



CORPORATE SCORECARD 2011/2012

Vision: A recognized Eastern Counties leader in the provision of exceptional health services.

Mission: With our partners, we provide, facilitate and enable safe, high quality health services and education to the communities we serve; in doing so, we are committed to the effective management and use of our resources.



Values: *ICARE - Integrity - Compassion - Accountability - Respect - Engagement*

EXCELLENCE IN QUALITY & SERVICE DELIVERY					
Indicator	References	Q1	Q2	Q3	Q4
Emergency Visits Admitted to Hospital	OPT/QIP	G	G	G	
Emergency Visits Non-Admitted (Low)	OPT/QIP	Y	G	G	
Emergency Visits Non-Admitted (High)	OPT/QIP	G	G	G	
Percentage ED Patients Left Without Being Seen	QIP	R	R	G	
ED Physician Initial Assessment Times	QIP	G	G	G	
ED Patient Satisfaction Survey	QIP	Y	Y	G	
Readmission Rates for Admitted	Board	R	R	R	
Incomplete Charts	Board	Y	R	G	
Wait Time CT Scans	HSAA	G	G	G	
Wait Time Cataract Surgery	HSAA	G	G	G	
Wait Time General Surgery	HSAA	G	G	G	
Wait Time Hip Replacement	HSAA	R	G	R	
Wait Time Knee Replacement	HSAA	R	R	R	
Pediatric Dental Surgical Volumes	HSAA	Y	G	Y	
ROP - Safe Surgery Checklist	QIP	Y	Y	Y	
ROP - Venous Thromboembolism Prophylaxis Target	QIP	R	R	R	
MRSA Colonization and Infection Incidence	MoHLTC	G	G	G	
Clostridium Difficile Incidence	MoHLTC	G	G	G	
VRE Colonization and Infection Incidence	MoHLTC	R	G	R	
Ventilator Associated Pneumonia	MoHLTC	G	G	G	
Central Line Infections	MoHLTC	G	G	G	
Hand Hygiene	MoHLTC	N/A	N/A	N/A	
Surgical Site Infection Prophylaxis	MoHLTC	Y	R	G	
Smoking Cessation Rates	HSAA	G	G	G	
Elective Repeat C-Section Rates	HSAA	N/A	N/A	N/A	

Results:

Metric underperforming benchmark
Metric within 10% of benchmark
Metric equal to or outperforming benchmark
Data not available

R
Y
G
N/A

Reference Explanations:

OPT - (Annual) Operating Plan Target
QIP - Quality Improvement Plan
HSAA - Hospital Services Accountability Agreement
MoHLTC - Public Reporting Requirement
Board - Board Directed

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

HEALTH SYSTEM INTEGRATION					
Indicator	References	Q1	Q2	Q3	Q4
Patients on Pathways	OPT	N/A	N/A	N/A	
ALC Medical/Surgical Occupancy	OPT	Y	R	R	
Percentage ALC Patients Referred to CCAC	HSAA	G	G	G	

OUTSTANDING OPERATIONAL & FINANCIAL PERFORMANCE					
Indicator	References	Q1	Q2	Q3	Q4
Departmental/Services Scorecards	OPT	G	G	G	
Total Margin	OPT/QIP	Y	G	G	
Current Ratio	HSAA	R	G	Y	
Admin Expense to Operating	Board	G	G	G	
Equipment Expense to Operating	Board	G	G	G	
Percentage Actual LOS to Expected LOS	Board	R	R	R	
ALOS - Hip Fracture	QIP	G	G	R	
ALOS - Total Hip Replacement	QIP	G	G	G	
ALOS - Total Knee Replacement	QIP	Y	R	G	
ED Worked Hours to Equivalent Visits	QIP	Y	Y	Y	

PEOPLE DEVELOPMENT/WORKPLACE OF CHOICE					
Indicator	References	Q1	Q2	Q3	Q4
Management Participation in Leadership Education	OPT	R	G	G	
Communication Plan	OPT	G	G	G	
Percentage of Full-Time Nurses	HSAA	G	G	G	
Staff Turnover	Board	R	R	R	
Absenteeism	Board	G	G	G	
Performance Appraisals	Board	R	R	R	
ROP Workplace Violence Prevention	QIP	R	R	R	

Corporate Scorecard FY 2011/2012

Emergency Patients Admitted to Hospital

[Scorecard](#)

SUCCESS FACTOR:

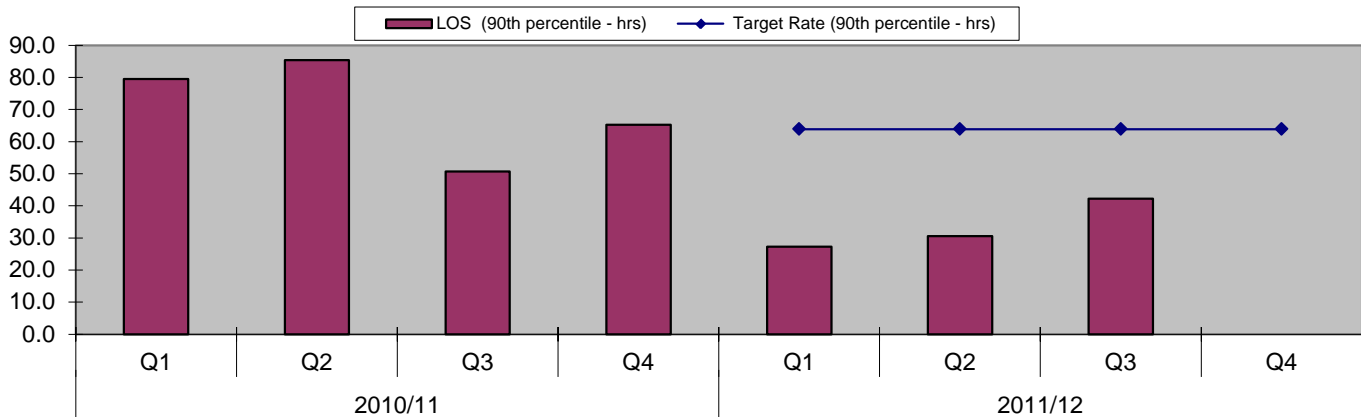
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: Using Pay-for-Results program indicator for admitted patients which is based on the 90th percentile ER length of stay. The target is 25 (twenty-five) hours. Time calculated from triage time to time patient left ED. Data Source - 2011/12: Ministry P4R Report (ERNI). Data Source - 2010/11 Report Generator (NACRS).

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
LOS (90th percentile - hrs)	79.5	85.4	50.7	65.3	27.3	30.6	42.2	
Benchmark (90th percentile - hrs)	25.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0
Target Rate (90th percentile - hrs)					63.9	63.9	63.9	63.9

Significance: The previous fiscal year's Provincial Benchmark was based on the percentage of patients who were admitted to an inpatient bed within 8 hours (triage to time patient left ED). We have adjusted the previous fiscal year's data to reflect the current Provincial Benchmark of 25 (twenty-five) hours for trending purposes.

ED Visits Admitted (%)



Analysis:

1st Quarter: Availability of in-patient beds during the first quarter of this fiscal year has allowed for patients to move to an in-patient bed in a timely manner and for CCH to perform extremely well in meeting targets for this metric.

2nd Quarter: In the second quarter, an increase in occupancy has led to an increase in length-of-stay in the department for admitted patients.

3rd Quarter: Increases in volumes, ALC patients and acuity of patients are responsible for increased wait-times to access to an in-patient bed. CCH continues to look at opportunities to improve patient flow.

Plan for Improvement/Timelines:

1st Quarter: The Medicine PIP team is looking at implementing (September 2011) solutions to improve the admissions process, decrease the turn-around time for patients to access an in-patient bed and improve discharge processes. 34 ALC beds were opened on August 22nd 2011 and will allow for increase access to acute in-patient beds.

2nd Quarter: Occupancy remains high and access to in-patient beds remain a challenge.

3rd Quarter: Education on overcapacity protocol and implementation of protocol by March 31st, 2012. The development and implementation of a revised 'Bed Manager Clerk' by Patient Registration will assist in improving bed assignment process.

Accountability: Director of Emergency Department and Chief of Emergency

Corporate Scorecard FY 2011/2012

Emergency Visits Non Admitted (Low Acuity)

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration

Excellence in Quality & Service Delivery

Outstanding Operational & Financial Performance

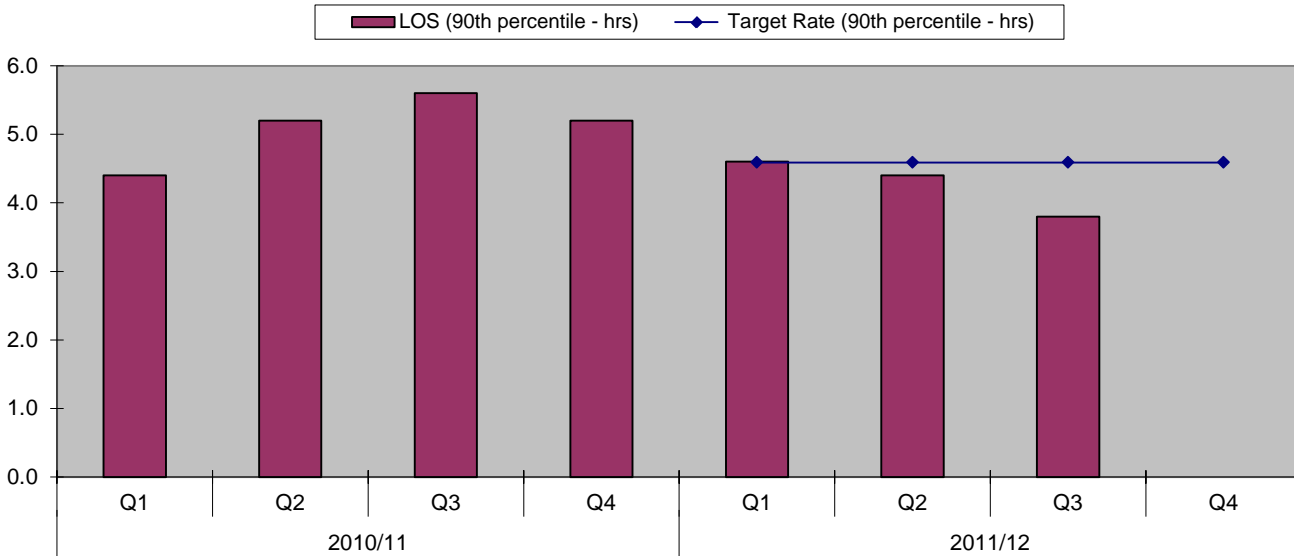
People Development/Workplace of Choice

Definition: The percentage of visits meeting provincial benchmark for Wait Time. On arrival at the ED, all patients are seen by a triage nurse and assigned a triage level based on the Canadian Triage Acuity Scale (CTAS). There are five triage levels ranging from #1 being the most critical to # 5 being non-urgent. CTAS levels 4 and 5 are considered Low Acuity. Patients are seen in the order of their triage level and not based on time of arrival. Time calculated from triage time to time patient left ED. Data Source - 2011/12: Ministry P4R Report (ERNI). Data Source - 2010/11 Report Generator (NACRS).

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
LOS (90th percentile - hrs)	4.4	5.2	5.6	5.2	4.6	4.4	3.8	
Benchmark (90th percentile - hrs)	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
Target Rate (90th percentile - hrs)					4.6	4.6	4.6	4.6

Significance: The Provincial Benchmark for ED Visits (non admitted patients) with a CTAS of 4 or 5 is a length of stay of 4 (four) hours at the 90th percentile. The previous fiscal year's Provincial Benchmark was based on the percentage of patients treated and discharged within 4 hours. We have adjusted the previous fiscal year's data to reflect the current Provincial Benchmark of 4 hours at the 90th percentile for trending purposes.

ED Visits Non-Admitted (Low Acuity)



Analysis:

1st Quarter: A decrease in physician coverage from July 2010 until March 2011 has negatively impacted the length-of-stay in the ED for our non-admitted low acuity patients for the second and third quarter of the 2010-2011 fiscal year. The overcrowding of admitted patient in the ED has for the 2nd and 3rd quarter of the last fiscal year made it challenging to assess patients.

2nd Quarter: The implementation of the See and Treat on September 7th, 2011 has had a positive impact on our LOS for non-admitted patients in the ED. Improved patient flow and shortened physician initial assessment times has decreased overall LOS for non-admitted.

3rd Quarter: Continued gains and efficiencies in patient flow. The See and Treat model of care ensures appropriate flow of patient throughout the ED

Plan for Improvement/Timelines:

1st Quarter: A Rapid Assessment Zone (RAZ) was implemented in February 2011 to improve patient flow and decrease length of stay in the ED. Full physician coverage as of April 2011. ED PIP has implemented a new See and Treat area on September 8th which combines FastTrack and RAZ patients, for all stable ambulatory patients. The aim of this area is to improve patient flow within the department and to further improve physician initial assessment as well as decrease average length-of-stay in the department.

2nd Quarter: The current plan is to maintain current efficiencies for wait times and look at other opportunities for improvement within the ED.

3rd Quarter: Maintain current status while looking at allied services and possible process improvements.

