to existing technical infrastructure to assist SHIIP performance and reduce technical asset duplication.
- Specific hospital deliverables will include:
  - Data Integration and Delivery – processing of identified data (e.g. ADT, DAD, NACRS)
  - Testing & Continuous Integration – User acceptance testing, performance testing, deployment
  - Security and privacy related requirements

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

Participation in Initiatives (Continued)

j) South East Regional Privacy Group
- The regional privacy group's primary focus is to enhance the capacity of providers in the region to manage the personal health information (PHI) in their custody, and to support providers in more efficient and robust sharing of PHI. At the same time that electronic health information systems are increasing the ease with which PHI can be shared, health system planners in Ontario and internationally have identified more efficient sharing of patient information as a key factor in improving the provision of health care, and patient outcomes. Supporting health service providers in in efficient and appropriate sharing of PHI is therefore a key priority for health system planners throughout Ontario.

Software/Hardware Compliance

It is in the best interest of the hospital and the local health system that information technology and information systems, are able to easily interface with other IT/IS systems within the LHIN, including systems employed by the primary care community. In support of this commitment, the hospital will employ the following consultation framework prior to making a material investment in information systems or technology.

IT/IS Consultation Framework:

1. The hospital will share the product specifications and identified need for the IT/IS solution with the LHIN Enabling Technologies project management office. The Enabling Technologies team will evaluate the submission to ensure that:
   a) The technology aligns with strategic IT/IS plans.
   b) Supports identified best practice standards within the LHIN.
   c) Meets the local performance obligation regarding compatibility.
   d) Does not result in duplicate investment that could be mitigated through a shared investment with other organizations with a similar need.
   e) Provide additional comments or recommendations regarding the submission that would improve its capacity to support local IT/IS interoperability.

2. The Enabling Technologies team will provide this information to the hospital within an agreed timeframe upon receipt of materials required to make these determinations.

3. Should the hospital not agree with the recommendations, it shall inform its primary LHIN consultant within 30 days of receipt of the team's recommendations and provide its rationale as to why the hospital should proceed without integrating the Enabling Technologies team's recommendations. The consultant may support the hospital's position, or may refer the matter to the LHIN executive for further review.

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

Required Participation in CritiCall

The Hospital will:

a) Use CritiCall to access medical consultations, facilitate transfers for patients who are emergent, urgent and critically ill and repatriate patient to home hospital.

b) Update:
   (i) the Critical Care Information System (CCIS) in accordance with the CCIS Data Collection Policy Guide (v. 2.0); and
   (ii) The Provincial Hospital Resource System in accordance with the requirements of that system.
   (iii) Implementation of Provincial Life and Limb Policy with the understanding repatriation of critical care clients would be within 24hrs of notification.

Planning and Collaboration

In the event the hospital has identified significant operating pressures associated with the implementation of the following (or other) initiatives, the hospital and the LHIN note that further review with the SE LHIN Executive and/or discussion at the South East CCAC and Hospital Executive Forum (SECHEF) may be required.

Integration Opportunities and Activities

The *Local Health System Integration Act, 2006*, requires health service providers to:

a) Identify integration opportunities to the LHIN and to

b) Advise the LHIN of any proposed voluntary integration activity sixty (60) days in advance of implementing that activity. In accordance with the *Act* the hospital agrees to submit:
   (i) Semi-annually, and using the template provided by the LHIN on its website, a list of potential integration opportunities which the hospital has identified as having potential value to the local health system.
   (ii) At the hospital's discretion, using the template provided by the LHIN on its website, any proposed voluntary integration activity to the LHIN. The hospital further agrees that it will take no action to implement the activity until the LHIN board of directors has considered the activity, or after sixty (60) days have elapsed, whichever is sooner.

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

Participation in Health Links

The hospital will work in conjunction with all health care partners in their associated Health Link(s) to:

- Contribute to the development and as required, initiation of Coordinated Care Plans to support the care pathways of complex patients who have been admitted and are identified as complex.
  - 100% of complex patients admitted without a Coordinated Care Plan will have one initiated with the Health Link care coordinator before discharge.
- Contribute data to support the Health Links metrics, as defined provincially.

Participation in Health Service Funding Reform (HSFR) Initiatives

The hospital will actively participate in the implementation of Health System Funding Reform (HSFR) initiatives and contribute expertise as required to South East LHIN HSFR local partnership. Participation will include the contribution of membership to regional capacity planning teams and actively participate in the roll out and implementation of the final work plan activities.

