Cornwall Community Hospital
Hôpital communautaire de Cornwall

CORPORATE SCORECARD 2022/2023

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	G	G	N/A
Current Ratio	HSAA	G	G	Y	N/A
Elective Repeat Low Risk C-Section (>37weeks) Rate	HSAA/Board	G	G	G	G
Emergency Visits - Wait Time for Inpatient Bed (TIB)	QIP/OPT	R	R	R	Y
Emergency Visits - Wait Time for Non-Admitted High Acuity	HSAA/OPT	Y	R	R	R
Emergency Visits - Wait Time for Non-Admitted Low Acuity	HSAA/OPT	R	R	R	R
Falls per 1,000 Patient Days	Senior Friendly	G	G	Y	G
Indication of Induction Post-Dates (<41 Weeks) Rate	HSAA	G	G	G	G
Inpatients Receiving Care in Unconventional Spaces/Day	QIP	G	G	G	G
Readmissions within 30-Days for Select HIG Conditions	HSAA	G	G	G	N/A
Repatriate Patients within 48-Hours Rate	HSAA	R	R	R	N/A
Repeat ED Mental Health Visits	QIP/HSAA/MSAA	G	G	Y	N/A
Repeat ED Substance Abuse Visits	HSAA/MSAA	G	G	G	N/A
Typical Average Length of Stay (ALOS) for Hospitalists	Board/OPT	R	Y	Y	N/A
Total Margin	HSAA	R	Y	G	N/A
Wait Time - CT Scans (Priority 2, 3, 4)	HSAA	R	R	R	R
**Wait Time - CT Scans (Priority 2, 3)	Board	G	G	G	G
Wait Time - Hip Replacement	HSAA	R	R	R	R
Wait Time - Knee Replacement	HSAA	R	R	R	R
Wait Time - MRI Scans (Priority 2, 3, 4)	HSAA	R	G	G	R
**Wait Time - MRI Scans (Priority 2, 3)	Board	G	G	G	G

INTEGRATION					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
ALC Rate	HSAA	R	R	R	R
Discharge Summary Sent to Primary Care Within 48 Hours	QIP	Y	G	G	R
Incomplete Charts	Board	Y	R	R	G
Medication Reconciliation on Discharge Rate (ROP)	QIP/Accreditation	G	G	G	G
Same Day Discharge to Home Care Rate	HSAA	G	G	G	G

PEOPLE					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Complaints Acknowledged	Board	G	G	G	N/A
Indigenous Cultural Awareness	HSAA	G	G	G	G
Overtime Rate	HSAA	R	R	R	N/A
Patient Experience Survey: Information	QIP	N/A	N/A	N/A	N/A
Smoking Cessation Rate	HSAA	G	G	G	G
Workplace Violence Prevention - Incidents	QIP	G	R	R	Y

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:	54%	58%	52%	52%
% Indicators within 10% of targets:	15%	6%	13%	10%
% Indicators underperforming targets:	31%	35%	35%	38%

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

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Indicator: Clostridium Difficile Incidence

Strategic Direction: RECOVERY

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

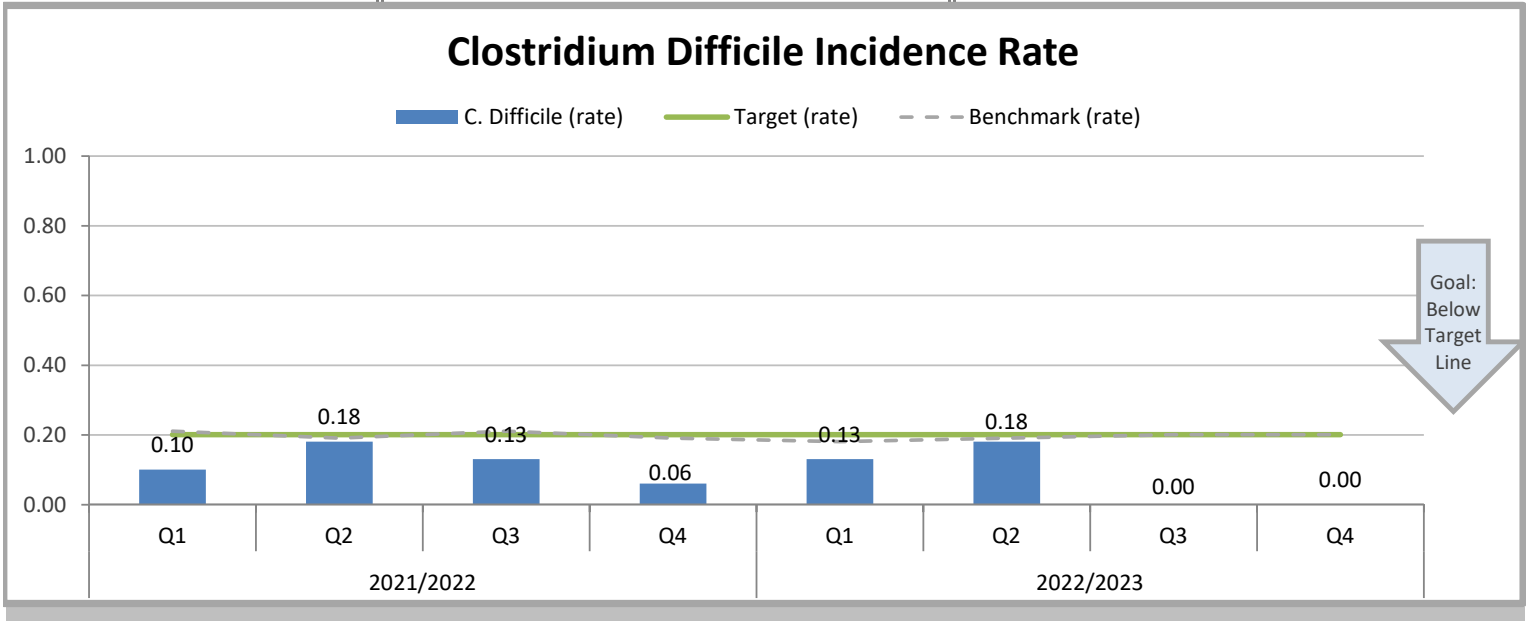
Significance: This bacteria is commonly found in the environment; it can exist in spore form and is resistant to some chemicals. It lives in approx. 3-5% of humans as normal flora and can develop if exposed to risk factors such as: prolonged antibiotic use, bowel surgery, chemotherapy and hospitalization.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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
C. Difficile (rate)	0.10	0.18	0.13	0.06	0.13	0.18	0.00	N/A
Benchmark (rate)	0.21	0.19	0.21	0.19	0.18	0.19	0.20	0.20
Target (rate)	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20



Performance Analysis:

Q1 Target met. There were a total of two cases this quarter.
Q2 Target met. There were a total of three cases this quarter..
Q3 Target met. No cases to report this quarter.
Q4 Results unavailable due to system failure (Virtuo).

Plans for Improvement:

Q1 Continue monitoring and audits.
Q2 Continue monitoring and audits.
Q3 Continue monitoring and audits.
Q4 N/A

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

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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.

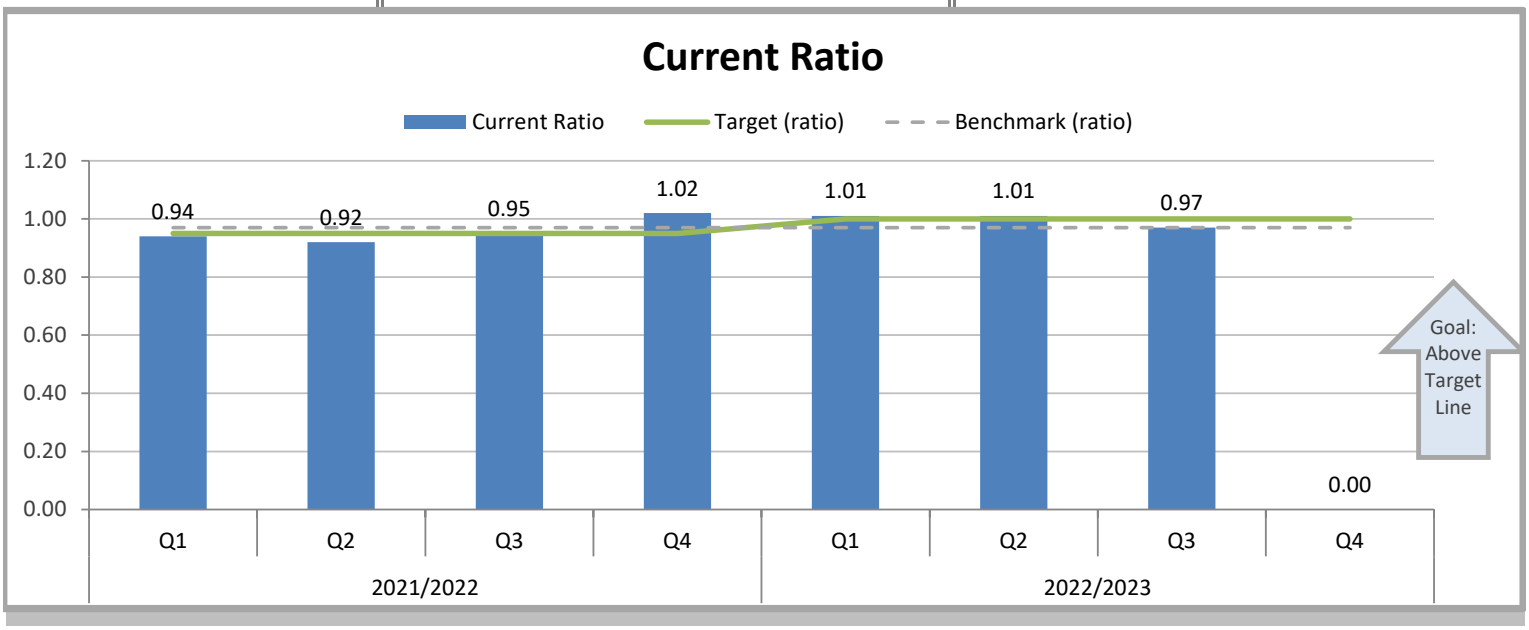
Significance: Indicates the overall financial health of the organization.

Data Source: Monthly Financial Statements - Balance Sheet

Target Information: Set according to HSAA obligations

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Current Ratio	0.94	0.92	0.95	1.02	1.01	1.01	0.97	N/A
Benchmark (ratio)	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97
Target (ratio)	0.95	0.95	0.95	0.95	1.00	1.00	1.00	1.00



Performance Analysis:

Q1 Current Ratio is on target.
Q2 Current Ratio is on target.
Q3 Current Ratio target not met due to timing of capital purchases.
Q4 Results unavailable due to system failure (Virtuo).

Plans for Improvement:

Q1 Monitor and continue to manage monthly revenues and expenses.
Q2 Monitor and continue to manage monthly revenues and expenses.
Q3 Monitor and continue to manage monthly revenues and expenses.
Q4 N/A

Accountable: Chief Financial Officer / Manager, Financial Services

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Indicator: Elective Repeat Low Risk C-Section (>37weeks) Rate

Strategic Direction: RECOVERY

Definition: The number of low-risk women with a caesarean section performed from 37 to <39 weeks' gestation (37 weeks + 0 days to 38 weeks + 6 days gestation), expressed as a percentage of the total number of low-risk women who had a repeat caesarean section at term (≥37 weeks). Calculation: Total # of elective caesarean sections in low risk women being done at <39 weeks divided by the number of women with a singleton pregnancy having a repeat C-section with no maternal health problems and with no obstetrical complications and with no labour. Excludes: Women who have had more than 1 caesarean section, women who have a BMI >40, and women who are >40 years of age.

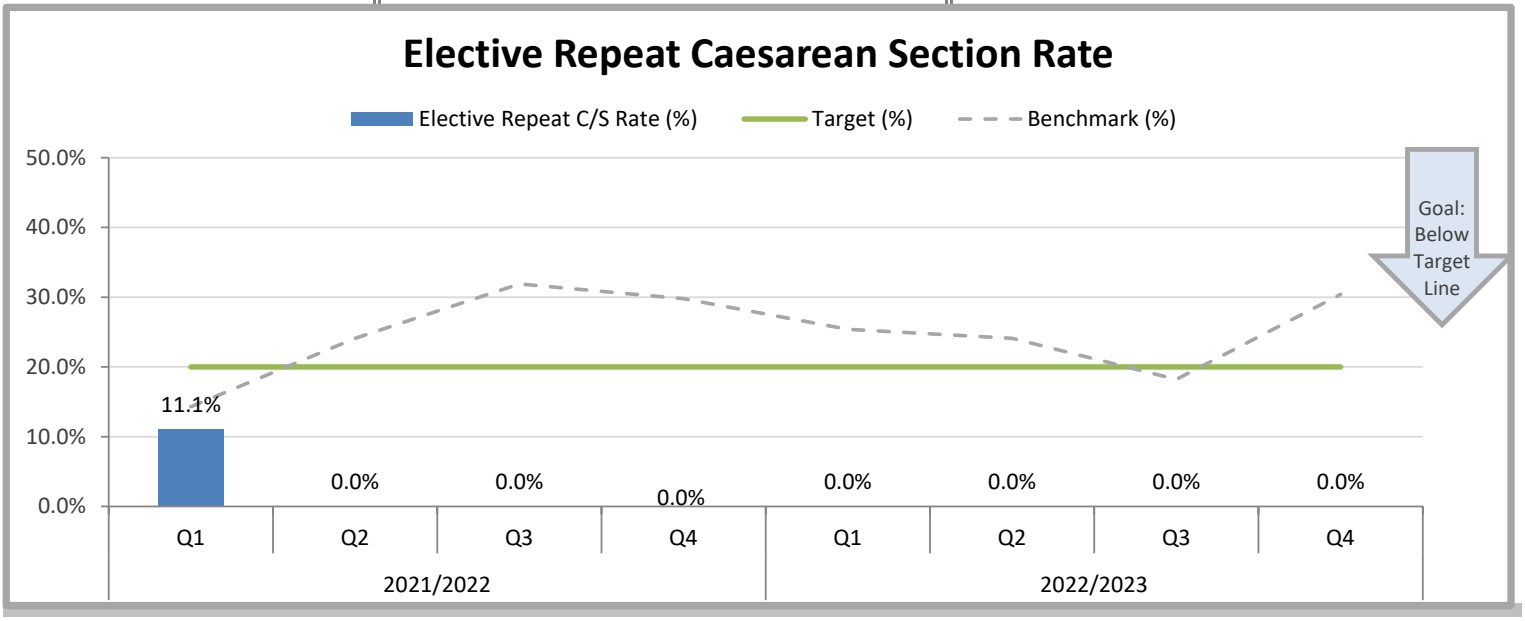
Significance: The long-term outcome is to minimize risk (greater risk of cardiac arrest, hysterectomy, infection, fever, pneumonia, blood vessel clotting and hemorrhaging, and neonatal risk).

Data Source: BORN (Better Outcomes Registry & Network) Ontario; KPI (Key Performance Indicator) 4

Target Information: Target is based on HSAA obligations

Benchmark Information: Benchmark performance is based on Other Neonatal Level 1 hospitals quarterly performance

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Elective Repeat C/S Rate (%)	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Benchmark (%)	14.3%	24.1%	31.9%	29.8%	25.4%	24.1%	18.2%	30.4%
Target (%)	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%



Performance Analysis:

Q1 Target met.
Q2 Target met.
Q3 Target met.
Q4 Target met.

Plans for Improvement:

Q1 Continue current strategies and review results at departmental meetings.
Q2 Continue to perform audits and ongoing team/client education.
Q3 Continue to perform audits and ongoing team/client education.
Q4 Continue to perform audits and ongoing team/client education.

Accountable: VP, Patient Services and Chief Nursing Officer / Chief of OB/GYN / Manager, Women and Children's Health

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Indicator: Emergency Visits - Wait Time for Inpatient Bed (TIB)

Strategic Direction: RECOVERY

Definition: This is a mandatory QIP indicator. The indicator is measured in hours using the 90th percentile, which represents the time interval between the Disposition Date/Time Patient Left the Emergency Room Department for admission to an Inpatient bed or Operating Room.

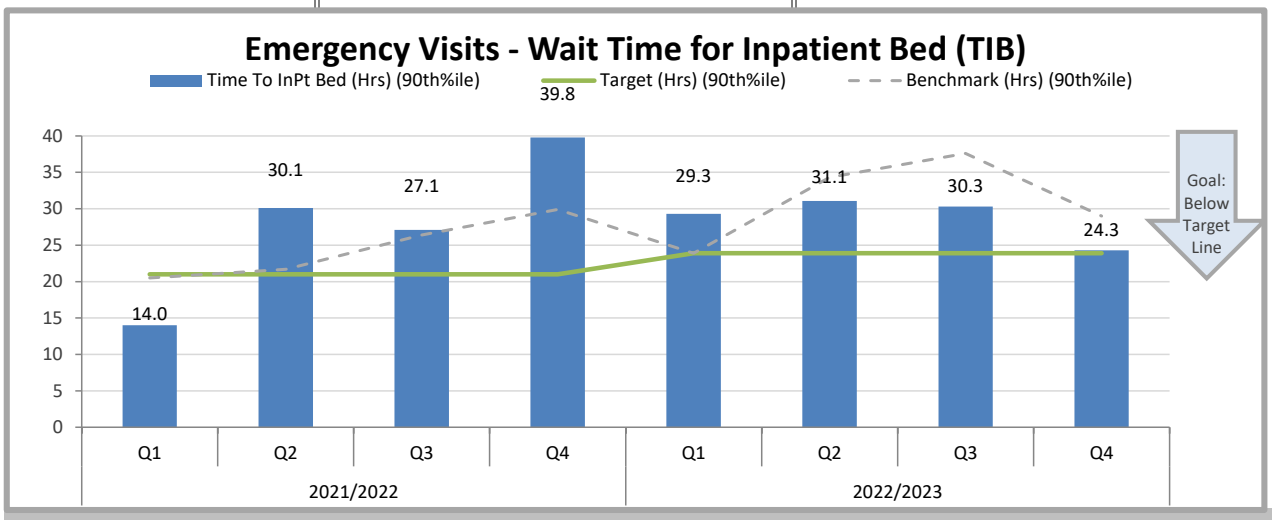
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. The 90th percentile of this indicator represents the maximum length of time that 90% of patients in the ED wait for an inpatient bed or an operating room in the ED.

