Ontario's LHINs

HOSPITAL ACCOUNTABILITY PLANNING SUBMISSION (HAPS) USER GUIDE

2019-2020

September 2018

Ontario
Local Health Integration Network

HAPS USER GUIDE 2019-20

Contents

1. Introduction

This document outlines the expectations for the development of Hospital Accountability Planning Submissions (HAPS) for the 2019-2020 fiscal year. The purpose of the HAPS User Guide is to support hospitals in the development of plans for the delivery of high quality, safe, accessible and sustainable hospital services within the resources available. The HAPS User Guide is designed to clarify expectations between the hospitals and the LHINs and to provide and support consistency across the province. Specific questions regarding the HAPS User Guide, HAPS submissions and Hospital Service Accountability Agreements (HSAAs) should be directed to the hospital's primary LHIN contact.

The HAPS is an annual, detailed operating plan, including financial and statistical budgets and performance indicators that will inform the Hospital Service Accountability Agreement (HSAA). The HAPS includes a narrative description of significant service assumptions/changes for the upcoming year. The HAPS is a hospital-owned, confidential planning submission which is submitted to the Local Health Integration Network (LHIN) to inform negotiations of the final targets and performance indicators to be included in the HSAA. Thus, the HAPS is an evolving document which informs current and future hospital plans linking financial and clinical plans. Once specific plans are agreed to between the hospital and the LHIN, the relevant information is incorporated into the HSAA.

The HSAA, a public document, is the legal agreement between the hospital and the LHIN. The HSAA commits the hospital to accountability for financial and service performance. The LHINs are committed to negotiating and achieving balanced and realistic HSAAs that are informed by regular discussion and collaboration. The HSAAs must fulfill the requirements of the Local Health System Integration Act (LHSIA). Once signed, the LHIN and the hospital each have a role in ensuring that the terms of the HSAA are fulfilled.

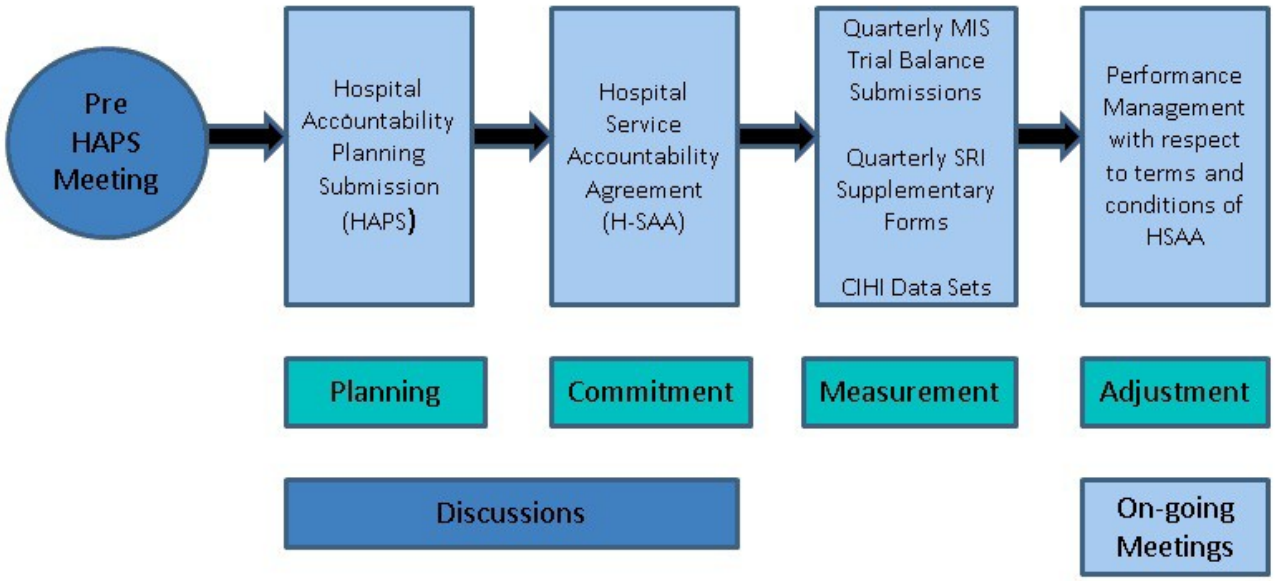
In keeping with the Excellent Care For All Act, 2010 (ECFAA) and Health Quality Ontario (HQO)'s attributes for a high performing healthcare system, hospitals and LHINs will work together to *ensure high quality, safe, accessible and sustainable hospital services within the resources available.*

More specifically,

- High quality means effective, patient/client-centred, equitable, integrated and focused on population health;
- Safe means people should not be harmed by the care that is intended to help them;
- Accessible means patients/clients in need should get appropriate care in the most appropriate setting;
- Sustainable means that an excellent system of care, informed by population need, can be maintained into the future within the financial, human and physical resources available.

1.1 Process for the Development of the HAPS

The process from development of HAPS through to performance monitoring activities during the period of the HSAA is depicted in the figure below.



Early meetings between hospitals and LHINs, prior to the completion of the HAPS submission, are recommended to: discuss, clarify and align expectations of roles in the process; agree and discuss principles, values and assumptions; understand the hospital's funding assumptions, negotiate performance targets, and share and discuss possible options and levers that both parties could draw on during the proceedings.

The HAPS will focus on one fiscal year, requiring the schedules of the HSAA to be refreshed each year using the most current information available at the time.

1.2 Roles and Responsibilities within the Health System

The roles and responsibilities of the primary participants in delivering on the hospital patient/client experience and affecting the health status of Ontarians are described below:

MOHLTC – set provincial strategic direction and standards; ensure that provincial government resources are appropriately allocated across the province and the continuum of health care services; and ensure value for those funds is received.

LHINs – plan, fund and integrate a local health care system to improve the health of Ontarians through better access to high quality health services, coordinated health care and effective and efficient management of the local health system. The *Patients First Act, 2016* gave the LHINs an expanded role, including responsibility for primary care planning, home and community care management and delivery, and the strengthening of public health linkages.

Hospitals - provide a variety of quality, effective, and efficient in-patient services, ambulatory services and community programs of an acute, rehabilitative, complex continuing care and/or specialty mental health nature at all levels, from primary to quaternary care, and from small community hospitals to large academic health centers.

1.3 Engaging Stakeholders

It is the hospital's responsibility to engage key stakeholders at the appropriate time through the year in the development of their plans. Effective stakeholder engagement will facilitate coordination within the system to deliver better, more efficient and effective care to the patient/client.

HAPS should be informed by this engagement so that impacts may be accommodated and mitigated. In some cases, it may be appropriate to hold stakeholder engagement sessions prior to finalizing the HAPS. Hospitals are encouraged to discuss their engagement plans with the LHIN. The LHINs may also assist in facilitating discussions with health care partners. A resource that offers an accessible, organized collection of tools, information and strategies on community engagement for health is Engaging People Improving Care (EPIC) at www.epicontario.ca.

1.4 Changes for 2019-20

Key updates to the HAPS for 2019-20 include but are not limited to the items below, and are detailed further within the HAPS User Guide and/or the provincial HAPS education materials:

- 2019-20 timelines for HAPS submission (as outlined in section 2.6)
- Updated section regarding HSFR (as outlined in section 2.3.1)
- Refined list of QBPs (as outlined in section 2.3.1)

- Updated Additional Input Form, with columns for Base funding and Incremental Base funding under Wait Time Strategy Services in the Schedule A Supplemental Input Form (as outlined in section 3.3)

2. Key Planning Considerations

This section lays out the expectations and requirements for hospitals in the development, assessment and completion of their HAPS. Hospitals are urged to review this section carefully to ensure that their submitted HAPS will be accepted by the LHIN. Some sections are prescriptive and required, while others are informative and directional. All LHINs will be using these planning considerations in their assessment, negotiation and approval processes. In addition, LHINs may add specific items that are relevant to their respective LHIN. Your LHIN will inform you if there are any such items.