Accountability: Director of Emergency Department and Chief of Emergency

Corporate Scorecard FY 2011/2012

Emergency Visits Non Admitted (High Acuity)

[Scorecard](#)

SUCCESS FACTOR:

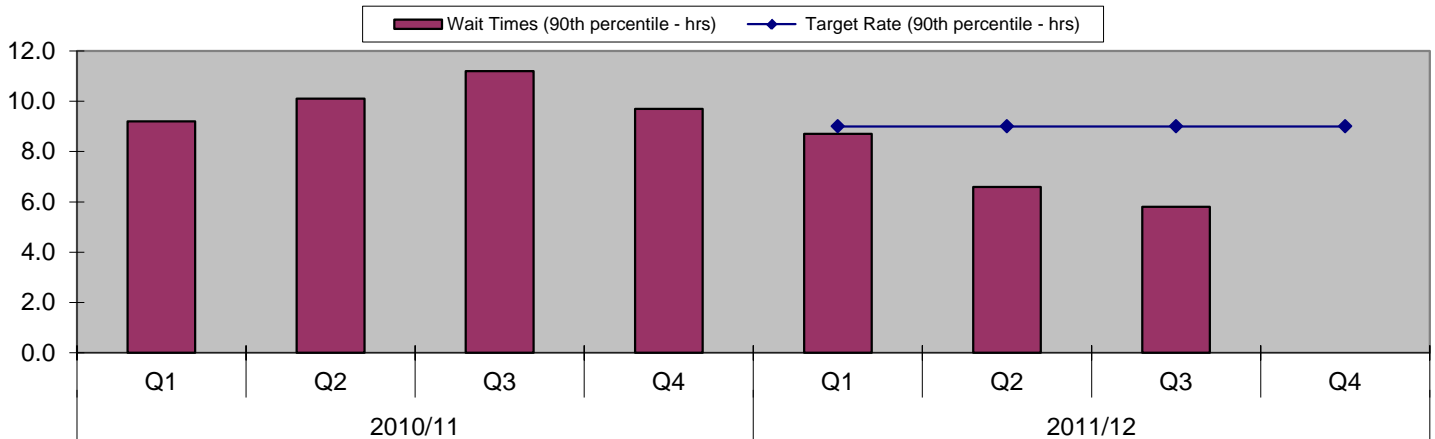
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: The percentage of visits meeting provincial benchmark for Wait Time. On arrival at the ED, all patients are seen by a triage nurse and assigned a triage level based on the Canadian Triage Acuity Scale (CTAS). There are five triage levels ranging from #1 being the most critical to # 5 being non-urgent. CTAS levels 1, 2, and 3 are considered High Acuity. Patients are seen in the order of their triage level and not based on time of arrival. Time calculated from triage time to disposition time. Data Source - 2011/12: Ministry P4R Report (ERNI). Data Source - 2010/11 Report Generator (NACRS).

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Wait Times (90th percentile - hrs)	9.2	10.1	11.2	9.7	8.7	6.6	5.8	
Benchmark (90th percentile - hrs)	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0
Target Rate (90th percentile - hrs)					9.0	9.0	9.0	9.0

Significance: As of April 2011 the Provincial Benchmark for ED Visits (non admitted patients) with a CTAS of 1, 2, or 3 is seven (7) hours at the 90th percentile. The previous fiscal year's Provincial Benchmark was based on the percentage of patients treated and discharged within 8 hours. We have adjusted the previous fiscal year's data to reflect the current Provincial Benchmark of 7 hours at the 90th percentile for trending purposes.

ED Visits Non- Admitted Patients



Analysis:

1st Quarter: A decrease in physician coverage from July 2010 until March 2011 has negatively impacted the length-of-stay in the ED for our non-admitted low acuity patients for the second and third quarter of the 2010-2011 fiscal year. The overcrowding of admitted patient in the ED has for the 2nd and 3rd quarter of the last fiscal year made it challenging to assess patients.

2nd Quarter: The implementation of the See and Treat on September 7th, 2011 has had a positive impact on our LOS for non-admitted patients in the ED. Improved patient flow and shortened physician initial assessment times has decreased overall LOS for non-admitted.

3rd Quarter: Continued gains and efficiencies of current model of care (Sub-Acute and See and Treat).

Plan for Improvement/Timelines:

1st Quarter: The Hospital is implementing the following plans: Initiatives to address the ALC issue, CDU policy approved, Education and feedback to staff on Triage, Implementation of "fast track" section and current review of processes in ED.

2nd Quarter: The current plan is to maintain current efficiencies for wait times and look at other opportunities for improvement within the ED

3rd Quarter: The current plan is to maintain current efficiencies for wait times and look at other opportunities for improvement within the ED.

Accountability: Director of Emergency Department and Chief of Emergency

Corporate Scorecard FY 2011/2012

% Emergency Department Patients LWBS (left without being seen)

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration

Excellence in Quality & Service Delivery

Outstanding Operational & Financial Performance

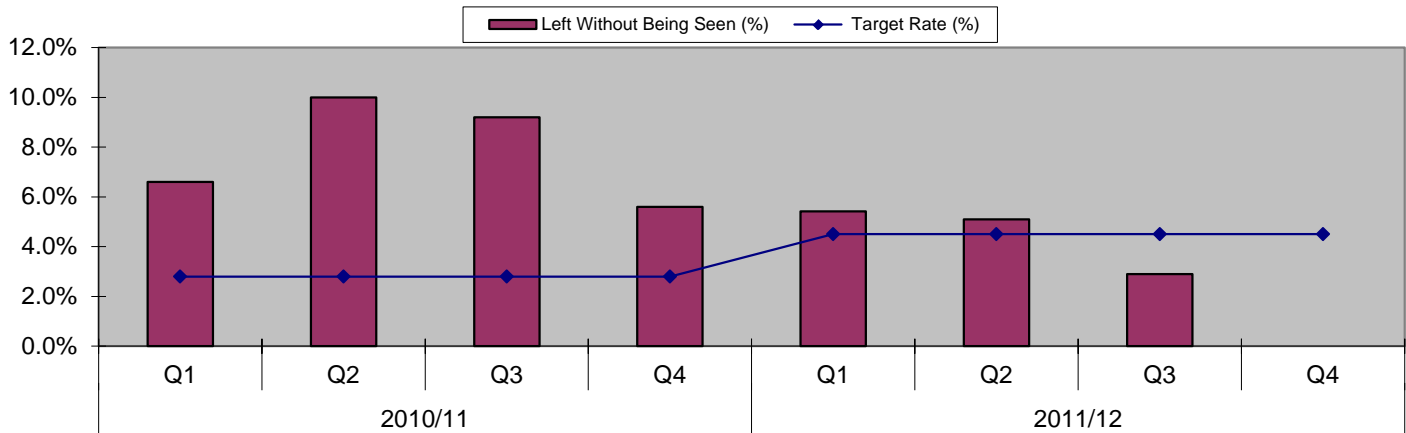
People Development/Workplace of Choice

Definition: Percentage of visits to the Emergency Department where the patient left without being seen by a physician. Visit Disposition 02 or 03. Data Source Report Generator (NACRS) and CIHI Portal.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Left Without Being Seen (%)	6.6%	10.0%	9.2%	5.6%	5.4%	5.1%	2.9%	
Benchmark (%)	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%	2.8%
Target Rate (%)	2.8%	2.8%	2.8%	2.8%	4.5%	4.5%	4.5%	4.5%

Significance: The Benchmark is based on the 25th percentile of our benchmark (peer) hospitals for fiscal year 2010/2011.

Percentage Left Without Being Seen



Analysis:

1st Quarter: An increase number of patients who left without being seen occurred during the second and third quarter of the 2010-2011 fiscal year, directly related to the time patients waited to see a physician. There has been marked improvement for the last quarter as well as the first quarter of 2011-2010 related to initiatives implemented in the ED and increased physician coverage in April 2011.

2nd Quarter: Patients who leave without being seen often relates to the time patients waited to see a physician. There has been marked improvement for the last quarter.

3rd Quarter: The decrease in physician initial assessment has contributed, again, to the decrease of patients who leave without being seen.

Plan for Improvement/Timelines:

1st Quarter: Time to physician initial assessment (PIA) has a direct correlation to Left without Being Seen and the time to PIA has increased due to manpower shortages. This manpower issue has been resolved and we know that the recent results are favourable. Other measures have been introduced to improve the patient experience in the Emergency Department and this has likely impacted the Left without Being Seen recent results.

2nd Quarter: The implementation of the new See and Treat has had a positive impact on decreasing the number of patients who leave without being seen. We will see continued improvement in this metric for the next quarter.

3rd Quarter: The current plan is to maintain current efficiencies for wait times and look at other opportunities for improvement within the ED.

Accountability: Chief of Emergency and Emergency Medical Associate

Corporate Scorecard FY 2011/2012

Time to Physician Initial Assessment

[Scorecard](#)

SUCCESS FACTOR:

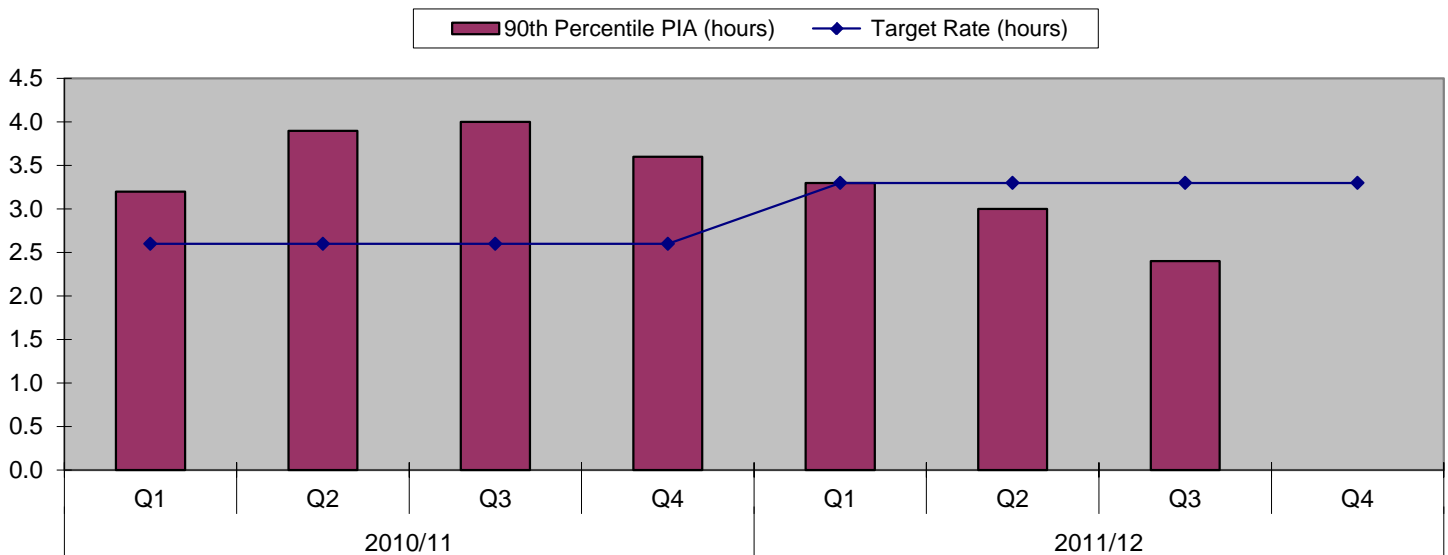
Health System Integration	<input type="checkbox"/>	Excellence in Quality & Service Delivery	<input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance	<input type="checkbox"/>	People Development/Workplace of Choice	<input type="checkbox"/>

Definition: The time lapsed from Triage Date & Time to Physician Initial Assessment Date & Time. LWBS (left without being seen), missing PIA, missing Disposition Date & Time and missing Time Patient Left ED excluded from data as per P4R criteria. Data Source - 2011/12: Ministry P4R Report (ERNI), ER iPort Access. Data Source - 2010/11 Report Generator (NACRS).

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
90th Percentile PIA (hours)	3.2	3.9	4.0	3.6	3.3	3.0	2.4	
Benchmark (hours)	2.9	2.9	2.9	2.9	2.7	2.7	2.7	2.7
Target Rate (hours)	2.6	2.6	2.6	2.6	3.3	3.3	3.3	3.3

Significance: Benchmark based on 25th percentile of CCH peer hospitals (FY 10/11 performance).

Time to Physician Initial Assessment



Analysis:

1st Quarter: Increased physician coverage has positively impacted the physician's ability to see patients within our target of 3.3 hours for the first quarter and part of the second quarter.

2nd Quarter: The implementation of the See and Treat area has further improved this metric.

3rd Quarter: Continued improvement in PIA with the implementation of the See and Treat.

Plan for Improvement/Timelines:

1st Quarter: ED PIP has implemented a new See and Treat area on September 8th for all stable ambulatory patients. The aim of this area is to improve patient flow within the department and further improve physician initial assessment and decrease average length-of-stay in the department.

2nd Quarter: The plan is to continue with this model of care and to look at opportunities for further improvement of patient flow in other areas of the department.

3rd Quarter: Maintain current initiatives and look at further process improvement initiatives

Accountability: Chief of Emergency and Emergency Medical Associate

Corporate Scorecard FY 2011/2012

Patient Satisfaction Survey ED

[Scorecard](#)

SUCCESS FACTOR:

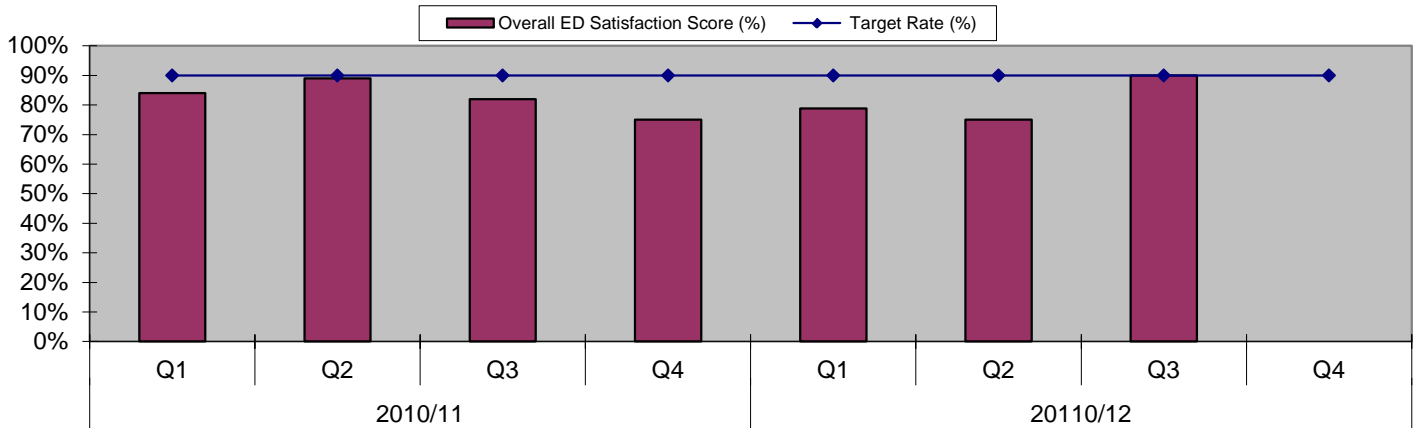
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development Workplace of Choice <input type="checkbox"/>

Definition: Percentage of positive scores on the question that assesses overall satisfaction with the patient care in the Emergency Department.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall ED Satisfaction Score (%)	84%	89%	82%	75%	79%	75%	90%	
Benchmark (%)	83%	83%	83%	83%				
Target Rate (%)	90%	90%	90%	90%	90%	90%	90%	90%

Significance: A high degree of patient satisfaction is linked with better outcomes for patients. Important knowledge for improving the quality of those aspects of care that are most important to patients. Benchmark taken from Ontario Community Hospital Averages. Data Source: NRC+ Picker Canada.