Data Source: Anzer -NACRS

Target Information: Target set in accordance to QIP indicator. Based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

Benchmark Information: Benchmark set in accordance to QIP indicator. Based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To InPt Bed (Hrs) (90th%ile)	14.0	30.1	27.1	39.8	29.3	31.1	30.3	24.3
Benchmark (Hrs) (90th%ile)	20.5	21.7	26.4	29.9	23.9	34.3	37.6	29.0
Target (Hrs) (90th%ile)	21.0	21.0	21.0	21.0	23.9	23.9	23.9	23.9



Performance Analysis:

Q1 Target not met but trending downward when comparing to Q4 of last fiscal year.

Q2 Target not met this quarter but trending below benchmark hospitals.

Q3 Target not met this quarter, but continue to trend below our benchmark Medium-Volume Community Hospitals.

Q4 Results slightly above target this quarter but continue to trend downwards and below our benchmark Medium-Volume Community Hospitals.

Plans for Improvement:

Q1 In Q1 CCH continued to maintain surge capacity beds to maintain additional inpatient beds. We were unable to occupy inpatient hall way beds on the inpatient units related to Infection Control restrictions. There were multiple COVID-19 outbreaks that impacted the Inpatient flow out of the Emergency Department (ED). We maintained our ED Flow Nurse position which facilitates flow within and out of the ED. Work was done with Decision Support to clarify our use of ED ISO, directly improving our time to inpatient bed.

Q2 In Q2 CCH continued to maintain surge capacity beds to maintain additional inpatient beds through most of this time period. We were still unable to occupy inpatient hall way beds on the inpatient units related to Infection Control restrictions. There were multiple COVID-19 outbreaks that impacted the Inpatient flow out of the Emergency Department (ED). We maintained our ED Flow Nurse position and expanded our Flow Nurse coverage, which facilitates flow within and out of the ED. We have experienced a high number of patients awaiting a bed on our Inpatient Mental Health Unit, attributing to the increase in Time to Inpatient Bed. Similar trends have been experienced across the Province.

Q3 In Q3, CCH continued to maintain surge capacity beds to maintain additional inpatient beds, including both in the Auditorium and beds in the hall way on inpatient units. There were multiple COVID-19 outbreaks that impacted the Inpatient flow out of the Emergency Department (ED). We maintained our ED Flow Nurse position and continued our expanded our Flow Nurse coverage, which facilitates flow within and out of the ED. Similar trends have been experienced across the Province.

Q4 In Q4 CCH continued to maintain surge capacity beds to maintain additional inpatient beds through most of this time period. We were able to utilize hallway beds on the Inpatient Units when seeing increased inpatient volumes. There were multiple COVID-19 outbreaks that impacted the Inpatient flow out of the Emergency Department (ED). We maintained our ED Flow Nurse position and expanded our Flow Nurse coverage, which facilitates flow within and out of the ED. We have experienced a high number of patients awaiting a bed on our Inpatient Mental Health Unit, attributing to the increase in Time to Inpatient Bed. Similar trends have been experienced across the Province. We optimized the use of our apple indicator through this time period. We have had regular discussions with our Patient Flow team to for awareness and improvement of this indicator.

Accountable: Chief of Information and Operating Officer / Manager, Emergency Department

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).

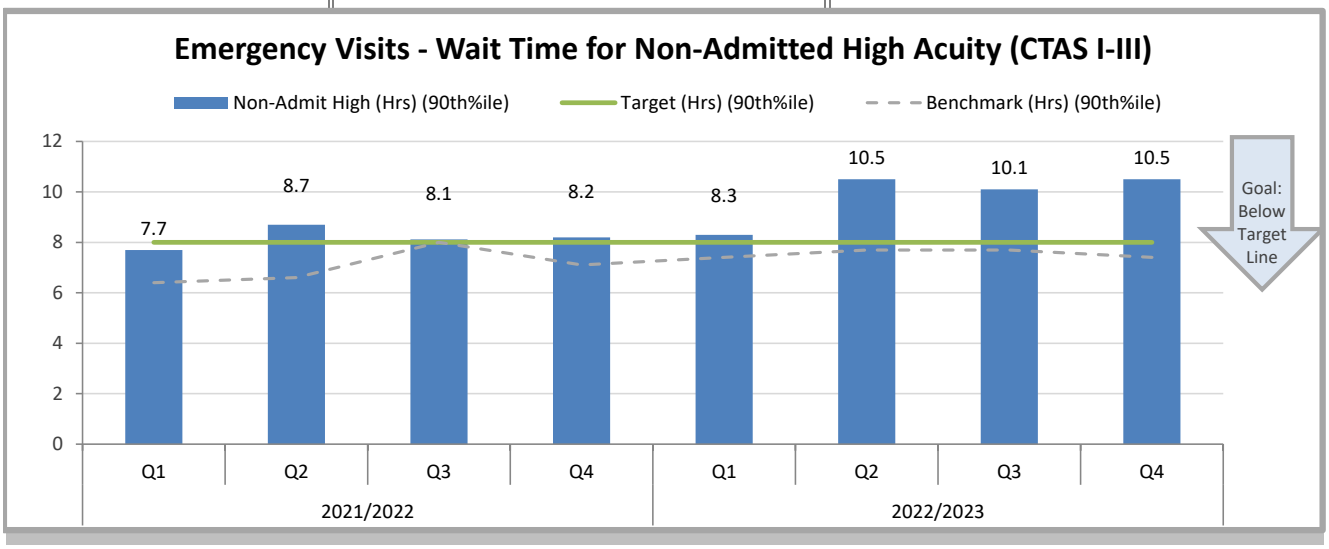
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer -NACRS

Target Information: Target to align with HSAA obligations

Benchmark Information: Benchmark performance is based on ATC ER Fiscal Year Report 'High-Volume Community Hospital Group' results in Q1; effective FY2021-Q2, benchmark performance is based on ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results due to our emergency visits dropping to just under 50,000 visits in FY1920. Benchmark results are presented as a year-to-date value.

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit High (Hrs) (90th%ile)	7.7	8.7	8.1	8.2	8.3	10.5	10.1	10.5
Benchmark (Hrs) (90th%ile)	6.4	6.6	8.0	7.1	7.4	7.7	7.7	7.4
Target (Hrs) (90th%ile)	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0



Performance Analysis:

Q1 Results slightly above target for this quarter. The results for April, May and June respectively are: 8.6 hrs, 8.6 hrs and 9.1 hrs.

Q2 Target not met. The results for July, August and September respectively are: 10.5 hrs, 11.3 hrs and 10.1 hrs.

Q3 Target not met. The results for October, November and December respectively are : 10.2 hrs, 10.7 hrs and 10.2 hrs.

Q4 Target not met. The results for January, February and March respectively are: 10.5 hrs, 9.7 hrs and 10.1 hrs.

Plans for Improvement:

Q1 In Q1 CCH maintained our ED Flow Nurse position. We continued to utilize CDU as appropriate and increased the education and awareness surrounding CDU. We continue to maximize our use of Medical Directives to facilitate a shorter time spent in the ED. The Emergency Department Physician group had staffing challenges which directly affects our wait times.

Q2 In Q2 CCH maintained our ED Flow Nurse position and expanded our Flow Nurse coverage. We continued to utilize CDU as appropriate and increased the education and awareness surrounding CDU. We continue to maximize our use of Medical Directives to facilitate a shorter time spent in the ED. The Emergency Department Physician group had increased staffing challenges which directly affects our wait times. Emphasis has been placed on facilitating safe and timely discharge plans within the ED. Similar trends have been experienced across the Province.

Q3 In Q3 CCH maintained our ED Flow Nurse position and continued our expanded Flow Nurse coverage. We continued to utilize CDU as appropriate and increased the education and awareness surrounding CDU. We continue to maximize our use of Medical Directives to facilitate a shorter time spent in the ED. The Emergency Department Physician group had staffing challenges which directly affect our wait times. Emphasis has been placed on facilitating safe and timely discharge plans within the ED. Similar trends have been experienced across the Province.

Q4 In Q4 CCH maintained our ED Flow Nurse position and expanded our Flow Nurse coverage. We continued to utilize CDU as appropriate and increased the education and awareness surrounding CDU. We continue to maximize our use of Medical Directives to facilitate a shorter time spent in the ED. The Emergency Department Physician group had staffing challenges which directly affects our wait times. Emphasis has been placed on facilitating safe and timely discharge plans within the ED. Similar trends have been experienced across the Province. During this time period funding for a Social Worker in the ED was approved and recruitment is currently in progress-this is anticipated to decrease the length of stay in the ED.

Accountable: Chief of Information and Operating Officer / Chief of Emergency Medicine / Manager, Emergency Department

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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 (whichever is earlier) to patient left ED for non-admitted low acuity (CTAS IV-V) patients. Excludes CDU Length of Stay (LOS).

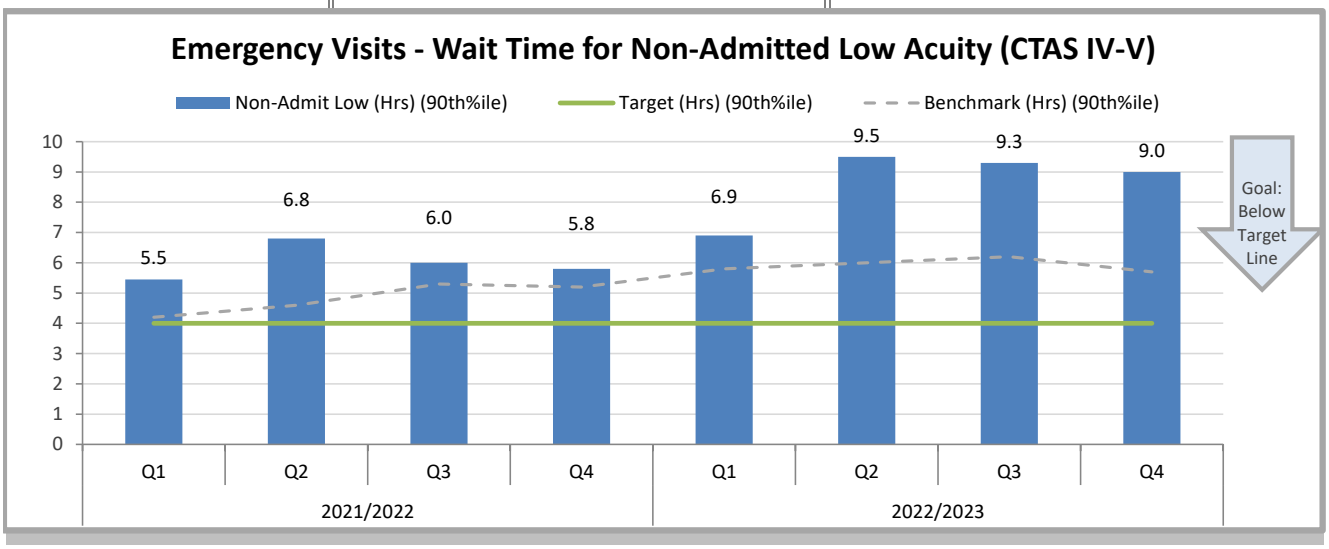
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer -NACRS

Target Information: Target to align with HSAA obligations

Benchmark Information: Benchmark performance is based on ATC ER Fiscal Year Report 'High-Volume Community Hospital Group' results in Q1; effective FY2021-Q2, benchmark performance is based on ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results due to our emergency visits dropping to just under 50,000 visits in FY1920. Benchmark results are presented as a year-to-date value.

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit Low (Hrs) (90th%ile)	5.5	6.8	6.0	5.8	6.9	9.5	9.3	9.0
Benchmark (Hrs) (90th%ile)	4.2	4.6	5.3	5.2	5.8	6.0	6.2	5.7
Target (Hrs) (90th%ile)	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0



Performance Analysis:

Q1 Target not met. The results for April, May and June respectively are: 6.6 hrs, 6.8 hrs and 7.7 hrs.

Q2 Target not met. The results for July, August and September respectively are: 9.3 hrs, 10.7 hrs and 8.3 hrs.

Q3 Target not met. The results for October, November and December respectively are: 9.9 hrs, 9.6 hrs and 8.5 hrs.

Q4 Target not met. The results for January, February and March respectively are: 9.3 hrs, 8.7 hrs and 9.0 hrs.

Plans for Improvement:

Q1 In Q1 we continued to work on our Left Without Being Seen metrics. We continued to maximize our use of Medical Directives to facilitate a shorter time spent in the ED. Our team in the ED is working with our internal stakeholders regarding our patient flow in the ED to decrease time spent in the ED. The Emergency Department Physician group had staffing challenges which directly affects our wait times.

Q2 In Q2 we continued to work on our Left Without Being Seen metrics. We continued to maximize our use of Medical Directives to facilitate a shorter time spent in the ED. Our team in the ED is working with our internal stakeholders regarding our patient flow in the ED to decrease time spent in the ED. The Emergency Department Physician group had increased staffing challenges which directly affects our wait times. Emphasis has been placed on facilitating safe and timely discharge plans within the ED. Similar trends have been experienced across the Province.

Q3 In Q3 we continued to work on our Left Without Being Seen metrics. We continued to maximize our use of Medical Directives to facilitate a shorter time spent in the ED. Our team in the ED is working with our internal stakeholders regarding our patient flow in the ED to decrease time spent in the ED. The Emergency Department Physician group had staffing challenges which directly affects our wait times. Emphasis has been placed on facilitating safe and timely discharge plans within the ED. Similar trends have been experienced across the Province.

Q4 In Q4 we continued to work on our Left Without Being Seen metrics. We continued to maximize our use of Medical Directives to facilitate a shorter time spent in the ED. Our team in the ED is working with our internal stakeholders regarding our patient flow in the ED to decrease time spent in the ED. The Emergency Department Physician group had staffing challenges which directly affects our wait times. Emphasis has been placed on facilitating safe and timely discharge plans within the ED. During this time period funding for a Social Worker in the ED was approved and recruitment is currently in progress-this is anticipated to decrease the length of stay in the ED. We had regular discussions with Diagnostic Imaging (DI) to improve our process and flow within the ED and DI. The ED Working Group has had discussions regarding strategies for improvement. Similar trends have been experienced across the Province.

Accountable: Chief of Information and Operating Officer / Chief of Emergency Medicine / Manager, Emergency Department

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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.

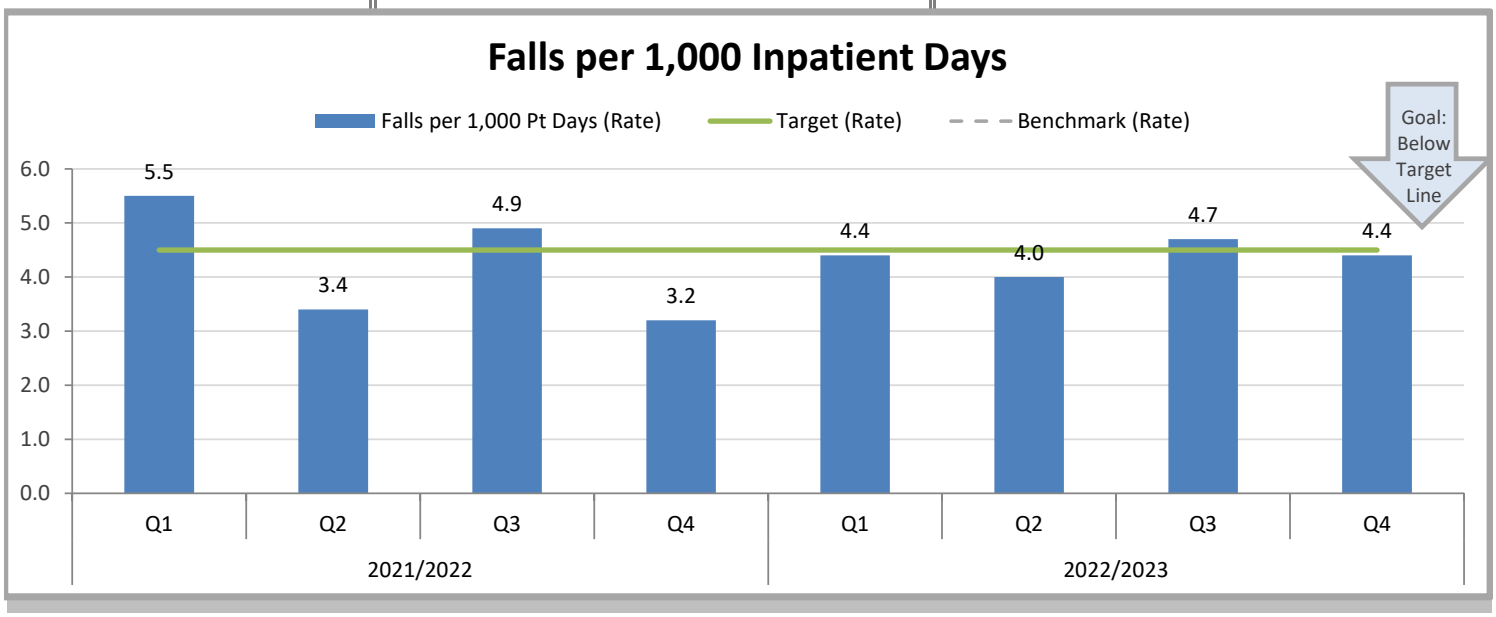
Significance: Falls, while in hospital, increase morbidity and mortality, increased length of stay, and decreased quality of life. Reducing falls indicates success in improving quality. According to Safer Healthcare Now, "A fall is defined as - An event that results in a person coming to rest inadvertently 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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Falls per 1,000 Pt Days (Rate)	5.5	3.4	4.9	3.2	4.4	4.0	4.7	4.4
Benchmark (Rate)								
Target (Rate)	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5



Performance Analysis:

Q1 Target met. All areas remain well within target, except Level 6 South with a falls rate of 10 and Rehab a falls rate of 11 per 1,000 patient days. Noted improved over Q1 prior year.