2.1 System Perspective

To ensure the achievement of the overarching strategy, the 2019-20 HAPS will be developed in the spirit of system contribution. The ultimate goals of the HAPS are to:

1. Ensure the best possible patient/client experience; and
2. Plan within the resources available.

The hospital's core activity and service delivery choices must be considered in terms of the hospital's role in the regional health system as a whole. Specifically, the hospital will consider the impact of its HAPS choices on:

1. Patients/Clients and their families;
2. Other hospitals
3. Community care providers;
4. Educational resources; and
5. Inter-LHIN service issues.

2.2 Links to LHIN, Pan-LHIN and Provincial Priorities

2.2.1. Provincial Priorities

Building on the expanded role of the LHINs, as enabled by the *Patients First Act, 2016* (PFA), the ministry and LHINs will continue to work together and with other provincial agencies, health service providers, patients, families and other stakeholders to build on a strong foundation to increase access to care, reduce wait times, and improve the patient experience – protecting health care today and the future.

Hospitals must ensure that the HAPS is closely aligned with provincial priorities. These priorities are articulated in the *Excellent Care for All Act, 2010* (ECFAA), *Patients First: Action Plan for Health Care*, and the related supportive materials, including various MOHLTC supportive documents. The priorities are developed to assist with implementation of these legislative and directional documents. A major area of focus is improving safer transitions of care, patient/client experience, and access for all Ontarians through a set of

prioritized quality indicators (refer to the QIP guidance document which can be accessed on the MOHLTC website at http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/quality_improve.aspx).

In addition, hospitals are expected to support Health Links. Health Links bring together health care providers in a community to better and more quickly coordinate care for high-needs patients. Where a hospital is a member or a coordinating partner of a Health Link, Quality Improvement Plans articulated under ECFAA should align with objectives provided as part of initial business planning process for each Health Link.

2.2.2. Pan-LHIN Strategic Directions

To support the implementation of the *Patients First: Action Plan for Health Care,* the LHINs are working in partnership with the provincial government, caregivers, providers and health care experts to provide access high quality care, transform home and community care and improve the experiences of patients and their families. The LHINs' key strategic directions are:

1. Transform the patient experience through a relentless focus on quality
2. Tackle health inequities by focusing on population health
3. Drive innovation and sustainable service delivery
4. Build and foster integrated networks of care

2.2.3. Ministry-LHIN Accountability Agreement (MLAA)

The MLAA between the MOHLTC and the LHIN sets out the responsibilities and obligations of each of the LHINs and the MOHLTC in respect to the planning, funding and integration of the LHIN's local health system. Provincial targets for each performance indicator have been established with the expectation that all LHINs will work towards achievement of these targets.

While the LHIN is accountable to the MOHLTC for the achievement of the system goals and objectives in the MLAA, each HSP within the LHIN's system has a role to play in enabling the LHIN to achieve these system goals and objectives. Therefore, a hospital will need to review its performance as it relates to the MLAA targets and describe how it will contribute to the achievement of these targets in its HAPS.

2.2.4. LHIN Priorities and Integrated Health Service Plans (IHSPs)

Each LHIN has an Integrated Health Service Plan (ISHP), which details the key priorities of the local health system. Hospitals should reflect those priorities in its planning submission. The LHIN's IHSP can be found on your LHIN's website.
Each LHIN may also have additional local priorities. Enabling strategies (such as Health Human Resources, Health Links, information management and enabling technologies, administrative and support services integration, etc.) may also be included to support the priorities. Your LHIN will inform you of any additional local priorities. All LHIN priorities should be addressed in the HAPS.

2.3 Common Expectations for the HAPS

Hospitals will individually and prudently determine the Health System Funding Reform funding (Health Based Allocation Model (HBAM) and Quality-Based Procedures (QBPs) including bundled care) and other prudent f u n d i n g assumptions that make the most sense for their unique situations and that reflect all information available at the time. These funding assumptions will be the same as those used by the hospital in preparing its annual internal budget as part of its regular, corporate fiduciary duty. O n l y known or announced funding should be incorporated in this estimate for planning purposes only. The HAPS must not include any additional requests for funding.

Service plans must be congruent with and deliver on provincial and LHIN strategies and priorities, specifically:

- Access to Care (wait times, emergency room/alternative level of care (ER/ALC), primary care);
- Information and Technology Strategy (provincial and local tactical plans);
- Ministry-LHIN Accountability Agreement (MLAA) obligations and performance targets not captured elsewhere; and
- LHIN Integrated Health Service Plan (IHSP) priorities.

Service plans must ensure care is delivered safely and at a high quality.

Hospitals that are participating in the bundled payment Expression of Interest pilot and/or bundled QBPs are encouraged to engage directly with their LHINs about how this can be reflected in their HAPS.

2.3.1. Health System Funding Reform Funding

Health System Funding Reform (HSFR) was introduced by the MOHLTC in April, 2012 to implement an evidence-based system organized around the health care needs of a community.

HSFR is expected to improve access to and quality of care, and value for tax dollars by:

- Funding hospitals, community and long-term care providers based on how many people they care for, the services they deliver, and the specific needs of the population they serve;
- Using the best available evidence and proven best clinical practices to provide care that works best for people and for the system; and
- Promoting efficient and high-quality service delivery.

Through the patient-based funding governance model, the Hospitals Advisory Committee (HAC) was established and is led trilaterally by the ministry, the Local Health Integration Networks (LHINs) and the Ontario Hospital Association (OHA). The committee provides strategic advice and recommendations to the

ministry leadership on all aspects patient-based funding, including existing and planned components of funding models. As part of its functions, HAC provides recommendations on annual Quality Based Procedure (QBP) volume planning and allocations.

It is recommended that hospitals utilize the forecasting tool (https://www.oha.com/health-system-transformation/health-system-funding-reform/hsfr-forecasting-tool) developed in partnership between the OHA and the ministry. The forecasting tool is designed to help hospitals project future funding allocations by providing additional education on patient-based funding: the inputs, data sources, how calculations work and how all of the information is consolidated in order to calculate Health-Based Allocation Model (HBAM), Quality Based Procedure (QBP) funding, and the HBAM Contribution. As a reminder, the forecasting tool is only intended to provide an estimate, and would not be considered final until the allocation is confirmed by the LHINs or the ministry.

Health System Funding Reform has two key components:

1. Health Based Allocation Model (HBAM):

The primary objective of HBAM is to equitably allocate available funding for local health services. HBAM is an evidence-based funding formula that uses clinical and financial information to redistribute a fixed funding pot annually, based on the number of patients treated and the complexity of their care. HBAM also takes into account the efficiency of hospitals. The final output from the model is a "share of expected expenses' that is used to determine each LHIN's, and ultimately each HSP's share of available funding and HBAM funding allocation.

2. Quality Based Procedures (QBPs) Funding:

The primary objective of QBPs are to facilitate the adoption of best evidence-informed clinical practices while reducing variation in costs and practice across the province to improve overall outcomes. Specific groupings of health services are chosen using an Evidence Based Framework to evaluate the impact on Practice Variation; Cost; Feasibility/Infrastructure for Change; Availability of Evidence, and; the Impact on Transformation. Funding is allocated on a "Price times Volume" basis. Health care providers are funded using a standard rate (or price) adjusted for the type of service and acuity of patients they serve.