Patient Satisfaction Survey - ED



Analysis: 1st Quarter: Results not yet finalized for Q2, significant improvement observed with results from July to September; increasing from 63% to 89%. Which coincides with the implementation of See and Treat model of care.

2nd Quarter: July, August and September continue to be preliminary, results will be finalized December, 2011.

3rd Quarter: Patient Satisfaction scores have increased, and are at their highest since March 2010. There is a positive correlation between the improvements related to wait-times and an increase patient satisfaction score.

Plan for Improvement/Timelines:

1st Quarter: The current focus on the Emergency Department is expected to positively impact these results. The Emergency Department Steering Committee (ED PIP) will monitor the impact of initiatives introduced to improve the patient experience in the Emergency Department (e.g. hourly "rounds", information at triage, greeters, waiting room improvements).

2nd Quarter: As this tends to be a lagging indicator, improvements in the patient experience based on ED-PIP initiatives implemented in August/September 2011 are not expected to be evident until Q3, 2011.

3rd Quarter: ED PIP initiatives implemented in September 2011 are now evident. The plan is to maintain current efficiencies and further improve our patient satisfaction scores.

Accountability: Director of Emergency Room, Director of Quality Performance , Chief of the Emergency Department.

Corporate Scorecard FY 2011/2012

Readmission Rates

[Scorecard](#)

SUCCESS FACTOR:

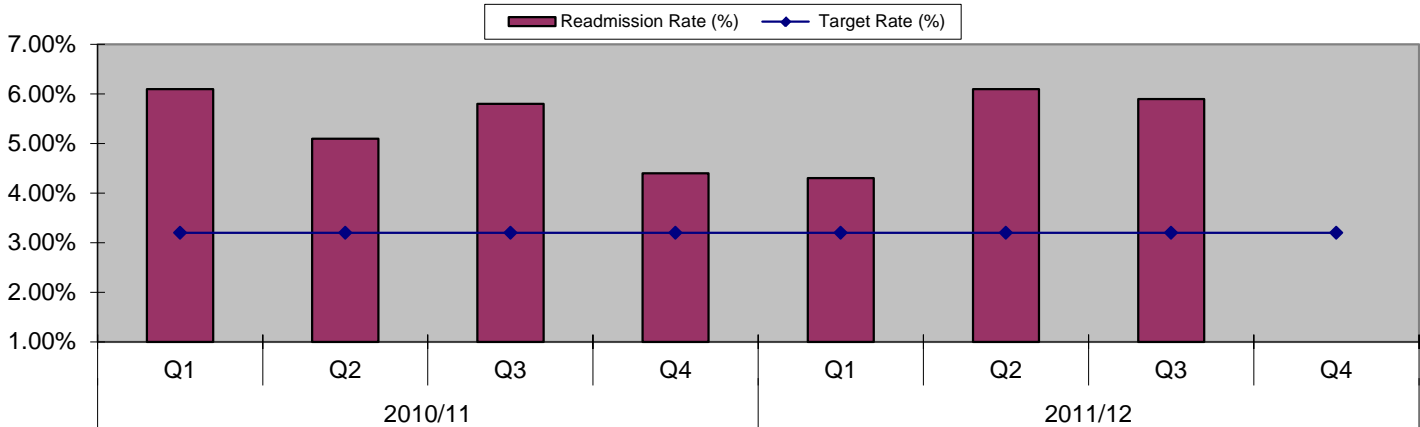
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: Percentage of admitted patients who return to the hospital within 28 (twenty-eight) days of discharge with the same or related diagnosis excluding transfers from acute care facilities. Data source CIHI Portal and Report Generator.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	6.1%	5.1%	5.8%	4.4%	4.3%	6.1%	5.9%	
Benchmark (%)	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
Target Rate (%)	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%

Significance: The Benchmark is based on the 25th percentile of our Benchmark (peer) hospitals for fiscal year 2010/2011 (Q1-Q3). Data source Report Generator and CIHI Portal.

Readmission Rates (%)



Analysis:

1st Quarter: Readmission rates are slightly above the target although there is a downward trend.

2nd Quarter: Readmission rates have again risen slightly.

3rd Quarter: Rates slightly down despite an almost 9% increase in discharge volumes and increased occupancy from 90% to 99%.

Plan for Improvement/Timelines:

1st Quarter: Indicator to be reported and monitored by Medical Quality Assurance Committee. Readmission charts are reviewed for trends.

2nd Quarter: Charts of readmitted patients (Q2) to be reviewed by the Chief of Staff November 2011.

3rd Quarter: No further improvement likely without increased bed resources to decrease pressure for Discharge.

Accountability: Chief of Staff / Medical Director Quality and Process Improvement

Corporate Scorecard FY 2011/2012

Incomplete Charts

[Scorecard](#)

SUCCESS FACTOR:

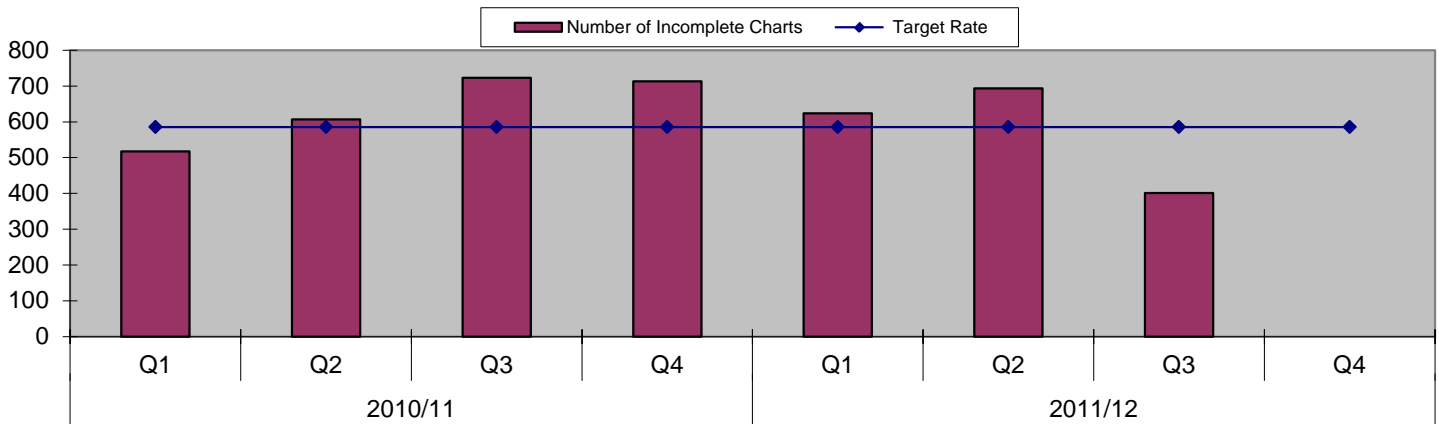
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: This measures incomplete charts at thirty days after discharge. It is a monthly snapshot of the incomplete (deficient and signatures) charts. Data source from the Incomplete Chart Report on Report Generator. For fiscal year 2010/2011 it will be generated on the last business day of each quarter.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Incomplete Charts	517	607	723	713	624	693	401	
Benchmark	585	585	585	585	585	585	585	585
Target Rate	585	585	585	585	585	585	585	585

Significance: The target rate is based on 50% of the monthly average of the total discharges and day surgeries for 2010/2011.

Total Incomplete Charts



Analysis:

1st and 2nd Quarters: Number of incomplete charts in the first quarter just slightly over target with improvement noted.

Plan for Improvement/Timelines:

1st and 2nd Quarter: Continue enforcing the Hospital policy - Incomplete Health Records. Process revised slightly and approved by Medical Advisory Committee.

3rd Quarter: Incomplete chart numbers have decreased significantly since Q2 (below target)- with changes in Health Records process.

Accountability: Chief of Staff

Corporate Scorecard FY 2011/2012

Wait Time CT Scans

[Scorecard](#)

SUCCESS FACTOR:

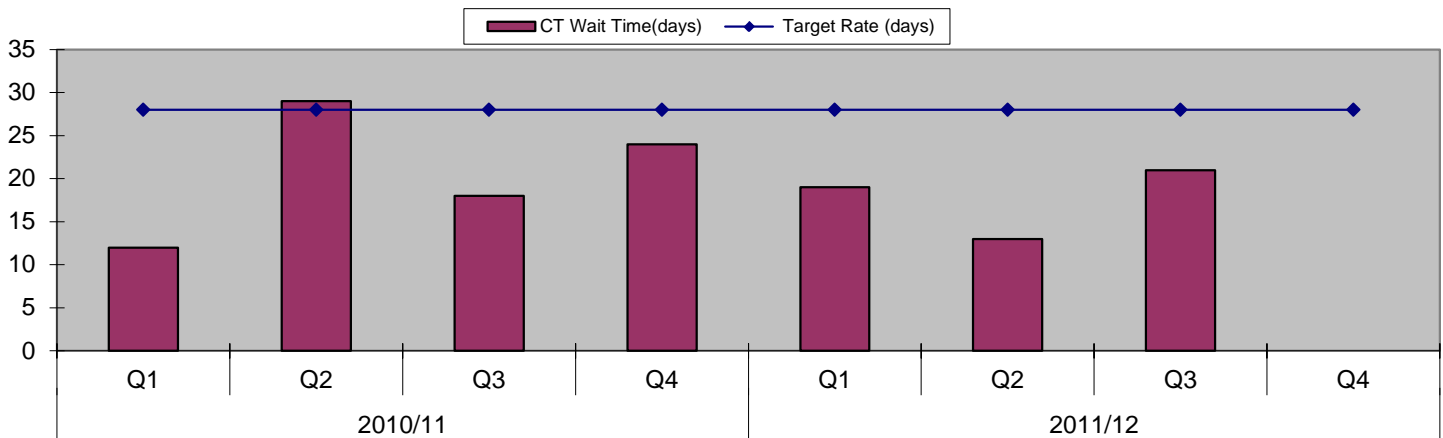
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: The number of days 9 out of 10 patients (90th percentile) wait for a CT from time of booking to first available appointment. Current wait time targets are measured at priority level IV (28 days).

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CT wait time (days)	12	29	18	24	19	13	21	
Benchmark (days)	28	28	28	28	28	28	28	28
Target Rate (days)	28	28	28	28	28	28	28	28

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.

CT Wait Time (days)



Analysis:

1st Quarter: Metric is outperforming MOHLTC (priority IV) by 9 days.

2nd Quarter: CCH included on the ten lowest CT Wait times list for the province of Ontario! CCH has the shortest wait time in the province.

3rd Quarter: Third quarter saw increased downtime of the CT scanner due to mechanical and software issues as the unit ages. Despite significant downtime, CT was able to outperform by 7 days.

Plan for Improvement/Timelines:

1st, 2nd, and 3rd Quarters: No improvement plan required.

Accountability: Director of Diagnostic Services

Corporate Scorecard FY 2011/12

Wait Time Cataract Surgery

[Scorecard](#)

SUCCESS FACTOR:

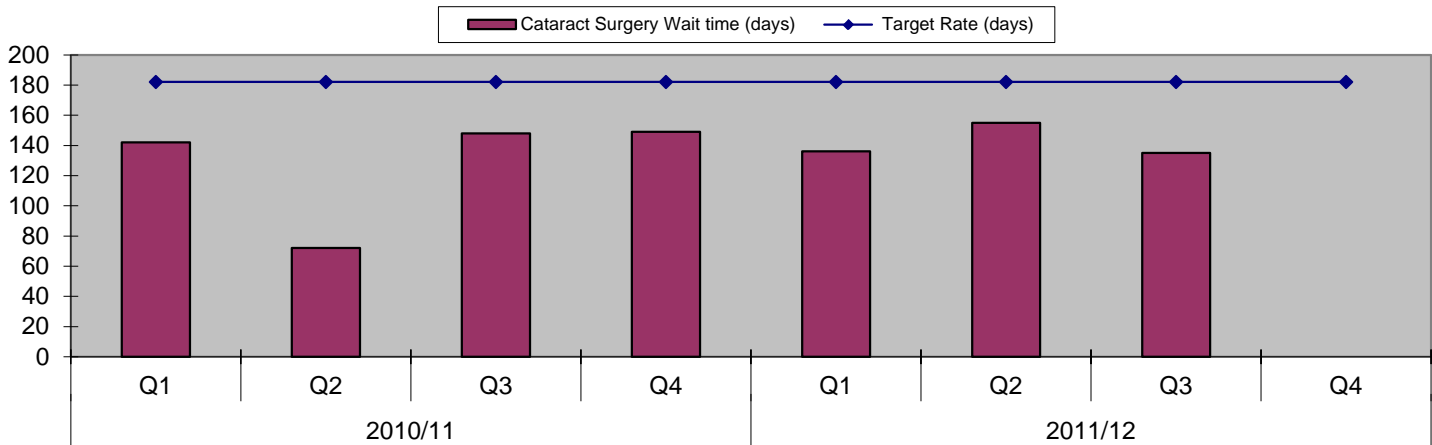
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: The number of days 9 out of 10 patients (90th percentile) wait for Cataract Surgery from time of booking to first available appointment. The current wait time target is 182 Days

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cataract Surgery Wait time (days)	142	72	148	149	136	155	135	
Benchmark (days)	182	182	182	182	182	182	182	182
Target Rate (days)	182	182	182	182	182	182	182	182

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.

