Cornwall Community Hospital
Hôpital communautaire de Cornwall

CORPORATE SCORECARD 2025/2026

Vision: Exceptional Care. Always.

Mission: Our Team collaborates to provide exceptional patient-centered care

Values: *I C A R E* *Integrity - Compassion - Accountability - Respect - Engagement*

Instructions: Clicking on the indicator takes the user to additional supporting details.

RECOVERY					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Clostridium Difficile (C.Diff) Incidence	HSAA/MoHLTC	G			
Current Ratio	HSAA	G			
Emergency Visits - Ambulance Offload Time	QIP	G			
Emergency Visits - Wait Time for Physician Initial Assessment	QIP	R			
Emergency Visits - Wait Time for Non-Admitted High Acuity	HSAA/OPT	Y			
Emergency Visits - Wait Time for Non-Admitted Low Acuity	HSAA/QIP/OPT	R			
Falls per 1,000 Patient Days	Senior Friendly	G			
Readmissions within 30-Days for Select HIG Conditions	HSAA	G			
Repeat ED Mental Health Visits*	OPT	R			
Typical Average Length of Stay (ALOS) for Hospitalists	Board/OPT	G			
Total Margin	HSAA	R			
Wait Time - CT Scans (Priority 2, 3, 4)	HSAA	R			
**Wait Time - CT Scans (Priority 2, 3)	Board	G			
Wait Time - Long Waiters for All Surgical Procedures*	HSAA	R			
Wait Time - MRI Scans (Priority 2, 3, 4)	HSAA	R			
**Wait Time - MRI Scans (Priority 2, 3)	Board	G			

INTEGRATION					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
ALC Throughput*	HSAA	Y			
Incomplete Charts	Board	Y			
Medication Scanning Compliance	QIP	Y			
Medication Reconciliation on Discharge Rate (ROP)	Accreditation	Y			
Patient Satisfaction Survey	QIP	G			

PEOPLE					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Complaints Acknowledged	Board	G			
Equality, Diversity, Inclusion and Anti-Racism Education	QIP	Y			
Indigenous Cultural Awareness	HSAA	G			

Results:

Metric underperforming target	R
Metric within 10% of target	Y
Metric equal to or outperforming target	G
Data not available	N/A

Overall Indicator Performance:	Q1	Q2	Q3	Q4
% Indicators equal to or outperforming targets:	46%			
% Indicators within 10% of targets:	25%			
% Indicators underperforming targets:	29%			

Reference Definitions:

Accreditation - Accreditation Canada
Board - Board Directed
HSAA - Hospital Services Accountability Agreement
MoHLTC - Public Reporting Requirement; Ministry directive
MSAA - Multi-Sector Service Accountability Agreement
OPT - (Annual) Operating Plan Target
Senior Friendly - Senior Friendly Initiative (HSAA)
QIP - Quality Improvement Plan

Return to Dashboard

Indicator: Clostridium Difficile Incidence

Strategic Direction: RECOVERY

Definition: The hospital-wide rate of nosocomial Clostridium Difficile infection measured per 1000 patient days.

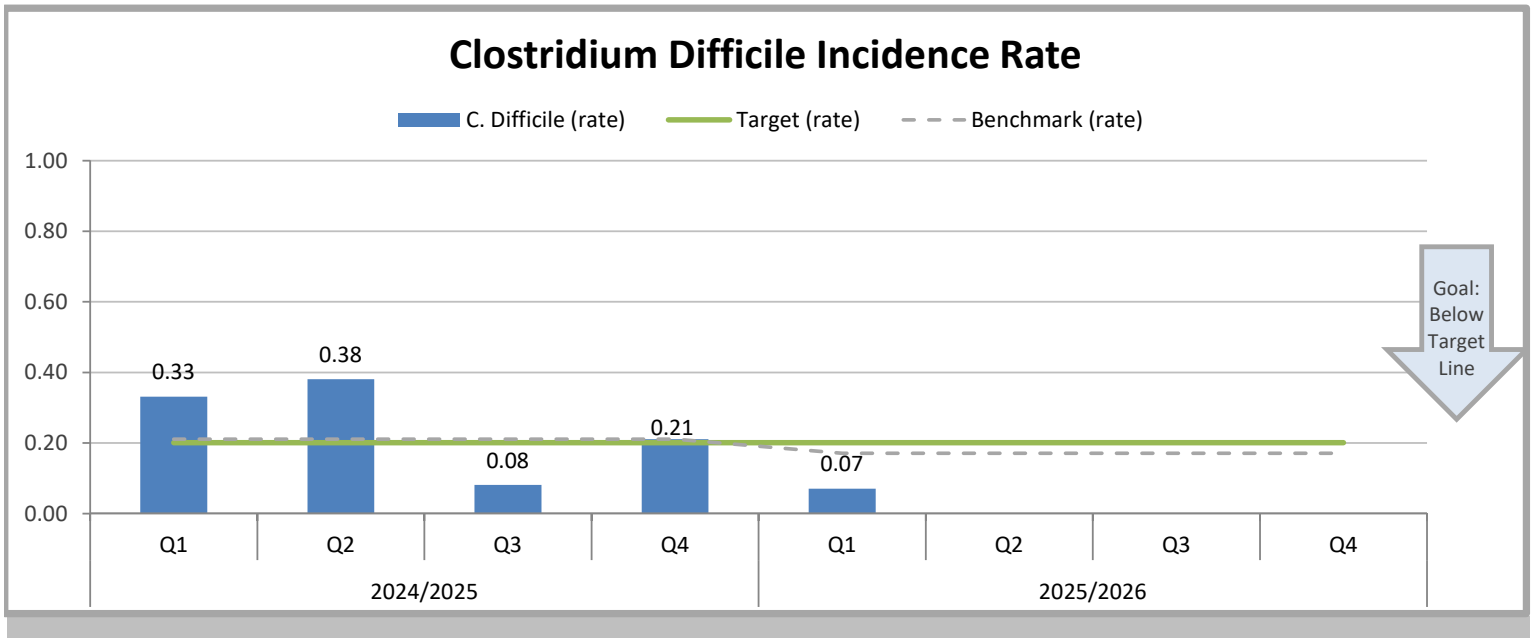
Significance: This bacteria is commonly found in the environment; it can exist in spore form and is resistant to some chemicals. It lives in approx. 3-5% of humans as normal flora and can develop if exposed to risk factors such as: prolonged antibiotic use, bowel surgery, chemotherapy and hospitalization. C Difficile is extremely transmissible.

Data Source: Infection Prevention & Control and Health Quality Ontario (HQO) -Hospital Patient Safety

Target Information: Target is based on HSAA performance standard obligations

Benchmark Information: Benchmark rates taken from HQO - Hospital Patient Safety prior fiscal year (Q4) provincial performance

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
C. Difficile (rate)	0.33	0.38	0.08	0.21	0.07			
Benchmark (rate)	0.21	0.21	0.21	0.21	0.17	0.17	0.17	0.17
Target (rate)	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20



Performance Analysis:

Q1 Target met. There was only 1 case this quarter (June).

Q2

Q3

Q4

Plans for Improvement:

Q1 Continue monitoring. Education is ongoing for PPE and Hand Hygiene.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer / Manager, Infection Control

Return to Dashboard

Indicator: Current Ratio

Strategic Direction: RECOVERY

Definition: Current Ratio is a key measure of liquidity. It reflects to what extent short-term financial obligations can be met from short term assets. Current Ratio = Current Assets/Current Liabilities. Performance is reported cumulatively on a year-to-date basis.

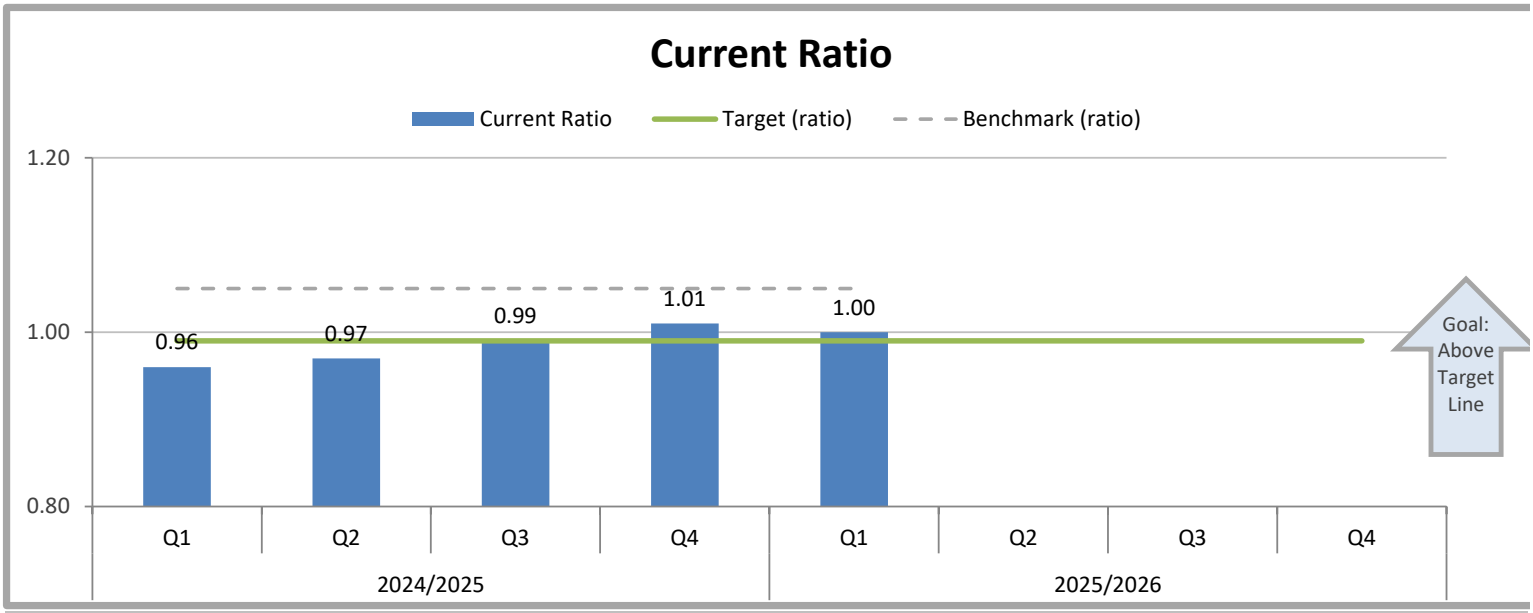
Significance: Indicates the overall financial health of the organization.

Data Source: Monthly Financial Statements - Balance Sheet

Target Information: Set according to HSAA obligations

Benchmark Information: Benchmark performance is based on prior fiscal year Champlain LHIN Hospitals performance

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Current Ratio	0.96	0.97	0.99	1.01	1.00			
Benchmark (ratio)	1.05	1.05	1.05	1.05	1.05			
Target (ratio)	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99



Performance Analysis:

Q1 Target Met.
Q2
Q3
Q4

Plans for Improvement:

Q1 Currently operating per budget.
Q2
Q3
Q4

Accountable: Chief Financial Officer / Director, Financial Services

Return to Dashboard

Indicator: Emergency Visits - Ambulance Offload Time (Mins)(90th percentile)

Strategic Direction: RECOVERY

Definition: The 90th percentile of total minutes elapsed from Ambulance Arrival (Offload) Date/Time to Ambulance Transfer of Care Process Date/Time. AOT = Ambulance Transfer of Care Date/Time minus Ambulance Offload Date/Time. (Current exclusion criteria: Cases where Ambulance Arrival Date/Time is after the Ambulance Transfer of Care Date/Time, cases where Ambulance Arrival Date/Time and Ambulance Transfer of Care Date/Time is unknown (9999) or blank, cases where Ambulance arrival indicator is other than A (air), G (ground), or C (combination), and cases AOT is greater than or equal to 1440 minutes (24 hours).