Q2 Target met. Falls rate decreased over previous quarter - exceeding target rate of 4.5%.

Q3 Target not met; slightly over target. Falls rate increased over previous quarter by 0.7%.

Q4 All nursing units remain within target, except Level 6 South with a rate of 8.3 and Level 1 Med with a rate of 5.8 for this quarter.

Plans for Improvement:

Q1 Falls data monitored/tracked; continues to be a priority for the Senior Friendly Committee. Falls policy and auditing processes under review and will be finalized end of Q2. Improvements to support higher rated areas (i.e. ALC - Level 6 and Rehab) in process.

Q2 Continue plans as per Q1. Decreasing the risk of falls remains a Senior Friendly priority; policy and auditing current processes under revision. Efforts underway to integrate falls data into unit huddles, performance boards, and clinical education to further mitigate potential risk.

Q3 Continue plans as per Q2. Auditing current processes monthly. Falls data and prevention strategies integrated into unit huddles, performance boards, and clinical education.

Q4 Continue plan as per Q3. Falls strategies and review are incorporated into unit huddles; falls auditing process currently in revision.

Accountable: VP, Patient Services and Chief Nursing Officer

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Indicator: Indication of Induction Post-Dates (<41 Weeks) Rate

Strategic Direction: RECOVERY

Definition: The number of women 40 years of age or less, who were induced with an indication for induction of labour of post-dates (≥41 weeks gestation) and were actually less than 41 weeks' gestation (less than or equal to 40 weeks + 6 days gestation), expressed as a percentage of the total number of women who were induced with an indication for induction of labour of post dates (in a given time and place). The numerator is the number of women who were induced with an indication of post-dates and were less than 41 weeks' gestation at delivery. The denominator is the total number of women whose maternal age at still or live birth was <= 40 years and who were induced with an indication of post-dates.

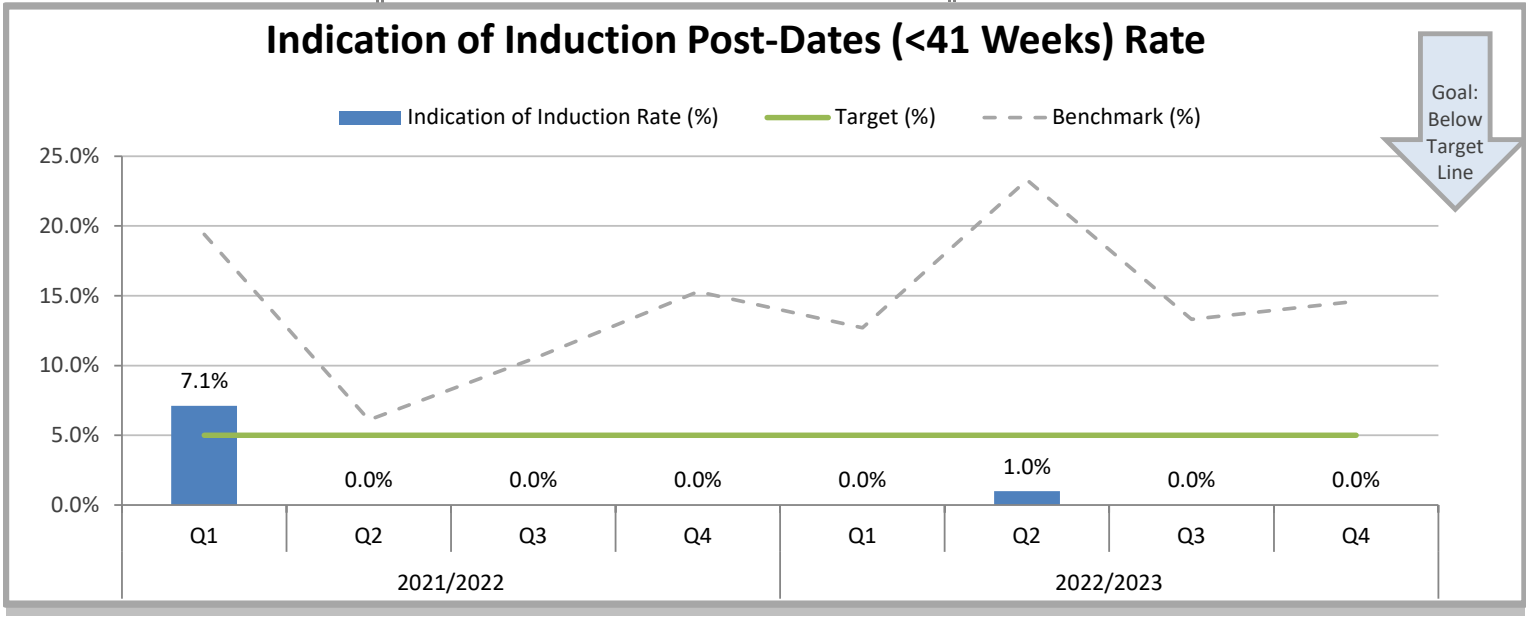
Significance: Inducing labour after the due date slightly lowers the risk of stillbirth or infant death soon after birth compared with watchful waiting. But the overall risk is very low. Induced deliveries may reduce admissions to the neonatal intensive care unit. Pregnant women having induced labour are less likely to have a caesarean section than those who wait for labour to begin naturally. Many pregnancies continue for longer than the average 40 weeks, because of the risks to infants, women are often offered the option of induced labour at between 41 and 42 weeks. However, induction also carries risks to mother and baby, which must be weighed against potential benefits.

Data Source: BORN (Better Outcomes Registry & Network) Ontario; KPI (Key Performance Indicator) 6

Target Information: Target set at 5% based on HSAA obligations

Benchmark Information: Benchmark performance is based on Other Neonatal Level 1 hospitals quarterly performance

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Indication of Induction Rate (%)	7.1%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%
Benchmark (%)	19.4%	6.1%	10.5%	15.3%	12.7%	23.3%	13.3%	14.6%
Target (%)	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%



Performance Analysis:

Q1 Target met. No cases this quarter.
Q2 Target met. No cases this quarter.
Q3 Target met. No cases this quarter.
Q4 Target met. No cases this quarter.

Plans for Improvement:

Q1 Continue current strategies and review results at departmental meetings.
Q2 Continue to perform audits and ongoing team/client education.
Q3 Continue to perform audits and ongoing team/client education.
Q4 Continue to perform audits and ongoing team/client education.

Accountable: VP, Patient Services and Chief Nursing Officer / Chief of OB/GYN / Manager, Women and Children's Health

Return to Dashboard

Indicator: Inpatients Receiving Care in Unconventional Spaces per Day

Strategic Direction: RECOVERY

Definition: This indicator measures the average number of inpatients admitted to bed/stretcher, etc. that is placed in an unconventional space to receive care at 12am. (Excludes patients admitted and discharged within same day). An unconventional space is an area in a hospital, which has been enabled to place beds to provide care to inpatients. Unconventional spaces refer specifically to the placement of a bed in any place spacious enough, i.e. an office, hallways, including hallways in the emergency department or inpatient unit, or auditorium that does not meet the required fire and safety standards. Patients placed in beds in unconventional spaces do not have access to nurse call-bell, washrooms, suction, oxygen, etc.

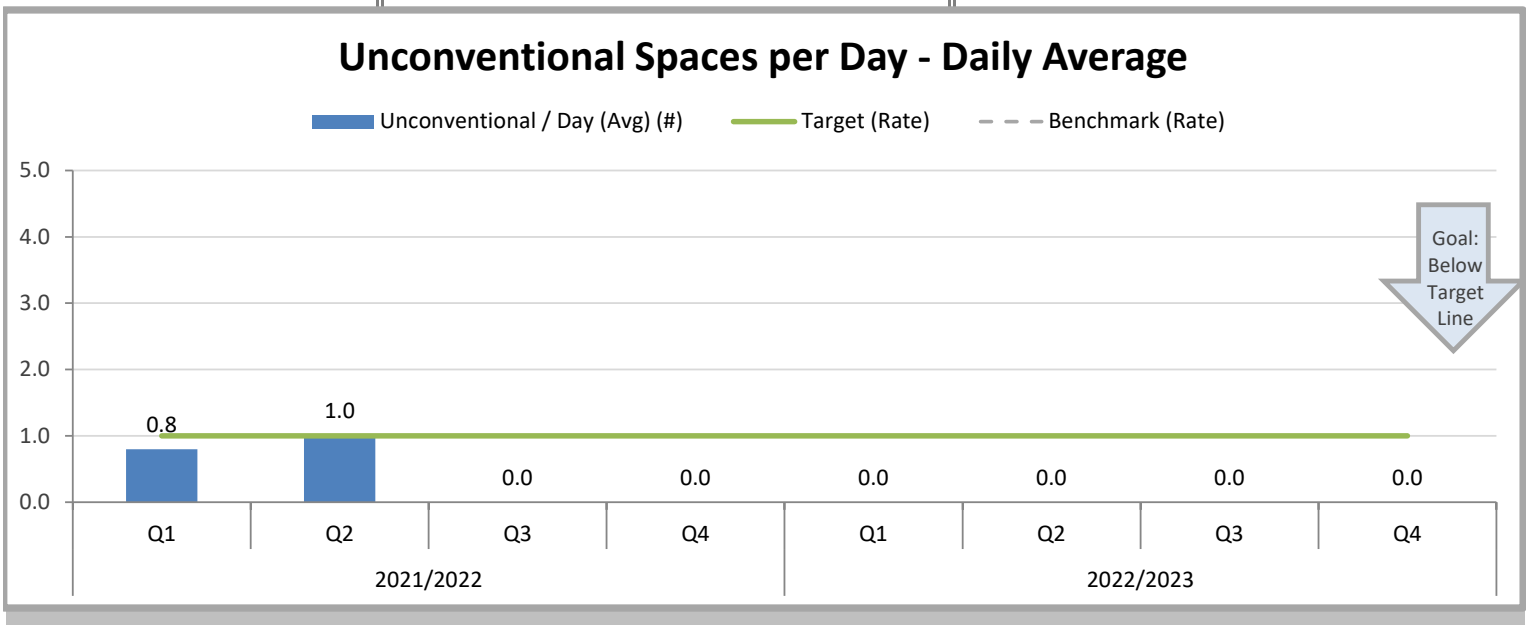
Significance: This indicator provides contextual information on the average number of patients who were admitted into hospitals receiving care in unconventional spaces during the third quarter, 2018/19. This may reflect seasonal surges. The indicator profiles the average number of beds over capacity in Ontario hospitals during this time. In conjunction with other indicators such as time to inpatient bed and the ALC rate, this indicator can be used to monitor a hospital's space capacity and contribute to a better understanding of the issue.

Data Source: Cerner - Discern Analytics (Daily Census Report)

Target Information: Target set internally; in accordance to QIP indicator

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Unconventional / Day (Avg) (#)	0.8	1.0	0.0	0.0	0.0	0.0	0.0	0.0
Benchmark (Rate)								
Target (Rate)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance Analysis:

Q1 Target met.
Q2 Target met.
Q3 Target met.
Q4 Target met.

Plans for Improvement:

Q1 Continue with current process.
Q2 Continue with current process.
Q3 Continue with current process.
Q4 Continue with current process.

Accountable: Chief Information and Operating Officer / Manager, Patient Flow and Bed Management

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 with same or related diagnosis 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.

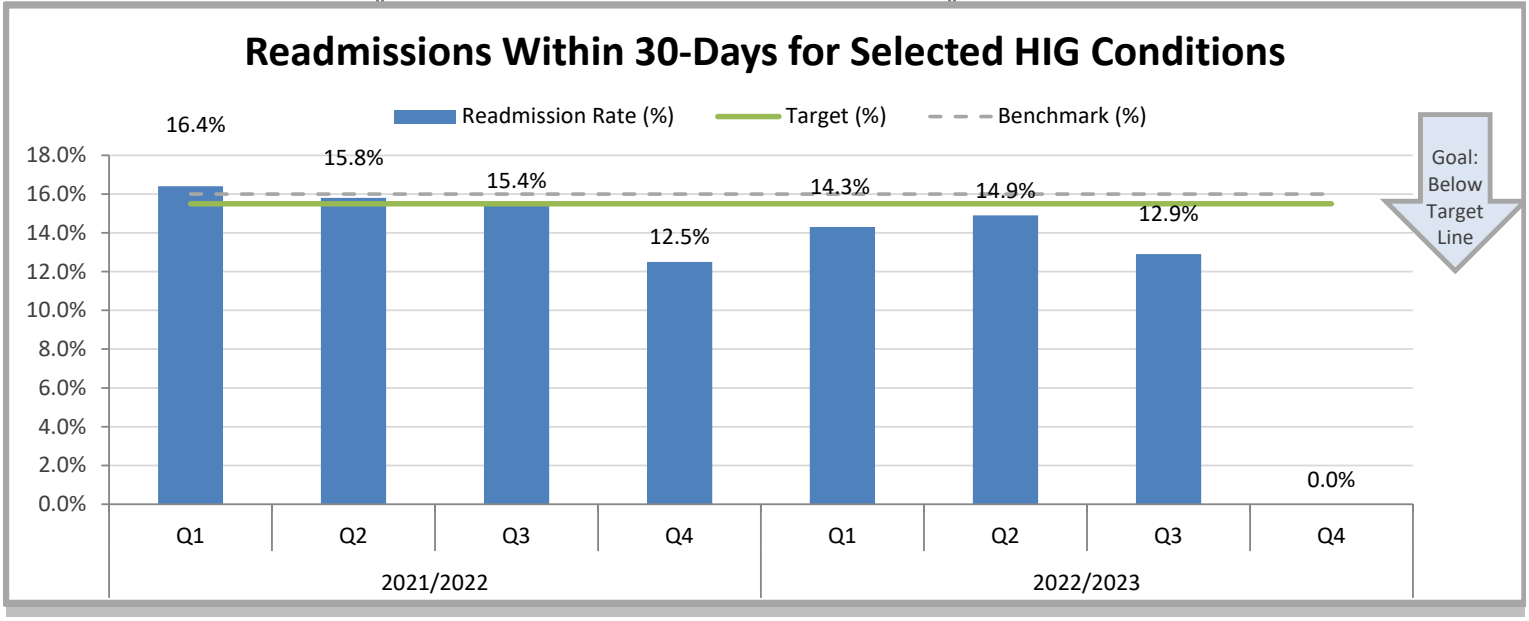
Significance: Unplanned hospital readmissions exact a toll on individuals, families and the health system. Avoidable readmissions remain a system-level issue that is also linked to integration among providers across the continuum of care. If patients get the care they need when and where they need it, 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 is based on HSAA performance standard obligations

Benchmark Information: Benchmark performance is based on our Peer Benchmark Hospitals prior year performance

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	16.4%	15.8%	15.4%	12.5%	14.3%	14.9%	12.9%	N/A
Benchmark (%)	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%
Target (%)	15.5%	15.5%	15.5%	15.5%	15.5%	15.5%	15.5%	15.5%



Performance Analysis:

Q1 Target met. There were a total of 349 applicable discharges with 50 repeats within 30 days for this quarter.
Q2 Target met. There were a total of 284 applicable discharges with 41 repeats within 30 days for this quarter.
Q3 Target met. There were a total of 363 applicable discharges with 45 repeats within 30 days for this quarter.
Q4 Results unavailable due to system failure (Anzer).

Plans for Improvement:

Q1 We continue to monitor the indicator for opportunities for improvement. Patient teaching and follow up post discharge with primary care is a focus of discharge planning.
Q2 Discharging patients with health teaching and discharge follow up instructions including primary care continues with good results. We continue to monitor for other opportunities for improvement.
Q3 To continue with health teaching and discharge follow up instructions and to monitor for other opportunities for improvement.
Q4 N/A

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

Return to Dashboard

Indicator: Repatriate Patients within 48-Hours

Strategic Direction: RECOVERY

Definition: The calculation is based on the number of requests that were repatriated within 2 days (48-hours) of the Requested Transfer Date by the total number of repatriations completed during the reporting period.