Cataract Surgery Wait Time (days)



Analysis:

1st, 2nd, and 3rd Quarters: Wait times for cataract surgery - excellent. Outperforming provincial target.

Plan for Improvement/Timelines:

1st, 2nd, and 3rd Quarters: No improvement plan required.

Accountability: Director of Surgery, Operating Room Medical Director

Corporate Scorecard FY 2011/2012

Wait Time General Surgery

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration

Excellence in Quality & Service Delivery

Outstanding Financial Performance

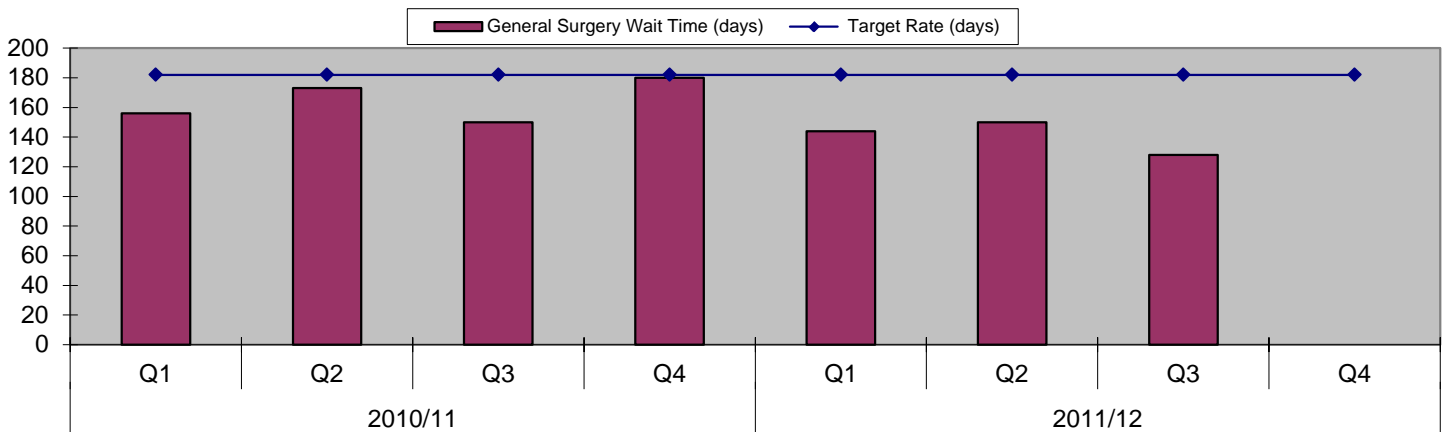
People Development/Workplace of Choice

Definition: The number of days 9 out of 10 patients (90th percentile) wait for General Surgery from time of booking to first available appointment. The current wait time target is 182 Days

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
General Surgery Wait Time (days)	156	173	150	180	144	150	128	
Benchmark (days)	182	182	182	182	182	182	182	182
Target Rate (days)	182	182	182	182	182	182	182	182

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.

General Surgery Wait Time (days)



Analysis:

1st, 2nd, and 3rd Quarters: General surgery wait time outperforming target.

Plan for Improvement/Timelines:

1st, 2nd and 3rd Quarters: No improvement plan required.

Accountability: Operating Room Medical Director

Corporate Scorecard FY 2011/2012

Wait Time Hip Replacement

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration

Excellence in Quality & Service Delivery

Outstanding Operational & Financial Performance

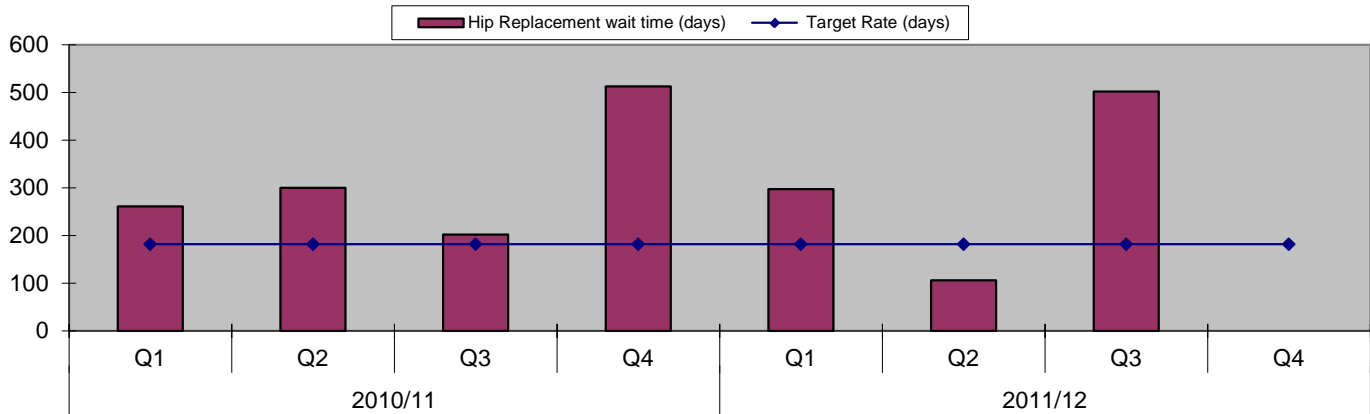
People Development/Workplace of Choice

Definition: The number of days 9 out of 10 patients (90th percentile) wait for Hip Replacement Surgery from time of booking to first available appointment. The current wait time target is 182 days. Benchmark based on Champlain LHIN hospitals 90th percentile.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Hip Replacement wait time (days)	261	300	202	513	297	106	502	
Benchmark (days)	182	182	182	182	299	299	299	299
Target Rate (days)	182	182	182	182	182	182	182	182

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.

Hip Replacement Wait Time (days)



Analysis:

1st Quarter: Hip replacement wait times in excess of benchmark. Long wait times caused by limited resources including inpatient beds and operating room time.

2nd Quarter: Wait times within target.

3rd Quarter: Wait times above target.

Plan for Improvement/Timelines:

1st Quarter: Working with the regional joint program to assist patients with access to surgery.

2nd Quarter: No improvement plan required.

3rd Quarter: Internal data cleansing done this quarter, with review of patients on wait list. The hospital is participating in a new regional committee, the Champlain Orthopedic Program Planning Initiative.

Accountability: Operating Room Medical Director

Corporate Scorecard FY 2011/2012

Wait Time Knee Replacement

[Scorecard](#)

SUCCESS FACTOR:

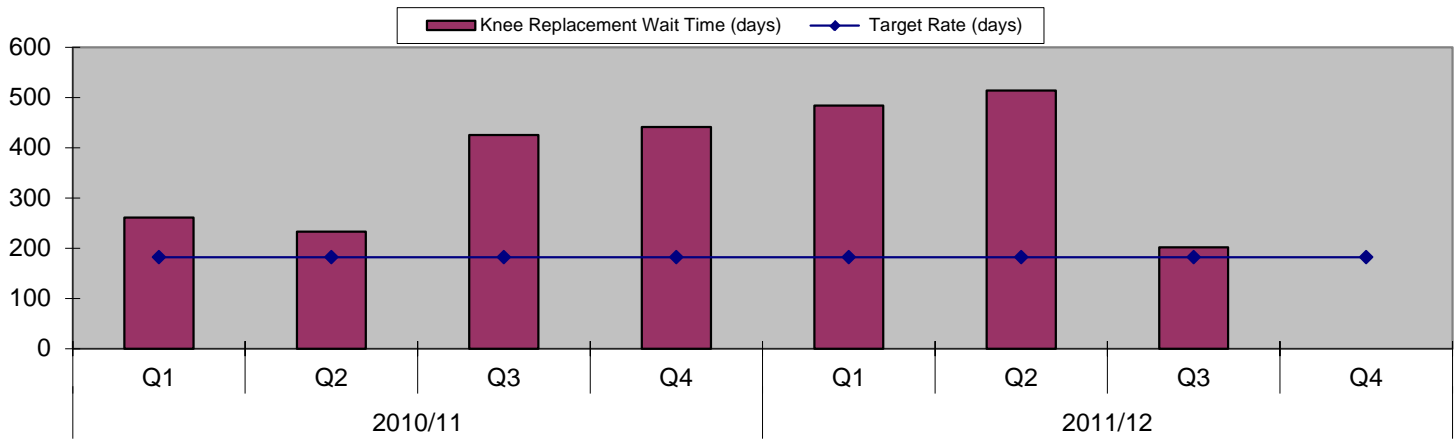
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: The number of days 9 out of 10 patients (90th percentile) wait for Knee Replacement from time of booking to first available appointment. The current wait time target is 182 Days

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Knee Replacement Wait Time (days)	261	233	425	441	484	514	202	
Benchmark (days)	182	182	182	182	182	182	182	182
Target Rate (days)	182	182	182	182	182	182	182	182

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.

Knee Replacement Wait Time (days)



Analysis:

1st Quarter: Wait times for knee replacements very high. This is a result of several cancellations (2010) due to inpatient bed occupancy.

2nd Quarter: Same trend.

3rd Quarter: Decrease in wait times for this quarter.

Plan for Improvement/Timelines:

1st Quarter: Work with the region through the total joint assessment program in an effort to assist patients with access to surgery.

2nd Quarter: The Senior Team is currently reviewing surgical bed capacity and developing a "trial plan" for 4th Quarter 2011/12 to significantly reduce surgical cancellations.

3rd Quarter: Trial plan in process. Internal data cleansing done this quarter, with review of patients on wait list. The hospital is participating in a new regional committee, the Champlain Orthopedic Program Planning Initiative.

Accountability: Operating Room Medical Director

Corporate Scorecard FY 2011/2012

Pediatric Dental Surgical Volumes

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

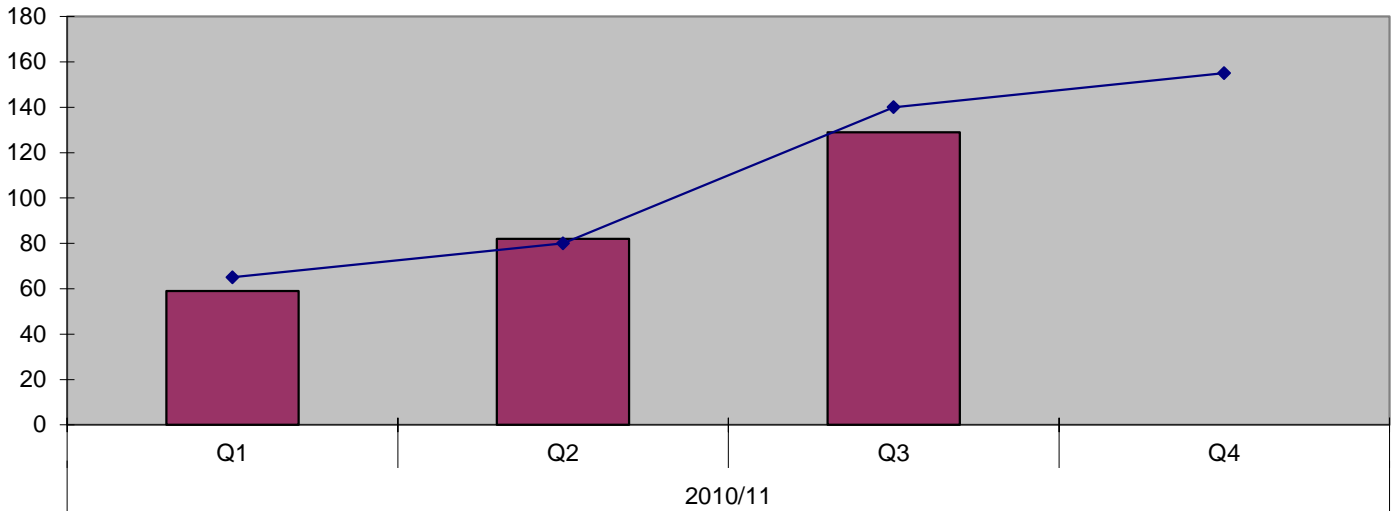
Definition: The number of Pediatric dental surgical cases performed by quarter.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Pediatric Dental Surgeries	N/A				59	82	129	
Benchmark					65	80	140	155
Target Rate					65	80	140	155

Significance: The Hospital has received Wait Times funding to perform additional cases due to long wait times for pediatric dental surgeries. In total, the Hospital expects to perform approximately a total of 440 cases in 2011/12.

Paediatric Dental Surgical Volumes

Pediatric Dental Surgeries
 Target Rate



Analysis:

1st, 2nd, and 3rd Quarters: The Hospital has allocated additional resources to expand this service and currently is on track to meet the total expected volume.

Plan for Improvement/Timelines:

1st, 2nd, and 3rd Quarters: No improvement plan required.