To date, the following QBPs have been rolled out:

2012-13
1. Chronic Kidney Disease
2. Cataract (Unilateral - Day Surgery)
3. Hip Replacement (Unilateral - Inpatient Surgery, Inpatient Rehab, Home Care Rehab)

2012-13
4. Knee Replacement (Unilateral - Inpatient Surgery, Inpatient Rehab, Home Care Rehab)

2013-14
5. Chemotherapy – Systemic Treatment
6. Gastrointestinal Endoscopy
7. Non-Cardiac Vascular (Lower Extremity Occlusive Disease)
8. Non-Cardiac Vascular Aortic Aneurysm
9. Stroke (Hemorrhage)
10. Stroke (Ischemic Or Unspecified)
11. Stroke (Transient Ischemic Attack)
12. Congestive Heart Failure (CHF)
13. Chronic Obstructive Pulmonary Disease (COPD)

2014-15
14. Hip Fracture
15. Tonsillectomy
16. Pneumonia
17. Hip/Knee Replacement (Bilateral - Inpatient Surgery, Inpatient Rehab, Home Care Rehab)

*Neonatal jaundice QBP was introduced in 2014-15 and funding was returned to base effective 2017-18

2015-16
18. Cancer Surgery (Prostate)
19. Cancer Surgery (Colorectal)
20. Knee Arthroscopy

2016-17
21. Cataract (Non-Routine and Bilateral – Day Surgery)
22. Cancer Surgery (Breast)
23. Cancer Surgery (Thyroid)

2017-18
24. Stroke (Endovascular Treatment)

2018-19
25. Corneal Transplant (Day Surgery)
26. Non-Emergent Spine (Non-Instrumented - Day Surgery)
27. Non-Emergent Spine (Non-Instrumented - Inpatient Surgery)
28. Non-Emergent Spine (Instrumented - Inpatient Surgery)
29. Shoulder (Arthroplasty)
30. Shoulder (Reverse Arthroplasty)
31. Shoulder (Repair)
32. Shoulder (Other)
33. Cancer Surgery (Neurosurgical (Brain, Spinal))
34. Cancer Surgery (Thorax (Lung, Esophagus, Thorax-other))
35. Cancer Surgery (Abdominal (HPB-Liver, HPB-Pancreas))
36. Cancer Surgery (Genitourinary (GU))
37. Hysterectomy (Cancer)

Until the final QBP allocations for the fiscal year have been communicated, QBP volume assumptions can be based on the previous year's funded volumes or preliminary HSFR hospital funding workbooks.

Hospitals can also flag for planning purposes their current year projected actual volumes if these are different from their funded volumes. Service volumes for other activities should be based on current year projected actual volumes except where:

- Post-Construction Operating Plan (PCOP) is in effect, i.e. where an approved capital construction project results in the expansion of service volumes, there will be a mutually agreed upon ramp-up schedule

- Integration opportunities have been realized, e.g. program transfers between hospitals and/or the community have been enacted
- The hospital has identified, discussed, and agrees to program service delivery changes with the LHIN

While the vast majority of government sourced funding comes from the LHINs, there are direct funding relationships between hospitals and Cancer Care Ontario and/or Ontario Renal Network (for example) to deliver certain QBPs. The hospital may have an accountability relationship with CCO and/or ORN for this specific funding while the LHIN has an overall accountability relationship with the organization as a whole via performance targets that include overall service levels and financial health that is affected by the CCO and/or ORN relationship.

For HAPS planning purposes, the hospital and the LHIN must plan and approve HSAA targets as a whole entity while being mindful of dedicated pockets of funding for specific service deliverables. Global budgets will continue to be used for activities that cannot be modeled or that are otherwise unique, such as outpatient service costs.

Note that where the HSFR assumptions used in planning are different than actual funding allocations, and these result in the hospital being unable to deliver on a performance commitment, this may trigger a resubmission/renegotiation of the affected HSAA schedules.

Please access the password protected site at https://hsim.health.gov.on.ca/hdbportal/ for additional HSFR information including education, historic results, etc. Specific questions may be emailed to the ministry at HSF@ontario.ca or communicated via phone at (416) 327-8379.

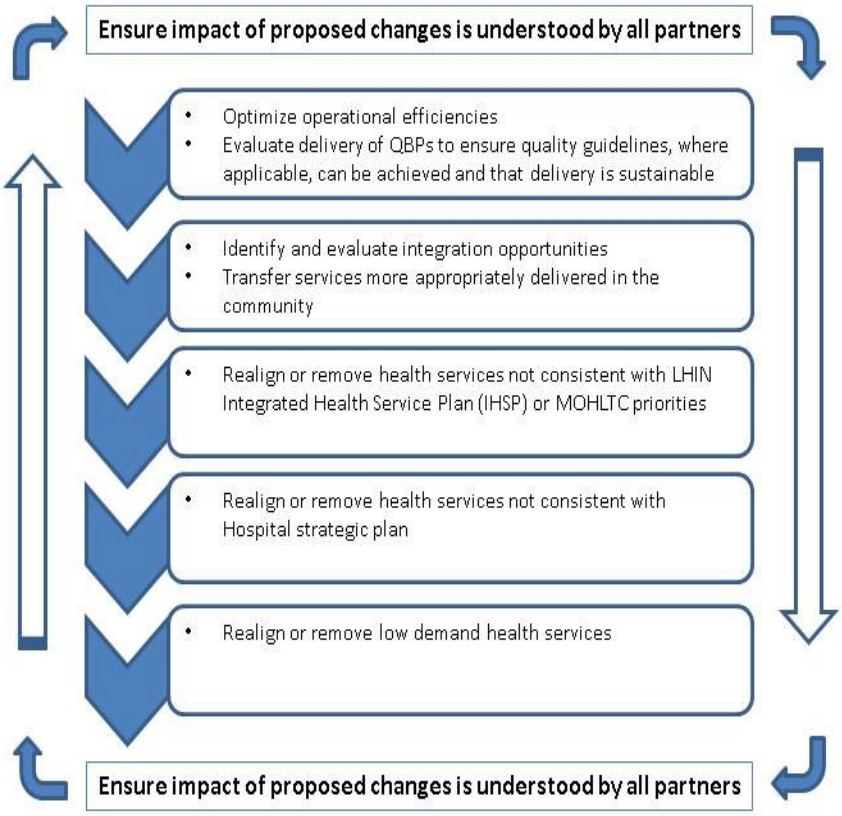
2.3.2. Hospital Programs and Services

Hospitals offer a wide variety of services through the use of base or global funding, patient-based funding and program specific funding. In addition to these revenue streams, the hospital generates extra revenues, for example marketed services, to offset some of the cost of providing health services. Some of the programs offered by the hospital have specific expectations, requirements and conditions. See Appendix 1 for details on these services.

2.3.3. Framework for Making Choices

Throughout the HAPS development process, hospitals need to consider the impact of their strategies, assumptions, and plans on their local health system. If a proposed reduction or removal of services is being considered, health service providers must follow appropriate procedures for engagement and notification with all stakeholders and to comply with the requirements of LHSIA. Health service providers are encouraged to contact their LHINs directly if they have any questions.

The following diagram and subsequent details depict how a hospital should approach their HAPS process.



Optimize Operational Efficiencies and Revenue Generation

Optimizing operational efficiencies is a continuous process which may include but not be limited to:

- Increasing self-generated revenue;
- Identifying and evaluating the operational cost of infrastructure and weigh it against direct patient care delivery requirements and overall available infrastructure capacity;
- Sharing clinical and administrative services between independent hospitals and other HSPs;
- Implementing evidence informed QBP processes and tools to assist hospitals in achieving efficiencies while maintaining high quality;
- Benchmarking exercises and using LEAN or similar processes to reduce costs;
- Reviewing staffing patterns and mix to ensure staff are working to maximum scope; and
- Maximizing the use of technology.

When considering options hospitals should answer the following questions:

- Will a change in one area to achieve targets result in an increase in expenditure in another area of the organization?

- Will implementation of the option transfer costs to other community partners?

Hospitals are reminded of the various tools and information available to assist in the continuous process of maximizing operational efficiencies:

- MOHLTC Financial and Information Management (FIM);
- Hospital Indicator Tool (HIT);
- Canadian Institute of Healthcare Information (CIHI);
- Discharge Abstract Dataset (DAD); National Ambulatory Care Reporting System (NACRS), and other clinical datasets reported to CIHI;
- Ontario Cost Distribution Methodology (OCDM);
- Health-Based Allocation Model (HBAM);
- Wait Time Information System iPort Access Tool
- OHA HSFR Forecasting Tool
- Ontario Case Costing Dataset

Evaluate Delivery of QBPs

Hospitals are advised to use the clinical handbooks for Quality-Based Procedures (QBPs), which include performance metrics. Evaluation of the delivery of QBPs should be undertaken at the individual provider and LHIN-wide levels.