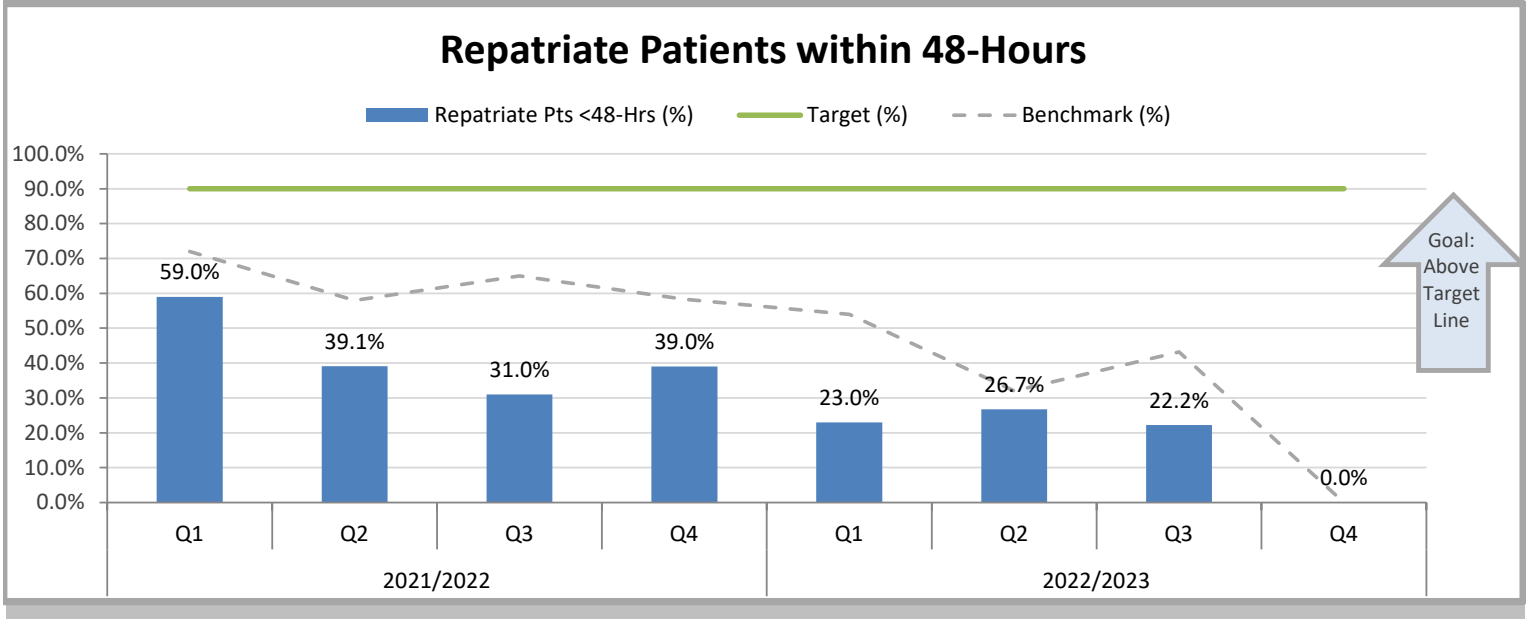
Significance: The process of transferring the patient to his or her referring acute care hospital or to the acute care hospital that is the "closest" to his or her home address once the patient is deemed to be medically stable and/or suitable for transfer. The receiving acute care hospital is determined based on geography and the ability for the patient to receive the required ongoing care.

Data Source: CritiCall Ontario PHRS (Provincial Hospital Resource System)

Target Information: Target is based on HSAA obligations

Benchmark Information: Benchmark performance is based on CritiCall Ontario - Champlain LHIN average quarterly performance

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repatriate Pts <48-Hrs (%)	59.0%	39.1%	31.0%	39.0%	23.0%	26.7%	22.2%	N/A
Benchmark (%)	72.0%	58.0%	65.0%	58.3%	54.0%	32.0%	43.2%	N/A
Target (%)	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Performance Analysis:

Q1 Target not met.
Q2 Target not met.
Q3 Target not met.
Q4 Results unavailable due to system failure.

Plans for Improvement:

Q1 Continued high admitted volumes and Life and Limb status limiting the ability to repatriate within 48 hours. Continue to work with Ottawa Hospitals to prioritize based on floor locations and needs to help with very high volumes, often resulting in repatriations greater than 48 hours. Receiving multiple requests at one, and the need to balance CCH ER admissions. Continue daily repatriations when able.
Q2 Strategies similar to Q1. Continue daily repatriations when able.
Q3 Continue with similar strategies as Q1 and daily repatriations when able.
Q4 N/A

Accountable: Chief Information and Operating Officer / Manager, Patient Flow and Bed Management

Return to Dashboard

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.

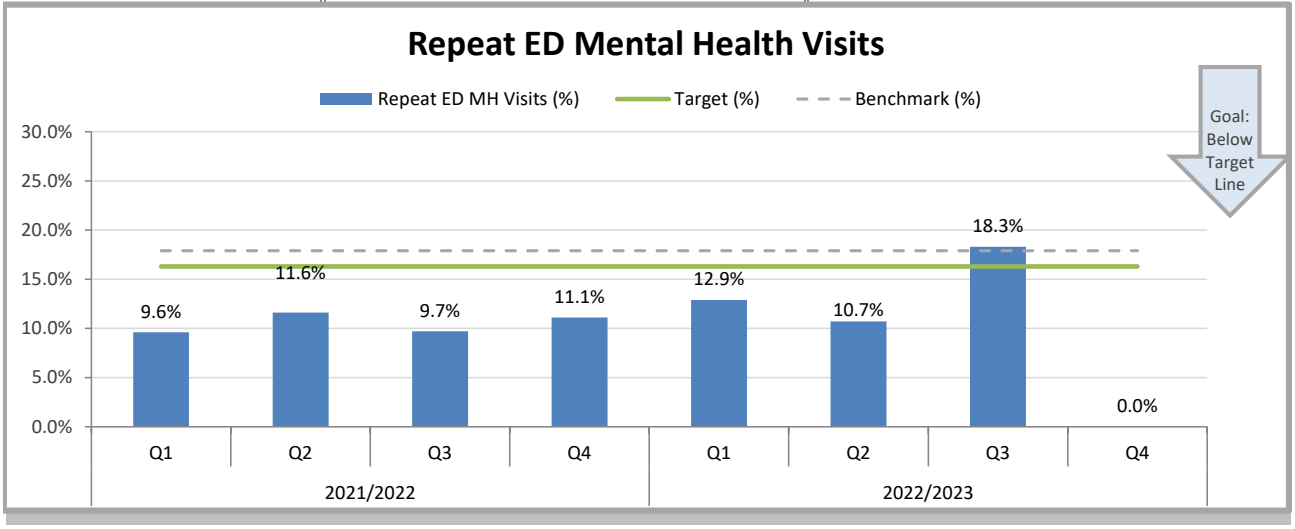
Significance: Repeat emergency visits among those with mental health conditions contribute to emergency visit volumes and wait times. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care. Given the chronic nature of the mental health conditions, 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 to align with 2018-2019 HSAA and MSAA

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED MH Visits (%)	9.6%	11.6%	9.7%	11.1%	12.9%	10.7%	18.3%	N/A
Benchmark (%)	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%
Target (%)	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%



Performance Analysis:

Q1 Data for Q1 is reported on and all coding has been completed. Total visits to the ED for mental health was 294. Of these, 38 were repeat visits representing 12.9% and below our target of 16.3%.

Q2 Data for Q2 is reported on and all coding has been completed. Total visits to the ED for mental health was 270. Of these, 29 were repeat visits representing 10.7% and below our target of 16.3%.

Q3 Data for Q3 is reported on. Total visits to the ED for mental health was 311. Of these, 57 were repeat visits representing 18.3% and slightly above our target of 16.3%.

Q4 Results unavailable due to system failure (Anzer).

Plans for Improvement:

Q1 We continue to work closely with police services in our co-response services which helps divert visits from the ED. The Safe Bed program is well underway and supports ED diversion as well. Will continue to monitor repeat visits in real time and follow-up where needed. Ongoing focus on discharge planning/collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and IMHU.

Q2 As with last quarter, we continue to work/collaborate closely with our Police partners in both co-response and Safe Bed programs which helps divert visits from the ED. As well, will continue to monitor repeat visits in real time and follow-up where needed. Continued focus on discharge planning/collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and IMHU.

Q3 We continue to work/collaborate closely with our Police partners in both co-response and Safe Bed programs to help divert visits from the ED as well as monitoring repeat visits real time and follow-up where needed. Continued focus on discharge planning/collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and IMHU.

Q4 N/A

Accountable: VP, Community Programs / Director, Community Addiction and Mental Health Services

Return to Dashboard

Indicator: Repeat ED Substance Abuse 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 substance abuse condition. The repeat visit must be within 30 days of the 'index' visit (first visit). This is based on the Most Responsible Diagnosis (substance abuse codes - ICD-10) and includes only CCH cases.

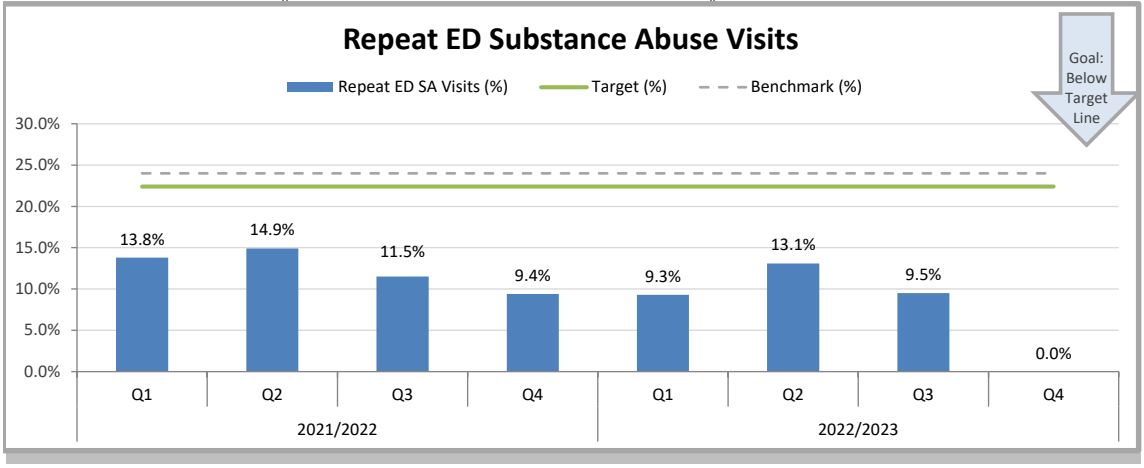
Significance: Repeat emergency visits among those with substance use disorders contribute to emergency visit volumes and wait times. Given the chronic nature of substance use disorders, access to effective community services should reduce the number of repeat unscheduled emergency visits. This indicator attempts to indirectly measure the availability and quality of community services for patients with substance use disorders. Investments in community addictions treatment services are intended to provide supports to those individuals requiring assistance. 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 addictions services.

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

Target Information: Target to align with 2018-2019 HSAA and MSAA

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED SA Visits (%)	13.8%	14.9%	11.5%	9.4%	9.3%	13.1%	9.5%	N/A
Benchmark (%)	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%
Target (%)	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%



Performance Analysis:

Q1 Data for Q1 is reported on and all coding has been completed. Total visits to the ED for substance use was 97. There were 9 repeat visits representing 9.3% and well below our target of 22.4%. Alcohol remained the primary identified substance in repeat visits. Slight increase noted in multiple drug use.

Q2 Data for Q2 is reported on and all coding has been completed. Total visits to the ED for substance use was 99. Of these, 13 were repeat visits representing 13.1% and well below our target of 22.4%. Alcohol remained the primary identified substance in repeat visits with cannabinoids and opioids being identified as well.

Q3 Data for Q3 is reported on. Total visits to the ED for substance use was 105. Of these, 10 were repeat visits representing 9.5% and well below our target of 22.4%.

Q4 Results unavailable due to system failure (Anzer).

Plans for Improvement:

Q1 The collaboration with Recovery Care in utilizing the cwms mobile clinic van continues with the goal of reaching hard to serve individuals. Will continue to engage internal stakeholders to enhance the feasibility of implementing opioid agonist therapy in ED (Rapid Access to Addiction Medicine - RAAM). Will continue ongoing initiatives including: monitor repeat visits in real time and follow-up where needed; continued focus on discharge planning and collaboration between community programs, IMHU and ED; continue to involve NP in cases needing medication to manage withdrawal (when appropriate) to reduce the need to attend ED. Will support Akwesasne where requested in the implementation of the new residential withdrawal management service and develop integrated care pathways as needed.

Q2 Implemented new policy/procedure in CWMS to immediately provide first dose of withdrawal medication protocol (when appropriate). Historically the program could wait up to 2 – 3 hours to receive the prescription from the local pharmacy. This resulted in needing to send clients to the ED if their withdrawal symptoms elevated to levels not manageable in a community service during the wait time. Having the medication immediately available better manages the symptoms and can avoid the need to involve ED. As with last quarter, we continue to support initiatives/collaborations to increase support to hard to reach clients and reduce ED visits including; Recovery Care/cwms mobile clinic van, engaged internal stakeholders to enhance the feasibility of implementing opioid agonist therapy in ED (Rapid Access to Addiction Medicine - RAAM), monitor repeat visits in real time and follow-up where needed, continued focus on discharge planning and collaboration between community programs, IMHU and ED, NP prescribing withdrawal protocols, and supporting Akwesasne where requested in the implementation of the new residential withdrawal management service/develop integrated care pathways as needed.

Q3 New policy/procedure in CWMS to immediately provide first dose of withdrawal medication protocol (when appropriate) in place and operating well. As with last quarter, we continue to support initiatives/collaborations to increase support to hard to reach clients and reduce ED visits including; Recovery Care/cwms mobile clinic van, engaged internal stakeholders to enhance the feasibility of implementing opioid agonist therapy in ED (Rapid Access to Addiction Medicine - RAAM), monitor repeat visits in real time and follow-up where needed, continued focus on discharge planning and collaboration between community programs, IMHU and ED, NP prescribing withdrawal protocols, and supporting Akwesasne where requested in the implementation of the new residential withdrawal management service/develop integrated care pathways as needed.

Q4 N/A

Accountable: VP, Community Programs / Director, Community Addiction and Mental Health Services

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.

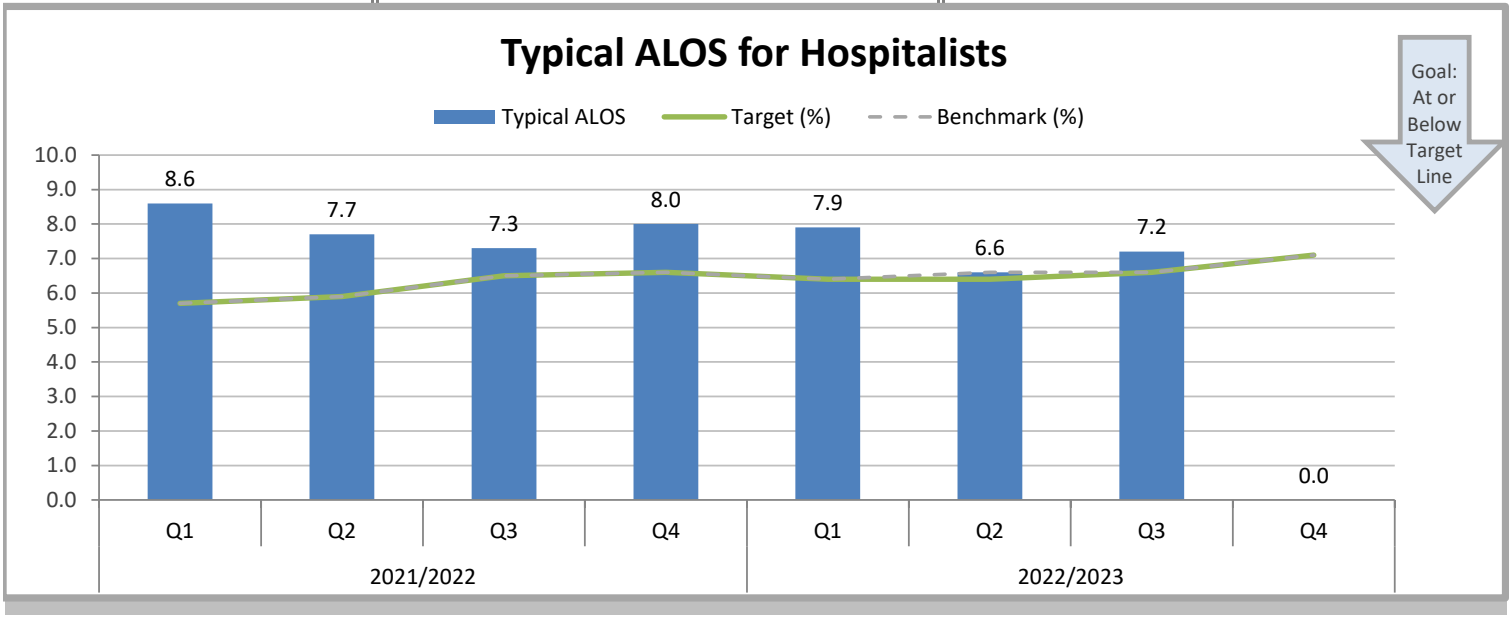
Significance: Be in more in line with our benchmark hospitals.

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 quarter.

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Typical ALOS	8.6	7.7	7.3	8.0	7.9	6.6	7.2	N/A
Benchmark (%)	5.7	5.9	6.5	6.6	6.4	6.6	6.6	7.1
Target (%)	5.7	5.9	6.5	6.6	6.4	6.4	6.6	7.1



Performance Analysis:

Q1 Target not met.