Accountability: Chief of Staff / Director of Surgical Services

Corporate Scorecard FY 2011/2012

ROP - Safe Surgery Checklist

[Scorecard](#)

SUCCESS FACTOR:

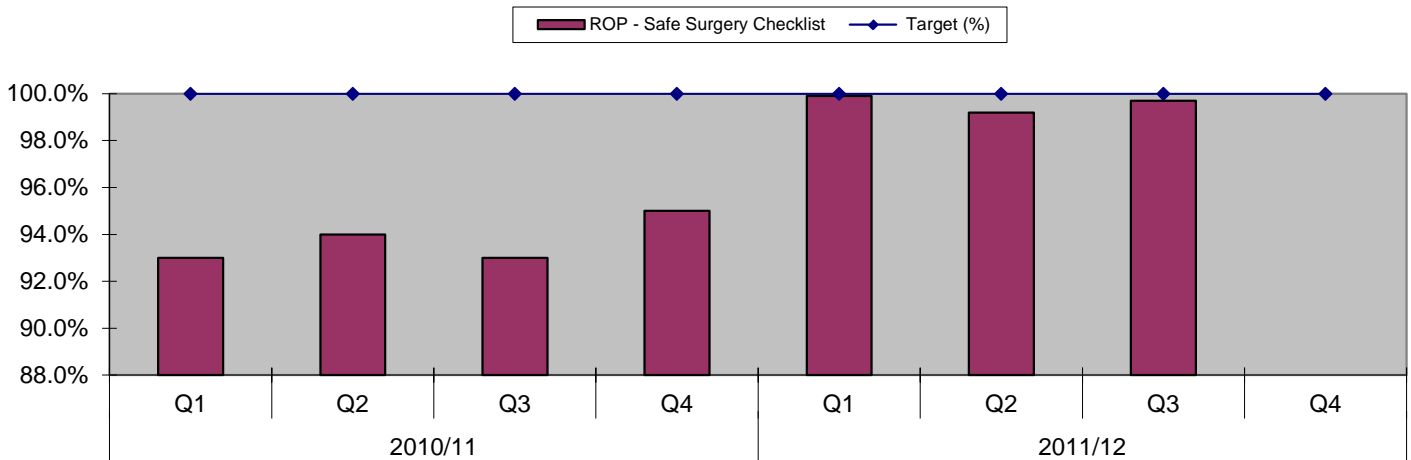
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: The Safe Surgery Checklist is a tool used by the surgical team to increase communication among members, in turn creating a safer environment for the patient. It is used to "ensure that the preoperative, intraoperative and postoperative steps that have been shown to benefit patients are undertaken in a timely and efficient way" (WHO Brochure, Safe Surgery Saves Lives). Data Source: SETP (Surgical Efficiency Targets Program) thru the WTIS.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ROP - Safe Surgery Checklist	93.0%	94.0%	93.0%	95.0%	99.9%	99.2%	99.7%	
Benchmark (%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Target (%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Significance: As of 2011 Accreditation Canada has introduced the use of a Safe Surgery Checklist as a Required Organizational Practice. The surgical team must use a checklist to ensure proper steps are followed prior to a procedure.

Safe Surgery Checklist



Analysis:

1st Quarter: CCH started to use a checklist in 2010 after OHA introduced the concept. The data is captured into the provincial database - Operating Room Benchmarking Collaborative (ORBC). All procedures performed in the OR theatres require that a checklist be completed.

2nd and 3rd Quarters: No change.

Plan for Improvement/Timelines:

1st Quarter: A policy and checklist has been developed and will be presented to the OR Committee and Department of Surgery (October 2011). Nursing documentation has been amended to reflect accountability and completion. The Chief of Staff indicates that the Anaesthetist will lead the check.

2nd and 3rd Quarters: No change.

Accountability: Director of Surgical Services / Medical Director

Corporate Scorecard FY 2011/2012

ROP - Venous Thromboembolism Prophylaxis Target

[Scorecard](#)

SUCCESS FACTOR:

<input type="checkbox"/> Health System Integration <input type="checkbox"/>	<input checked="" type="checkbox"/> Excellence in Quality & Service Delivery <input type="checkbox"/>
<input type="checkbox"/> Outstanding Operational & Financial Performance	<input type="checkbox"/> People Development/Workplace of Choice

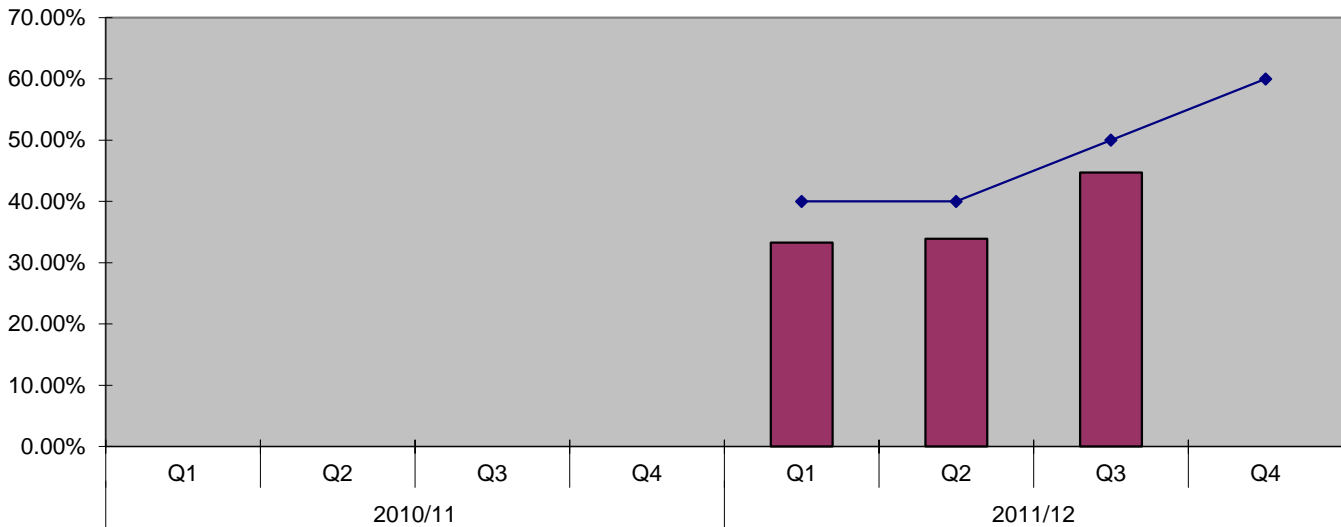
Definition: Accreditation Canada defines venous thromboembolism (VTE) as the collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE). By identifying those patients at risk for VTE and providing prophylactic interventions, incidence rates can be reduced, in turn supporting patient safety and quality service. Data Source: Ambulatory Care.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Venous Thromboembolism Target					33.3%	33.9%	44.7%	
Benchmark (%)								
Target (%)					40.0%	40.0%	50.0%	60.0%

Significance: As of 2011 Accreditation Canada has introduced the use of Venous Thromboembolism Prophylaxis as a Required Organizational Practice. The team will identify those clients at risk of VTE and provide appropriate prophylaxis.

Venous Thromboembolism Prophylaxis Target

Venous Thromboembolism Target Target (%)



Analysis:

1st Quarter: Chart reviews and audits. Monthly audits are broken down and reported by specialty (surgical, medical and CCU). CCH belongs to a provincial collaborative. To date, audit tool has been refined.
2nd and 3rd Quarters: No change.

Plan for Improvement/Timelines:

1st Quarter: Need to identify physician champion.
 Policy/protocol developed - for review at September medical meetings.
2nd Quarter: No change.
3rd Quarter: Successfully secured a physician champion - Dr. Baitz. VTE prophylaxis orders are now embedded in the new pathway orders - Hip and Knee Arthroplasty, Fractured Hip and Bowel Resection, as well as the ER short term orders. Completion of an organizational policy related to VTE prophylaxis still outstanding. Q2 weeks audits continue on medicine, surgery and CCU.

Accountability: Chief of Staff / Chief Clinical Officer

Corporate Scorecard FY 2011/2012

MRSA Colonization and Infection Incidence

[Scorecard](#)

SUCCESS FACTOR:

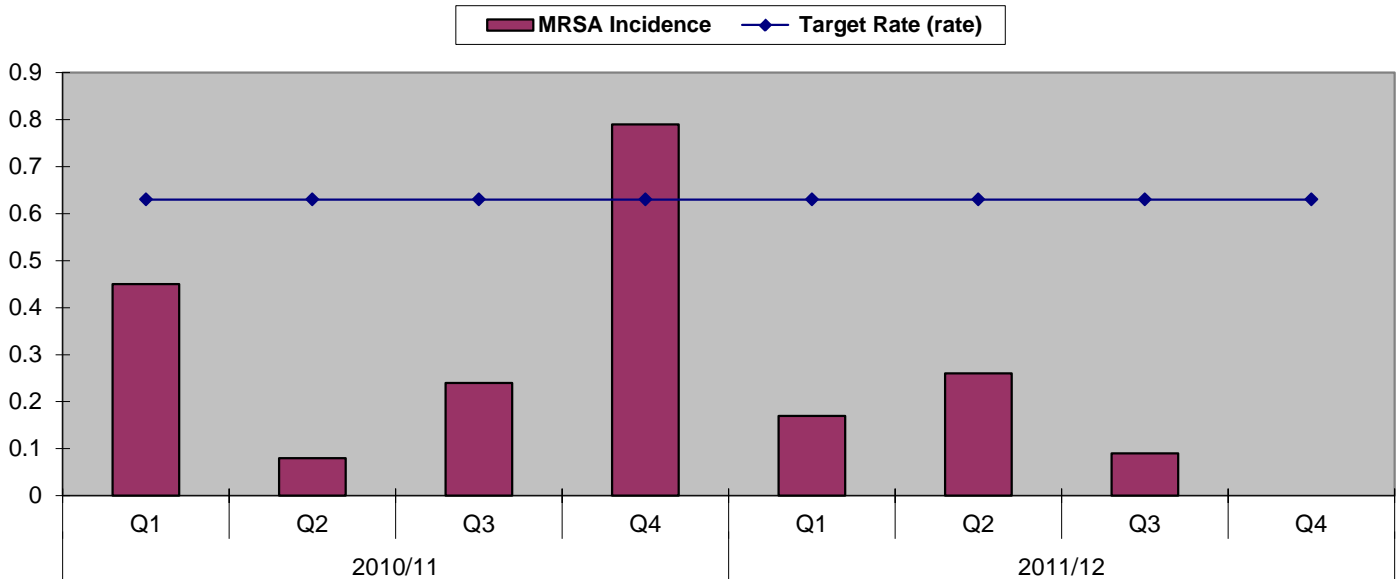
<p>Health System Integration</p> <input type="checkbox"/>	<p>Excellence in Quality & Service Delivery</p> <input checked="" type="checkbox"/>
<p>Outstanding Operational & Financial Performance</p> <input type="checkbox"/>	<p>People Development/Workplace of Choice</p> <input type="checkbox"/>

Definition: The hospital-wide colonization and infection rate of nosocomial MRSA measured per 1000 patient days. Benchmark is taken from the Canadian Nosocomial Infection Surveillance Program (CNISO); Surveillance for Methicillin resistant Staphylococcus aureus. The regional Benchmark rate is currently underdevelopment by the Champlain Regional Infection Control Network.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
MRSA Incidence	0.45	0.08	0.24	0.79	0.17	0.26	0.09	
Benchmark (rate)	0.63	0.63	0.63	0.63	0.63	0.63	0.63	0.63
Target Rate (rate)	0.63	0.63	0.63	0.63	0.63	0.63	0.63	0.63

Significance: Methicillin resistant (MRSA) organism or methicillin resistant Staphylococcus : MRSA organisms (commonly nosocomial) can cause serious infections if passed on to someone who is already ill. A lower rate of MRSA incidence indicates a vigilance in infection control practices.

MRSA INCIDENCE



Analysis:

1st Quarter: Incidence has returned to Normal thresholds.
2nd Quarter: No further updates since reporting period July-September, 2011.
3rd Quarter: No change

Plan for Improvement/Timelines:

1st Quarter: Risk factor based screening tool implemented in July/11.
2nd Quarter: No change.
3rd Quarter: No change

Accountability: Infection Prevention and Control

Corporate Scorecard FY 2011/2012

Clostridium Difficile Incidence

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration

Excellence in Quality & Service Delivery

Outstanding Operational & Financial Performance

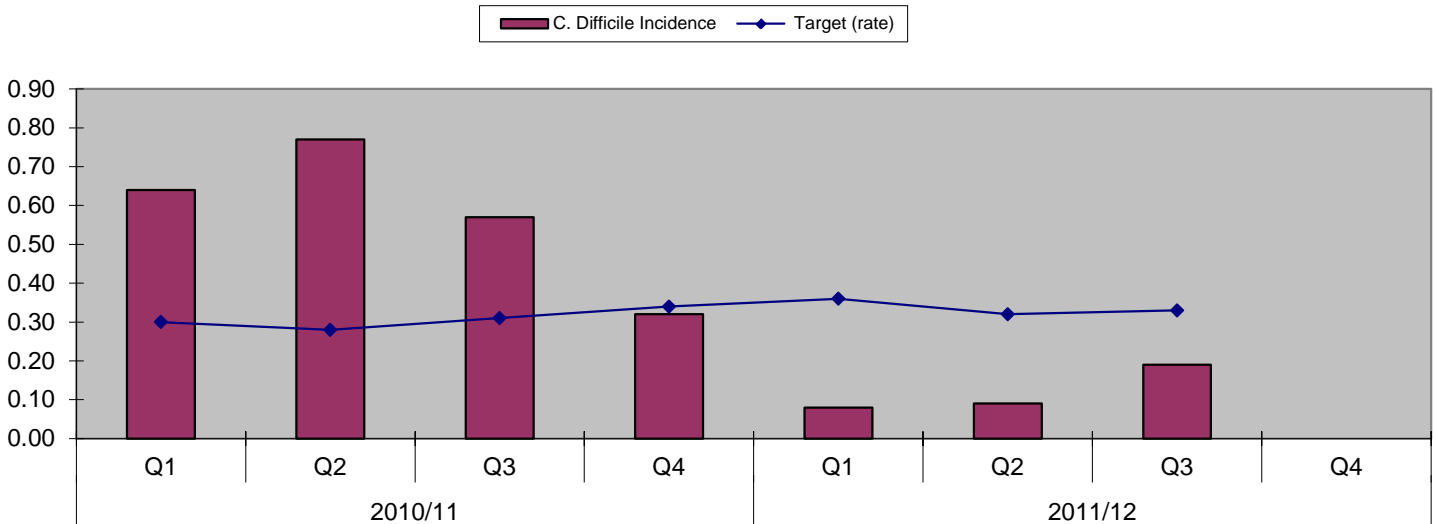
People Development/Workplace of Choice

Definition: The hospital-wide rate of nosocomial Clostridium Difficile infection measured per 1000 patient days. Benchmark rates taken from regional data and target rates taken from provincial surveillance.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
C. Difficile Incidence	0.64	0.77	0.57	0.32	0.08	0.09	0.19	
Benchmark (rate)	0.36	0.30	0.33	0.38	n/a	n/a	n/a	
Target (rate)	0.30	0.28	0.31	0.34	0.36	0.32	0.33	

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.