Sharing patient information with primary care, CCAC and other community providers

The hospital and other care providers will work together to support the efficient and effective transfer of:

a) Inpatient discharge information, as defined by the Ontario Discharge Summary Specification.

b) Emergency Department visit information, as defined by the Clinical Document Specification, the National Ambulatory Care Reporting System, and other relevant standards.

The hospital will continue their commitment to protecting patient privacy, confidentiality and security of all personal health information. Hospitals will work with / participate in regional working groups and collaborations to ensure there is a consistent approach and transfer of information.

Health Care Tomorrow

Hospital and system leaders within the South East Local Health Integration Network (LHIN) – represented by the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) – are currently working together to explore the future of services across the South East region.

The hospitals are committed to working collaboratively and making sure that the options developed best meet the needs of patients now and in the future – delivering the selected options for ***Health Care Tomorrow***.

The project currently is in the planning phase, identifying opportunities to pursue in the interests of the optimal health care. To that end, each hospital will participate in the Healthcare

Tomorrow project and the associated working groups to develop options for implementation while engaging patients and their families for input throughout.
The options being explored include:

- Business services
  - Including but not limited to:
    - Finance
    - HR
    - I.T.
    - Facility Services
- Diagnostics and Therapeutics
  - Laboratories
  - Diagnostics
  - Pharmacy
- Clinical Services
  - Urgent & Emergent Care
  - Elective Care
  - Tertiary Quaternary Care

Patient Flow

To ensure patients receive the right care, at the right time in the right place, all hospitals are to collaborate with system partners, to optimize patient flow internal to their organization and system wide. Each organization will focus on one or more of these areas:

- actively divert ER patients where appropriate,
- address unnecessary hospital admission or readmission,
- focus on intra-hospital process to improve patient flow,
- assist in better transition of care to alternative care setting, and
- Optimize patient discharge to home.

Kingston General Hospital will collaborate with system partners to:

- Adopt a patient flow framework. This framework will include the following characteristics:
  - Identifies accountability within the organization at multiple levels;
  - VP level involvement in bed management discussions (i.e. Corporate Scrums) ;
  - Patient flow metrics that triggers actions for improvement; and
  - An internal and system wide patient flow communication.
- Target an improvement in the organization's predicted discharge accuracy rate to 95%.

Hospitals will work in partnership to develop and implement an internal and system wide patient flow action plan for the next three years (Fiscal 2015/16 to Fiscal 2018/19) with an associated performance monitoring framework. Reporting on the activities identified in the action plan will occur quarterly.

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

All hospitals will commit to the development, and early adoption of the Regional Patient Flow dashboard. This commitment includes identification of resources needed for development and implementation of the dashboard, timely submission of required data, approval of operational protocols based on metrics and the development of an escalation process based on triggers.

Senior Care Strategy

All hospitals are to execute a Senior Care performance monitoring framework for internal monitoring and quarterly reporting to the LHIN.

Three explanatory indicators to be included are:

- % of hospitalized patients (65 and over) receiving assessment of ADL function with a validated tool at both admission and discharge (applicable only to acute care setting - Providence Care & post care beds excluded)
- % of hospitalized patients (65 and over) receiving delirium screening with a validated tool at both admission and discharge
- Incidence of delirium in patents (65 and over) acquired over the course of hospital admissions.

Participation in CCAC Coordinated Access

The hospital agrees to work collaboratively with the LHIN and the South East CCAC to plan and successfully implement the transfer of responsibility for the assessment of eligibility and placement of patients to their appropriate discharge destination, from the hospital staff to the South East CCAC care coordinators

Addictions and Mental Health Redesign

The hospital will collaborate with the three AMH entities to successfully deliver on the Ideal Individual Experience of the AMH Redesign. As the entities develop they will continue to reach out to partners to refine the foundational work of coordinated access and intake processes to improve efficiencies, capacity and delivery of care. This includes:

- Development of service contracts between the AMH entity and the hospital for delivery of Schedule 1 services;
- Adoption of the South East Ontario Access and Intake Assessment Forms;
- Standardization of regional wait times reporting for Counseling and Treatment, Case Management and Transitional Case Management, as it related to specified hospitals; and
- Participate in privacy training to create a common approach and understanding of the "circle of care" to better provide quality care to AMH clients presenting to ED with challenging behaviors.

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

The expectation with respect to Mental Health Fund Type 1 Hospital Mental Health services is that the base budgets as outlined in the table below will be maintained in whole including any efficiencies which will be re-directed as follows:

- **Administrative efficiencies within the Mental Health Area**- Redirect savings to Direct Mental Health Services
- **Direct Services efficiencies within the Mental Health Area**- Redirect savings to increase Mental Health Services.