Q2 Although results are slightly above target, there is significant improvement compared to previous quarters. CCH results align with our peer benchmarking hospitals.

Q3 Results are above target for Q3, however when looking at the months separately, the average LOS is trending downward (Oct: 8.2, Nov: 7.2 and Dec: 6.5 days).

Q4 Results unavailable due to system failure (Anzer).

Plans for Improvement:

Q1 Establishing the new role of the medical director discharge team with main duties of: Admission prevention, Post-Discharge follow-up and Discharge facilitation. Kick-off for the two projects aimed at reducing the length of stay such as: Establishing a new team-based model for inpatient care, optimize our discharge services to facilitate patient transitions and ADEPT (Anticipated Discharge Engagement Patient-Centred Teams), transition the hospitalists to a team based model.

Q2 Physician Assistant recruited to assist with ALC patients. Continuous refinement and improvement to the teams model is expected to improve this metric.

Q3 Q3 had an increase in ALC patient discharges which contributes to the increase of the average LOS for hospitalists. Continuing to work with the Hospitalists Team Model is expected to improve the results.

Q4 N/A

Accountable: Chief of Staff / Chief Information and Operating Officer

Corporate Scorecard FY 2022/2023

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.

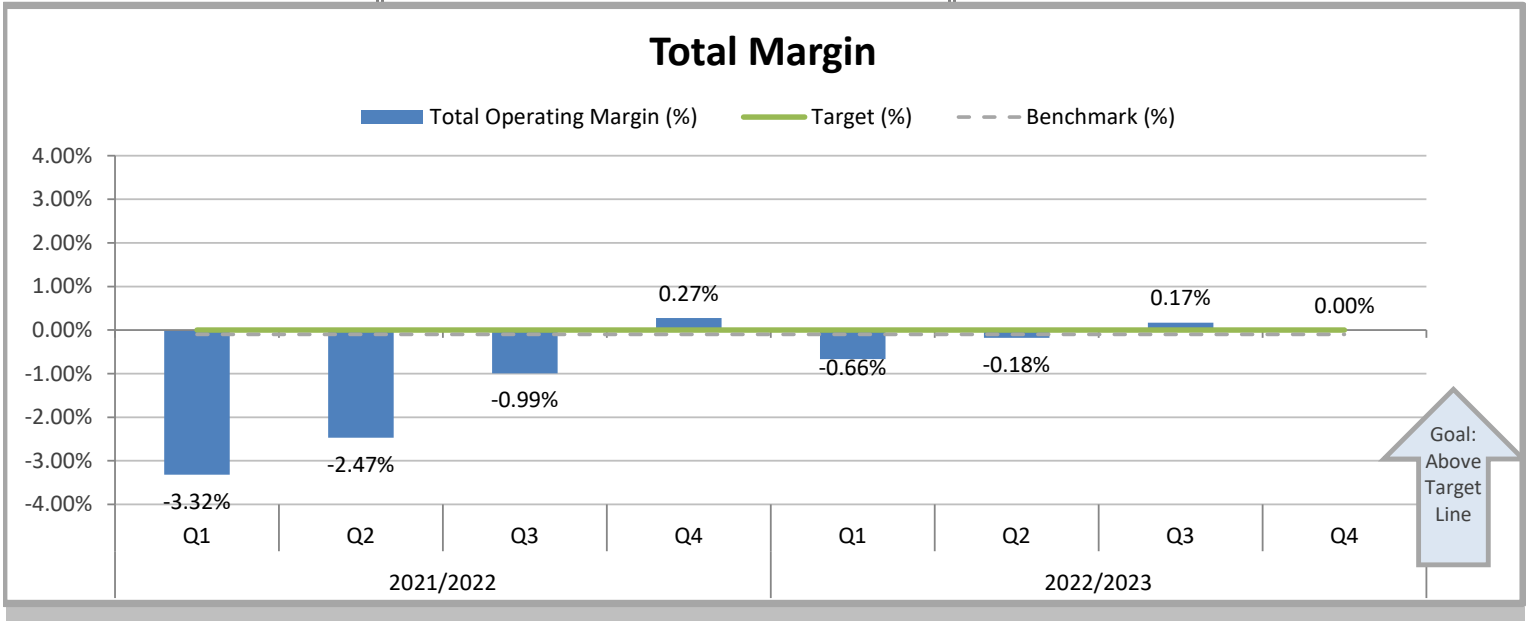
Significance: Indicates a balanced operating position.

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total Operating Margin (%)	-3.32%	-2.47%	-0.99%	0.27%	-0.66%	-0.18%	0.17%	N/A
Benchmark (%)	-0.10%	-0.10%	-0.10%	-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 as a result of continued pandemic pressures, including Health Human Resources (HHR) and occupancy pressures

Q2 Target not met as a result of continued pandemic pressures, including Health Human Resources (HHR) and occupancy pressures

Q3 Target met.

Q4 Results unavailable due to system failure (Virtuo).

Plans for Improvement:

Q1 Actively manage monthly revenues and expenses and leverage additional volume funding.

Q2 Actively manage monthly revenues and expenses and leverage additional volume funding.

Q3 Continue to actively manage monthly revenues and expenses and leverage additional volume funding.

Q4 N/A

Accountable: Chief Financial Officer / Manager, 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).

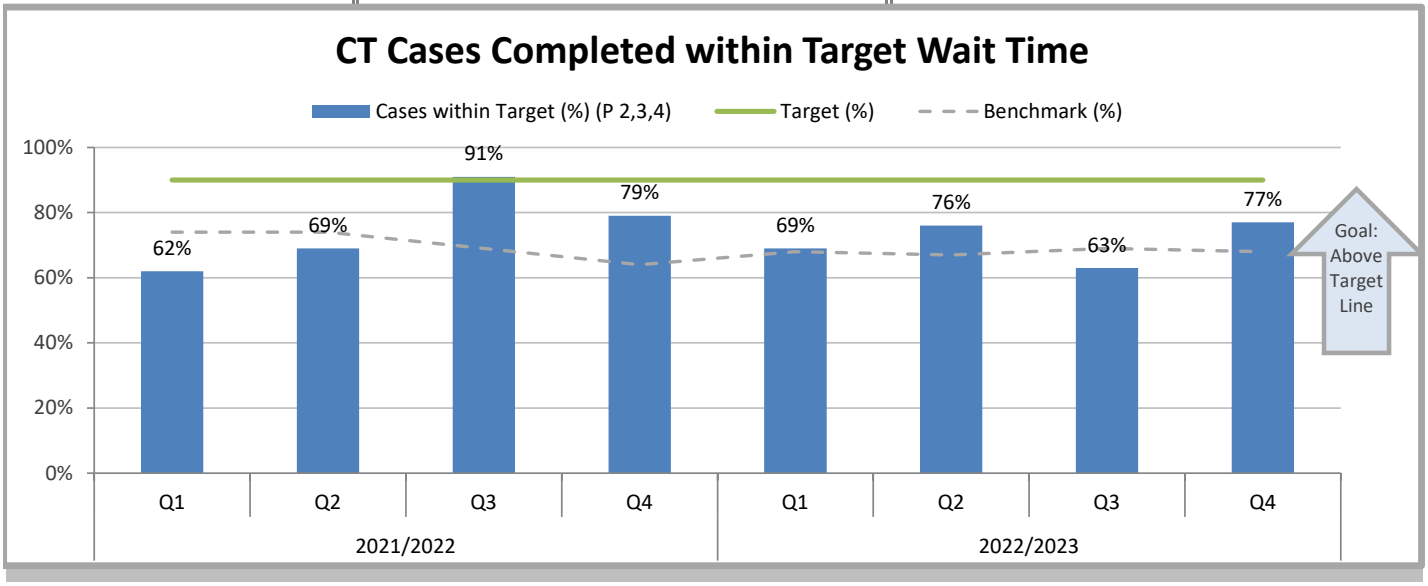
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%) (P 2,3,4)	62%	69%	91%	79%	69%	76%	63%	77%
* Priority 2	100%	97%	99%	96%	97%	98%	99%	82%
* Priority 3	98%	99%	99%	97%	97%	97%	99%	79%
Benchmark (%)	74%	74%	69%	64%	68%	67%	69%	68%
Target (%)	90%	90%	90%	90%	90%	90%	90%	90%



Performance Analysis:

Q1 Metric continues to have the same challenges of demand exceeds capacity when ethically the focus must be given to the higher priority patients in the P2 and P3 categories, little access remains available for the routine studies in the P4 category

Q2 Metric continues to inch closer to target for all CT priorities however resources are still limited and staff are tired but holding in their demonstration towards patient needs. Same day ED demands remain overwhelming.

Q3 The situation in CT remains challenging. Demands far exceed capacity. Resources are still impacted by long term sick leaves and the National MRT shortage for recruiting to fill vacant positions.

Q4 Target not met but there has been an overall increase of 14% since Q3 and remain above our benchmarking hospitals.

Plans for Improvement:

Q1 All efforts for recovery with ongoing recruitment to improve access and expand service to 24/7 are ongoing. Staffing shortages remain a provincial challenge.

Q2 Recruitment remains ongoing but challenging with the national MRT shortage. New graduates from our training program at CCH will be available in early Q4 for employment therefore hiring incentives are being investigated to compete with regional partners. With successful recruitment, 24/7 services will be introduced to further meet demands.

Q3 Recruitment remains ongoing. Initiatives in place to move whatever CT volume can be appropriately rerouted to MRI is underway.

Q4 Staffing remains a challenge with the MRT shortage and ever increasing volumes and demands.

Accountable: Chief Information and Operating Officer / Director, Diagnostic Services

Return to Dashboard

Indicator: Cases Completed within Target Wait Time - Hip Replacement

Strategic Direction: RECOVERY

Definition: The percentage of Hip Replacement Surgery Cases completed within Access Target - Surgery (Wait 2) days (182 days) for patients >=18 years of age. Included in this measurement are those Elective cases reported as being at **Priority Level 2 (Inpatient/Urgent), Level 3 (Semi-Urgent), or Level 4 (Non-Urgent).** This indicators measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted.

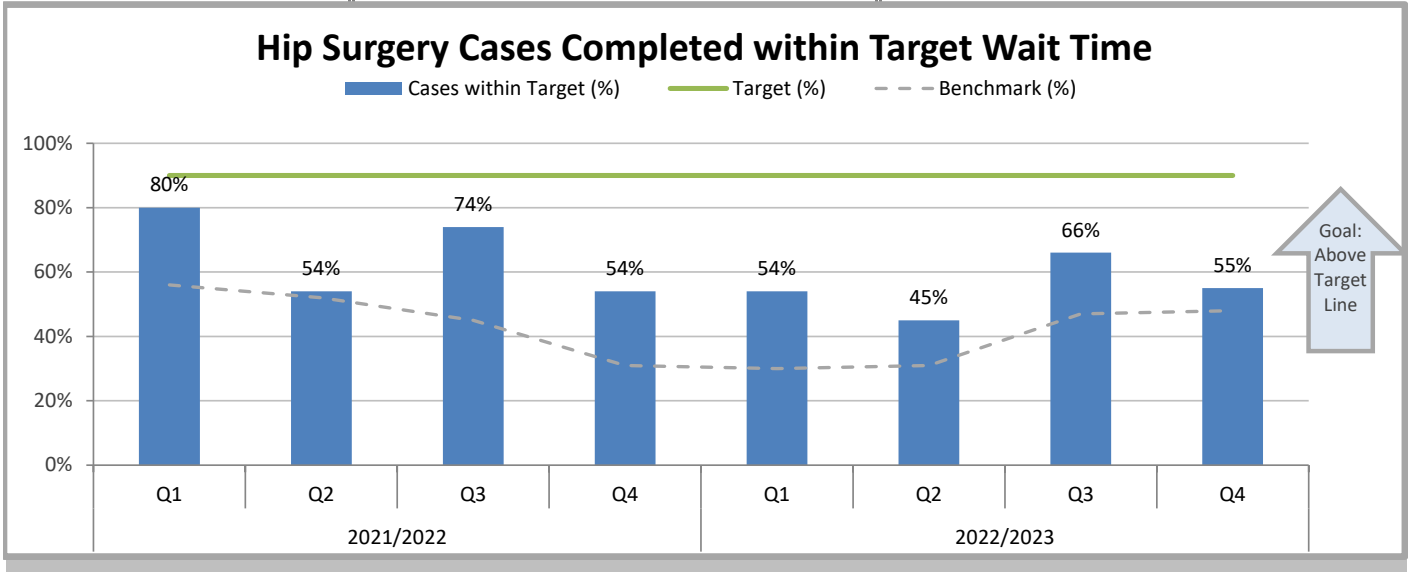
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. It will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	80%	54%	74%	54%	54%	45%	66%	55%
Benchmark (%)	56%	52%	45%	31%	30%	31%	47%	48%
Target (%)	90%	90%	90%	90%	90%	90%	90%	90%



Performance Analysis:

Q1 Wait Times expanded and become longer over the past two years due to COVID and disruptions in the OR operating time. We are currently performing above the benchmark. The OR's were running the first quarter at pre-pandemic levels.

Q2 Continue to have the waitlist build. We continue to perform above the benchmark, have performed more knees than hips this quarter and were down OR rooms by one over the July and August. Up to 100% in the OR for rooms in September, expect this to improve in the 3rd and 4th quarter.

Q3 The waitlist is still long however we are making strides and have improved in wait times over the last quarter.

Q4 Continue to improve this quarter for knee surgeries. More knee surgeries than hips were complete thus the decrease for hips meeting wait times for

Plans for Improvement:

Q1 Currently operating at 94% of pre-pandemic levels with one OR closed over summer to support staff and physician vacations. Back to normal OR functions at the beginning of September. New data to the end of July 2022 shows we are halfway through our allotted volumes for hips and knees which demonstrates that it is expected CCH will overperform on these volumes which in turn will bring the times down.

Q2 The operating rooms ran at 100%, no shut down is planned over the holidays, just a short slow down. Consideration of adding an additional room per week.

Q3 Will continue with current work - this number will improve - the physician who had some very long waits, office has been impressed upon to pull these in first for Surgery to get closer to meeting wait times.

Q4 Will be meeting with physicians offices to reiterate the importance and need to look at long waiters and to move them to the front of the list and to reassess the entries still on the list. Continue with the same number of surgeons and expect to outperform QBP volumes again this fiscal year.

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 - Knee Replacement

Strategic Direction: RECOVERY

Definition: The percentage of Knee Replacement Surgery Cases completed within Access Target - Surgery (Wait 2) days (182 days) for patients >=18 years of age. Included in this measurement are those Elective cases reported as being at **Priority Level 2 (Inpatient/Urgent), Level 3 (Semi-Urgent), or Level 4 (Non-Urgent)**. This indicators measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted.

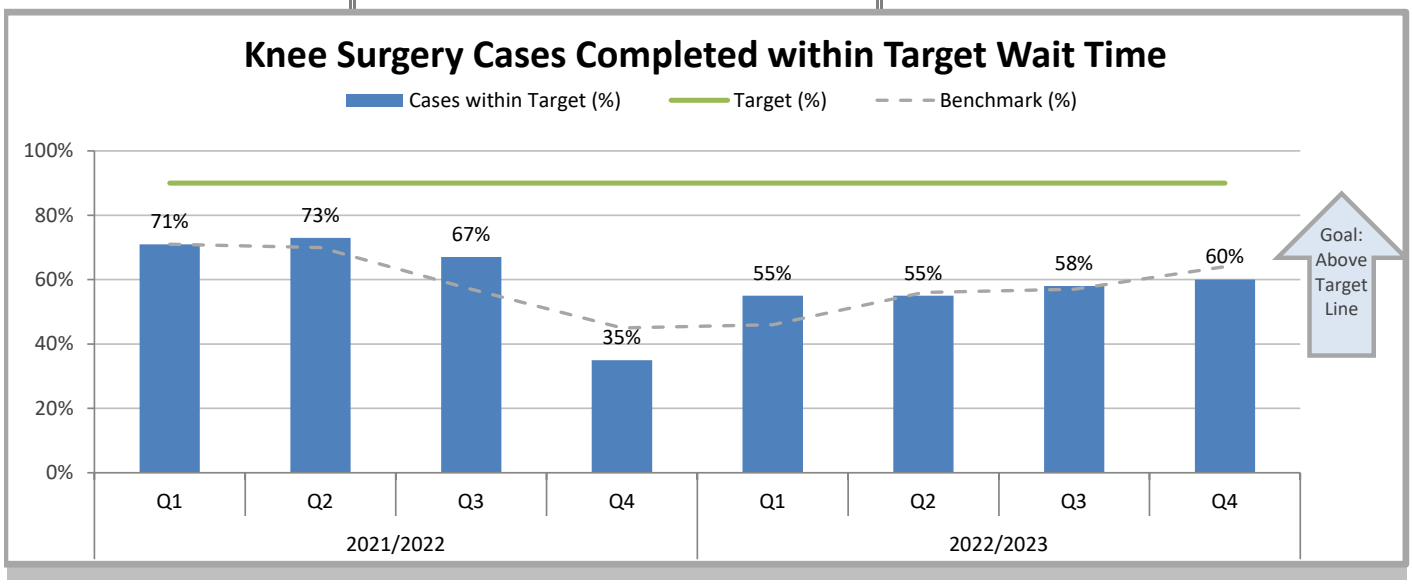
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. It will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	71%	73%	67%	35%	55%	55%	58%	60%
Benchmark (%)	71%	70%	57%	45%	46%	56%	57%	64%
Target (%)	90%	90%	90%	90%	90%	90%	90%	90%



Performance Analysis:

Q1 Wait Times expanded and become longer over the past two years due to COVID and disruptions in the OR operating time. We are currently performing above the benchmark. The OR's were running the first quarter at pre-pandemic levels.