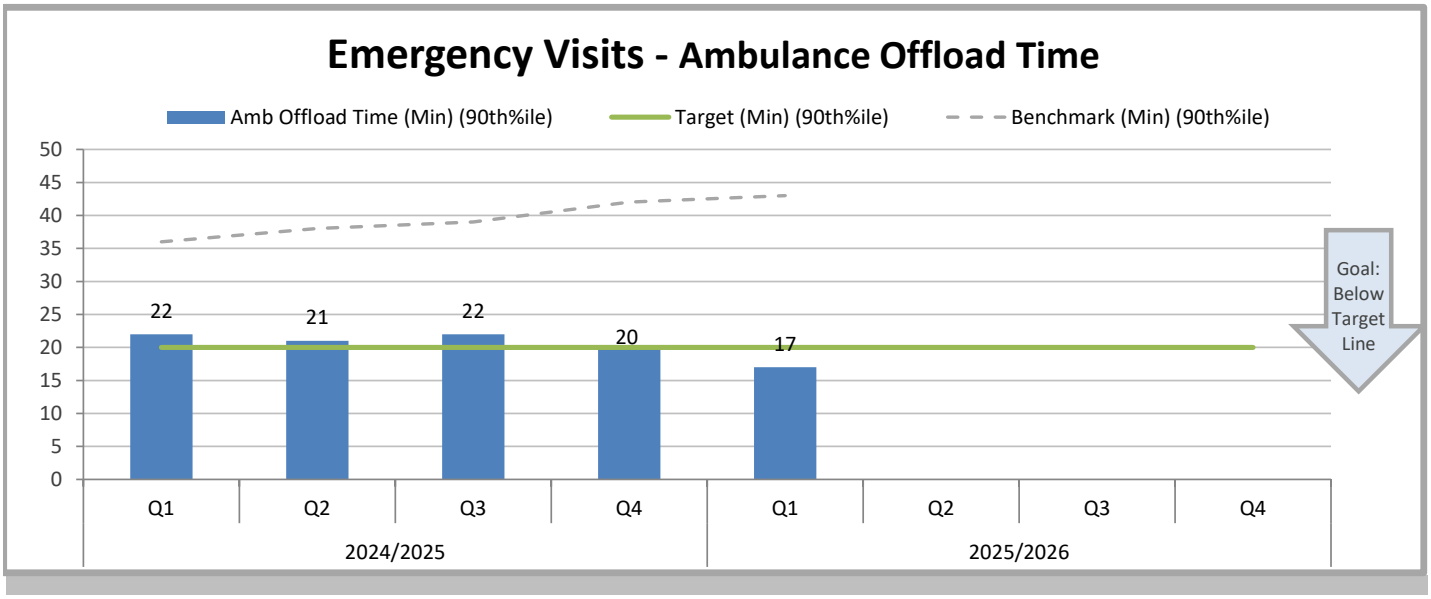
Significance: Ambulance offload times, the time between when a patient arrives at the hospital and the transfer of care, is a critical metric which helps evalute the efficiency and responsiveness of the healthcare system. These times directly impact the availability of emergency medical services, patient outcomes, and overall system capacity. This indicator can be affected by various factors, including the capacity of emergency departments, the severity of patients' conditions, and inefficiencies within the healthcare system.

Data Source: Anzer-NACRS

Target Information: Target set in accordance to QIP indicator, to obtain a 10% ranking score improvement of prior P4R year (Dec2023-Nov2024) of peer 75 hospital at the 90th percentile.

Benchmark Information: Benchmark performance is based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Amb Offload Time (Min) (90th%ile)	22	21	22	20	17			
Benchmark (Min) (90th%ile)	36	38	39	42	43			
Target (Min) (90th%ile)	20	20	20	20	20	20	20	20



Performance Analysis:

Q1 Target met. In Q1, the ambulance offload time improved by 15% when compared to prior quarter, decreasing from 20 minutes to 17 minutes. 22.2% of all emergency visits (2,808 out of 12,660) arrived by ambulance.

Q2

Q3

Q4

Plans for Improvement:

Q1 The Emergency Department works closely with our Community Partners to continue to collaborate in maintaining and reducing Ambulance Offload Time (AOT). During Q1, the ED Leadership team continued to collaborate with Decision Support by auditting all delays of 15 minutes or greater for AOT. Collaboration with Clinical Informatics has allowed the ED Leadership team to optimize the data collection and reporting of Fit2Sit, with a direct correlation in reducing AOT. Charge Nurse specific scorecards have been created and shared with the full-time Charge Nurses in the ED to increase awareness of AOT delays.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Emergency Department

Return to Dashboard

Indicator: Emergency Visits - Wait Time for Physician Initial Assessment (PIA)

Strategic Direction: RECOVERY

Definition: The indicator is measured in hours using the 90th percentile, which represents the time interval between the Triage Date/Time or Registration Date/Time and the Physician Initial Assessment and Non-Physician Initial Assessment (PIA / NPIA) Date/Time in the ED. PIA / NPIA includes; Physicians, Physician Assistants, Dentist, and Nurse Practitioner. Exclusions are: Left Without Being Seen (LWBS), Missing PIA Date/Time, Missing Disposition Date/Time, and Missing Time Left ED Date/Time as per P4R criteria).

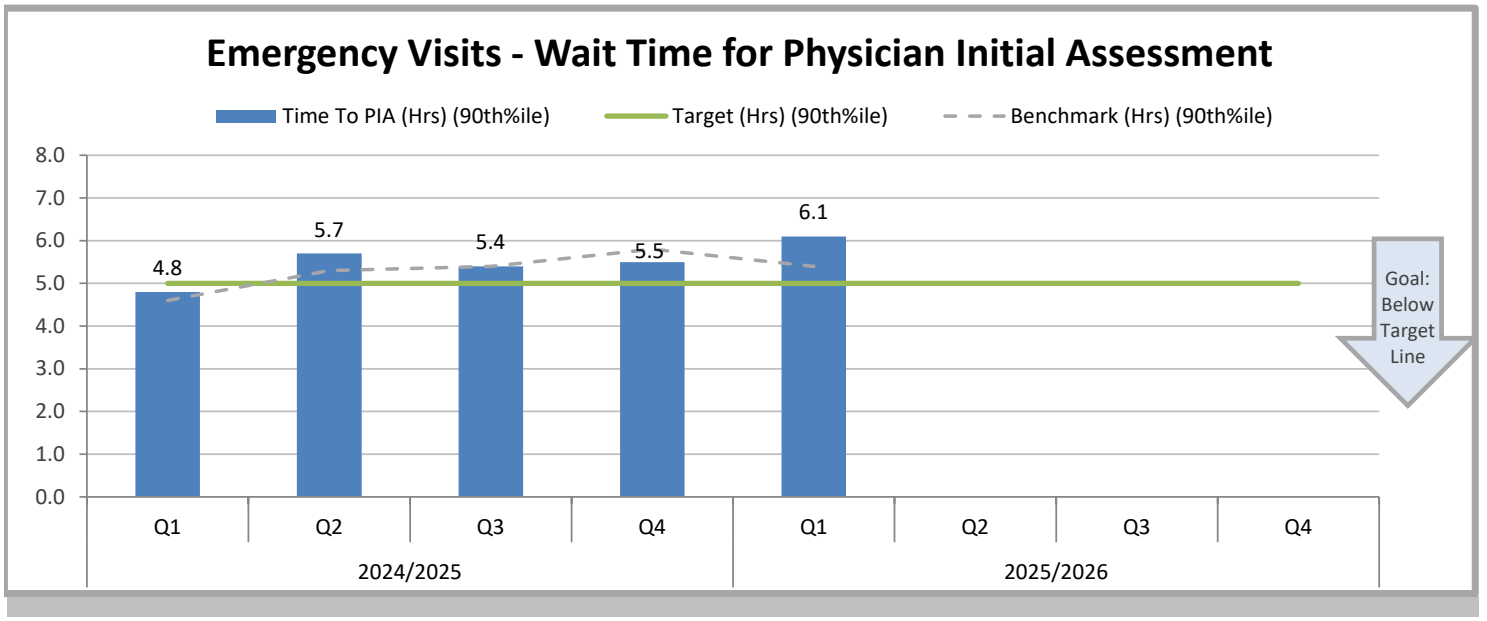
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. Multiple factors can influence the indicator results, including triage level, patient population and availability of resources. The 90th percentile of this indicator represents the maximum length of time that 90% of patients waited in the ED for a Physician Initial Assessment (PIA).

Data Source: Anzer-NACRS

Target Information: Target set in accordance to QIP indicator, to obtain a 10% ranking score improvement of prior P4R year (Dec2023-Nov2024) of peer 75 hospital at the 90th percentile.

Benchmark Information: Benchmark performance is based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To PIA (Hrs) (90th%ile)	4.8	5.7	5.4	5.5	6.1			
Benchmark (Hrs) (90th%ile)	4.6	5.3	5.4	5.8	5.4			
Target (Hrs) (90th%ile)	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0



Performance Analysis:

Q1 Target not met. Q1 had a total of 10,631 visits, 77% of which occurred during daytime hours (0800-2100hrs). This quarter, we were 13% higher than ur benchmark peers (5.4 hrs vs 6.1 hrs).

Q2

Q3

Q4

Plans for Improvement:

Q1 The Emergency Department continues to explore alternative care methods for patients who are visiting through See and Treat. Unfortunately, Emergency Department Physician staffing challenges have affected this metric and have posed a challenged in maintaining and reducing PIA. We continue to work with our Physician Assistant in an attempt to reduce PIA, where possible.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Emergency Department

Return to Dashboard

Indicator: Emergency Visits - Wait Time for Non-Admitted High Acuity (CTAS I-III) (Hrs) (90th Percentile)

Strategic Direction: RECOVERY

Definition: The indicator is measured in hours using the 90th percentile, which represents the total time elapsed from triage or registration (whichever is earlier) to patient left ED for non-admitted high acuity (CTAS I-III) patients. Excludes CDU Length of Stay (LOS).

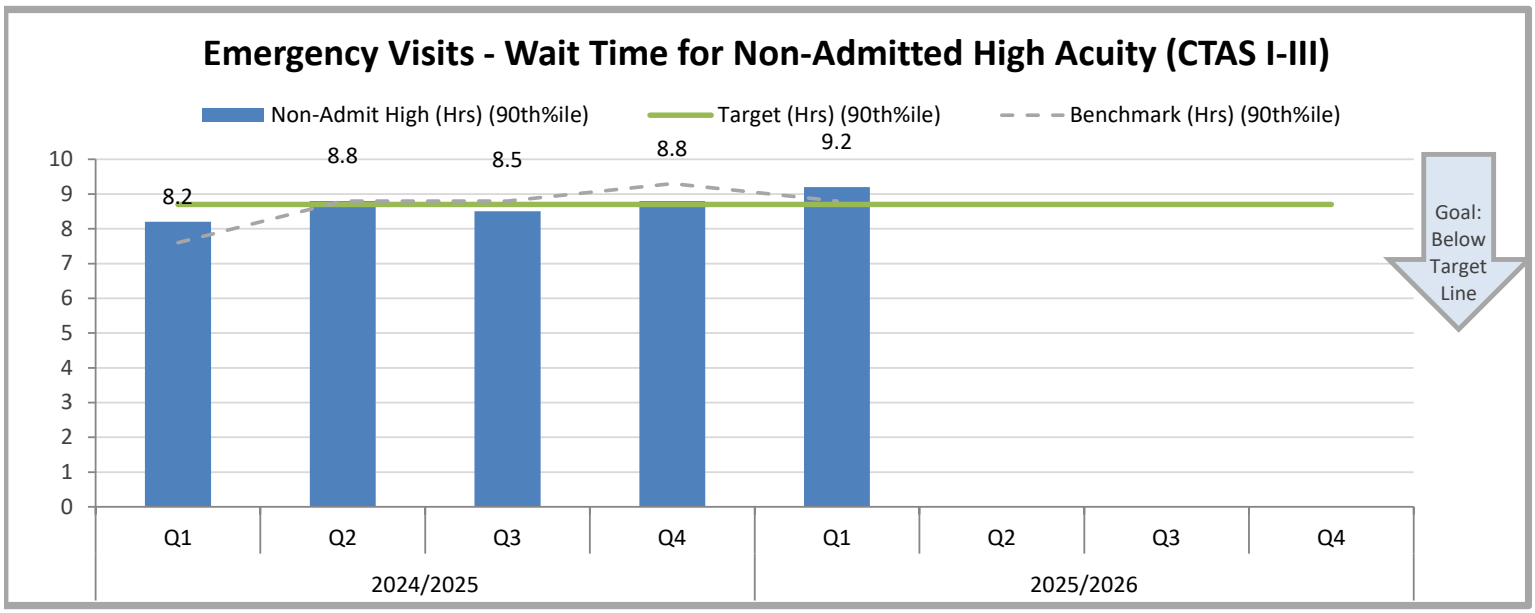
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer -NACRS

Target Information: Target based on 10% improvement from prior fiscal year performance.