Hospital Mental Health Services Funding 2015-2016

		Base	Base Year	Notes
619	Brockville General Hospital	$12,200,172	2012-2013	Transfer from ROH
692	Kingston Hotel Dieu	$2,220,300	2013-2014	2013-14 OCDM Actual MH Expense (Direct & Overhead)
693	Kingston General Hospital	$6,933,200	2011-2012	Transfer from Hotel Dieu
695	Providence Care	$24,604,088	2013-2014	$29,864088 initial, Less 2.16M FCMHS,2.30M BSTU, .800 Transitional
957	Quinte Health Care	$4,516,213	2013-2014	13-14 OCDM IP and OP Mental Health Direct and Overhead Net Expense

Healthcare Acquired Infections

Hospitals will continue to provide quarterly hand-hygiene compliance reports and work towards the establishment of regional compliance targets.

Quality Improvement Plans and Continuous Quality Improvement

Pursuant to the *Excellent Care For All Act, 2010*, the hospital prepares a Quality Improvement Plan (QIP) for submission to Health Quality Ontario (HQO) in a form prescribed by HQO on timelines established by that agency. In addition to meeting this statutory obligation, the hospital agrees:

a) To receive and provide LHIN comments to the hospital's quality committee for consideration when finalizing the plan and in the development of the subsequent year's plan.

b) Ensure Service Accountability targets are included in the QIP plans.

c) To provide the LHIN with the final version of their QIP concurrent with the submission to HQO. Reports should be submitted to the sedatateam@lhins.on.ca Attention: Joe Sherman.

d) The organizations are expected, through the Local Partnership, to engage collaboratively to review their QIP's to ensure Regional system alignment.

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

Performance Obligations

Identified Agencies under the *French Language Services Act (FLSA)*

As the hospital is identified by the South East LHIN to provide services in both Official Languages (English and French) in a designated area under the French Language Services Act (FLS Act), the HSP must: Develop and provide services available in French to the public; Implement the designation work plan in order to work towards the intention of the Designation under the FLS Act; and For new initiatives, integrate FLS components at the planning and implementation stages.

The expectation of the LHIN is that the HSP will:

a) Actively participate in activities designed to support the implementation of their FLS plan, including working with the LHIN and engaging the Réseau in order to seek support related to the implementation of FLS, and the Designation.

b) Submit a FLS work plan in line with the designation requirements including actions and timelines for current year - Q1 (template will be provided), and Implement the FLS work plan for the current year.

c) Annually report to the LHIN with respect to FLS, including the progress status on the implementation of the FLS work plan, in format supplied by the LHIN (Q4).

d) Support the development and implementation of a SE LHIN plan to capture information on Francophone clients/patients.

Data Quality Assurance

The hospital agrees that it will work collaboratively with the LHIN and other regional Health Service Providers to take appropriate actions to support the improvement of the quality of data reported to the LHIN, the Ministry of Health and Long-Term Care, the Canadian Institute of Health Information and other agencies which may be designated by the LHIN to the extent that it is able without impacting its capacity to meet its other obligations including this agreement.

Required Participation in Provincial Life and Limb policy which includes utilization of CritiCall

The Hospital will:

a) Work with CritiCall to establish and maintain schedules that Criticall can use to obtain on-call coverage for critical care and related medical specialties from the Hospital. Note: A further review is underway to reduce the amount of reporting for the Small Hospitals.

b) Accept calls for consultation from CritiCall in accordance with the agreed schedule, regardless of bed status and will implement minor surge strategies to accommodate transfers in accordance with the provincial Critical Care Surge Capacity Management Plan.

c) Submit a "Critical Care Service Inventory Notice of Change Form" form to Critical Care Services Ontario and the LHIN within 30 days of any substantive changes to the hospital's critical care capacity.

d) Ensure that the Hospital's senior leadership and Intensive Care Unit (ICU) leaders review and assess CCIS data and implications with Critical Care LHIN leaders on a quarterly basis.

e) Participate in Ontario's Surge Capacity Management Plan.

f) Implement, monitor and support staff to abide by the Provincial Life and Limb Policy. Based on the data reported from CCSO, the hospital will act upon the information to improve the process.

g) Utilizing Criticall Ontario's repatriation tool to track and monitor repatriation process

Facility #:	693
Hospital Name:	Kingston General Hospital
Hospital Legal Name:	Kingston General Hospital

2015-2016 Schedule C3: LHIN Local Indicators and Obligations

Local Explanatory Indicators

Indicator
ALC Post-Acute – CCC
ALC Post-Acute – Rehab
ALC Post-Acute – Mental Health
Wait Time % for Priority 2 & 3 clients (% based on clinical guidelines)