Identify and Evaluate Integration Opportunities

Hospitals are required by the LHSIA to identify and evaluate the potential benefits of integration opportunities within and among themselves. These obligations are intended to support system transformation by having providers participate in the identification of better, faster, more effective and efficient service delivery, while continuing to support population health care needs. Service improvements could mean service expansion, or could result in a provider reducing service where the need is no longer warranted, or where another provider is better positioned to provide those services to the community.

Proactive service changes including service integrations may benefit patients/clients and providers. Shared services may reduce cost profiles. Better coordination may improve access, staff knowledge and patient/client satisfaction. The definitions of “integrate” and “integration” under the LHSIA include:

- To coordinate services and interactions between different persons and entities;
- To partner with another person or entity in providing services or in operating;
- To transfer, merge or amalgamate services, operations, persons or entities;
- To start or cease providing services; and
- To cease to operate or to dissolve or wind up the operation of a person or entity.

See Local Health System Integration Act, 2006, S.O. 2006, c.4 and LHIN/HSP governance resources on your LHIN website.

To be included in the HAPS, any such option must incorporate detailed planning information including population demographics and health status, utilization patterns, agreements with other providers detailing their ability and/or willingness to take on a program, and the calculation of funds to be transferred with the program.

Transfer Services More Appropriately Delivered In the Community

When considering options in this category, hospitals may want to ask the following questions:

1. Does the service require the resources of a hospital to operate?
2. Could the service be assumed by other HSPs or community providers (note that funding may need to be transferred to the assuming partner)?
3. Has the hospital addressed collective agreement considerations prior to, during and after transfers?
4. Are services currently operating in the community similar in type (same care) or result (similar conditions and outcomes) to hospital services?
5. Would provision of the service in the community free up human, financial, and physical resources that could be employed to improve core service delivery?
6. Would the patient's experience and outcome be improved with the transfer?
7. Has the hospital completed an HBAM analysis on the impact of the transfer in future years?

In developing options under this category, the hospital will have high level discussions with the potential "receiving" provider to determine willingness and capacity to receive the service and to determine the appropriate funds necessary to transfer with the service. The LHINs may assist in facilitating these discussions.

Realign or Remove Health Services Not Consistent with LHIN IHSP and MOHLTC Priorities

Ensuring equitable access based on need is a mandate of each hospital, community provider and LHIN. Hospitals will work with each other and in collaboration with other LHIN-funded and non-LHIN-funded service providers to ensure that provincial targets for access are met or bettered. Providers and LHINs will also align services towards achievement of IHSP priorities (see Section 2.2.4).

Realign or Remove Health Services Not Consistent with Hospital Strategic Plan

Hospitals develop strategies and plans to fulfill a specific vision and mission. A strategic plan provides hospitals with a roadmap for positive change with the ultimate goal of system improvement. As part of the Making Choices Framework, hospitals will look at their existing services to ensure they are in close alignment with their vision and strategy. In addition, hospitals will review services that are not generating anticipated results.

Hospitals may also choose to reconsider their role, vision and mission in light of the current and future environment.

Realign or Remove Low Demand Health Services

Provision of existing low demand services will be reviewed as part of the hospital's Framework for Making Choices process. For mission-critical or LHIN-critical services the hospital will partner with another provider to enable opportunities for consistent and improved clinical outcomes and for efficiency gains. Low demand services for conditions that have alternate therapies or treatment protocols will be reconsidered, especially if the hospital is providing more than one treatment approach for the same condition.

It is recognized that a decision to discontinue certain low demand services will be dependent on the type of organization or availability of the service from another health care partner.

2.4 Proposing Service Changes

Developing the HAPS for fiscal 2019-20 and future years within the HSAA presents the opportunity to review a hospital's services in light of the hospital's vision, mission and strategic direction, potential for service integration, new care models and demographic trends. Hospitals need to explore the potential for shifting services to other HSPs or community providers to achieve better outcomes or equivalent but more efficient care.

As noted in the Making Choices Framework section above, certain types of operational changes will require acceptance by the LHIN before the proposed change can be incorporated into the hospital's finalized HAPS. These would include any changes affecting funding, service levels identified as MOHLTC and/or LHIN priorities, and activities falling under the definition of integration as noted in the LHSIA.

Health service providers that are proposing to change the delivery of a health care service that is funded by the LHIN or the MOHLTC are required to submit a Service Delivery Change Form (SDCF) to the LHIN. This form is available through the HAPS Narrative. Depending on the extent of change, the service may be considered an integration under LHSIA and therefore the LHIN may request the HSP undertake a formal integration process before the change can be incorporated in the HAPS – see section 2.5 for additional details and guidance.

2.5 Obtaining LHIN Acceptance of a Service Change for Inclusion in the HAPS

If a change will or could impact other providers, discussion of the components of proposed service changes with key stakeholders and the LHIN will occur prior to the HAPS submission. These discussions will aid the hospital in ensuring that the choices included in the HAPS are acceptable to the LHIN prior to signing the HSAA.

The discussion and evaluation of possible service changes for inclusion in the HAPS should focus on the implications for patients/clients, the accomplishment of MOHLTC and LHIN health system priorities, LHIN MLAA commitments, the contribution to development of the health care system in the LHIN and overall sustainability of the hospital. Hospitals should check with their LHIN regarding their local HAPS process and the appropriate forms to be used for completion and submission in regards to proposed service changes.

It is recognized that there may be significant service changes required to meet the HSAA performance requirements that cannot be fully developed or reviewed prior to the HAPS submission due date. Specific local processes may need to be developed to address large-scale issues.

2.5.1. Inter-LHIN Service Changes

If the proposed service change affects residents or HSPs in other LHINs, the following process will be followed:

1. The initiating hospital will engage their LHIN early in the process to enable early notification of the expected change to their local LHIN.
2. The local LHIN will contact the affected LHINs about the expected change.
3. The affected LHINs will determine if the change is material and contact their local HSPs.
4. The affected LHINs will notify the local LHIN of the expected impacts.
5. The initiating LHIN will negotiate the service change revision with their initiating hospital and inform the potentially affected LHINs of the decision.

2.5.2. Transfer of Funding

When a hospital reduces, transfers, or eliminates a service, a new or additional service demand is often placed upon another HSP. If the recipient HSP can provide equivalent or better care at a lower cost (e.g. the recipient hospital has a superior economy of scale or lower cost LTC home placement for patients/clients designated ALC), the transferring hospital may be able to retain some of the funds associated with the displaced service. Any transfer of funding will need to be reviewed and approved by the LHIN, in consultation with the transferring and recipient HSPs on a case-by-case basis.

2.5.3. Compliance with LHSIA

Hospitals are reminded that the provisions of LHSIA relating to integrations apply equally to changes to services accepted by LHINs in HAPS; and, that with respect to those changes, hospitals and LHINs must follow the processes, and comply with their obligations, under LHSIA, particularly Part V – Integration and Devolution.

2.6 Timelines

The HAPS User Guide and HSAA Schedules will be communicated to hospitals in the fall of 2018. This will occur annually to support the refresh of the schedules during the term of the HSAA. The HAPS submission

will be available on SRI on October 1st and will be due back to the LHINs on Friday, November 23 (8 weeks). Hospitals are asked to contact their LHINs to discuss any locally determined requests or direction regarding HAPS submission.

2.7 Funding Planning Targets

A similar approach to 2018-19 for determining funding planning targets is being used with the 2019-20 HAPS and HSAA. The premise underlying this approach may be described as follows:

- Provincial funding targets are anticipated to be available in spring of the applicable fiscal year;
- Hospitals are currently engaged in developing budgets to guide operations for fiscal 2019-20 as part of their organization's fiduciary duty;
- Hospital services will continue to be provided to patients according to the hospital's internal plan and based on the hospital's best assumptions;
- Actual funding allocations are not available until after the start of the fiscal year.