Benchmark Information: Benchmark performance is based on ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group'.

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit High (Hrs) (90th%ile)	8.2	8.8	8.5	8.8	9.2			
Benchmark (Hrs) (90th%ile)	7.6	8.8	8.8	9.3	8.8			
Target (Hrs) (90th%ile)	8.7	8.7	8.7	8.7	8.7	8.7	8.7	8.7



Performance Analysis:

Q1 Target not met. April was the contributing factor for not reaching target this quarter (Apr. 10.2, May 8.6, Jun. 8.6).

Q2

Q3

Q4

Plans for Improvement:

Q1 We continue to optimize the use of our Medical Directives to facilitate a shorter time spent in the ED. ED Physician staffing has been a challenge when reviewing LOS in the ED. Discussions have taken place regarding consult wait times.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Emergency Department

Return to Dashboard

Indicator: Emergency Visits - Wait Time for Non-Admitted Low Acuity (CTAS IV-V) (Hrs)(90th Percentile)

Strategic Direction: RECOVERY

Definition: The indicator is measured in hours using the 90th percentile, which represents the total time elapsed from Triage/Registration Date/Time (whichever is earlier) to Patient Left ED Date/Time for non-admitted low acuity (CTAS IV-V patients. Exclusions are CDU Length of Stay (CDU LOS).

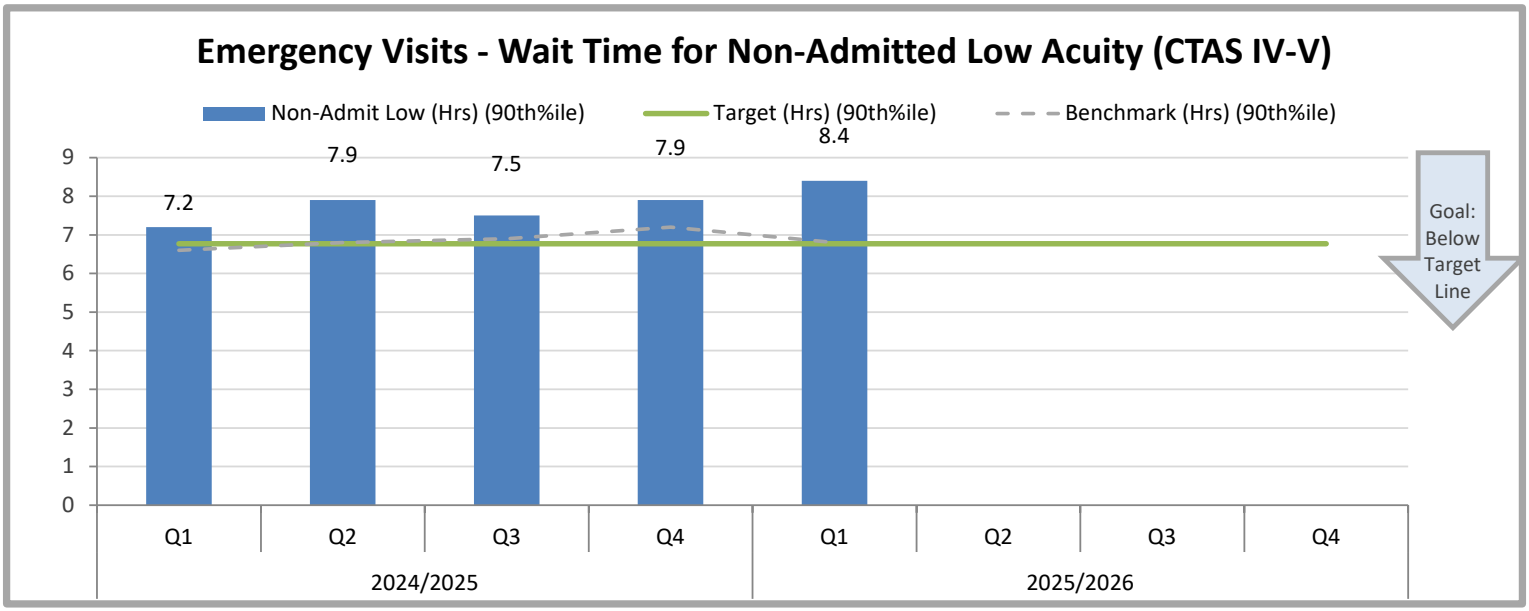
Significance: Time is crucial to the effectiveness and outcomes of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the emergency department in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer-NACRS

Target Information: Target set in accordance to QIP indicator, to obtain a 10% ranking score improvement of prior P4R year (Dec2023-Nov2024) of peer 75 hospital at the 90th percentile.

Benchmark Information: Benchmark performance is based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit Low (Hrs) (90th%ile)	7.2	7.9	7.5	7.9	8.4			
Benchmark (Hrs) (90th%ile)	6.6	6.8	6.9	7.2	6.8			
Target (Hrs) (90th%ile)	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8



Performance Analysis:

Q1 Target not met. In Q1, there were 2,326 low acuity visits (23%) out of 9,987 visits. All months in Q1 were above target (Apr. 9.2, May 8.1, Jun. 7.9) but results are beginning to trend downwards.

Q2

Q3

Q4

Plans for Improvement:

Q1 The Emergency Department continues to explore alternative care methods for patients who are not admitted and visit the ED with a CTAS 4 or 5 (low acuity). Unfortunately Emergency Department Physician staffing challenges have affected this metric.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Emergency Department

Return to Dashboard

Indicator: Falls per 1,000 Inpatient Days

Strategic Direction: RECOVERY

Definition: The calculation is based on the total number of falls with Severity Level >=1 (no harm/damage - excluding near misses) reported and divided by the total number of patient days for all inpatient units (includes Medicine, Surgery, CCU, Women/Children, Mental Health, and Rehabilitation) per 1000 Inpatient days.

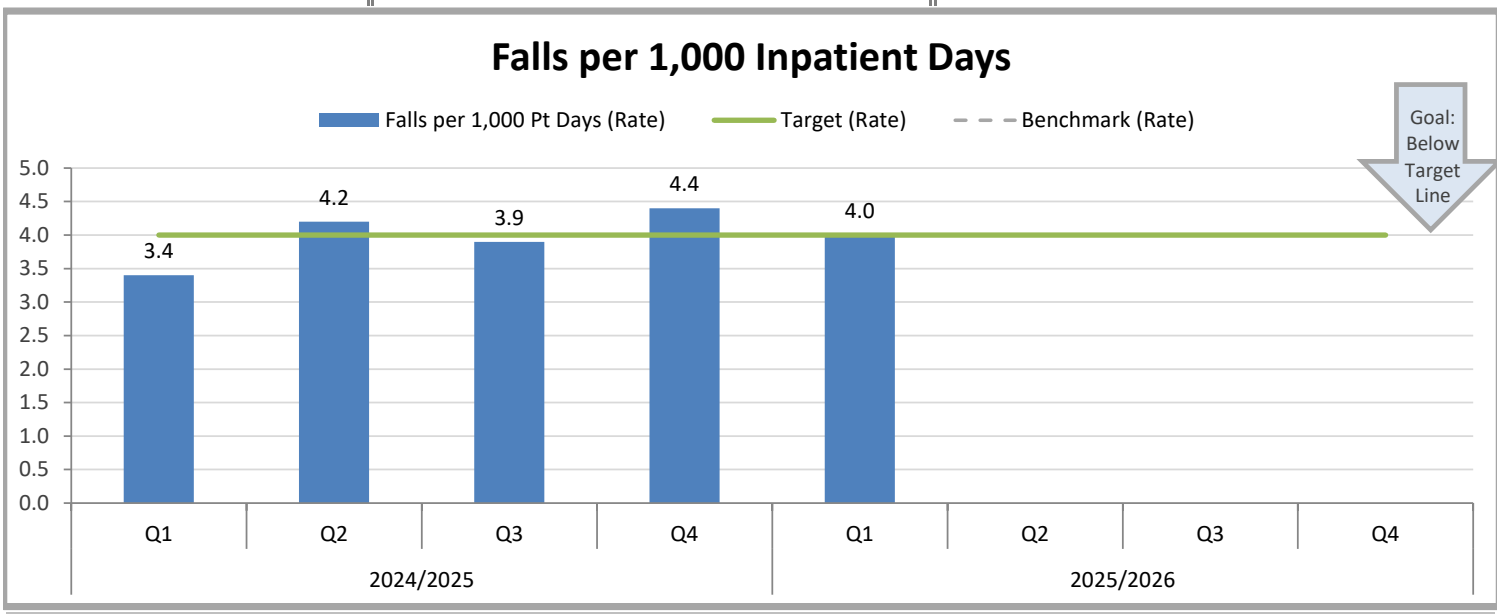
Significance: Falls, while in hospital, increase morbidity and mortality, increased length of stay, and decreased quality of life. Reducing falls indicates success in improving quality. According to Safer Healthcare Now, "A fall is defined as - An event that results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without injury."

Data Source: RL Solutions; Virtuo MIS - General Ledger

Target Information: Target is based on internal directives

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Falls per 1,000 Pt Days (Rate)	3.4	4.2	3.9	4.4	4.0			
Benchmark (Rate)								
Target (Rate)	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0



Performance Analysis:

Q1 Target met. Q1 had a total of 52 falls reported. Level 1 Med (22) contributed to a higher result this quarter.

Q2

Q3

Q4

Plans for Improvement:

Q1 Falls reduction strategies continue to be a priority; a risk assessment checklist (RAC) will be completed in Q2. Level 1 Medicine is focusing on fall reduction strategies over the next quarter through increased huddles and fall awareness. Spot audits will be conducted in real time to reinforce fall prevention strategies, along with a review of causation factors (lighting, environment clutter, and equipment needs). Additional efforts include encouraging safe mobilitzation through Mobility Team support and implementing the Purposeful Rounding Policy.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer

Indicator: Repeat ED Mental Health Visits

Strategic Direction: RECOVERY

Definition: The percentage of repeat emergency visits (for a mental health or substance abuse condition) following an emergency visit for a mental health condition. The repeat visit must be within 30 days of the 'index' visit (first visit). This is based on the Most Responsible Diagnosis (mental health codes - ICD-10) and includes only CCH cases.

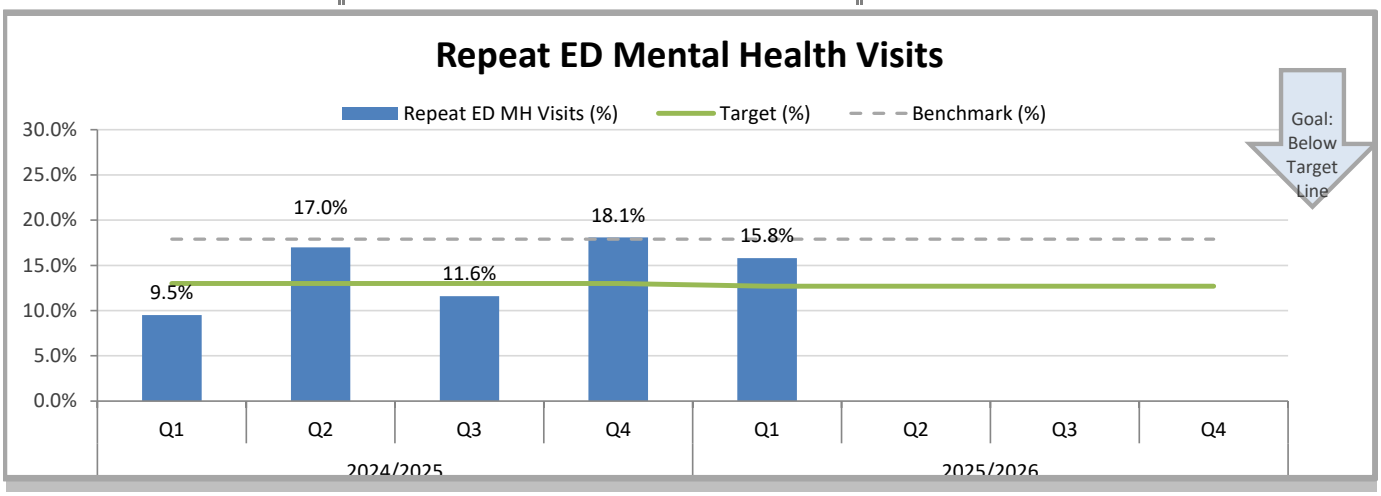
Significance: Repeat emergency visits among those with mental health conditions contribute to emergency visit volumes and wait times. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care. Given the chronic nature of the mental health conditions, access to effective community services should reduce the number of repeat unscheduled emergency visits. This indicator attempts to indirectly measure the availability and quality of community services for patients with mental health conditions. Investments in community mental health services such as crisis response and outreach, assertive community treatment teams, and intensive case management are intended to provide supports to allow individuals with mental illness to live in the community (CMHA, 2009; Every door is the right door, 2009). This indicator also supports the future development and improvement of data collected that could be used to directly measure the quality and availability of community mental health especially relating to wait times.