Q2 Continue to have the waitlist build. We continue to perform above the benchmark, have performed more knees than hips this quarter and were down OR rooms by one over the July and August. Up to 100% in the OR for rooms in September, expect this to improve in the 3rd and 4th quarter

Q3 Continue to improve over each quarter and expect Q4 to improve more.

Q4 Continue to improve this quarter for knee surgeries. More knee surgeries than hips were complete thus the decrease for hips meeting wait times for Q4.

Plans for Improvement:

Q1 Currently operating at 94% of pre-pandemic levels with one OR closed over summer to support staff and physician vacations. Back to normal OR functions at the beginning of September. New data to the end of July 2022 shows we are halfway through our allotted volumes for hips and knees which demonstrates that it is expected CCH will overperform on these volumes which in turn will bring the times down.

Q2 The operating rooms ran at 100%, no shut down is planned over the holidays, just a short slow down. Consideration of adding an additional room per week.

Q3 Have discussed with the offices to ensure they are booking the longest waits first, expect to see even better improvement in Q4 and we are exceeding our QBP targets.

Q4 Will be meeting with physicians offices to reiterate the importance and need to look at long waiters and to move them to the front of the list and to reassess the entries still on the list. Continue with the same number of surgeons and expect to outperform QBP volumes again this fiscal year.

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

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).

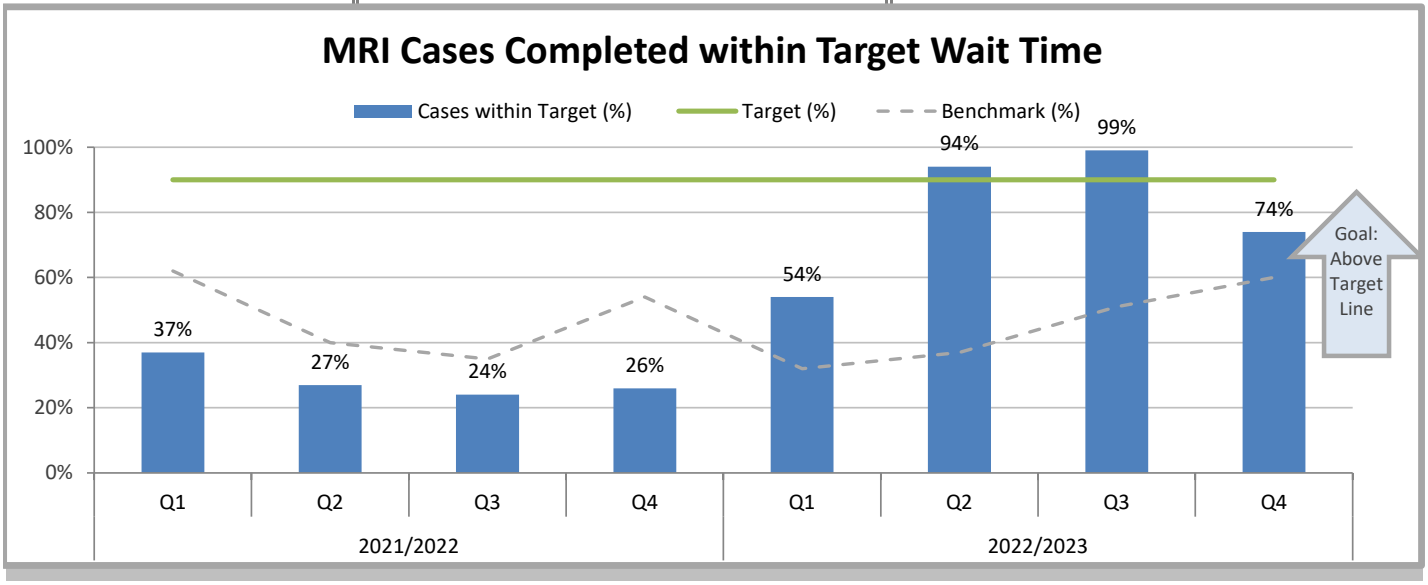
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	37%	27%	24%	26%	54%	94%	99%	74%
* Priority 2	100%	98%	98%	96%	100%	96%	98%	100%
* Priority 3	98%	97%	89%	97%	100%	94%	98%	96%
Benchmark (%)	62%	40%	35%	54%	32%	37%	51%	60%
Target (%)	90%	90%	90%	90%	90%	90%	90%	90%



Performance Analysis:

Q1 Results of the metric is in question. Wait time is less than a month and should be reflected in the data that the target of P4 cases completed within 28 days has been achieved.
Q2 Target achieved
Q3 Target achieved and holding
Q4 Target not met. Results continue to be above our benchmarking hospitals.

Plans for Improvement:

Q1 Departmental review of data collection and calculations in consultation with Decision Support ongoing.
Q2 Recovery efforts achieved. Focus is now on ensuring recovery initiatives are sustainable and staffing resources are supported for retention given the
Q3 Close monitoring to ensure sustainability now that targets achieved.
Q4 Slight dip in performance as we shifted several CT P4 cases over to MRI when it was appropriate to do so.

Accountable: Chief Information and Operating Officer / Director, Diagnostic Services

Indicator: Alternate Level of Care (ALC) Rate

Strategic Direction: INTEGRATION

Definition: The percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment. The calculation is the total number of inpatient days designated as ALC for patients in acute beds discharged in a given time period divided by the total number of acute inpatient days in a given time period x 100. (Includes Pediatric Days).

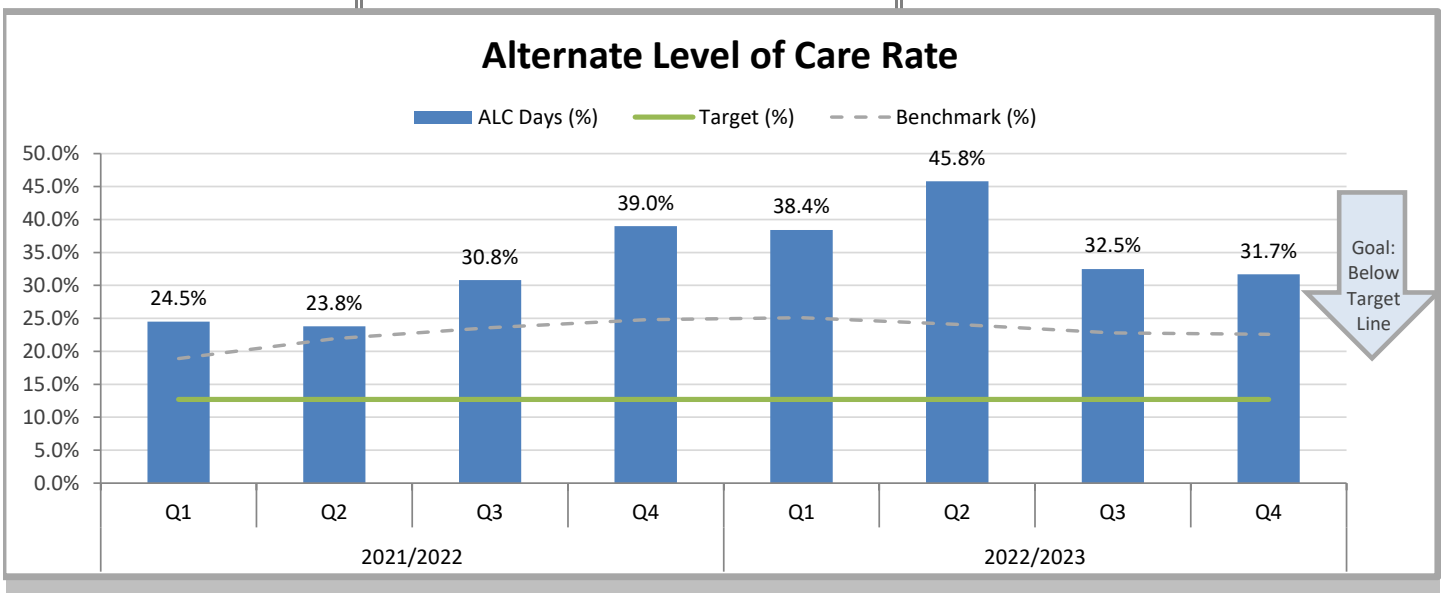
Significance: Cornwall Community Hospital will continue to identify and implement additional strategies with Champlain health care providers to reduce alternate level of care days.

Data Source: Numerator Data Source: Cancer Care Ontario-Wait Time - ALC data
Denominator Data Source: Bed Census Summary (General Ledger) - Inpatient Days

Target Information: Target rate is standardized according to HSAA specifications

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Days (%)	24.5%	23.8%	30.8%	39.0%	38.4%	45.8%	32.5%	31.7%
Benchmark (%)	18.9%	21.9%	23.6%	24.8%	25.1%	24.1%	22.8%	22.6%
Target (%)	12.7%	12.7%	12.7%	12.7%	12.7%	12.7%	12.7%	12.7%



Performance Analysis:

Q1 Target not met. Increased volumes of ALC patients awaiting appropriate destinations is a factor that is contributing to this quarter. Minimal decrease from prior quarter.

Q2 Target not met; ALC numbers exceed previous quarter. Increased volumes as well as outbreaks a factor contributing to discharge delays and transitions.

Q3 Target no met: ALC rate decreased from previous quarter by 13.3%. Increased volumes remain a factor.

Q4 Target not met.

Plans for Improvement:

Q1 Continue to meet with key stakeholders to identify appropriate destinations (i.e., Joint Discharge Review). Working on plans to support a new Team-Based Model of Care; this will allow for consistency in discharge processes and identifying patients at risk prior to ALC designation.

Q2 Continue plans as per Q1. The Team-Based Model of Care has been implemented; daily discharge rounds also occurring to support discharge readiness as well as the identification of therapies required to minimize the risk of ALC designation. Ongoing efforts with regional stakeholders in place to support patient transitions (i.e. Joint Discharge Review meetings).

Q3 Continue plans as per Q2. The Team-Based Model of Care supports consistency in treatment plans; discharge readiness strategies continue to be the focus. In Q4, CCH will partner with Bay shore HealthCare to extend services with the CCH@Home program; this initiative assists frail older adults transition safely out of hospital with care services up to 16 weeks.

Q4 Continue plan as per Q3. ALC rates have decreased in Q4 as a result of increased access to community resources (i.e. LTC beds, etc.).

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

Indicator: Discharge Summary Sent from Hospital to Primary Care Provider Within 48 Hours of Discharge

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of patients discharged from hospital for which discharge summaries are delivered to their primary care provider (PCP) within 48 hours of patient's discharge from hospital.

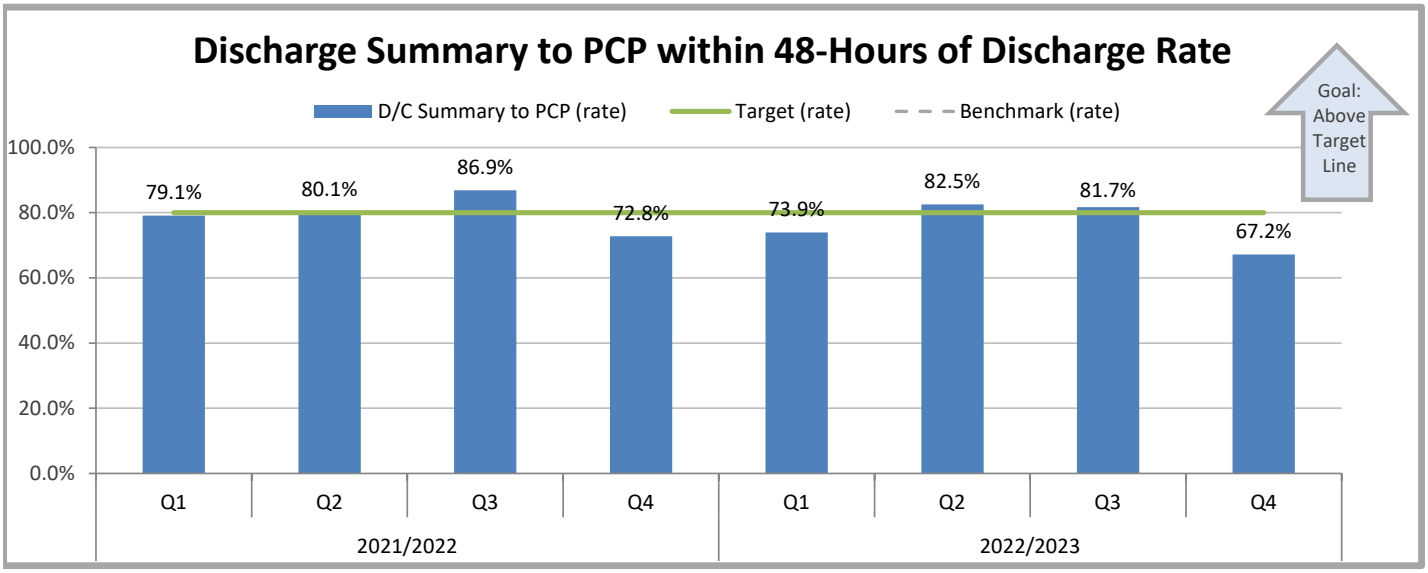
Significance: Health Quality Ontario (HQO) explains "Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow-up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up."

Data Source: Cerner - Discern Analytics, Electronic Health Record

Target Information: Target is set internally at 80.0% in accordance to QIP indicator

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
D/C Summary to PCP (rate)	79.1%	80.1%	86.9%	72.8%	73.9%	82.5%	81.7%	67.2%
Benchmark (rate)								
Target (rate)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Performance Analysis:

Q1 Results slightly below target. There were a total of 1348 applicable discharges with 996 completed within 48 hours for Q1.

Q2 There was an 11% increase in performance between Q1 and Q2.

Q3 Target met. There were a total of 1332 applicable discharges with 1088 completed within 48 hours for Q3.

Q4 Results have fallen below target for this quarter, with 932 of 1386 applicable discharges completed within 48 hours. The results for January, February and March are 76.9%, 69.2% and 56.7% respectively indicating a strong trend in performance decline.

Plans for Improvement:

Q1 Performance remains below target. Several new discharge support processes (i.e. post-discharge follow up clinic, enhanced discharge planning) will be implemented over Q2 and Q3. We anticipate these to have very favourable impacts on this indicator and look forward to being able to provide our external partners with timely access to the information they need.

Q2 As anticipated, the discharge support processes implemented in Q2 appear to have had a positive impact on this indicator. Plan to continue implementation and optimization of these new processes.

Q3 Continue to monitor the implemented discharge support processes.

Q4 Current compliance workflow is a highly manual process for reminding physicians to complete their outstanding summaries; reminders are already present in their worklist in Millennium, the compliance reminders are a 'nag' process. HIS will investigate methods to incentivise or assist in the completion of summaries to improve adherence.

Accountable: Chief Information and Operating Officer / Manager, Health Information 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 and signatures) charts. Report is generated on the last business day of each quarter.

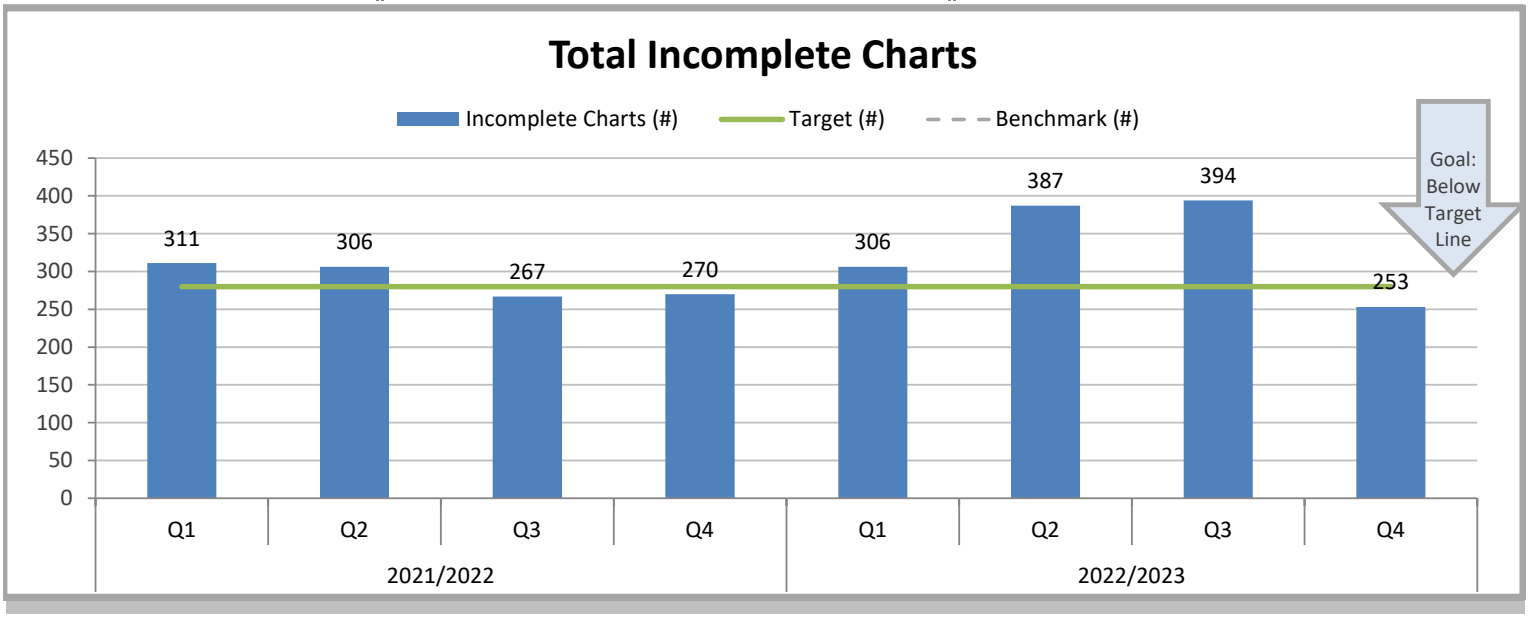
Significance: The purpose of this policy is to ensure that patient health records are completed in accordance with legal requirements, including the Public Hospitals Act (PHA) and Hospital Management Regulation 965 (Regulation), professional obligations, as well Hospital by-Laws, policies, rules and 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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incomplete Charts (#)	311	306	267	270	306	387	394	253
Benchmark (#)								
Target (#)	280	280	280	280	280	280	280	280



Performance Analysis:

Q1 Performance slightly above target.
Q2 Target not being met.
Q3 Target not met this quarter.
Q4 Target met.