There is great benefit for both the hospital and the LHIN to agree on performance expectations within a set of parameters that begins on day one of the fiscal year in question provided that the risk to both parties is adequately mitigated. Hospitals will individually and locally determine reasonable planning assumptions (for global, HBAM, QBP funding, etc.) for use in the completion of the HSAA for fiscal 2019-20 schedules. The LHIN will assess these assumptions for reasonableness and the HSAA and populated 2019-20 schedules will be completed for March 31, 2019.

The risk that actual funding allocations will differ substantially from planning assumptions used to populate the HSAA will be mitigated through the use of a materiality trigger in the HSAA template. Where the HSFR assumptions used in planning are different than actual funding allocations, and these result in the hospital being unable to deliver on a performance commitment, this may trigger a resubmission/renegotiation of the affected HSAA schedules.

Wait Times: converted from one-time funding to base funding in 2015/16.

Provincial Programs: Since multi-year planning targets are not possible, hospitals are advised to use a planning target based on 2018-19 allocated volumes and rates. LHINs will work with the hospitals, the ministry and appropriate agencies to determine the appropriate distribution of the funds in each program amongst the various procedures incorporated within those programs, with the exception of the CKD Program where the ORN is to work with the hospitals and LHINs to determine the appropriate distribution of the funds within the CKD Program. The distribution amongst the procedures within each program may change subject to agreement with the LHIN. Note that program funds may not be distributed between provincial programs without the approval of the MOHLTC.

Post Construction Operating Plans (PCOP): Adjustments for PCOP funding for hospitals which have recently completed construction or are scheduled to complete construction within the period of the HSAA are not included in the planning targets. LHINs and hospitals, in consultation with the Health Capital Investment Branch, will need to determine reasonable assumptions to inform service and funding targets

for the years in question and prudence is recommended with regard to setting those assumptions. LHINs and hospitals will consider population need, the overall LHIN situation with regard to access to care and the economic environment when planning for higher service volumes. Furthermore, it is recommended that the funding planning assumptions be determined separately for additional fixed costs related to new space and variable or additional service related costs.

2.8 Capital Planning

MOHLTC / LHIN Joint Review Framework for Early Capital Planning Stages: Toolkit

The Framework and Toolkit, released on November 9, 2010 (and available on LHIN websites), outlines the requirements for HSP submissions at each of the following early capital planning stages: Pre-Capital, Proposal, Functional Program, the review and endorsement process for LHINs, and the review and approvals process for the MOHLTC. The Framework contains a Process Guide, Pre-Capital Submission Form (PCSF) and guidelines, and checklists for HSP submissions for Proposal and Functional Program stages, as well as a LHIN Review Guide.

Note: When the Framework and Toolkit was released in 2010, all hospitals and eligible community HSPs were part of this. Through the Community Health Capital Programs Policy released in December 2015, there is now a separate Toolkit, application, review and approval process for eligible community HSPs.

LHIN involvement in the early stages of capital planning is critical in developing program and service projections with a system context; providing direction for program and service integration, collaboration, and alternate service delivery models including key support functions; and setting short-term program and service priorities for implementation.

3. HAPS Submission Components

Note: Instructions on how/where to submit all of the components that follow are included in the embedded files below

3.1 Revenue Planning Guidelines

The form embedded below will guide the Hospitals on the completion of the major Revenue components in HAPS and the Additional Input Form. The Guidelines document does not have to be submitted with the HAPS.

Revenue Completion Guideline.pdf

3.2 HAPS SRI Planning Form (Main HAPS document)

This Excel document is available on October 1, 2018 through the SRI website at https://www.sri.moh.gov.on.ca/SRI/faces/login.xhtml.

The completed file should be submitted through SRI using the normal SRI submission process.

3.3 *HAPS Additional Input 2019-20

This Excel document is embedded below to provide supplemental funding details (QBP, Wait Times, One-time, etc.) that are not available in the SRI HAPS form in 3.2 above. The submission instructions are contained within the file.

*Note: When submitting the file ensure the name is provided exactly as:
HAPS Additional Input 2019-20.xlsx

HAPS Additional Input 2019-20.xlsx

3.4 HAPS Narrative Guide

(Refer to 3.4.1 below for the embedded Narrative form.)

The narrative section provides an opportunity for hospitals to explain their plans to provide hospital services within available resources while maintaining high quality, safe, accessible, patient/client-centered care. The hospitals will frame the narrative submission in terms of how the hospital, and implementation of its plan, will support the sustainability of the local health care system. This section should focus on risks, opportunities, and proposed changes to services.

The completed narrative template should be submitted with your HAPS on SRI as a document attachment at the same time the HAPS budget is submitted to SRI.

An additional narrative submission for capital, if applicable, must also be self-contained, complete and not exceed two pages. The hospitals should identify and describe any pre-capital submission being developed for submission in 2019-20.

The table below notes the narrative requirements for operations in Section 1 of the HAPS narrative.

Narrative Component	Response/Considerations
Planning assumptions	Refer to the Worksheet in the SRI HAPS file.
Health System	The hospital's role in the health system: • Who is served and why • How provincial and local priorities are met • The determination of current and future services
Hospital Performance: Efficiency and Effectiveness	• Areas the hospital has identified that require the most improvement with regard to efficiency • Strategies adopted to manage such inefficiencies • Where savings will be reinvested
Service Delivery	• Service changes proposed to improve the local health system and/or achieve a balanced budget (with supporting justification) and the expected impact on patients/clients and costs • How health partner engagement has been utilized in determining choices to ensure a sustainable system for the region, including the impact on those partners • Critical risks to success and mitigation/management plans
Alignment and System Contributions	• Initiatives in place or to be implemented to contribute to the achievement of provincial and LHIN priorities, and to a more integrated health system.
Risks	Key risks and mitigation strategies should include: • Strategic • Clinical • Financial (including working capital)
Quality	• Identify whether the submission reflects the quality improvement initiatives and targets included in the hospital's annual QIPs. • Note specifically how the hospital will be achieving the quality targets for the QBPs.

3.4.1 Provincial Interest Programs

Sections 2a of the HAPS Narrative Guide are used to capture the services provided, staff resources, and community outreach and training for HIV Outpatient Clinics.

The Provincial Interest Programs total budget for the following programs (where applicable) is entered in the HAPS SRI document on the "Other Programs" tab. The programs include:

- HIV Outpatient Clinics;
-
- Cochlear Implants; and
- Cleft Lip and/or Palate (CLP).

Various definitions have been developed to guide hospitals in determining which costs to include when reporting the budgets for these programs. These definitions are provided in Appendix 3 of this document.

3.5 French Language Health Services Requirements and Reporting

LHINs must respect the requirements of the French Language Services Act (FLSA) and requirements under LHSIA in planning for and serving the French-speaking community. Hospitals that are required to provide services to the public in French are required to work with their respective LHIN and the French Language Health Planning Entity (FLHPE) to meet planning and reporting obligations. Hospitals that are not required to provide services to the public in French are required to provide a report to the LHIN on how the hospital addresses the health needs of the local Francophone community.

4. LHIN Evaluation of HAPS

The HAPS review may vary within each LHIN. The review will likely include and/or confirm the following:

- Planning Session
  - Initial meeting to understand the hospital's funding assumption for budget purposes, to discuss other key assumptions, to initiate negotiation of key performance targets for inclusion in the HSAA Schedules, and to review and discuss local and provincial priorities and the hospitals contribution to those priorities.

- Submission Status
  - The planning submission was submitted on time;
  - The planning submission is complete, including information for all mandatory forms;

- Financial Review
  - Funding assumptions for LHIN and MOHLTC revenues are consistent with the initial planning session information;
  - Other revenues and expenses are based on reasonable operating assumptions;
  - Financial performance indicators including total margin and current ratio are acceptable to the LHIN and hospital;

- Statistical Performance
  - Planned activity trends are reasonable and aligned with LHIN clinical services planning;
  - Volumes are reflective of funding assumptions for LHIN and MOHLTC revenue;
  - HSAA performance indicators reflect initial negotiation and are acceptable to the LHIN and the hospital;
  - Other planned performance metrics are aligned with existing agreements (e.g., other funding agreements, the quality improvement plan, Health Links business plan, etc.);

- Narrative Review
  - The narrative component is consistent with the financial and statistical forms;
  - Consultation with key stakeholders has occurred by the hospital as part of its planning process;
  - The hospitals plans are aligned with the LHIN's Integrated Health Services Plan (IHSP) and the hospital's annual QIP; and
  - Integration initiatives/opportunities and other performance improvement strategies are presented consistent with the Making Choices Framework.