Data Source: Anzer - NACRS (National Ambulatory Care Reporting System)

Target Information: Target set internally using prior year performance.

Benchmark Information: Based on Champlain LHIN 2017/18 Q2 - Appendix A results as reported in Champlain LHIN Measuring Performance Second Quarterly Report 2017-18 January 2018

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED MH Visits (%)	9.5%	17.0%	11.6%	18.1%	15.8%			
Benchmark (%)	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%
Target (%)	13.0%	13.0%	13.0%	13.0%	12.7%	12.7%	12.7%	12.7%



Performance Analysis:

Q1 Target not met. There were 43 repeat ED MH visits out of 272 visits. 30% of the repeat visits were for reasons related to anxiety (F41.9).

Q2

Q3

Q4

Plans for Improvement:

Q1 Will continue to work with ED Social Work, Inpatient Mental Health, and Outpatient Mental Health services to maintain and improve repeat ED Mental Health visits. The CCH Mental Health Support Resources handbook is provided to appropriate patients and their families in the ED. Peer Support services have been beneficial in supporting patients with repeat visits to the ED through our ED Social Work group.

Q2

Q3

Q4

Indicator: Repeat ED Substance Abuse Visits

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED SA Visits (%)	13.2%	12.2%	11.2%	9.2%	5.6%			

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Emergency Department

Return to Dashboard

Indicator: Readmissions to Own Facility within 30-Days for Selected HIG Conditions

Strategic Direction: RECOVERY

Definition: The measuring unit of this indicator is an admission for specified chronic condition as defined by HSAA. Results are expressed as the number of select HIG (HBAM Inpatient Grouper) condition patients readmitted within 30-days of discharge. Denominator includes total number of **indexed** discharges (for a given period) from hospital with the exclusion of records where patient had an acute transfer out, or discharge disposition is sign out or death. Overall criteria includes: select HIG conditions, Ontario resident, valid Health Care Number, and select Age.

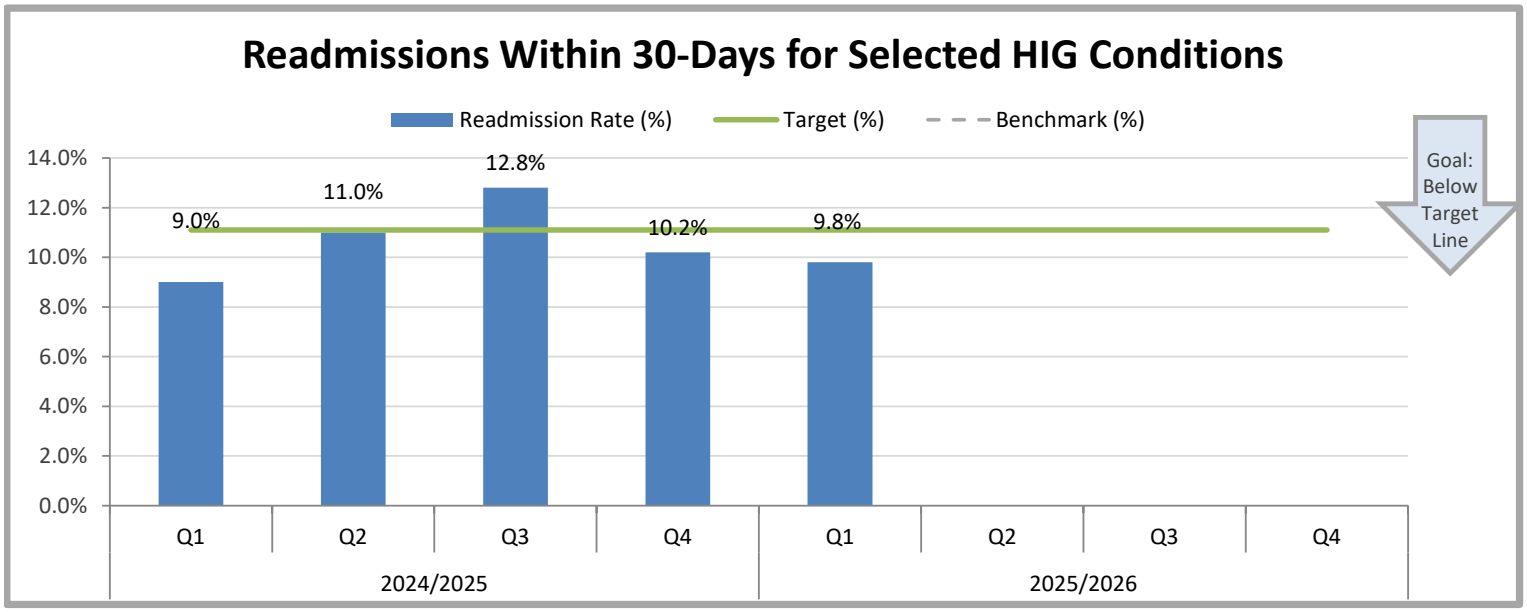
Significance: Unplanned hospital readmissions exact a toll on individuals, families and the health system. Avoidable readmissions remain a system-level issue that is also linked to integration among providers across the continuum of care. If patients get the care they need when and where they need it, this can help to reduce the number of preventable hospital readmissions. (MOHLTC - Excellent Care for All Act (2014)).

Data Source: Anzer -DAD (Discharge Abstract Database)

Target Information: Target based on 10% improvement from prior fiscal year performance.

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	9.0%	11.0%	12.8%	10.2%	9.8%			
Benchmark (%)								
Target (%)	11.1%	11.1%	11.1%	11.1%	11.1%	11.1%	11.1%	11.1%



Performance Analysis:

Q1 Target met. Q1 had 398 select HIG condition index visits with 39 readmission visits within 30 days. May had the highest readmission rate of 15.2% this quarter (23/151 visits).

Q2

Q3

Q4

Plans for Improvement:

Q1 Performance within target. Will continue to monitor closely.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Medicine, Rehab and Women and Children's Health

Return to Dashboard

Indicator: Typical Average Length of Stay (ALOS) for Hospitalists

Strategic Direction: RECOVERY

Definition: The typical average length of stay for admitted inpatients, admitted under the provider service of hospitalists. Excluded patients are mental health, rehabilitation and atypical cases.

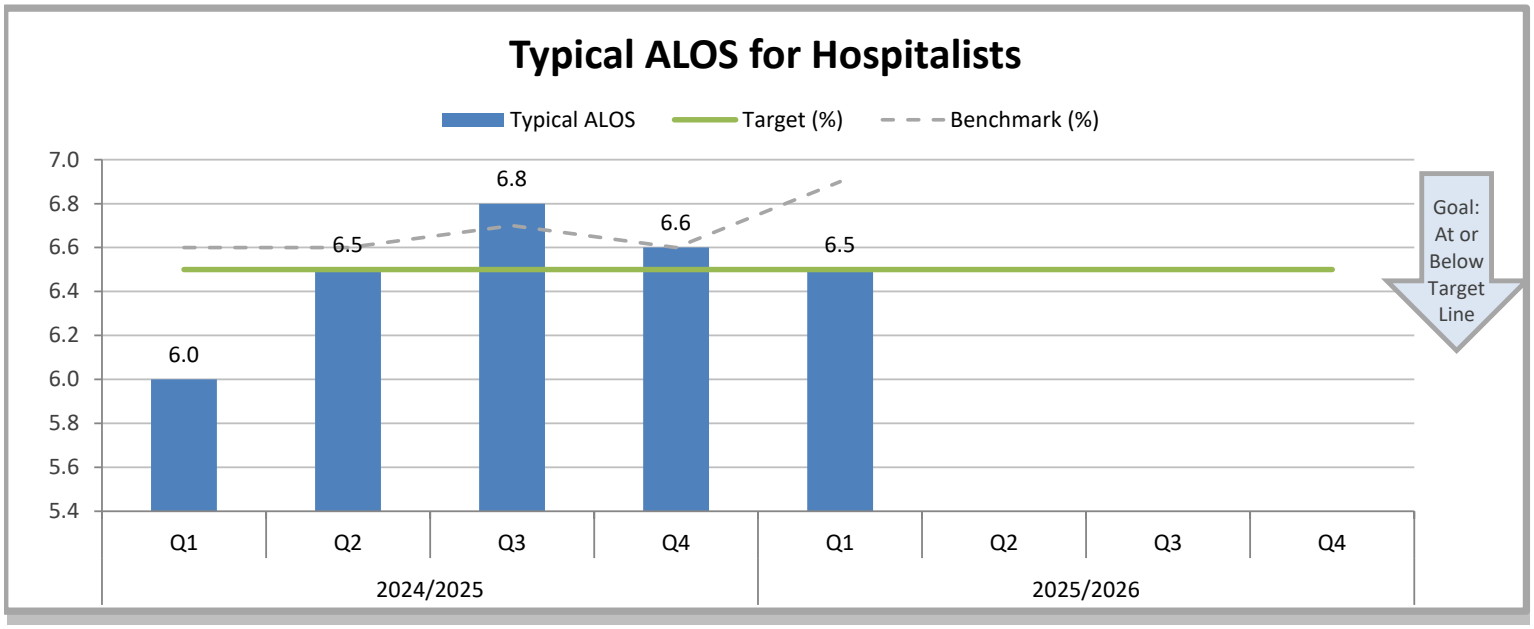
Significance: Be in more in line with our benchmark hospitals.

Data Source: CIHI Portal and Anzer -DAD (Discharge Abstract Database)

Target Information: Target based on median typical ALOS for benchmark (20) Peer Hospitals using prior year.

Benchmark Information: Benchmark based on median typical ALOS for benchmark (20) Peer Hospitals using prior quarter.

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Typical ALOS	6.0	6.5	6.8	6.6	6.5			
Benchmark (%)	6.6	6.6	6.7	6.6	6.9			
Target (%)	6.5	6.5	6.5	6.5	6.5	6.5	6.5	6.5



Performance Analysis:

Q1 Target met. May had this quarter's highest ALOS at 7.1 with 256 cases (Apr. 256 cases - 6.0, Jun. 248 cases- 6.3).

Q2

Q3

Q4

Plans for Improvement:

Q1 Continue to monitor closely and endeavour to ensure full hospitalist coverage.

Q2

Q3

Q4

Accountable: Chief of Staff / Chief Executive Officer

Return to Dashboard

Indicator: Total Margin

Strategic Direction: RECOVERY

Definition: The percentage by which total revenues exceed total expenses. A negative value indicates that expenses have exceeded revenues and a positive value indicates an excess of revenue over expenses. Performance is reported cumulatively on a year-to-date basis.