C.Difficile Incidence



Analysis:

1st Quarter: Incidence has returned to normal thresholds.

2nd Quarter: 2 Cases within 3,610 patient days. Outbreaks reported within 5 hospitals; 3 resolved within the reporting period, 2 remained in outbreak status.

3rd Quarter: Remain below provincial average

Plan for Improvement/Timelines:

1st Quarter: Change in C. Difficile testing should provide more accurate results - improve management of patients.

2nd Quarter: No change.

3rd Quarter: No significant change

Accountability: Infection Prevention and Control

Corporate Scorecard FY 2011/2012

VRE Colonization and Infection Incidence

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration

Excellence in Quality & Service Delivery

Outstanding Operational & Financial Performance

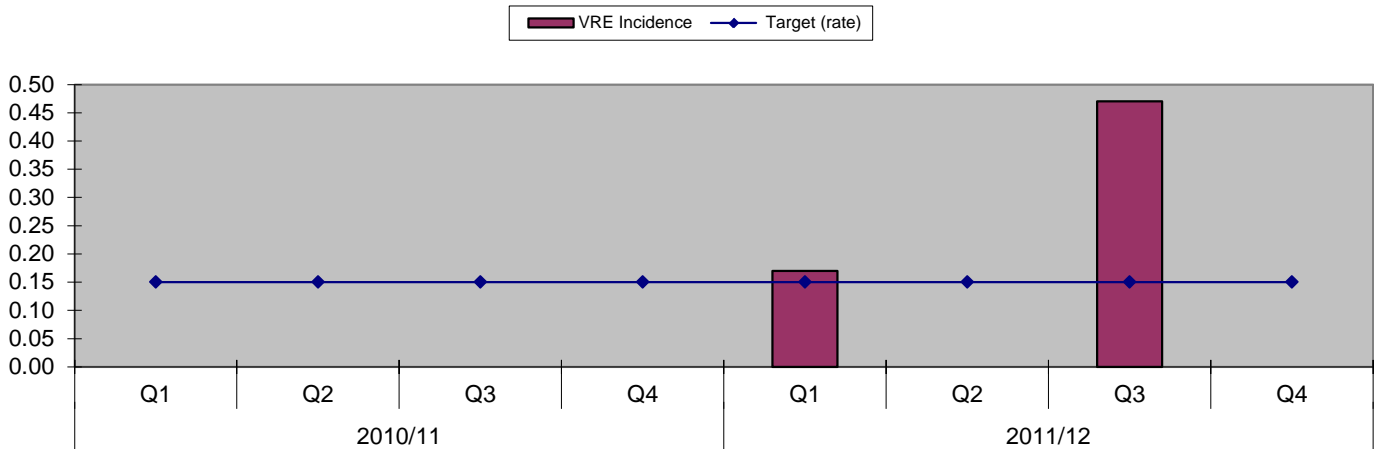
People Development/Workplace of Choice

Definition: The hospital-wide colonization and infection rate of nosocomial VRE infection measured per 1000 patient days. Benchmark rate is taken from the Canadian Nosocomial Infection Surveillance Program (CNISP); Surveillance for Vancomycin resistant Enterococcus faecalis.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
VRE Incidence	0.00	0.00	0.00	0.00	0.17	0.00	0.47	
Benchmark (rate)	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15
Target (rate)	0.15	0.15	0.15	0.15	0.15	0.15	0.15	0.15

Significance: Vancomycin Resistant Enterococci is an antibiotic resistant organism, easily spread by direct contact. Enterococci is part of the normal bowel flora. The transmission of VRE can be accelerated if found in combination with diarrhea, such as clostridium Difficile diarrhea (CAD).

VRE Incidence



Analysis:

1st Quarter: 1 case.

2nd Quarter: No incidence. No further updates since reporting period July-September, 2011.

3rd

Quarter: Significant increase

Plan for Improvement/Timelines:

1st Quarter: Risk - factor based screening tool implemented in July 2011.

2nd Quarter: No change.

3rd Quarter: Met with staff in affected areas, reinforced IPAC practices, hand hygiene, troubleshooting re bowel management -will monitor

Accountability: Infection Prevention and Control

Corporate Scorecard FY 2011/2012

Ventilator-Associated Pneumonia

[Scorecard](#)

SUCCESS FACTOR:

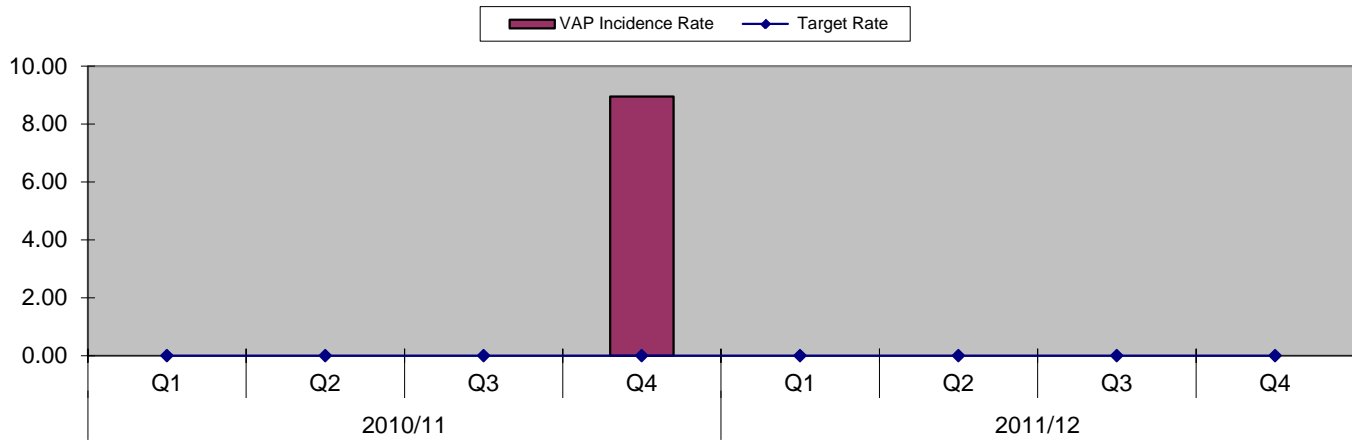
<p>Health System Integration</p>	<p>Excellence in Quality & Service Delivery</p>
<p>Outstanding Operational & Financial Performance</p>	<p>People Development/Workplace of Choice</p>

Definition: Intensive Care (ICU) Ventilator-Associated Pneumonia (VAP) cases per 1000 device days. Benchmark Safer Healthcare Now (SHN) starting Q4 Provincial (Ontario).

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
VAP Incidence Rate	0.00	0.00	0.00	8.95	0.00	0.00	0.00	
Benchmark	2.16	N/A	1.48	1.33	1.33	1.03	1.26	
Target Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Significance: One Component of the Safer Healthcare Now (SHN) reporting initiative and is required by the Ministry of Health and Long Term Care (MOHLTC).

Ventilator-Associated Pneumonia



Analysis:

1st Quarter: No cases.
2nd Quarter: No cases.
3rd Quarter: No cases

Plan for Improvement/Timelines:

1st Quarter: No action required
2nd Quarter: No further updates since reporting period July-September, 2011.
3rd Quarter: No action required

Accountability: Infection Prevention and Control & Director of Critical Care

Corporate Scorecard FY 2011/2012

Central Line Infections

[Scorecard](#)

SUCCESS FACTOR:

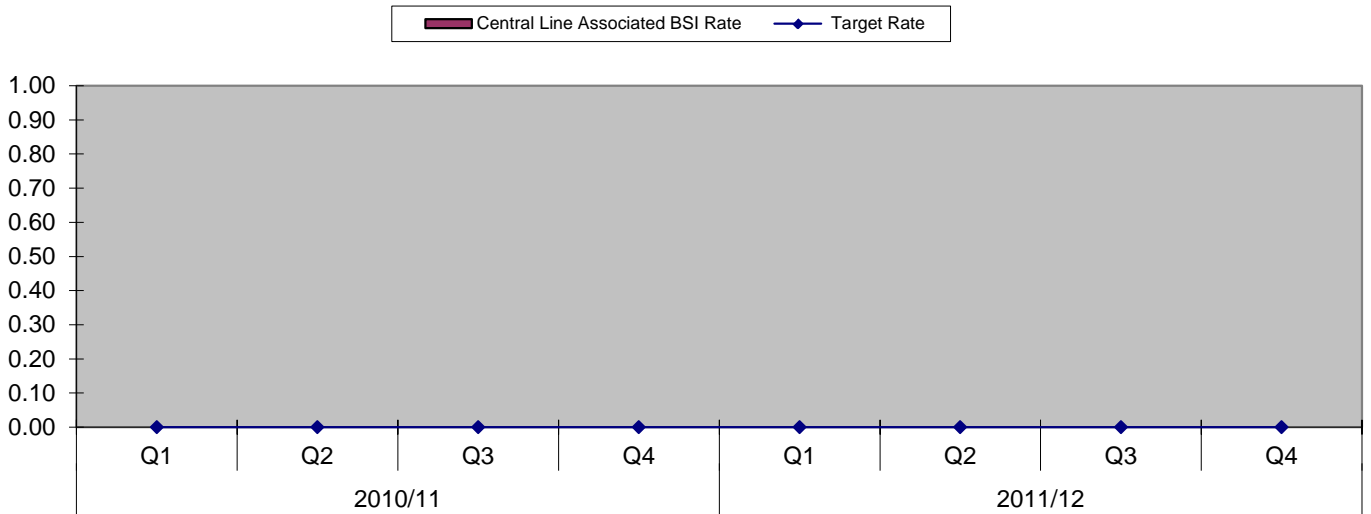
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: Intensive Care Unit (ICU) central line-associated bloodstream infections (CLI) per 1000 device days. Benchmark taken from Safer HealthCare Now (SHN) starting Q4 2010 Provincial (Ontario)

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Central Line Associated BSI Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Benchmark	0.94	NIA	0.76	0.79	0.69	0.77	0.48	
Target Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Significance: One Component of the Safer Healthcare Now (SHN) reporting initiative and is required by the Ministry of Health and Long Term Care (MOHLTC).

Central Line Infections



Analysis:

1st Quarter: No cases.
2nd Quarter: No cases.
3rd Quarter: No cases

Plan for Improvement/Timelines:

1st Quarter: No action required.
2nd Quarter: No further updates since reporting period July-September, 2011.
3rd Quarter: No action required

Accountability: Patient Safety - Infection Prevention and Control & Director of Critical Care

Corporate Scorecard FY 2011/2012

Hand Hygiene

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration

Excellence in Quality & Service Delivery

Outstanding Operational & Financial Performance

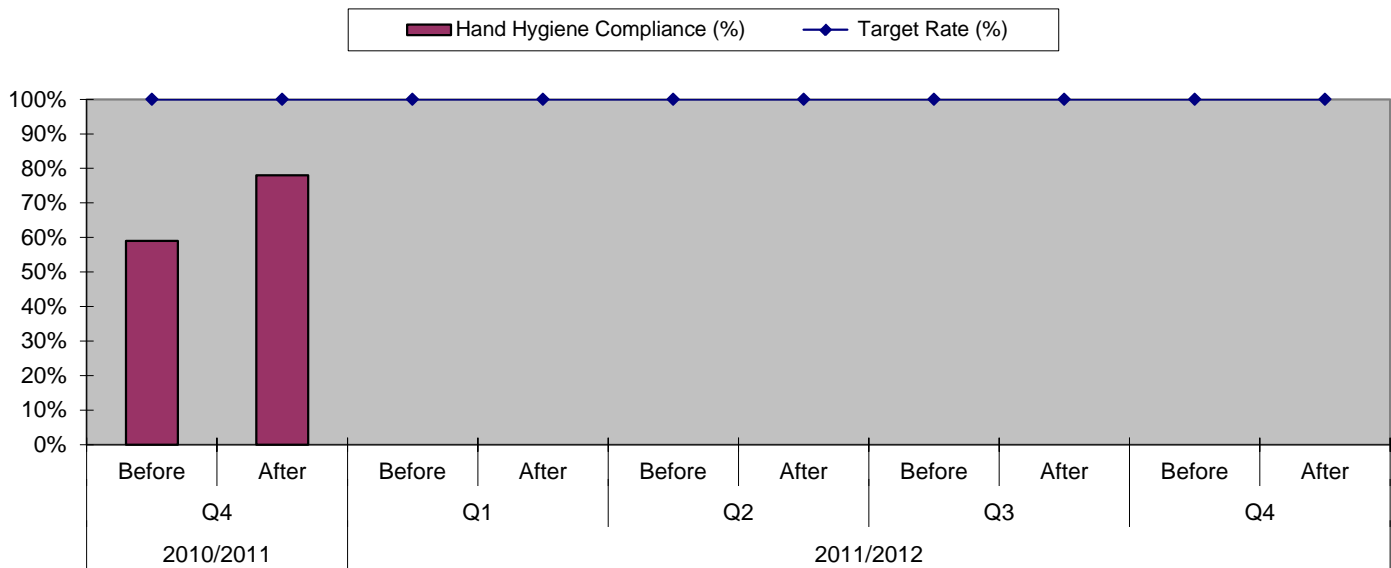
People Development/Workplace of Choice

Definition: A general term referring to any action of hand cleaning. The percentage compliance before and after initial patient/patient environment contact by combined health care provider type. (i.e. # of times hand hygiene performed before and after care).
For fiscal year 2010/2011 CCH was reporting annually. We will be reporting quarterly for fiscal year 2011/2012.

	2010/2011		2011/2012								
	Q4		Q1		Q2		Q3		Q4		
	Before	After	Before	After	Before	After	Before	After	Before	After	
Hand Hygiene Compliance (%)	59%	78%									
Benchmark (%)	73%	83%									
Target Rate (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Significance: 1. To reduce the spread of infection and antibiotic-resistant organisms by limiting the acquisition of preventable Healthcare-Associated Infections (HAIs) 2. Reportable to the MOHLTC.

Hand Hygiene



Analysis:

1st Quarter: Q1 data is not available at this point. As it becomes available, the indicator will be updated.