- Capital Review (if applicable)
  - The narrative component is clear
  - It is aligned with the LHINs and hospital strategic plans
  - The rest of the HAPS forms do not yet reflect/incorporate any assumptions made in the capital narrative component

The process for engaging hospitals during the submission clarification phase and schedule negotiation phase will vary by LHIN.

LHINs may refer to the Guidelines for Hospitals Audits and Reviews in conducting their reviews of the HAPS. This document is also available for hospitals' use through the respective LHIN.

Appendix 1: Conditions/Requirements for Specific Hospital Services

Hospital Specialized Services

Hospital Specialized Services include: core inpatient, outpatient and day surgery programs, hospital-based Acquired Brain Injury (ABI), Cochlear Implants, Regional Geriatrics Program, Cleft Lip and Palate / Craniofacial Dental Services; and Specialized Hospital Services, which include Trauma, Provincial Regional Genetic Services, HIV Outpatient Clinics, Hemophiliac Ambulatory Clinics, and Cardiac Rehabilitation Services.

For hospital programs funded through base budgets, the hospital will confirm in its HAPS that service volumes and/or service coordination functions will be maintained as in the previous fiscal year.

MOHLTC-Managed Services

Ministry-managed services include: Stem Cell Transplants, Adult Interventional Cardiology for Congenital Heart Defects, Cardiac Laser Lead Removals, Pulmonary Thromboendarterectomy Services, Thoracoabdominal Aortic Aneurysm Repair.

For Provincial Resources, the hospital will confirm in its HAPS that the volume or activity levels and scope of service delivery to at least the levels set out in the hospital's 2007-08 Hospital Accountability Agreement (HAA) will be maintained. If the hospital plans for any reductions or discontinuation in provincial resources, the LHIN must approve reallocation of the service(s) and funding to another hospital in consultation with the Ministry.

Provincial Strategies

Provincial strategies include: emerging services that are still in the pilot/developmental phase.

For Provincial Strategies, the hospital will apply available strategic and operational program policy including funding methodologies, accountability frameworks, performance indicators, volumes and service delivery models.

Cardiac Services

Cardiac services include: Cardiac Catheterization, Cardiac Surgery, Permanent Cardiac Pacemaker Services, Electrophysiology Studies (EPS)/Ablation, Percutaneous Coronary Intervention (PCI), Implantable Cardioverter Defibrillators (ICD) Transcatheter Aortic Valve Implantation (TAVI) and Transcatheter Mitral Valve Implantation (TMVI).

For cardiac services, using a population-based planning process, the hospital, the LHIN, the ministry and CorHealth Ontario will identify how provincial service delivery requirements, standards and any other conditions for Cardiac Services will be met within the dedicated funding envelope provided.

Chronic Kidney Disease (CKD) Services

Chronic Kidney Disease services include: Pre-dialysis care, education on renal replacement therapy options, dialysis modality training, creation of dialysis body access sites (vascular and peritoneal), provision of all dialysis modalities (hemodialysis and peritoneal dialysis), including home and facility based dialysis and their associated sites, and supportive care.

For CKD, the total Quality Based Procedure bundles will be estimated by the hospital for inclusion in the planning submission until the Ontario Renal Network (ORN) provides each LHIN with the detailed appendix identifying the actual QBP bundles for the fiscal year in questions. For CKD services, the hospital, in collaboration with the ORN, will identify how provincial service delivery requirements, standards and any other conditions for CKD Services will be met within the dedicated funding envelope provided.

Mental Health Services

Hospitals, as designated by the MOHLTC, are required to provide Schedule 1-5 services under the Mental Health Act at least at the service levels provided for each respective fiscal year, and discuss any material changes to the service delivery or service levels with the LHIN. Designated hospitals are also required to provide the number and type of Forensic Mental Health beds as determined by the MOHLTC and discuss any changes to the service delivery or service levels with the LHIN and the Forensic Mental Health section of the MOHLTC.

Stroke Services

For designated Regional and Enhanced District Stroke Centers, the host hospital will:

- Sustain and act as the trustee for the funds for regional planning, implementation, improvement and education roles and infrastructure throughout their region and across all points in the care continuum (including health promotion; primary, secondary, and tertiary prevention; pre-hospital care; emergency, diagnostic, and acute care; rehabilitation; LTC and community reintegration) according to the original service guidelines. This includes infrastructure for stroke prevention.
- Lead a regional network (committee) of health care agencies and others for collaboration, integration, access and approval and monitoring of the regional plan and implementation of stroke best practices across the continuum.

For designated District Stroke Centers, the host hospital will:

- Sustain and act as the trustee for the funds for district/local planning, implementation, improvement and education roles and infrastructure throughout their district and across all points in the care continuum (including health promotion; primary, secondary, and tertiary prevention; pre-hospital care; emergency, diagnostic, and acute care; rehabilitation; long-term care and community reintegration) according to the original service guidelines. This includes infrastructure for stroke prevention.
- Collaborate with district/local health care agencies and others for integration, access and approval and monitoring of the district plan and implementation of stroke best practices across the continuum.

For designated Community Hospital Stroke Prevention Clinics the host hospital will:

Sustain the infrastructure and roles for stroke prevention focusing on those individuals that are at high risk and serving its geographic catchment area, according to the original service guidelines.

Wait Times Strategy Funded Services

This includes: MRI/CT, Revision Hip and Knee, General and Paediatric Surgical areas.

The hospital will work towards meeting the Ontario Wait Time and Efficiency targets for these procedures to those that apply. Publicly, the access targets are defined as the 90th percentile wait time and applicable MLAA or SAA targets measure performance based on percentage of cases completed within access target.

The hospital will present plans to meet or exceed its SAA targets and confirm that it will use the Wait Time allocations for the intended purposes, or notify the LHIN as soon as it determines it cannot expend all the funds so that those funds may be reallocated. The LHIN may include additional conditions of funding that are consistent with the specifications determined by the MOHLTC. These additions should also be incorporated into the HAPS.

Emergency Departments (ED): The amount of time a patient spends in the ED (i.e. duration of the entire visit – from registration until discharge) will be measured for all complex patients, admitted patients, complex non-admitted patients and non-admitted minor/uncomplicated patients.

The ED LHIN Lead will confirm that the hospital's HAPS plans are consistent with the province's and LHIN's ED strategy; relating to emergency department access, quality of care, and effectively managing and improving ED length of stay.

Quality Based Procedures

Introduced in 2012, Health System Funding Reform (HSFR) creates a patient-centred, evidence-informed funding model that reflects local population needs and strengthens the link between high-quality care and fiscal sustainability. One of the key levers of HSFR is the implementation of Quality-Based Procedures (QBPs). QBPs are health services selected using an evidence-based framework that presents opportunities to facilitate the adoption of clinical best practices and reduce variation in costs and practice while improving outcomes. QBPs are funded based on a standard "rate x volume" approach that is adjusted to meet local population needs.

Provincially, QBP volumes are determined each year in consultation with LHINs and are based upon the previous year's activity and additional factors such as age and population growth. The LHIN will then determine how to best allocate the volumes in consultation with its hospitals. A list of QBPs that have already been implemented is outlined in section 2.3.1 of the HAPS User Guide.

For QBPs, hospitals will present plans to ensure the agreed upon QBP volumes are met. If the hospital determines that allocated volumes cannot be achieved, the LHIN should be notified so that related funds may be reallocated in accordance with the QBP Volume Management Instructions (VMI) developed by the MOHLTC. Hospitals are encouraged to work towards providing QBP services at a cost equal to or below the provincial average QBP price while achieving compliance with established quality and performance indicators. As per the QBP VMI (Appendix: General Conditions Section 2.1), hospitals are required to work towards meeting Ontario's QBP Quality Targets, Wait Time Access Targets, and Surgical Efficiency Targets Program (SETP) Targets as applicable. Hospitals are also required to plan accordingly to provide services evenly throughout the year.