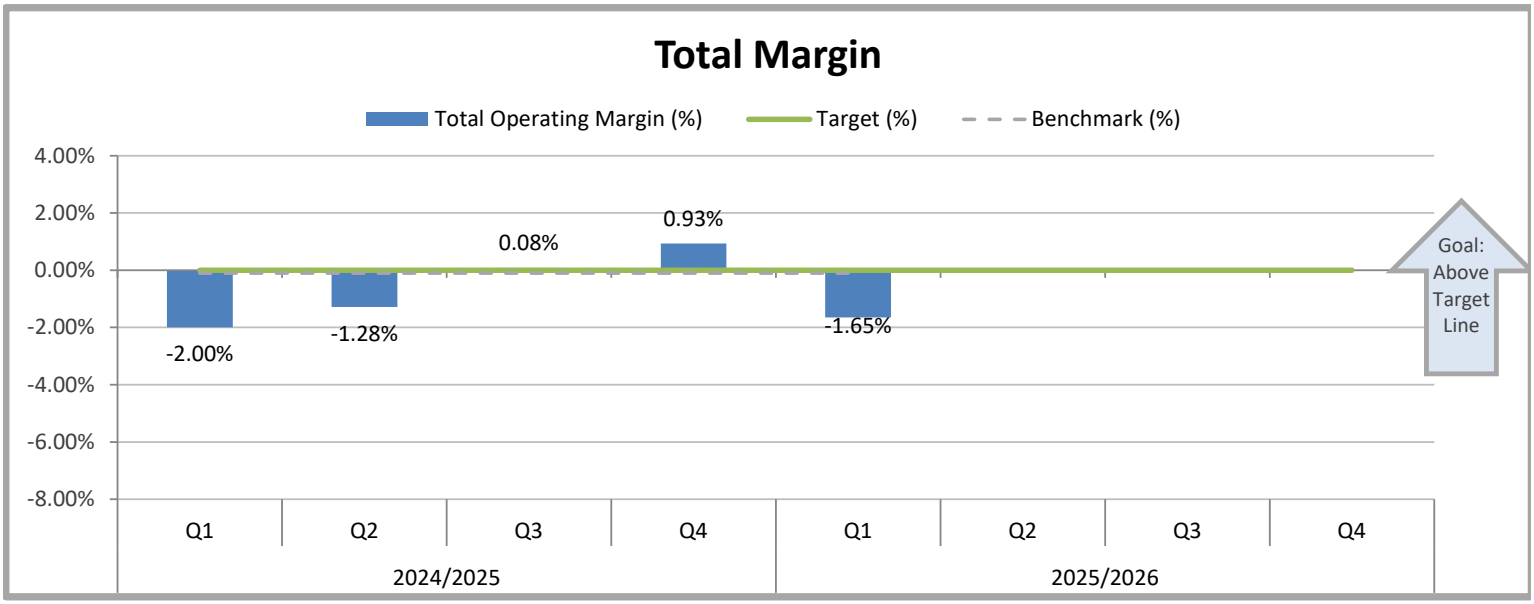
Significance: Indicates a balanced operating position.

Data Source: Monthly Financial Statements - Income Statement

Target Information: Target set according to HSAA obligations

Benchmark Information: Benchmark performance is based on prior fiscal year (Q1-Q2) Champlain LHIN Hospitals performance

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total Operating Margin (%)	-2.00%	-1.28%	0.08%	0.93%	-1.65%			
Benchmark (%)	-0.10%	-0.10%	-0.10%	-0.10%	-0.10%			
Target (%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%



Performance Analysis:

Q1 Target not met.
Q2
Q3
Q4

Plans for Improvement:

Q1 Revenue expected to increase; confirmed rate increase of 3%.
Q2
Q3
Q4

Accountable: Chief Financial Officer / Director, Financial Services

Return to Dashboard

Indicator: Cases Completed within Target Wait Time - Computed Tomography Scans

Strategic Direction: RECOVERY

Definition: The percentage of Diagnostic Computed Tomography (CT) Scans completed within Access Target for patients >=18 years of age. Included in this measurement are those cases reported as being at Priority Level 2 (Inpatient/Urgent - Target within 48 hrs), Priority Level 3 (Cancer Staging or Restaging - Target within 10 days), or Priority Level 4 (Non-Urgent - Target within 28 days). This indicators measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted (not timed procedure).

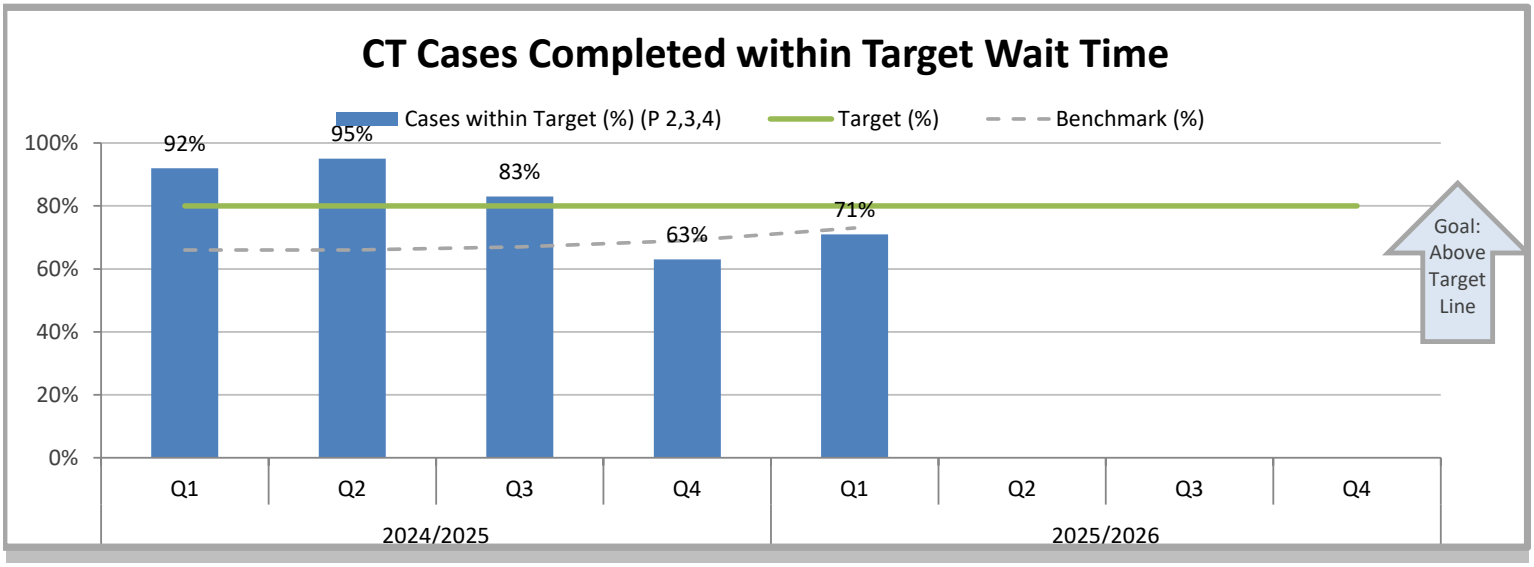
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target their resources to where they will have the most impact.

Data Source: WTIS iPort Access

Target Information: Target is set accordingly to provide a minimum service level to patients. Target is measured at Priority Level 2, 3, 4.

Benchmark Information: Benchmark is based on iPort, Champlain LHIN quarterly performance

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%) (P 2,3,4)	92%	95%	83%	63%	71%			
* Priority 2	98%	98%	97%	94%	96%			
* Priority 3	97%	95%	96%	93%	79%			
Benchmark (%)	66%	66%	67%	69%	73%			
Target (%)	80%	80%	80%	80%	80%	80%	80%	80%



Performance Analysis:

Q1 Target not met. Priority 4 remains the primary factor for not reaching target; however, priority 4 increased significantly compared to the previous quarter, increasing from 52% to 66%.

Q2

Q3

Q4

Plans for Improvement:

Q1 Reduce CT scan wait times by extending operating hours to include earlier appointments, improving access and throughput without compromising quality of care.

Q2

Q3

Q4

Accountable: Chief Financial Officer / Director, Diagnostic Services

Indicator: Cases of Long Waiters Exceeding Target Wait Times for All Surgical Procedures

Strategic Direction: RECOVERY

Definition: The percentage of Long Waiters whose total number of days waiting for their surgical procedure has exceeded the associated Priority Level Access Target. Included in this measurement are all surgical procedures reported through the Wait Times Information System(WTIS) and cases reported as being Priority Level 2 (Inpatient/Urgent), Level 3 (Semi-Urgent), or Level 4 (Non-Urgent).

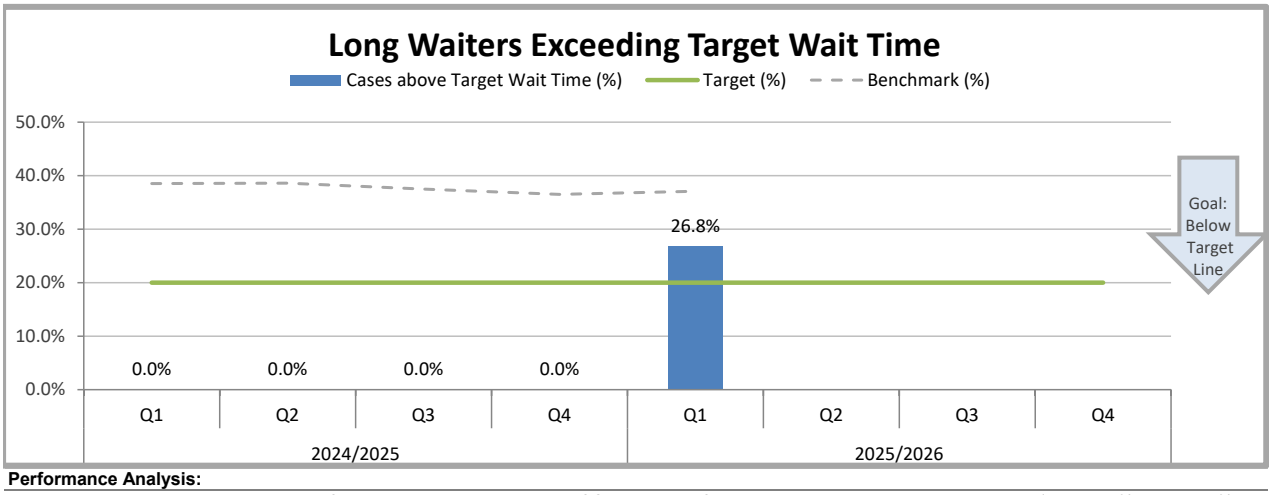
Significance: New HSAA indicator identified to decrease the volume of long waiters. Patients whose surgeries have been delayed longer than their maximum clinical guidelines are considered long waiters. The Ministry Surgical Recovery Programs are targeted at reducing the number of long waiter patients from current levels. According to a recent report by the Fraser Institute on Access to Healthcare in Canada, long wait times are more than a "benign inconvenience", they can lead patients with serious consequences, such as increase pain and suffering, mental health anguish and long-term risks.

Data Source: WTIS iPort Access

Target Information: Target is based on HSAA obligations and is measured at Priority Level 2, 3, 4

Benchmark Information: Benchmark is based on iPort, Champlain LHIN quarterly performance

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases above Target Wait Time (%)	N/A	N/A	N/A	N/A	26.8%			
Benchmark (%)	38.5%	38.6%	37.5%	36.5%	37.1%			
Target (%)	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%



Performance Analysis:

Q1 Target not met. There was a total of 1,309 open cases at the end of Q1 with 351 of those cases above priority access target (P2 - 37.5%, P2 - 30.6%, P4 - 25.1%).

Q2

Q3

Q4

Plans for Improvement:

Q1 Target not met, likely due to reduced O.R. activity during the summer months and limited anethesia availability. Will continue to monitor.

Q2

Q3

Q4

Indicator: Cases Completed within Target Wait Times - Cancer Surgery

(Priority 2,3,4)

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	59%	44%	62%	65%	88%			

Indicator: Cases Completed within Target Wait Times - Cataract Surgery

(Priority 2,3,4)

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	30%	52%	30%	71%	85%			

Accountable: VP, Patient Services and Chief Nursing Officer / Chief of Surgery / Director, Perioperative Services and Inpatient Surgery

Return to Dashboard

Indicator: Cases Completed within Target Wait Time - Magnetic Resonance Imaging Scans

Strategic Direction: RECOVERY

Definition: The percentage of Diagnostic Magnetic Resonance Imaging (MRI) Scans completed within Access Target for patients >=18 years of age. Included in this measurement are those case reported as being at Priority Level 2 (Inpatient/Urgent - Target within 48 hrs), Priority Level 3 (Cancer Staging or Restaging - Target within 10 days), or Priority Level 4 (Non-Urgent - Target within 28 days). This indicators measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted (not timed procedure).