2nd Quarter: No change.

Plan for Improvement/Timelines:

Accountability: Patient Safety - Infection Prevention and Control

Corporate Scorecard FY 2011/2012

Surgical Site Infection Prophylaxis

[Scorecard](#)

SUCCESS FACTOR:

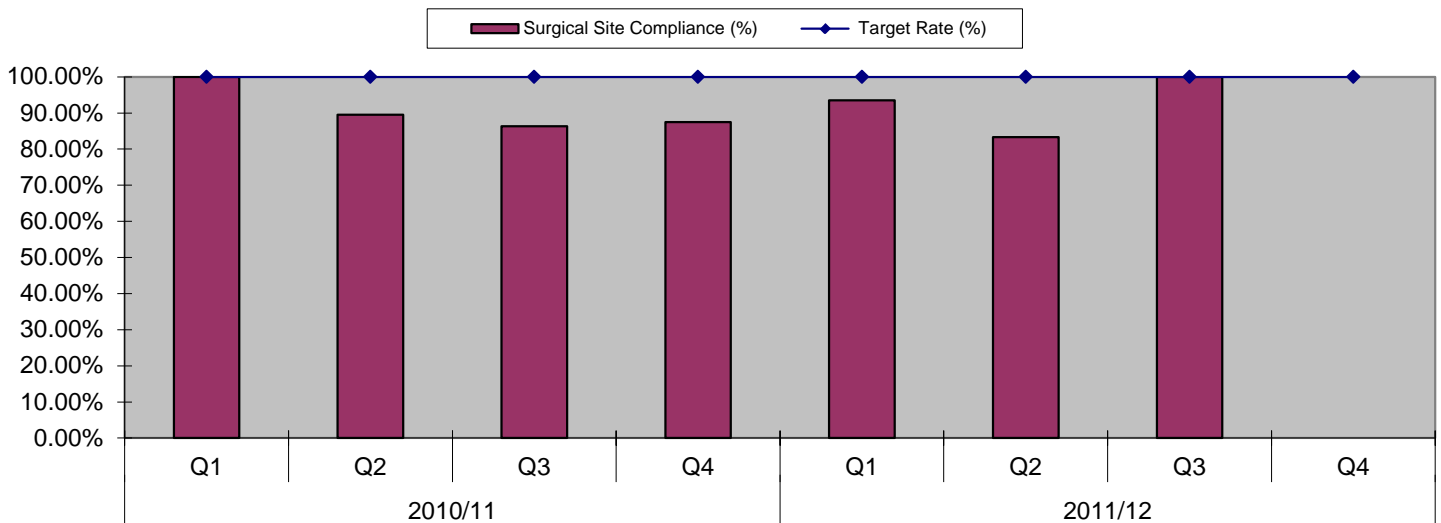
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: Surgical site infection prophylaxis as measured by the appropriateness of prophylactic antibiotic use for total knee and hip procedures. Calculated by dividing the number of Hip/Knee joint replacement surgeries who received usual antibiotics within 60 mins of skin incision plus the number of Hip/Knee joint replacement surgeries who received Vancomycin within 120 mins of skin incision by the total number of patients during the reporting period who had a primary Knee/Hip joint replacement surgical procedure.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Surgical Site Compliance (%)	100.00%	89.50%	86.36%	87.50%	93.50%	83.33%	100.00%	
Benchmark (%)	96.00%	96.00%	96.60%	96.60%	90.00%	96.74%	97.09%	
Target Rate (%)	100%	100%	100%	100%	100%	100%	100%	100%

Significance: One component of the Safer Healthcare Now (SHN) reporting initiative and is required reporting by the Ministry of Health and Long Term Care (MOHLTC). The Benchmark is based on the provincial average for each respective quarter beginning Q1 2009/2010.

Surgical Site Infection Prophylaxis



Analysis:

1st Quarter: Safer Healthcare Now and Canadian Patient Safety Institute identify 4 components to reduce SSI; one of these is perioperative antimicrobial coverage. A nurse in the OR is assigned responsibility for I.V. antibiotic administration. Need to analyze how to increase compliance.

2nd Quarter: No change.

3rd Quarter: Increased compliance with clippers versus razors.

Plan for Improvement/Timelines:

1st Quarter: Plan to implement other 3 quality initiatives related to SSE prevention.

Review literature provided by Safer Healthcare Now and present to Department of Surgery to address physician concerns and gain support and leadership.

2nd and 3rd Quarters: Ongoing monitoring and improving.

Accountability: Director of Surgical Services / Chief of Staff

Corporate Scorecard FY 2011/2012

Inpatient Smoking Cessation

[Scorecard](#)

SUCCESS FACTOR:

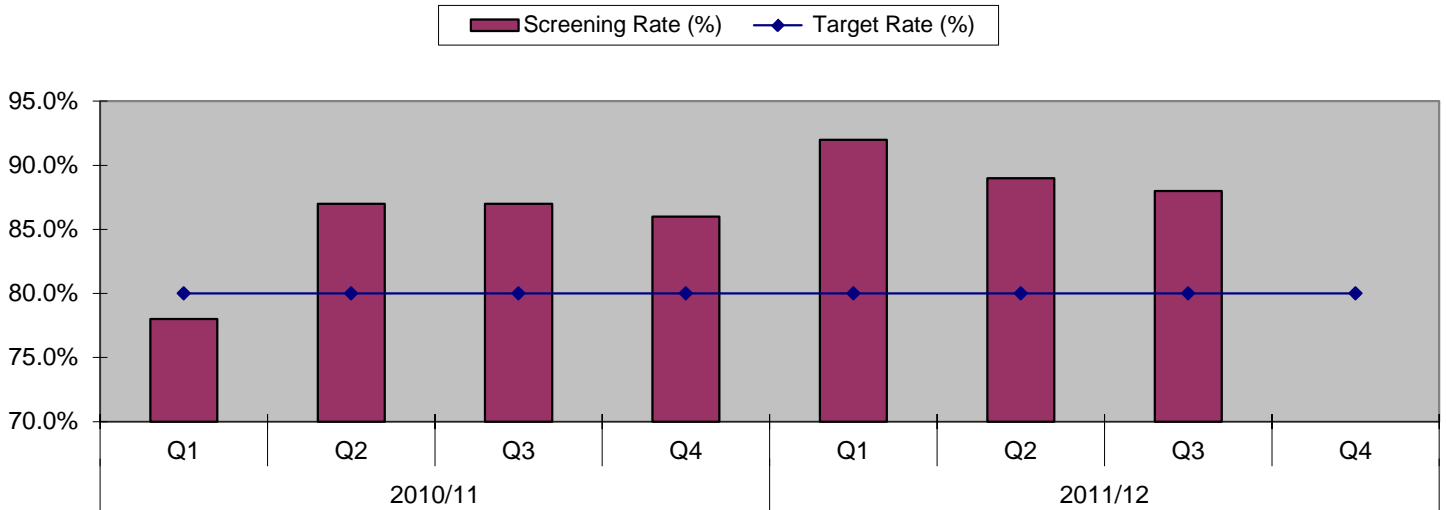
Health System Integration	<input type="checkbox"/>	Excellence in Quality & Service Delivery	<input checked="" type="checkbox"/>
Outstanding Operational & Financial Performance	<input type="checkbox"/>	People Development/Workplace of Choice	<input type="checkbox"/>

Definition: The percentage of inpatient smokers screened through the smoking cessation program.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Screening Rate (%)	78.0%	87.0%	87.0%	86.0%	92.0%	89.0%	88.0%	
Benchmark (%)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Target Rate (%)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

Significance: The Hospital is to work towards a goal to ensure that the Ottawa Hospital Model of smoking cessation reaches 80% of inpatient smokers by March 2013. For 2011/12 the target rate is 25% improvement over 2010/11.

Smoking Cessation Rate



Analysis:

- 1st Quarter:** Metric is outperforming by 12%
- 2nd Quarter:** Metric is outperforming by 9 %
- 3rd Quarter:** Metric outperforming by 8%

Plan for Improvement/Timelines:

1st, 2nd and 3rd Quarters: It should be noted that we can further improve our screening rate by timely notification when an inpatient smoker has been identified. Surgical pre-admission has been recruited to assist in flagging these patients and sending notification to cardio-respiratory. Nursing re-education will also be addressed to improve notification rates.

Accountability: Director, Diagnostic Services

Corporate Scorecard FY 2011/2012

Elective Repeat C-Section Rates

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration

Excellence in Quality & Service Delivery

Outstanding Operational & Financial Performance

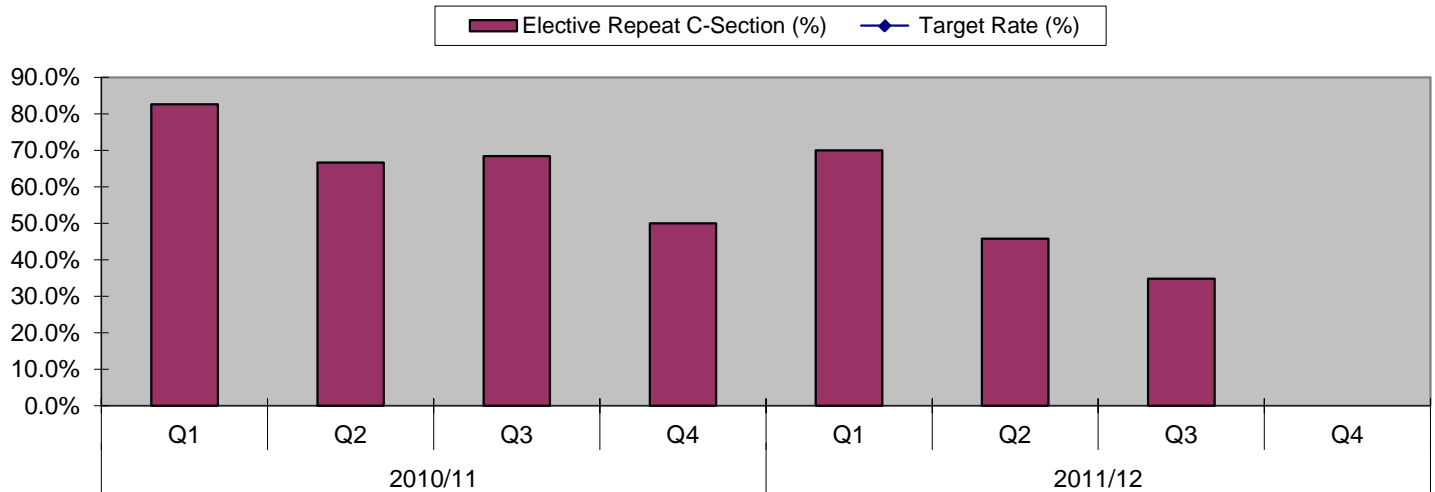
People Development/Workplace of Choice

Definition: Percentage of elective repeat caesarean sections in low risk women being done at 37 or 38 weeks gestational age.
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.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Elective Repeat C-Section (%)	82.6%	66.7%	68.4%	50.0%	70.0%	45.8%	34.8%	
Benchmark (%)								
Target Rate (%)								

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: 2010/11/12 - BORN database. Quarterly reporting - no known provincial level indicators to date although a PCMCH scorecard and the BORN dashboard are both under development.
 There is no target rate as the LHIN will not be providing that information for this fiscal year.

Elective Repeat C-Section Rate



Analysis:

1st Quarter: The LHIN has indicated that based on expert opinion and the evidence review, there is significant risk to newborns if the elective repeat C/S for low risk women not in labour and with no obstetrical or health complication is done before 39 weeks GA.
2nd Quarter: Manager of Women and Children's Health reported to the Board on this indicator (October 2011); further information requested.
3rd Quarter: Ongoing monitoring.

Plan for Improvement/Timelines:

1st Quarter: At this time, there is an increased awareness of the issue. Data is presented at the Department of Obstetrics/Gynecology.
2nd Quarter: Reviewing OR Blocks to increase compliance.
3rd Quarter: Discussion held at Medical Quality Assurance. Ongoing monitoring reported monthly to departmental chief.

Accountability: Chief of Staff / Chief Clinical Officer

Corporate Scorecard FY 2011/2012

Patients on Pathways

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration <input checked="" type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

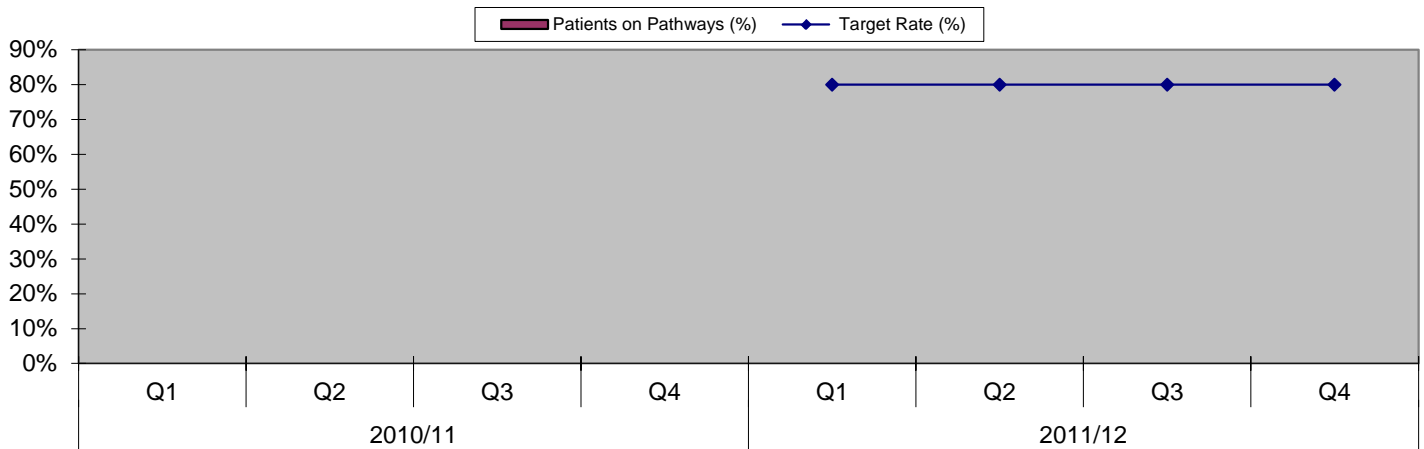
Definition: The number of patient care/referral pathways explored, established or implemented divided by the total number of potential patients on pathways.