The following set of conditions apply to specific QBPs (per Schedule C to the 2018-19 hospital funding letters from the MOHLTC to LHINs:

1) For all new incremental cataract surgery and hip and knee replacement QBP funding:
    - Hospitals will be required to complete their base volumes (set to 2017-18 actual volumes completed) in order to be eligible for this additional funding; therefore, these incremental volumes must be performed in addition to base volumes (similar to the terms and conditions for Wait Time Strategy funding).
    - Data on actual volumes completed is available through the QBP Volume Tool for LHIN-Managed QBPs, which is posted to the Health Data Web Portal at hsim.health.gov.on.ca/hdbportal (user registration required) under "Health System Funding Reform" and "Quality-Based Procedures".
2) For cataract incremental QBP funding: The ministry will work with partners to develop and implement a plan to link incremental volumes to the recruitment of new ophthalmology surgeon graduates in select hospital sites across the province. Starting in 2019-20, these volumes, in select sites, will be contingent on new graduate recruitment.
3) For Stroke Endovascular Treatment (EVT): Hospitals that receive EVT funding will be required to comply with service delivery requirements set out by CorHealth Ontario. Funding is subject to recovery if CorHealth Ontario's service delivery requirements are not met.
4) For Knee Arthroscopy: The ministry will update the QBP in response to a growing body of evidence that shows that knee arthroscopies do not, on average, result in an improvement in long-term pain or function for degenerative knee conditions such as osteoarthritis and degenerative meniscus tears.
    - In 2018-19, the initial focus will be on clinical implementation to support the adoption of evidence-based best practices.
    - In 2019-20, knee arthroscopy volume targets will be adjusted (reduced) according to a new cohort definition to be confirmed through a revised clinical handbook. This adjustment will be implemented so that LHINs can reinvest funding towards other Musculoskeletal (MSK) procedures within each hospital.
    - LHINs will be required to support change management efforts at the LHIN and hospital levels and to identify reallocations from arthroscopy to other MSK QBPs in advance of the 2019-20 adjustment; LHINs will also have the option to submit base reallocations during the 2018-19 fiscal year to accelerate the uptake of clinical best practices.
5) 2018-19 will see the introduction of three new LHIN-Managed QBPs (Non-Emergent Integrated Spine

Care, Degenerative Disorders of the Shoulder and Integrated Corneal Transplant). LHINs are asked to work with their Health Service Providers (HSPs), Health Quality Ontario, and other lead agencies to support adoption of best practices in the clinical handbooks. http://www.health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding_qbp.aspx

6) The LHIN is required to maintain financial records for this funding. For QBPs, unspent funds and funds not used for the intended and approved purposes are subject to recovery in accordance with the ministry's year-end reconciliation policy.

The LHIN may include additional conditions of funding that are consistent with the specifications determined by the MOHLTC. These additions should also be incorporated into the HAPS.

Bundled Care Models for Primary Unilateral Hip and Knee Replacements

In 2018/19, the ministry has launched the scale and spread of Bundled Care based on the positive results seen in six provincial pilots. Bundled models provide a single payment for an episode of care across multiple settings and providers. Provincial expansion is beginning in 2018/19 with voluntary participation in a bundled model for the primary unilateral hip and knee replacement QBPs. Each LHIN was offered the option to identify cross-provider teams to participate in the voluntary expansion of these models and the bundled price for these teams will be introduced in 2018/19.

- An introductory bundled QBP price has been set, using the QBP pricing methodology. The bundled price is built so that surgical patients can receive post-acute rehabilitative care, according to best practice;
- The price excludes readmissions and revisions; outcomes will be monitored and tracked to inform future bundle scope;
- The bundled price for hips is $9,631 and the bundled price for knees is $8,627;

2018/19 is an introductory year. The price will evolve over time as data gaps are filled.

Critical Care Strategy

The Critical Care Strategy includes the adoption of MOHLTC-developed specifications, including volumes, funding levels, dedicated funding envelopes and any other conditions that will be part of the Critical Care Strategy.

For the Critical Care Strategy, the hospital will work with the LHIN Critical Care Lead. The LHIN Critical Care Lead will confirm that the hospital's HAPS plans are consistent with the province's and LHIN's Critical Care Strategy.

The hospital is obligated to participate in provincial strategies related to One-Number –to Call, Life and Limb and to provide updates to the bed registry systems (Provincial Hospital Resources Systems), repatriation tools and to the Community Care Information Systems. These systems are managed through CritiCall Ontario and Critical Care Services Ontario (CCSO). The following obligations are noted:

Critical Care, One-number-to-call, Provincial Life and Limb.

1. Hospital utilization of CritiCall Ontario to access medical consultation and transfers for all critically ill/emergent patients that may require transfer to another hospital within or outside of the LHIN.
2. Hospital accountability for the provision of specific specialty services within the LHIN will be responsive to requests for consultation from CritiCall Ontario on behalf of LHIN hospitals regardless of bed status and will implement minor and moderate surge strategies to accommodate adult, paediatric and neo-natal transfers.
3. Hospital accountability for the provision of specific specialty services for a defined set of referral hospitals (Neurosurgery, Trauma, etc.) will be responsive to requests for consultation from CritiCall Ontario on behalf of these hospitals regardless of bed status and will implement minor surge strategies to accommodate transfers.
4. Hospital use and update of the Critical Care Information System (CCIS) immediately for each admission and discharge to a critical care bed and complete patient specific data a minimum of once per day during their stay in a critical care bed. Note: Neurosurgical Centres are required to update every 4 hours.
5. Hospital use and update of CritiCall Ontario's Provincial Hospital Resource System 4 times a day (0800, 1200, 1600, 2400) to provide other hospital stakeholders with accurate bed availability information and to enable CritiCall Ontario to respond to urgent requests for non-critical beds during natural disasters or hospital Code Green or Orange situations.
6. Hospitals partnerships with CritiCall Ontario and other hospitals within the LHIN and province to establish on-call coverage for critical care and related medical specialties. CritiCall Ontario will utilize these schedules to facilitate consultations and referrals if necessary for emergently ill or injured patients in Ontario.

Specialized Programs

This includes: bariatric services, burns (severe), cancer (not funded by Cancer Care Ontario), external ventricular devices (Berlin Heart), hand and foot reattachment, interventional radiology, in-vitro fertilization, lithotripsy, coil embolization and neuromodulation services (neurosciences), organ and tissue donation and transplant (and related services), paediatric oncology, paediatric surgery, tuberculosis (TB) inpatient units and clinics.

As presented by the "Final Report of Provincial Program Task Group (September 2008)", these programs were identified as ones that meet the criteria for inclusion as provincial programs but are not yet designated as "Provincial Strategy" or "Provincial Resource" programs. The sponsoring hospital will work with its LHIN to ensure appropriate and coordinated care for patients/clients, recognizing that Ontario residents should have reasonable access to all programs under discussion with the understanding that not all programs will be offered in all LHINs.

Appendix 2: HAPS Additional Input Instructions

Use the following process to submit the HAPS Additional Input form as a separate document when submitting the 2019-20 HAPS in SRI.