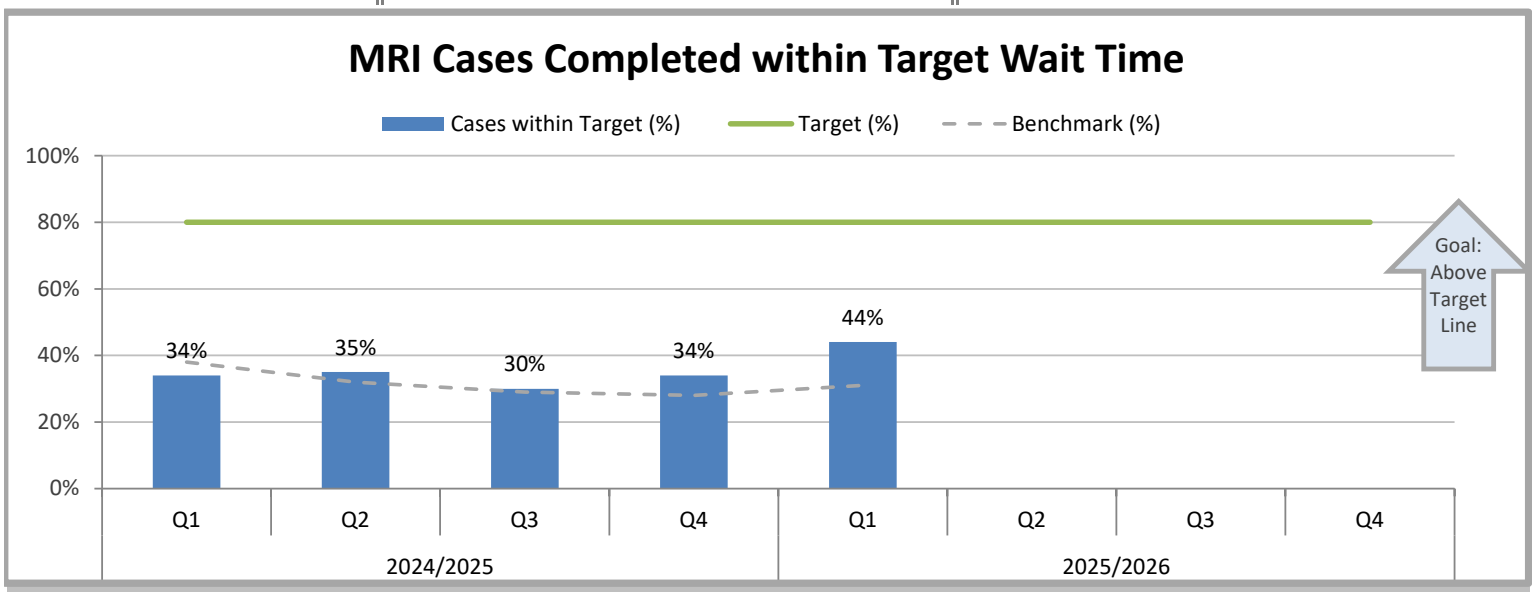
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target their resources to where they will have the most impact.

Data Source: WTIS iPort Access

Target Information: Target is set accordingly to provide a minimum service level to patients. Target is measured at Priority Level 2, 3, 4.

Benchmark Information: Benchmark is based on iPort, Champlain LHIN quarterly performance

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	34%	35%	30%	34%	44%			
* Priority 2	96%	96%	93%	97%	100%			
* Priority 3	90%	97%	97%	100%	98%			
Benchmark (%)	38%	32%	29%	28%	31%			
Target (%)	80%	80%	80%	80%	80%	80%	80%	80%



Performance Analysis:

Q1 Target not met. Priority 2 and 3 were both above target with priority 4 being the primary factor for not meeting target. Priority 4 was 33% this quarter but results continue to remain above our benchmark peers.

Q2

Q3

Q4

Plans for Improvement:

Q1 Continued efforts are underway to recruit a part-time MRI technologist in order to mitigate potential service disruptions due to absenteeism and staffing vacancies.

Q2

Q3

Q4

Accountable: Chief Financial Officer/ Director, Diagnostic Services

Return to Dashboard

Indicator: Incomplete Charts

Strategic Direction: INTEGRATION

Definition: This measures incomplete charts at thirty days after discharge. It is a snapshot of the incomplete (deficient, expected to sign and signatures) charts. Report is generated on the last business day of each quarter.

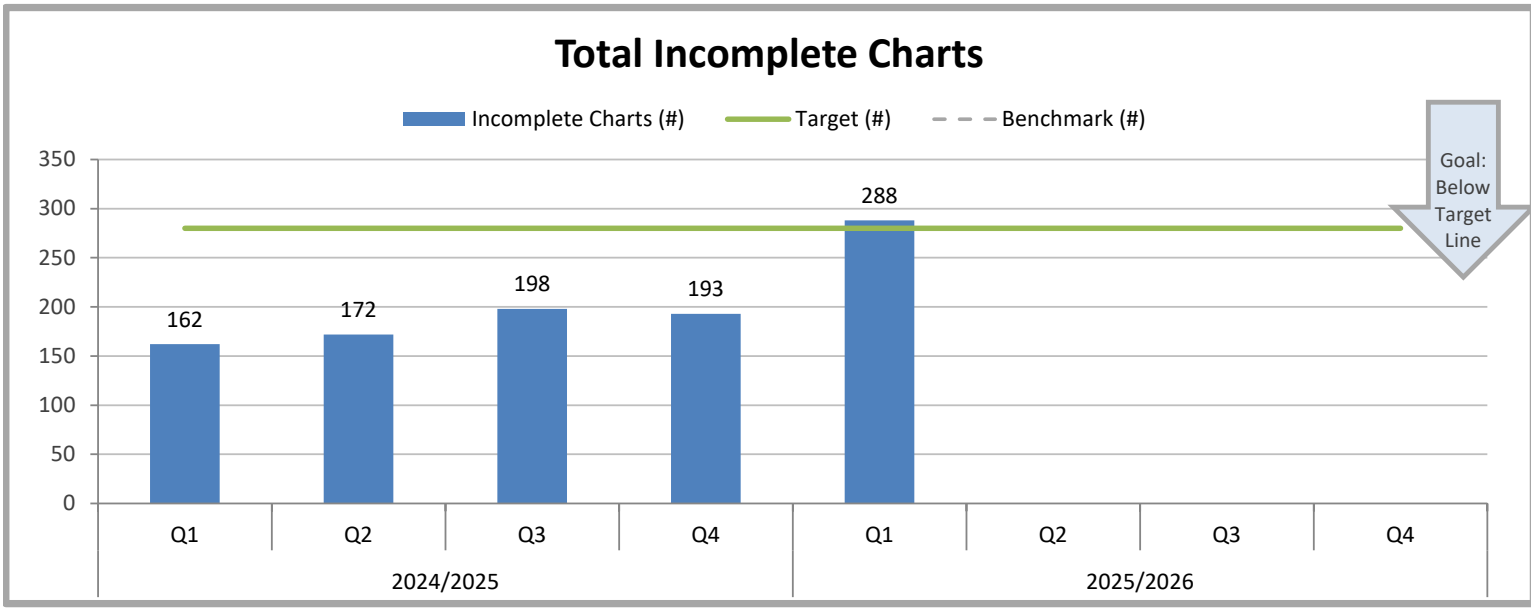
Significance: The purpose of this policy is to ensure that patient health records are completed in accordance with legal requirements, including the Public Hospitals Act (PHA) and Hospital Management Regulation 965 (Regulation), professional obligations, as well Hospital by-Laws, policies, rules and procedures. Record completion is necessary for continuity of patient care, to support a collaborative care services delivery model and for the protection of the individual practitioner from potential liability.

Data Source: Cerner - Discern Analytics (Incomplete Chart Report)

Target Information: Continue with prior year target.

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incomplete Charts (#)	162	172	198	193	288			
Benchmark (#)								
Target (#)	280	280	280	280	280	280	280	280



Performance Analysis:

Q1 Target not met. There were 8 individuals who had 10 or more total deficiencies out of 69 individuals. The incorporation of 'Saved Not Signed with 10 or less' has resulted in a significant increase in this indicator in comparison to previous quarters.

Q2

Q3

Q4

Plans for Improvement:

Q1 Target is expected to be met by Q3. A change in recording signatures etc. has resulted in an increase, however workflows are being introduced to address the issue.

Q2

Q3

Q4

Accountable: President and Chief Executive Officer / Chief of Staff

Return to Dashboard

Indicator: Medication Scanning Compliance

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of medication administered for which a medication scan was completed for all inpatient and emergency department patients (Excludes Outpatient, Day Surgery, Ambulatory Care).

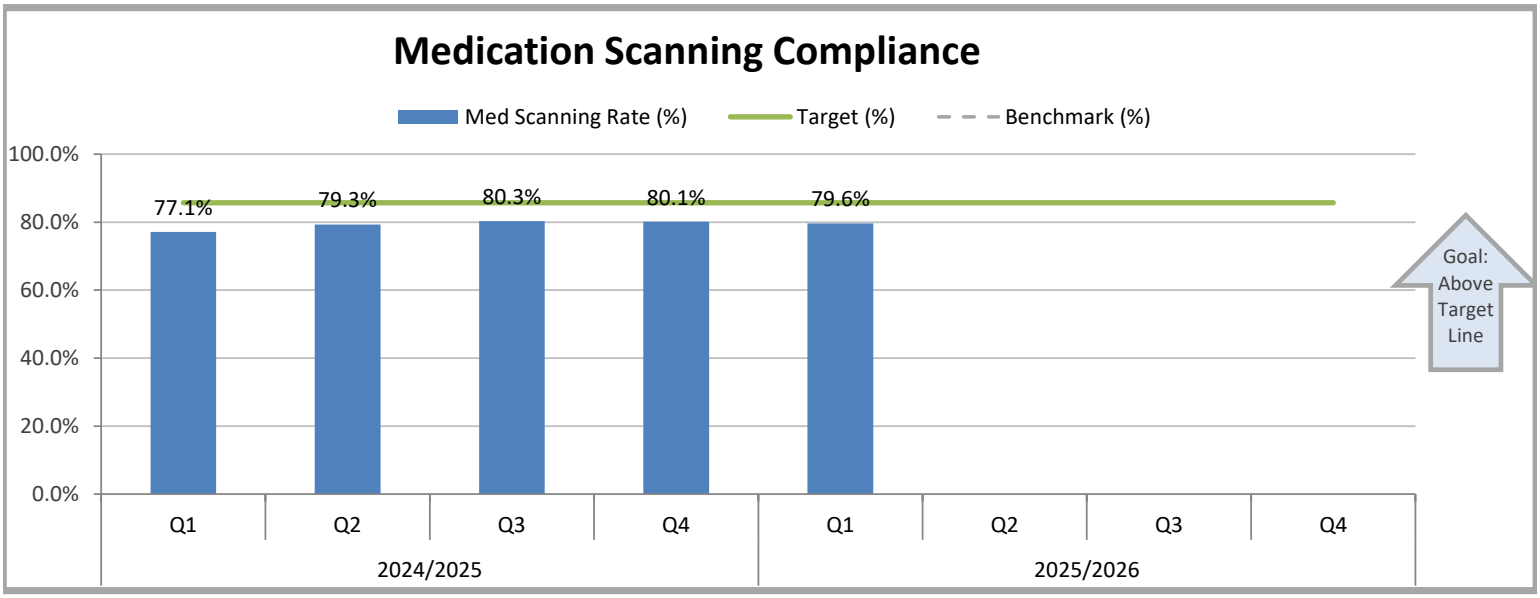
Significance: Barcode medication administration (BCMA) systems scan a patient's wristband and medication to be given in order to prevent medication errors. BCMA has shown to reduce medication administration errors significantly and to reduce harm from serious medication errors.

Data Source: Cerner Reporting Portal

Target Information: Set internally at 85.7% in accordance to QIP indicator

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Scanning Rate (%)	77.1%	79.3%	80.3%	80.1%	79.6%			
Benchmark (%)								
Target (%)	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%



Performance Analysis:

Q1 Target not met. Q1 had 199,320 medications scanned out of 250,448. Of the 9 nurse units, 5 units were within 10% of reaching target.