Plans for Improvement:

Q1 Communication with physicians >10 incomplete has occurred. Discussion/reminder will occur at September MAC meeting.
Q2 Discussion held at MAC meeting in November. These charts will be completed; as it is a requirement of annual credentialing of professional staff.

Q3 Significant improvement since the end of Q3. Target is now met weekly.
Q4 Continue with regular monitoring to ensure target is met.

Accountable: President and Chief Executive Officer / Chief of Staff

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).

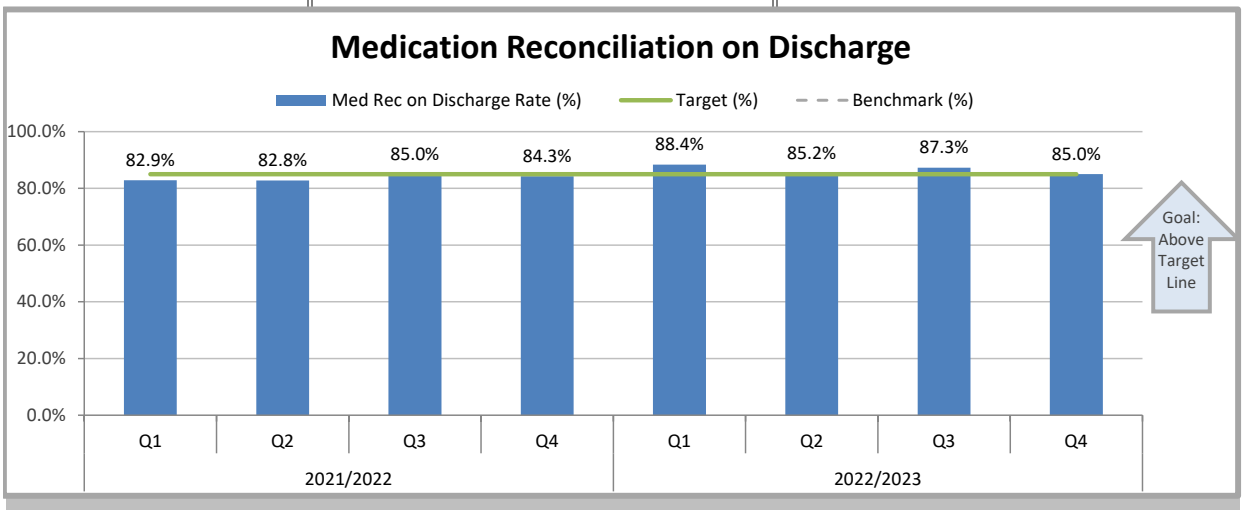
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a 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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	82.9%	82.8%	85.0%	84.3%	88.4%	85.2%	87.3%	85.0%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Above target at 88.4% this quarter.

Q2 Target met. L6S improved substantially, sitting below target at 78% in Q1 and now up to 93% in Q2.

Q3 The overall target met this quarter at 87.3%.

Q4 The overall target was met this quarter.

Plans for Improvement:

Q1 Target met. There were a total of 940 medication reconciliations on discharge completed out of the 1063 total discharges.

Q2 L2 Med, L2 Surg and L4 Psych are below target. Discussed with the unit managers who will bring this forward to the physicians at their next meeting, to highlight the importance. Level 4 Psych expects some improvements now that they have more consistent inpatient physician coverage. The Unit Manager reached out to psychiatrists to better understand what caused the decline and to plan how it will be addressed. It was discussed that discharges <24hrs from admission are to be excluded from the audit. Education to be provided to psychiatry team on the importance of discharge med recs being completed.

Q3 Meeting target overall this quarter. L4 MH is sitting at 72.7%; continue to work with the department to ensure compliance with Med Rec on discharge. From discussion, it seems the Med Rec on discharge that are not being completed are those leaving AMA or who are not on any meds. These two instances still require a Med Rec on discharge. Working with Decision Support to obtain more details on the three departments below target (L4 MH, Level 2 Surg and Level 6 S) to audit the types of discharges.

Q4 We were successful at improving the target for L4P (Q3 = 72.7%, Q4 = 85.4%). This is a great improvement. Outstanding units sitting below target are L6S (83.7%) and L2S (77%). Discussed L2S's and L6S results with the Managers and this will be added as a point of discussion to review with the physicians at their next meeting, identify any gaps and discuss the importance of this being completed for all discharges.

Accountable: Chief Information and Operating Officer / Chief of Staff

Return to Dashboard

Indicator: Same Day Discharge (D/C) to Home Care Rate

Strategic Direction: INTEGRATION

Definition: The hospital will improve notice time for hospital discharge to home care. The hospital will achieve a rate of <=35% for patient referred to home care on same day of hospital discharge by March 31, 2020. This will be measured through periodic homecare referral snapshots. (Acute care only).

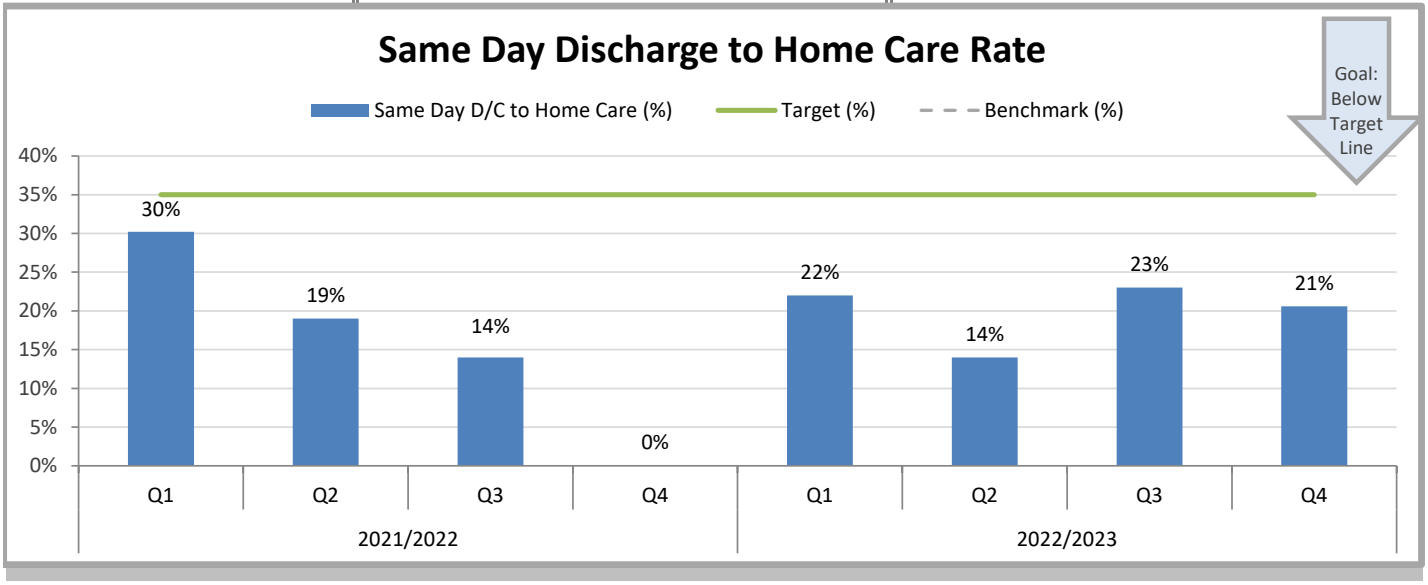
Significance: Effective transition from acute care to community care is an essential element of high quality patient care and is a core business of hospitals and Community Care Access Centres (CCACs). Transition planning is most effective when hospitals, community providers and primary care physicians work together to coordinate care for patients. The journey home for a patient after hospital admission is challenging; poor transitions increase the risk of complications and can put a strain on the system. It's a sensitive time with potential for miscommunication despite the fact that patients and care providers all want it to go smoothly and error free. Having strong processes between hospital and community-based teams is critical to ensuring a seamless care transition.

Data Source: Cerner electronic health record and Anzer -DAD (Discharge Abstract Database)

Target Information: Target to align with HSAA obligations

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Same Day D/C to Home Care (%)	30%	19%	14%	N/A	22%	14%	23%	21%
Benchmark (%)								
Target (%)	35%	35%	35%	35%	35%	35%	35%	35%



Performance Analysis:

Q1 Target met for this quarter.
Q2 Target met.
Q3 Target met.
Q4 Target met.

Plans for Improvement:

Q1 Continue with current strategies and reviewing performances.
Q2 Continue with current strategies and reviewing performances.
Q3 Continue with current strategies and reviewing performances.
Q4 Continue with current strategies and reviewing performances.

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

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.

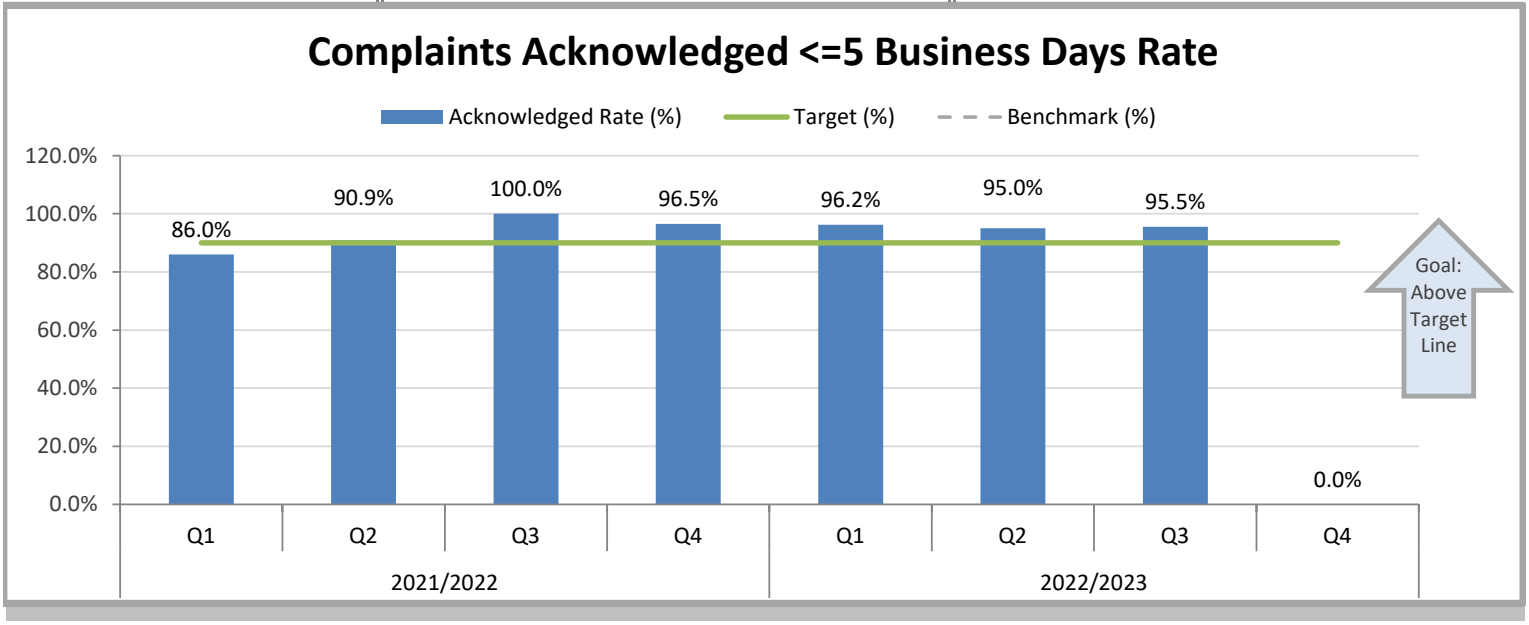
Significance: This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint. This indicator is calculated on the number of complaints received in the reporting period. By regulation, hospitals must acknowledge complaints within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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acknowledged Rate (%)	86.0%	90.9%	100.0%	96.5%	96.2%	95.0%	95.5%	N/A
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 a total of 75 complaints acknowledged out of 78 complaints for Q1.
Q2 Target met. There were a total of 35 complaints acknowledged out of 37 complaints for Q2.
Q3 Target met. There were a total of 43 complaints acknowledged out of 45 complaints for Q3.
Q4 Results unavailable due to system failure (RL Solutions).

Plans for Improvement:

Q1 Continue monitoring performance.
Q2 Continue monitoring performance.
Q3 Continue monitoring performance.
Q4 N/A

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

Indicator: Indigenous Cultural Awareness

Strategic Direction: PEOPLE

Definition: The percentage of people (including staff, students, physicians, and volunteers) who participated in Indigenous training over the total number of people. Denominator is set at 1,000 people. Performance is cumulative year-to-date.

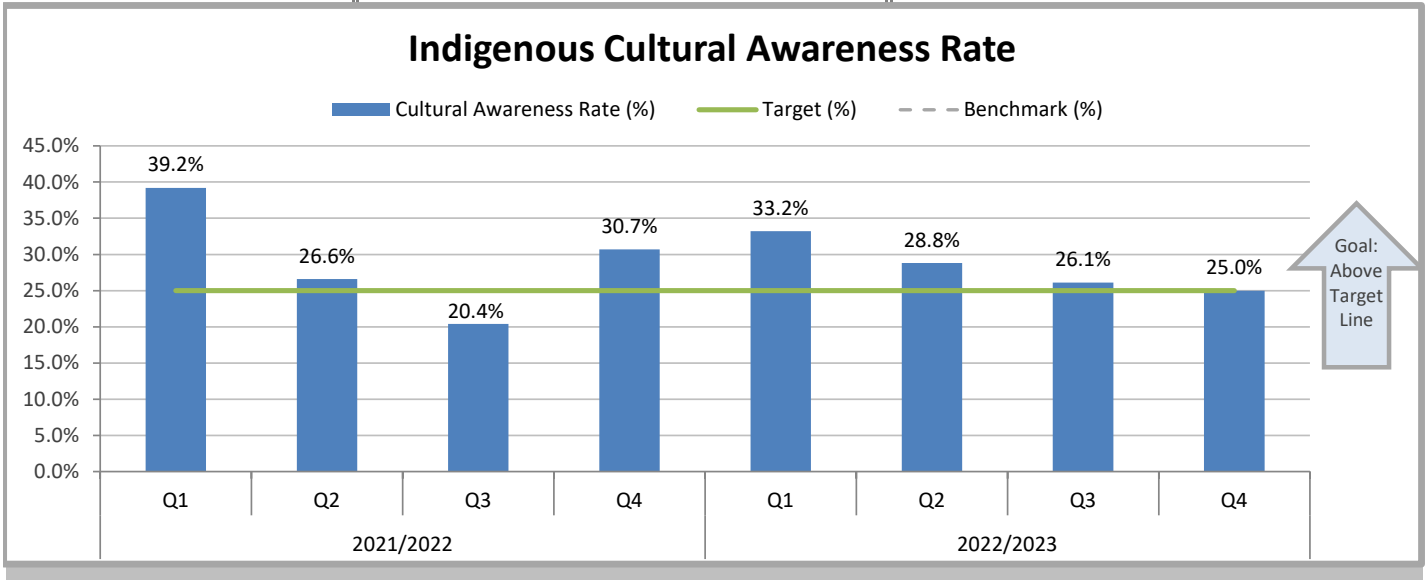
Significance: As part of our CCH Strategic Plan for 2016-2021, it identifies that CCH will partner with experts and our peers to foster a climate of culture competency. We will increase access to training with a focus on frontline staff, create a policy on smudging and plan to do at least one smudging ceremony, offer sessions that are more available to front line staff, and make reports available to managers and Chief of staff with number of participants. The Champlain Indigenous Health Circle Forum (Circle) works closely with the LHIN to improve health outcomes for Indigenous peoples across the region. The work of the Circle helps inform the LHIN on Indigenous health issues and needs and contributes to program planning and implementation. Circle activities include regular meetings focused on planning and engagement, and participation in training and other events.

Data Source: Internal Tracking. Reported cumulatively year-to-date.

Target Information: Target is set at 25.0% in accordance to HSAA Obligation

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cultural Awareness Rate (%)	39.2%	26.6%	20.4%	30.7%	33.2%	28.8%	26.1%	25.0%
Benchmark (%)								
Target (%)	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%



Performance Analysis:

Q1 Target met .
Q2 Target met.
Q3 Target met.
Q4 Target met.

Plans for Improvement:

Q1 Continue with current strategy.
Q2 Continue with current strategy.
Q3 The hospital in partnership with the Cornwall Police Services have jointly hired an EDI Coordinator to enhance awareness and lead education sessions for all staff.
Q4 Continue with current strategy.