HAPS Additional Input Submission Instr

Appendix 3: Provincial Interest Programs

Function(s)	Associated Costs
HIV Outpatient Clinics	
Direct Treatment Costs	FTEs: Nursing and allied health service providers (SW, RD, OT) for specialty medical care, case management, nutrition and diet counselling, access to, and advice and teaching about HIV medications, diagnostic lab testing, nursing care and supportive counselling
Indirect Costs	FTEs: program administration, monitoring/evaluation, communications/outreach, health promotion (printed publications) Administrative costs: supplies/sundries, office space, cleaning
Cochlear Implants	
Assessment and Eligibility	FTEs: Physician's services, audiologist Administrative costs: office space, cleaning
Surgery – direct & indirect	FTEs: Physician(s) time and services, allied health professionals (nursing) Physical costs: cochlear device Hospital administrative costs: OR time/room, recovery bed, cleaning, food
Post-op – direct & indirect	Physical costs: Sound processor, replacement speech processor(s) (ADP[1]) FTEs: Ongoing audiology appointments (tuning, counselling, training for use of device), speech language pathology Administrative costs: office space, cleaning
Cleft Lip and Palate	
Assessment and Eligibility	FTEs: Geneticist, physician(s), multi-disciplinary team (allied health)
Surgery – direct & indirect	FTEs: Plastic surgeon(s) time and services, allied health professionals (nursing)

[1] Assistive Devices Program currently funds up to 75% of the cost of a new processor

Function(s)	Associated Costs
	Hospital administrative costs: OR time/room, recovery bed, cleaning, food
Post-op – direct & indirect	FTEs: physicians (ENT), dentist, orthodontist, and allied health professionals (feeding assessment, OT, SLP, Audiologist, etc.) provide information, education and support to patient, families and health-care providers Hospital administrative costs: program admin FTEs, OR time/room, recovery bed, cleaning, food, health promotion (printed publications), office space

Appendix 4: Glossary of Terms

Accessible: patients/clients in need should get appropriate care in the most appropriate setting.

ALC: Alternate Level of Care. ALC refers to those patients/clients who are in the hospital and waiting to move from their current bed type to more appropriate services.

Balanced Budget: Annual Operating Balanced Budget means that in a given fiscal year the total corporate revenues (excluding interdepartmental recoveries and facility-related deferred revenues) of the hospital are greater than or equal to the total corporate expenses (excluding interdepartmental expenses, facility-related amortization expenses and facility-related interest on long-term liabilities) of the hospital when using the consolidated corporate income statements (all fund types and sector codes).

EPIC: Engaging People Improving Care. EPIC is a web-site which offers an accessible, organized collection of resources for strategies on community engagement. Further information can be found at www.epicontario.ca

ER/ED: Emergency Room or Department.

FLHPE: The French language health planning entities appointed under O. Reg. 515/09, Engagement with the Francophone Community under Section 16 of the Local Health System Integration Act, 2006.

Francophone: Those whose mother tongue is French and those whose mother tongue is neither French nor English, but who have a particular knowledge of French as an official language and use French at home.

HAA: Hospital Accountability Agreement. The 2007-2008 HAA was assigned by the Minister to the LHINs. In 2008, the HAA was replaced by the 2008-2010 HSAA.

HAPS: Hospital Accountability Planning Submission. The HAPS is the planning tool used by hospitals to inform the negotiation of the Hospital Service Accountability Agreement (HSAA).

Health Links: A MOHLTC initiative that brings together health care providers in a community to better and more quickly coordinate care for high-needs patients. All Health Links will have a coordinating partner such as a Family Health Team, Community Health Centre, Community Care Access Centre or hospital. Health Links will share information, including through Electronic Health Records, and measure results while working with their Local Health Integration Network (LHIN) to achieve short- and long- term goals.

High quality: Dimensions of quality as set out in the Excellent Care for All Act, 2010 as: accessible, effective, safe, patient-centered, equitable, efficient, appropriately resourced, integrated, and focused on population health.

HSAA: Hospital Service Accountability Agreement. The HSAA is the service accountability agreement that the LHINs are required to enter into with the hospitals pursuant to the terms of the Local Health Integration Act (LHSIA). More information on service accountability agreements can be found in s. 20 of the LHSIA and Part III of the CMFA.

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

HSFR: Health System Funding Reform. HSFR is comprised of HBAM Funding and QBP Funding.

HSP: Health Service Provider. HSP refers to hospital and community health providers.

HQO: Health Quality Ontario. HQO is the business name of the Ontario Health Quality Council (OHQC). HQO is designated as Board-Governed Provincial Agency (Operational Service) in accordance with the Agency and Appointments Directive, 2015. The Excellent Care for All Act, 2010 (ECFAA) legislation expanded the mandate of the previous OHQC and this expanded organization officially launched on April 1, 2011.

The functions of Health Quality Ontario are: a) to monitor and report to the people of Ontario on: (i) access to publicly funded health services, (ii) health human resources in publicly funded health services, (iii) consumer and population health status, and (iv) health system outcomes; b) to support continuous quality improvement; c) to promote health care that is supported by the best available scientific evidence by (i) making recommendations to health care organizations and other entities on standards of care in the health system, based on or respecting clinical practice guidelines and protocols, and (ii) making recommendations, based on evidence and with consideration of the recommendations in sub clause (i), to the Minister concerning the Government of Ontario's provision of funding for health care services and medical devices. Through the passage of Bill 8, the *Public Sector and MPP Accountability and Transparency Act, 2014*, HQO's mandate will be expanded to include: (i) the monitoring and reporting on the performance of health sector organizations with respect to patient relations; (ii) the promotion of enhanced patient relations in health sector organizations through the development of patient relations performance indicators and benchmarks for health sector organizations; (iii) Providing quality improvement supports and resources for health sector organizations with respect to patient relations; and (iv) providing support to the patient ombudsman in carrying out his or her functions. Further information can be found at http://www.hqontario.ca.

Integration: As defined in the LHSIA, to integrate includes:

1. To co-ordinate services and interactions between different persons and entities;
2. To partner with another person or entity in providing services or in operating;
3. To transfer, merge or amalgamate services, operations, persons or entities;
4. To start or cease providing services;
5. To cease to operate or to dissolve or wind up the operations of a person or entity.

Integration activities can be:

- Self-initiated by a HSP under sections 24 and 27 of the Act ("voluntary integration initiatives");
- Facilitated and negotiated by a LHIN under section 25 of the Act;
- Resulting from changes in funding under section 19 of the Act;
- Required by a LHIN under section 26 of the Act; or
- Ordered by the Minister under section 28 of the Act.

IHSP: Integrated Health Service Plan. Published by each Local Health Integration Network (LHIN) pursuant

to s. 15 of the LHSIA. A copy of a LHIN's IHSP is available through the LHIN's office and on its web site.

LHIN: Local Health Integration Network. The LHINs are 14 networks established by the LHSIA across the province of Ontario. Specific information about their geographic parameters and contact information can be found at www.lhins.on.ca.

LHSIA: Local Health System Integration Act, 2006. This is the legislation that established the LHINs and sets out the terms under which the LHINs may exercise the powers devolved from the Minister in respect of the planning, funding and integration of their local health system.

Materiality: Materiality is the threshold that determines the relevance or significance of an item or an action; it is situational and is not always quantifiable. In the context of the HAPS and HSAA, an item or proposed change is considered material if a reasonable person can foresee that the impact can be reasonably expected to have a concerning impact (favourable or unfavourable) for the organization, on another health service provider, on another service or program serving the same community, or on a particular patient/client population.

Minister: Refers to the Minister of Health and Long Term Care, an elected official.

MLAA: Ministry-LHIN Accountability Agreement. The purpose of the accountability agreement is to set out the mutual understandings between the MOHLTC and the LHIN of their respective performance obligations for the stated period. It is an accountability agreement for the purposes of section 18 of the LHSIA.

MOHLTC: Ministry of Health and Long-Term Care.

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

QIP: Quality Improvement Plans. A requirement of the Excellent Care for All Act, 2010 (ECFAA), the QIP is an annual plan developed by the hospital that outlines the organization's commitment to accountability, delivering high-quality care and being transparent to their public, patients/clients, and staff. QIPs are developed and aligned with provincial priorities, and should be incorporated as part of a hospital's overall hospital planning process.

Service: As defined by the LHSIA, includes: a service or program that is provided directly to people a service or program, other than a service or program described above, that supports a service or program provided directly to people; or a function that supports the operations of a person or entity that provides a service or program as described above.

Sustainable system: An excellent system of care, that is informed by population need and can be maintained into the future within the financial, human and physical resources available.