Q2

Q3

Q4

Plans for Improvement:

Q1 Multidisciplinary working group established to identify root causes when medications are not scanning. Ongoing system improvements within medication profiles and the EHR to correct issues in a timely manner.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Quality and Risk Management

Return to Dashboard

Indicator: Patient Satisfaction Survey

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of Inpatient respondents who responded positively (positive response includes "completely" and "quite a bit") (Top2Box) to "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?" (Ontario Adult Inpatient Short Form Survey - Question #7).

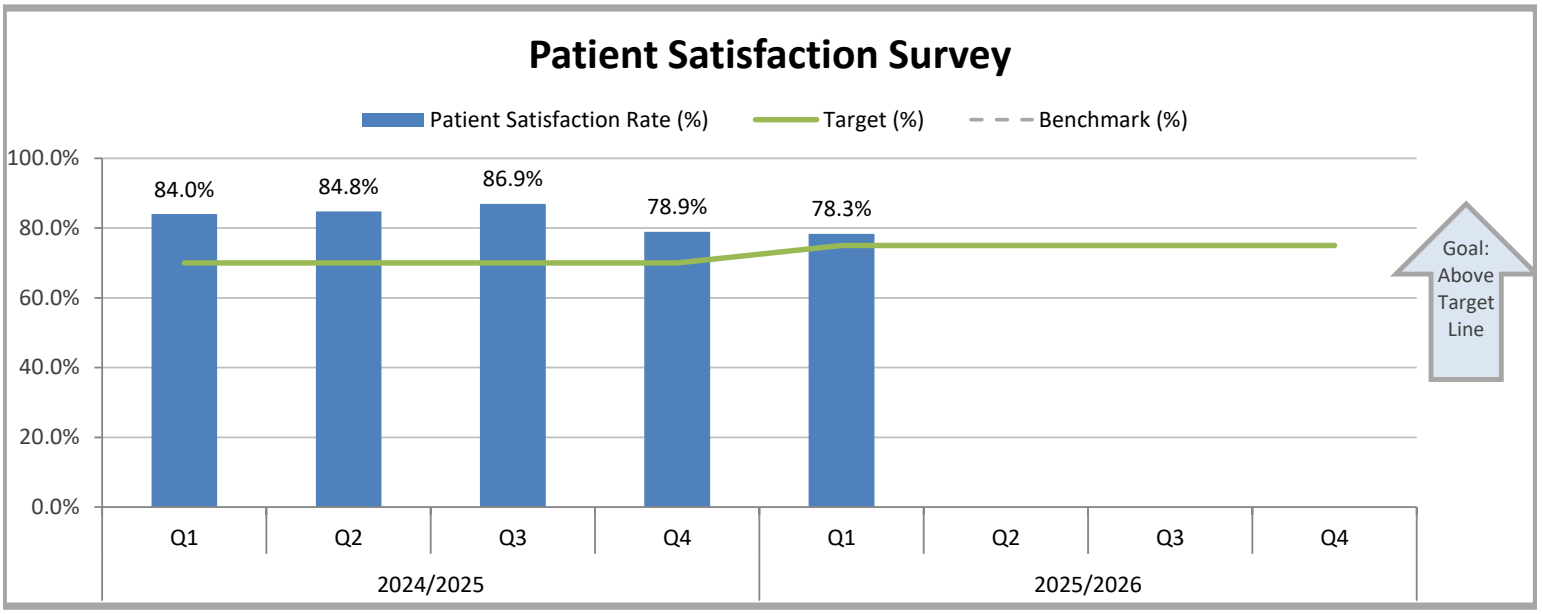
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that is sensitive to patients' concerns and comfort, and that actively involves patients and family members in shared decision-making about their care."

Data Source: Qualtrics

Target Information: Target set in accordance with QIP indicator, based on prior year's performance.

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Patient Satisfaction Rate (%)	84.0%	84.8%	86.9%	78.9%	78.3%			
Benchmark (%)								
Target (%)	70.0%	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%



Performance Analysis:

Q1 Target met. In Q1, 65 out of 83 respondents answered positively, though the overall response rate for Q1 was lower than previous quarters.

Q2

Q3

Q4

Plans for Improvement:

Q1 Target met, however slight decline. Will continue to monitor and employ change ideas that include Manager Patient Rounding to identify opportunites for early intervention.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

Indicator: Accreditation Canada Required Organizational Practice (ROP) - Medication Reconciliation on Discharge Rate

Strategic Direction: INTEGRATION

Definition: This is a priority indicator; medication reconciliation at care transition has been recognized as best practice, and is an Accreditation Required Organization Practice. Total number of discharged patients with completed Medication Reconciliation divided by the total # of discharged patients. (Excludes - Interfacility Transfers, Deaths, ED Hold, PACU, Obstetrical and Newborn patients).

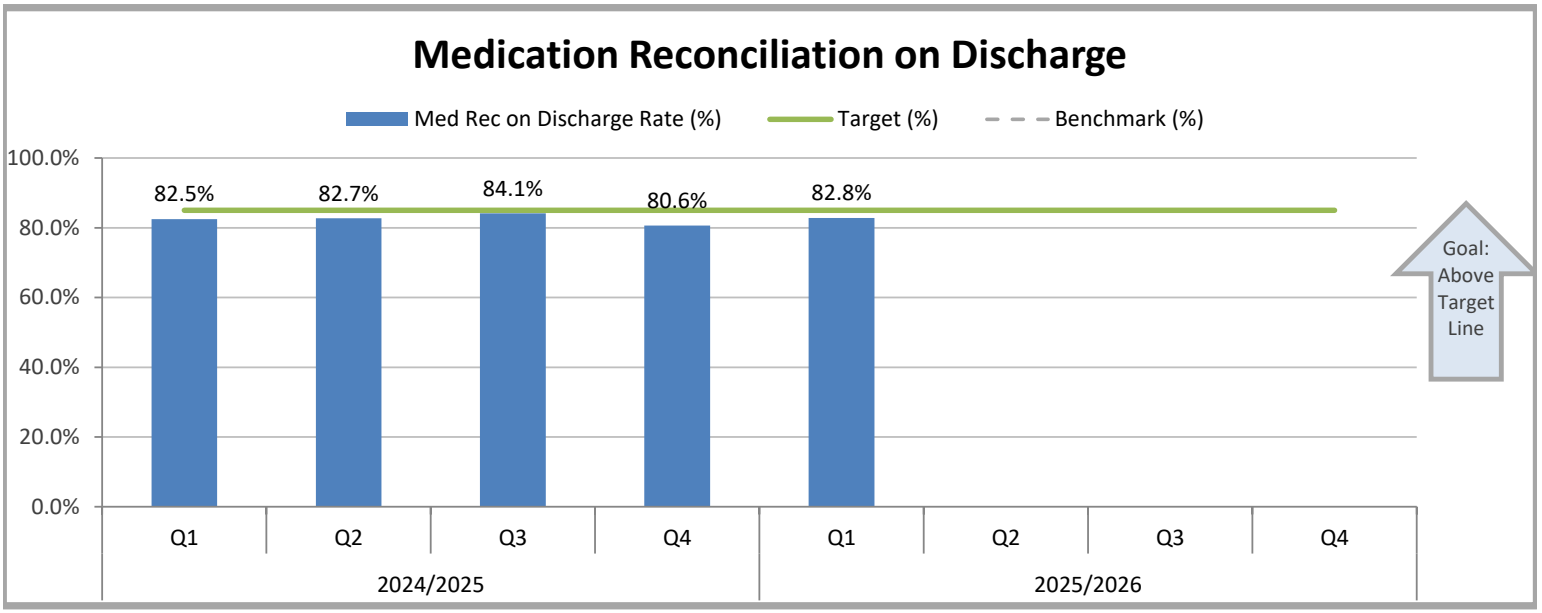
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient (Safer Healthcare Now! Medication Reconciliation in Acute Care Toolkit, Sept 2011).

Data Source: Cerner electronic health record

Target Information: Set internally at 85% in accordance to QIP indicator

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	82.5%	82.7%	84.1%	80.6%	82.8%			
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target not met. Monthly results are within 5% of meeting target (Apr. 81.8%, May 81.6%, Jun. 84.9). There were 1,106 medication reconciliations completed out of 1,336. 5 of the units were above target with 1 unit being within 10%.

Q2

Q3

Q4

Plans for Improvement:

Q1 Target not achieved; focused education is planned for identified outliers.

Q2

Q3

Q4

Accountable: VP, Patient Services and Chief Nursing Officer / Chief of Staff

Return to Dashboard

Indicator: Alternate Level of Care (ALC) Throughput

Strategic Direction: INTEGRATION

Definition: ALC Throughput represents the flow of patients designated and discharged by using the ratio of the number of discharged ALC cases to the number of newly added ALC cases with a specific period of time (Excludes: Discontinued cases and ALC cases of 0 days).

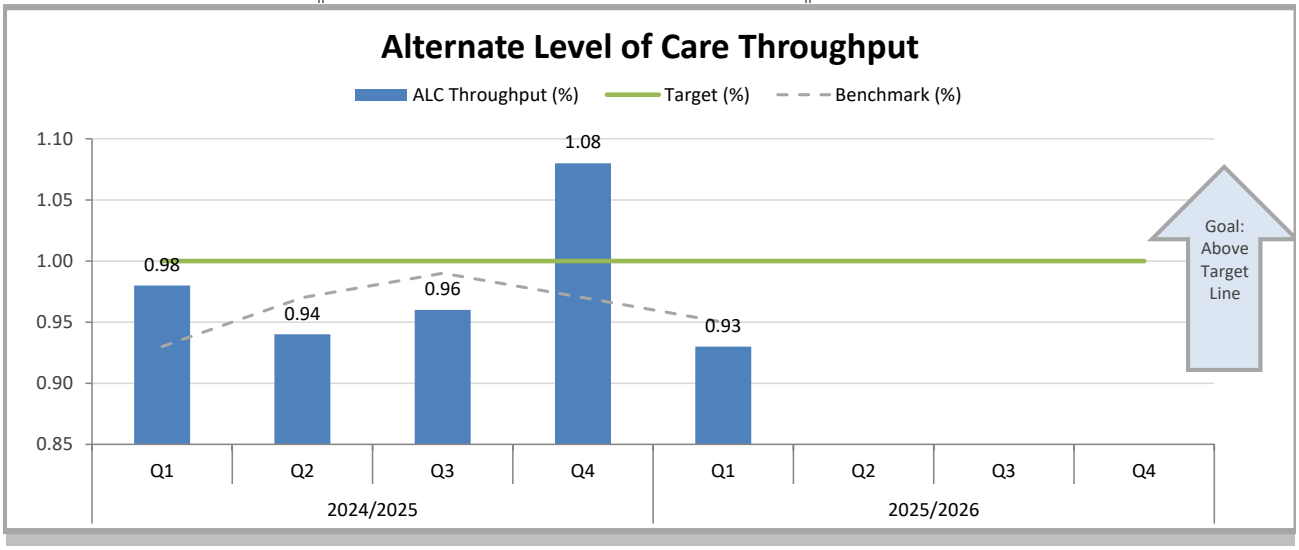
Significance: Cornwall Community Hospital will continue to identify and implement additional strategies with Champlain health care providers to reduce alternate level of care days.

Data Source: ATC CCO ALC Throughput Report

Target Information: Target rate is standardized according to HSAA specifications

Benchmark Information: Benchmark performance is based on ATC iPort - Champlain LHIN quarterly performance

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Throughput (%)	0.98	0.94	0.96	1.08	0.93			
Benchmark (%)	0.93	0.97	0.99	0.97	0.95			
Target (%)	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00



Performance Analysis:

Q1 Target not met. 11 ALC designated cases exceeded the total volume of ALC discharges (146 discharges/157 designated).

Q2

Q3

Q4

Plans for Improvement:

Q1 The ALC working group is refining the ALC policy and implementing new workflows to streamline internal processes. Targeted measures are ongoing to support reduction of ALC and to mitigate risk of patients becoming ALC (ie Mobility Team, Behavioral Support strategies).

Q2

Q3

Q4

Indicator: Alternate Level of Care (ALC) Rate

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Rate (%)	29.5%	30.0%	27.5%	24.4%	24.8%			

Indicator: Acute Alternate Level of Care (ALC) Days excluding (closed cases)

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Days (%)	34.0%	35.4%	32.3%	28.3%	28.8%			

Accountable: Director, Subacute Medicine / Manager, Patient Flow and Bed Management

Return to Dashboard

Indicator: Complaints Acknowledged Within Five (5) Business Days

Strategic Direction: PEOPLE

Definition: The percentage of complaints acknowledged to the individual who made a complaint within five (5) business days divided by the total number of complaints received in the reporting period.