Accountable: Chief Human Resources Officer / Manager, Human Resources

Return to Dashboard

Indicator: Overtime Rate

Strategic Direction: PEOPLE

Definition: Overtime hours / Total Earned Hours. Indicator includes all fund type departments and staffing discipline (i.e.. full-time, part-time, etc.). Performance is reported cumulatively on a year-to-date basis.

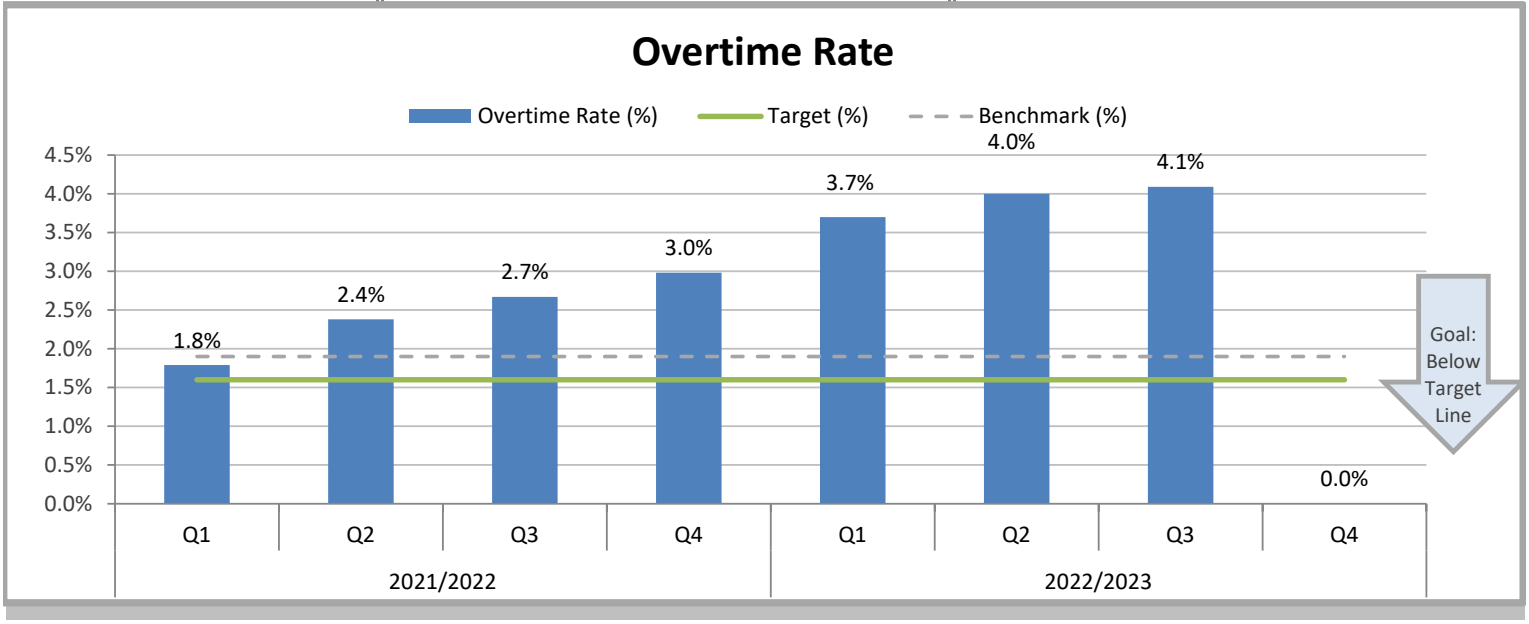
Significance: To control healthcare costs it is essential to analyze and improve staffing, the largest organizational expense, by improving utilization of human resources. Consideration of other factors is recommended, including staff turnover rates, productivity and efficiency, staff competency and training. Further analysis of overtime utilization should be conducted per employees' grade and profession, to compare the utilization of the technical, non-technical and administrative staff members.

Data Source: Virtuo MIS - General Ledger

Target Information: Set according to HSAA obligations

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

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overtime Rate (%)	1.8%	2.4%	2.7%	3.0%	3.7%	4.0%	4.1%	N/A
Benchmark (%)	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
Target (%)	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%



Performance Analysis:

Q1 Target not met due to significant Health Human Resources (HHR) challenges.
Q2 Target not met due to significant Health Human Resources (HHR) challenges.
Q3 Target not met due to significant Health Human Resources (HHR) challenges.
Q4 Results unavailable due to system failure (Virtuo).

Plans for Improvement:

Q1 Continue to monitor, explore alternate staffing complements and focus on recruitment and retention.
Q2 Continue to monitor, explore alternate staffing complements and focus on recruitment and retention.
Q3 Continue to monitor, explore alternate staffing complements and focus on recruitment and retention.
Q4 N/A

Accountable: Chief Financial Officer / Manager, Financial Services

Return to Dashboard

Indicator: Patient Experience Survey - Information Inpatient

Strategic Direction: PEOPLE

Definition: Percentage of Inpatient respondents who responded positively (positive response include "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?" (Question #38).

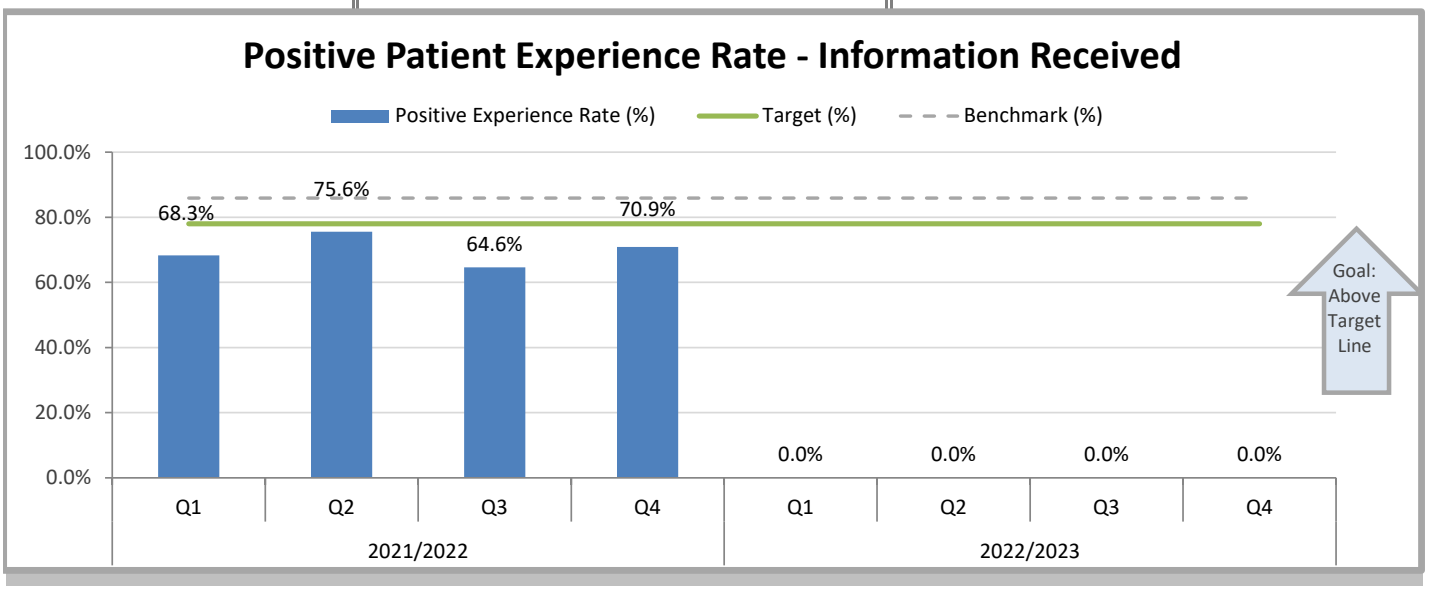
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that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

Data Source: NRC (National Research Corporation)

Target Information: Set internally at 78%

Benchmark Information: Benchmark performance is based on NRC - Champlain LHIN average quarterly performance

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	68.3%	75.6%	64.6%	70.9%	N/A	N/A	N/A	N/A
Benchmark (%)	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%	85.9%
Target (%)	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%



Performance Analysis:

Q1 No data due to OHA survey transition to new vendor.
Q2 No data due to OHA survey transition to new vendor.
Q3 No data due to OHA survey transition to new vendor.
Q4 No data due to OHA survey transition to new vendor.

Plans for Improvement:

Q1 CCH currently in the process of signing a new contract with new vendor.
Q2 CCH currently in the process of signing a new contract with new vendor.
Q3 CCH currently in the process of signing a new contract with new vendor.
Q4 CCH currently in the process of signing a new contract with new vendor.

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

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Indicator: Inpatient Smoking Cessation Screening Rate

Strategic Direction: PEOPLE

Definition: Inpatient smoker is defined as a user of any tobacco product in the last six months. The percentage of identified inpatient smokers offered a smoking cessation consult while admitted.

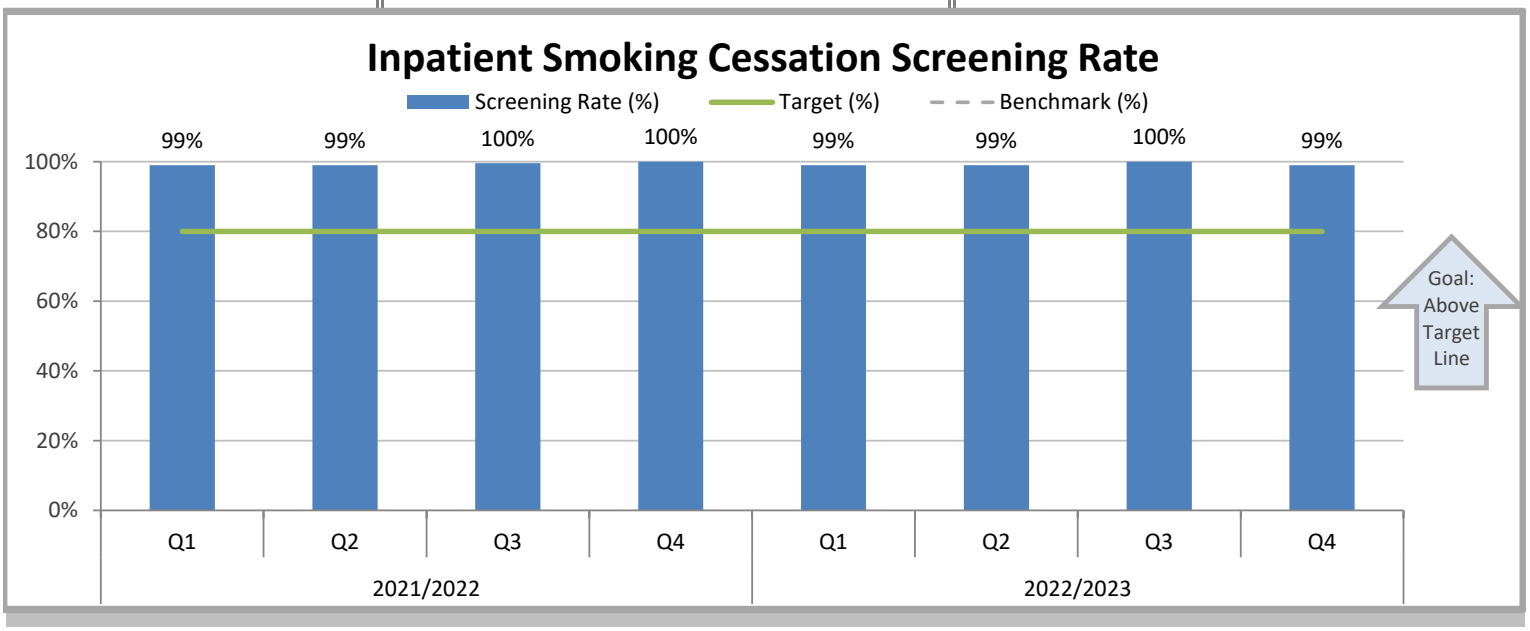
Significance: The Champlain LHIN has incorporated a performance standard in its Hospital Accountability Agreements stating that by 2013, 80% of smokers admitted to hospital must receive the OMSC intervention.

Data Source: Internal Tracking

Target Information: Target is set in accordance to the HSAA

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Screening Rate (%)	99%	99%	100%	100%	99%	99%	100%	99%
Benchmark (%)								
Target (%)	80%	80%	80%	80%	80%	80%	80%	80%



Performance Analysis:

Q1 Target met.
Q2 Target met.
Q3 Target met.
Q4 Target met.

Plans for Improvement:

Q1 On target and no action required.
Q2 No action required
Q3 No action required
Q4 No action required

Accountable: Chief Information and Operating Officer / Director, Diagnostic Services

Indicator: Workplace Violence Prevention - Incidents Reported

Strategic Direction: PEOPLE

Definition: This is a mandatory QIP indicator. The number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12-month period. Directive of Improvement is focused on building our reporting culture to increase the number of reported incidents. Awareness created in FY2018-19, the goal for 2019-20 will be to have less incidents.

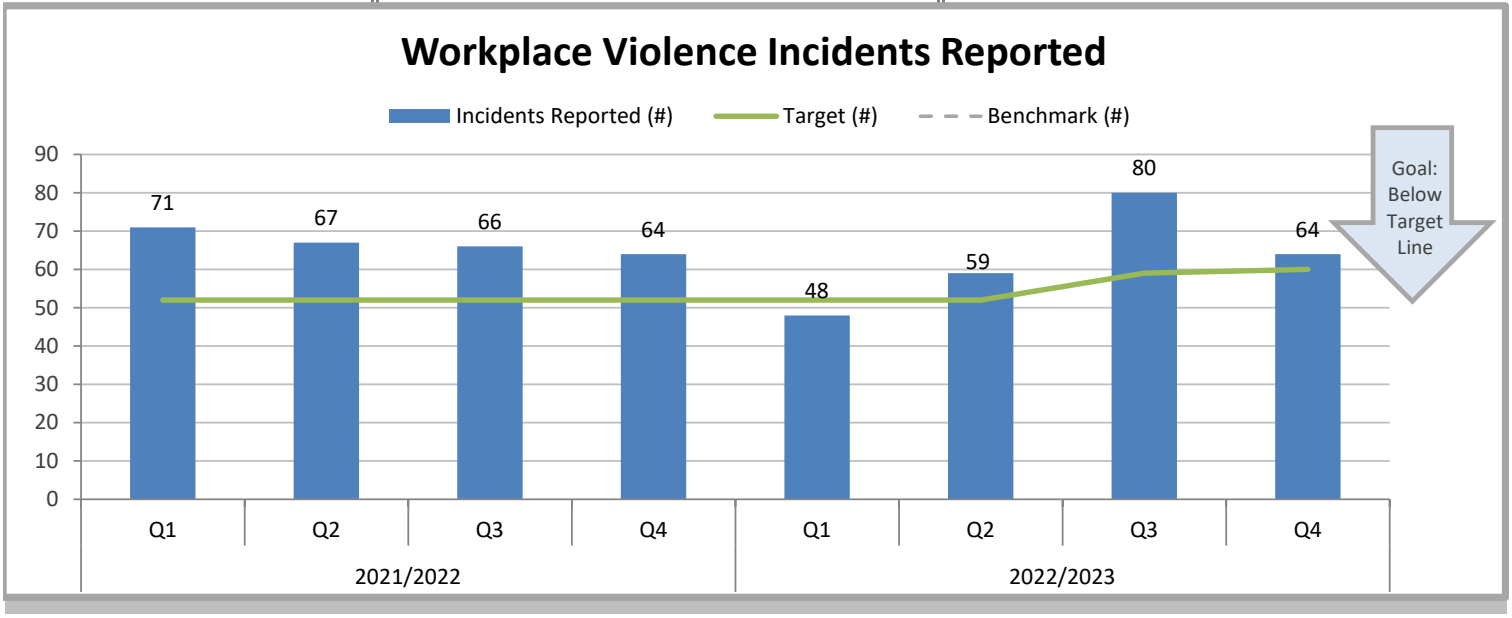
Significance: Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Violence in the workplace is an increasingly serious occupational hazard. Like other injuries, injuries from violence are preventable. Reporting all incidents is done for the purpose of identifying priorities for intervention to reduce hazards.

Data Source: RL Solution -Incident Management System

Target Information: Target is set internally at 223 annually in accordance to QIP indicator.

Benchmark Information: N/A

	2021/2022				2022/2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incidents Reported (#)	71	67	66	64	48	59	80	64
Benchmark (#)								
Target (#)	52	52	52	52	52	52	59	60



Performance Analysis:

Q1 Target met.

Q2 Results slightly above target for this quarter.

Q3 Results are above target for this quarter. There was 43 incidents for Emergency Department this quarter, which accounts for 54% of the total.

Q4 Target not met this quarter with a total of 64 incident reported, however the incidents have decreased compared to Q3.

Plans for Improvement:

Q1 A sub-committee has been created as part of the JHSC to put together action plans to take a more detailed approach to eventually decrease this number.

Q2 Sub-committee held it's first meeting in October. Continue with current strategy and monitor outcomes.

Q3 In Q3 the sub-committee conducted an education session in the ED to assist staff to identify and evaluate factors which may lead to workplace violence. This lead to an increased number of reported near misses. The committee will continue to evaluate and make recommendations for violence prevention.

Q4 The committee will continue to evaluate and make further recommendations for violence prevention.

Accountable: Chief Human Resources Officer / Manager, Human Resources

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