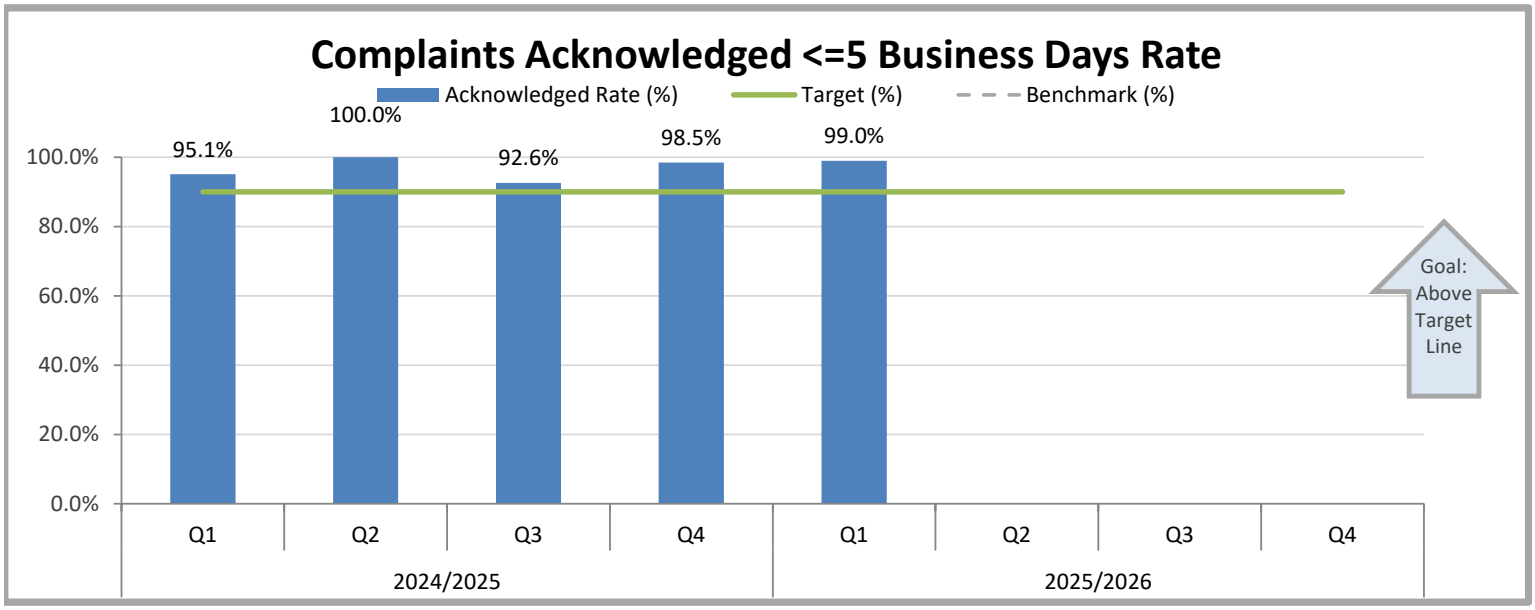
Significance: This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint. This indicator is calculated on the number of complaints received in the reporting period. By regulation, hospitals must acknowledge complaints within five business days. Complaints received by the facility need to be formally acknowledged to the individual who made the complaint.

Data Source: RL Solutions

Target Information: Target is set internally at 90.0%

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acknowledged Rate (%)	95.1%	100.0%	92.6%	98.5%	99.0%			
Benchmark (%)								
Target (%)	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Performance Analysis:

Q1 Target met. There were 76 complaints this quarter with 75 of those complaints being acknowledged within 5 business days.
Q2
Q3
Q4

Plans for Improvement:

Q1 Q1 improvements noted; ongoing monitoring will continue.
Q2
Q3
Q4

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

Indicator: Indigenous Cultural Awareness

Strategic Direction: PEOPLE

Definition: The number of reports (from Indigenous Patient Navigator or Senior Leadership) provided to Management Huddle on feedback received from the Indigenous community.

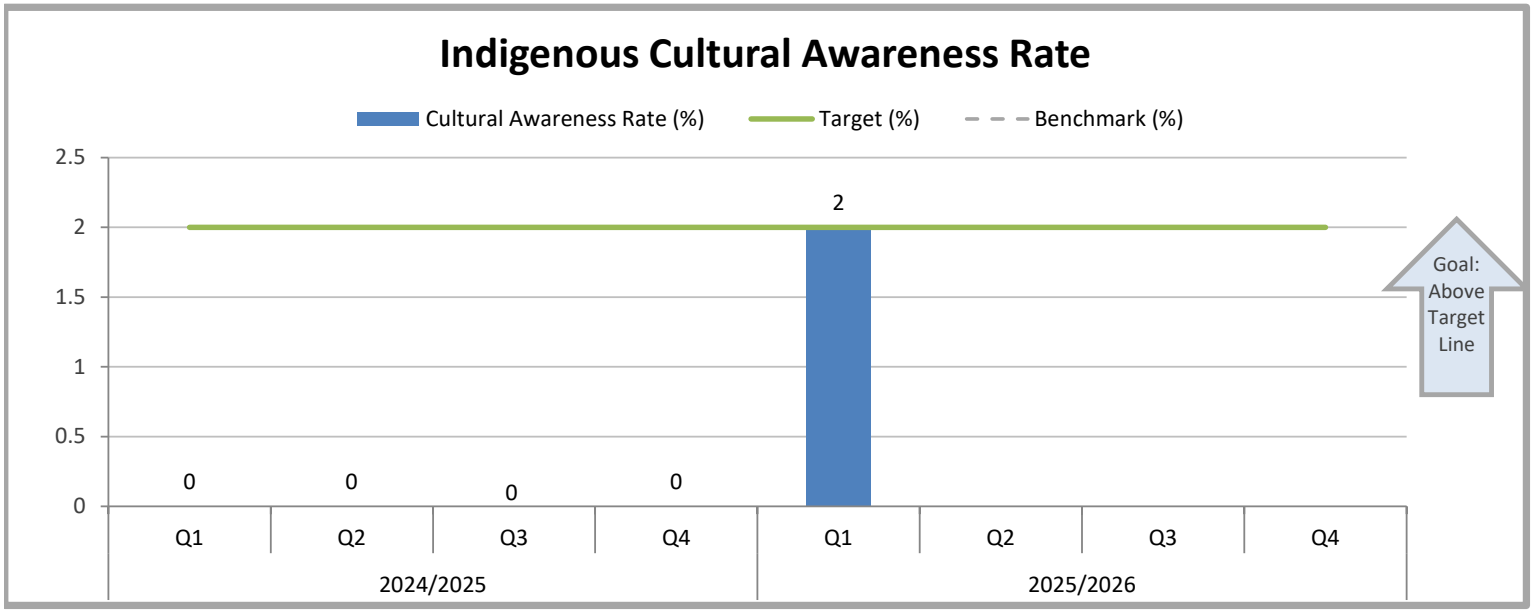
Significance: As part of our CCH Strategic Plan for 2016-2021, it identifies that CCH will partner with experts and our peers to foster a climate of culture competency. We will increase access to training with a focus on frontline staff, and we will work closely with the Akwasasne community to better understand their needs.

Data Source: Internal Tracking.

Target Information: Target is set at 2 per quarter.

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cultural Awareness Rate (%)	N/A	N/A	N/A	N/A	2			
Benchmark (%)								
Target (%)	2	2	2	2	2	2	2	2



Performance Analysis:

Q1 Target met.
Q2
Q3
Q4

Plans for Improvement:

Q1 Continue engagement with the Akwesasne community and encourage feedback from the Indigenous Patient Navigator.
Q2
Q3
Q4

Accountable: Chief Executive Officer

Return to Dashboard

Indicator: Equity, Diversity, Inclusion and Anti-Racism Education

Strategic Direction: PEOPLE

Definition: This indicator measures the percentage of staff (excluding casual) who have completed relevant equity, diversity, inclusion and anti-racism education. Includes executive-level, all management, chief of departments, and volunteers. Performance is cumulative year-to-date.

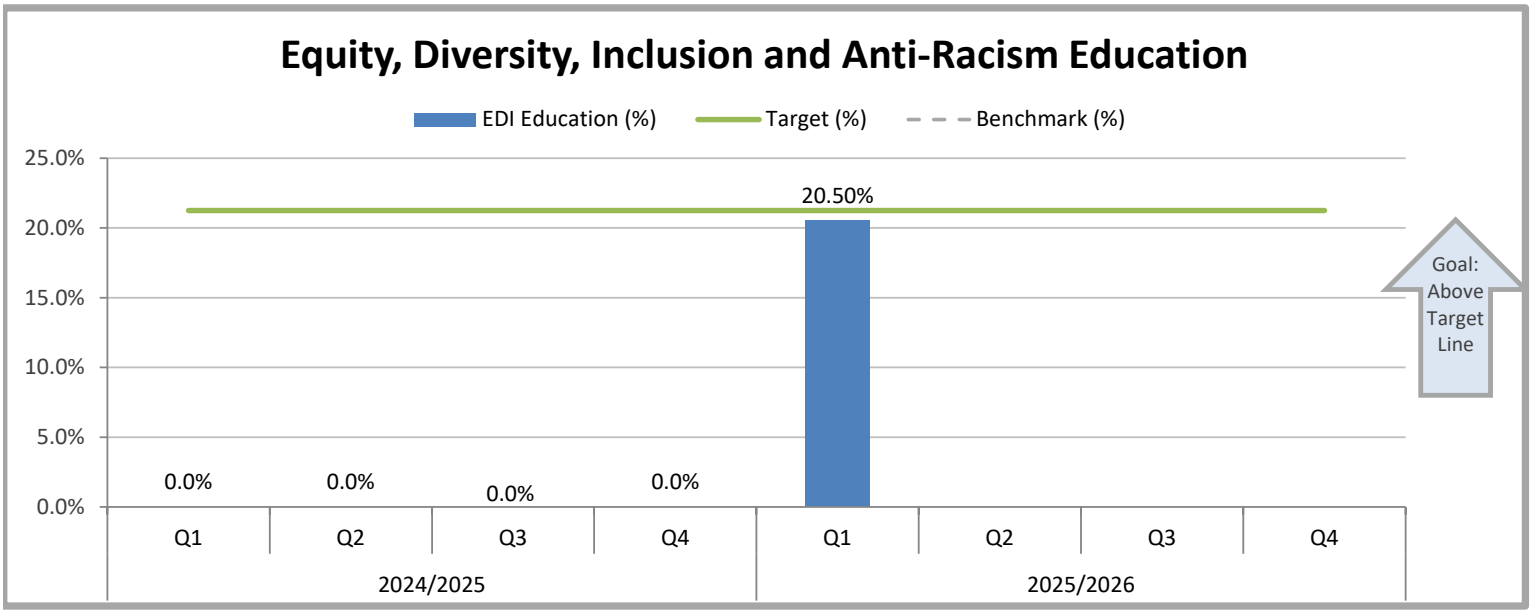
Significance: Education is essential to help guide and build a culture focused on equity, diversity, inclusion, and anti-racism, and to contribute to better outcomes for patients, families, and providers within the health system. The commitment to addressing racism and discrimination, reducing inequities in the health system, and recognizing that our organizational culture needs to be equitable to contribute to better outcomes for the communities we serve.

Data Source: Learning Management System (LMS)

Target Information: Target is set internally at 21.25% per quarter (total of 85% annually) in accordance to QIP indicator.

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
EDI Education (%)	N/A	N/A	N/A	N/A	20.50%			
Benchmark (%)								
Target (%)	21.25%	21.25%	21.25%	21.25%	21.25%	21.25%	21.25%	21.25%



Performance Analysis:

Q1 Target not met. 230 active staff have completed EDI training.
Q2
Q3
Q4

Plans for Improvement:

Q1 Focus on promoting and importance of completing the LMS training module for all staff.
Q2
Q3
Q4

Accountable: Chief Human Resources Officer / Director, Human Resources

Return to Dashboard