Of patients admitted to hospital with admission diagnosis of stroke (after June), fractured hip (after September) or Total Joint Replacement (hip and knee), 80% will be on a pathway.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Patients on Pathways (%)								
Benchmark (%)								
Target Rate (%)					80%	80%	80%	80%

Significance: Cornwall Community Hospital will continue working with community based services, eastern counties' community hospitals and tertiary centres to identify service gaps and establish care pathways to facilitate patient service throughout the continuum of care for children, youth, adults and seniors in order to drive quality and play a leading role in health system integration.

Patients on Pathways



Analysis:

1st, 2nd and 3rd Quarters: CCH has developed a template for pathways to be used for all pathways to increase understanding and implementation of them. Need to analyze why they are not consistently used/ordered by physicians. Benefit of pathways is that they ensure consistent care, improve plans for discharge and facilitate improved understanding of diagnosis for patient and family. Protocols are developed based on evidence-based care.

Plan for Improvement/Timelines:

1st Quarter: Meet with orthopedic surgeons in September to gain acceptance and MAC approval by October (for total joints and fractured hips). Present to Medical Staff Committee re: CVA pathways and protocols (June 20th, 2011 & MAC November 2011).

2nd Quarter: An admission order sheet has been developed for all patients admitted through ER; this is in an attempt to facilitate the use of the pathways. The trial for the stroke protocol/pathway is being amended and will be presented both to the Dept of ER and P&T in December 2011. Work is ongoing with the development of other pathways.

3rd Quarter: Data began being captured regarding the Hip & Knee Replacement, Hip Fracture, and Stroke pathways in December. In order to ensure data quality remains high we will include results beginning January; Q4 information will be available.

Accountability: Chief Clinical Officer / Chief of Staff

Corporate Scorecard FY 2011/2012

Alternate Level of Care Medical/Surgical Occupancy

[Scorecard](#)

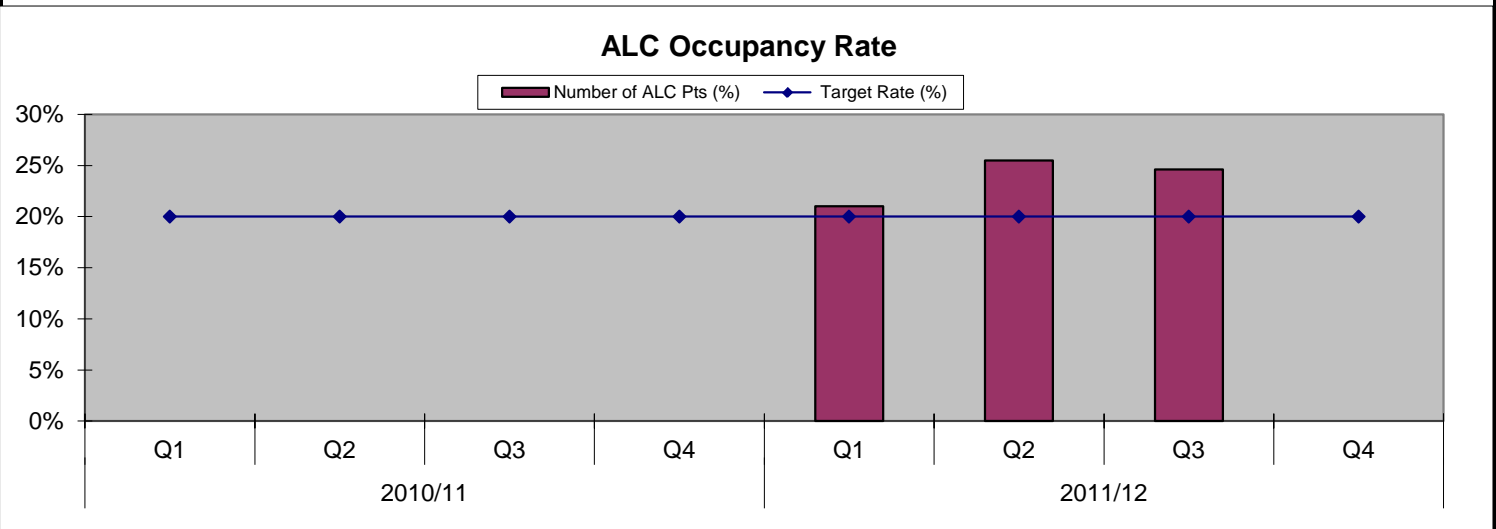
SUCCESS FACTOR:

Health System Integration <input checked="" type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: The percentage of beds occupied by ALC patients to the total number of inpatient beds. Calculation: ALC Occupancy (data from Anzer Report) divided by total Medical and Surgical beds.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of ALC Pts (%)					21.0%	25.5%	24.6%	
Benchmark (%)								
Target Rate (%)	20%	20%	20%	20%	20.0%	20.0%	20.0%	20.0%

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



Analysis:
1st Quarter: Alternative level of care (ALC) occupancy rates for first quarter improved significantly over previous year. On target.
2nd Quarter: Alternative Level of Care rates increased in Q2 and above target.
3rd Quarter: ALC rates continue to be above target.

Plan for Improvement/Timelines:
1st Quarter: Rates for ALC expected to continue to improve with CCAC Home First Program and the Assess and Restore beds at Second Street Site.
2nd Quarter: 32 Access and Restore beds were opened late Quarter 2; CEO and Chief Clinical Officer meeting with CCAC Executive to ensure patient flow from acute care to placement options, including home.
3rd Quarter: Several efforts to address the ALC rates are underway, including focus on the Home First Philosophy, Assess and Restore Beds and attention to discharge options prior to ALC designation.

Accountability: CEO

Corporate Scorecard FY 2011/2012

Percentage ALC Patients Referred to CCAC

[Scorecard](#)

SUCCESS FACTOR:



Health System Integration

Excellence in Quality & Service Delivery

Outstanding Operational & Financial Performance

People Development/Workplace of Choice

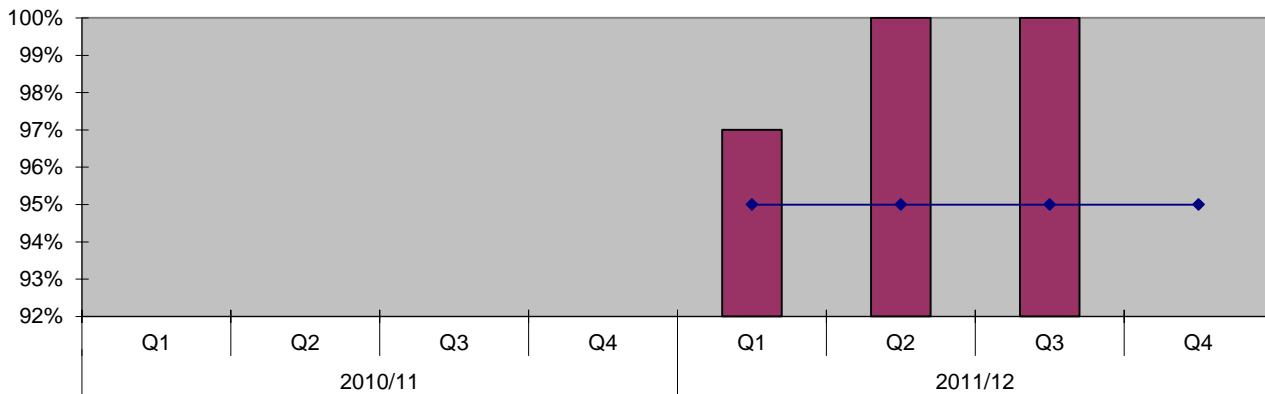
Definition: Number of eligible ALC patients referred to CCAC divided by the Total number of eligible ALC patients. (Excludes those patients waiting for Rehab or Continuing Complex Care)

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Patients Referred to CCAC (%)					97%	100%	100%	
Benchmark (%)								
Target Rate (%)					95%	95%	95%	95%

Significance: With consent, all eligible ALC patients will be referred to CCAC.

ALC patients Referred to CCAC (%)

ALC Patients Referred to CCAC (%)
 Target Rate (%)



Analysis:

1st Quarter: As a means of reducing ALC admission to Long Term Care, it is crucial that patients be referred to CCAC. In November 2010, the Home First Program was introduced for clients at CCH. To date, CCH has a very high percentage of referrals. Data obtained through manual audits.

2nd Quarter: CCH have taken a lead in the Champlain LHIN towards full immersion into the Halton Model of Home First, which not only addresses ALC efficiencies but also supports ED-PIP and subsequently ED wait times through timely patient flow. New initiatives and measures implemented have resulted in 100% compliance with referrals to CCAC for eligible ALC patients.

3rd Quarter: CCH continues to exceed the 95% target. The Discharge Planning Nurses continue to maintain 100% referral rate for all eligible patients.

Plan for Improvement/Timelines:

1st Quarter: Ongoing analysis and review to ensure sustainability at various LHIN committees that involve both CCH and CCAC.

With the advancement of the Home First Philosophy at CCH, new collaborative initiatives between CCH and CCAC, as well as future education sessions to staff and physicians, CCH can achieve 100% of all eligible ALC patients being referred to CCAC. A new process is being implemented whereby the Discharge Planning Nurses refer to the CCAC Case Managers to determine discharge disposition.

The emphasis is on Home First and not doing LTC applications from hospital. CCAC will implement all possible measures to return patients to the community, including a discharge to Assess and Restore for further therapy/improvement and then discharge back to the community from there.

2nd Quarter: Ongoing collaboration with CCAC continues with a focus of ensuring early referrals to CCAC for the purposes of determining discharge destination and avoiding ALC designation if at all possible. The main objective remains with respect to patients returning to the community from hospital and if Long Term Care is required, the application process would begin from home.

3rd Quarter: CCH's approach and current practice and philosophy of patients returning home to the community supports our success in exceeding the 95% target. No further action required related to this indicator.

Accountability: Chief Clinical Officer

Corporate Scorecard FY 2011/2012

Departmental/Services Scorecard

[Scorecard](#)

SUCCESS FACTOR:

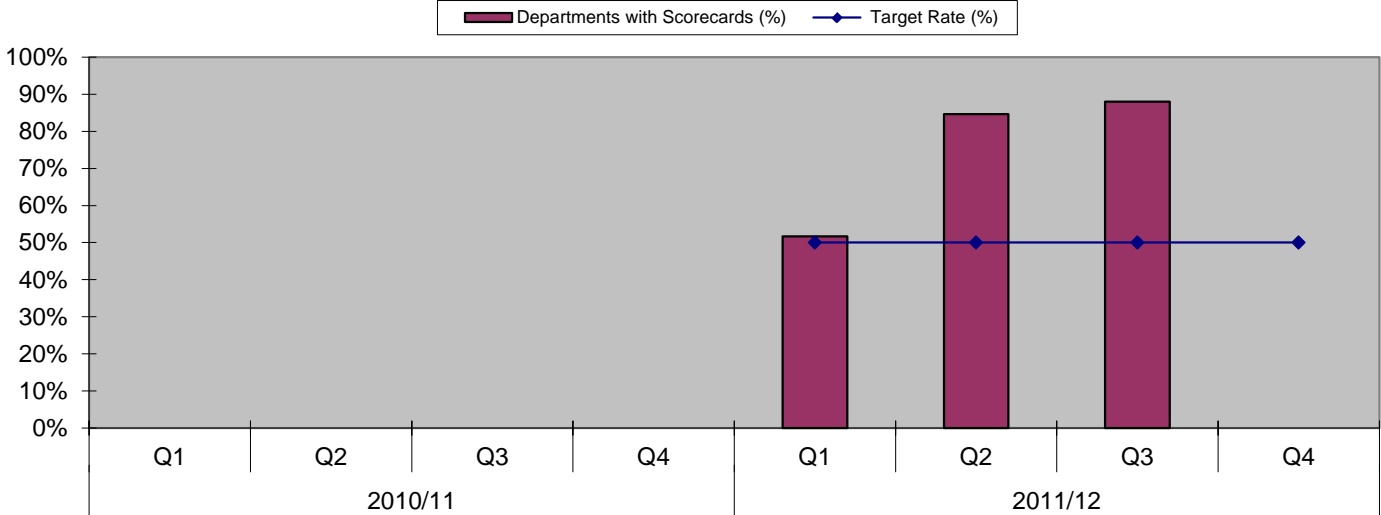
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input checked="" type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: The percentage of Departments/Services with scorecards to the total number of departments/services.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Departments with Scorecards (%)					52%	85%	88%	
Benchmark (%)					50%	50%	50%	50%
Target Rate (%)					50%	50%	50%	50%

Significance: Cornwall Community Hospital is committed to maintain notable operational gains and recognizes the need to provide and understand appropriate information through key performance indicators. These reporting structures and processes will drive accountability throughout the organization for optimum financial and operational performance.

Percentage with Departmental Scorecards



Analysis:

1st Quarter: Fifteen out of twenty-nine proposed departments have scorecards started.

2nd Quarter: Adjustments made to the number of departments requiring scorecards, some departments have been combined. There are now 22 out of 26 departments with scorecards. Decision Support has been developing training for SharePoint which has caused a delay in updating the departmental scorecards.

3rd Quarter: There are currently 23 out of 26 departments with scorecards.

Plan for Improvement/Timelines:

1st Quarter: No improvement plan required.

2nd Quarter: Training for SharePoint 2010 began November 2011; current versions of departmental scorecards will be migrated to this new site shortly. This will allow for enhanced collaboration between Decision Support and Departmental Managers/Directors, in turn increasing the efficiency with which we are able to provide data for the scorecards.

3rd Quarter: Training for SharePoint 2010 was successful and departmental scorecards are currently available on this new site.

Accountability: COO, CPRO, CCO, CD

Corporate Scorecard FY 2011/2012

Total Margin

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input checked="" type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

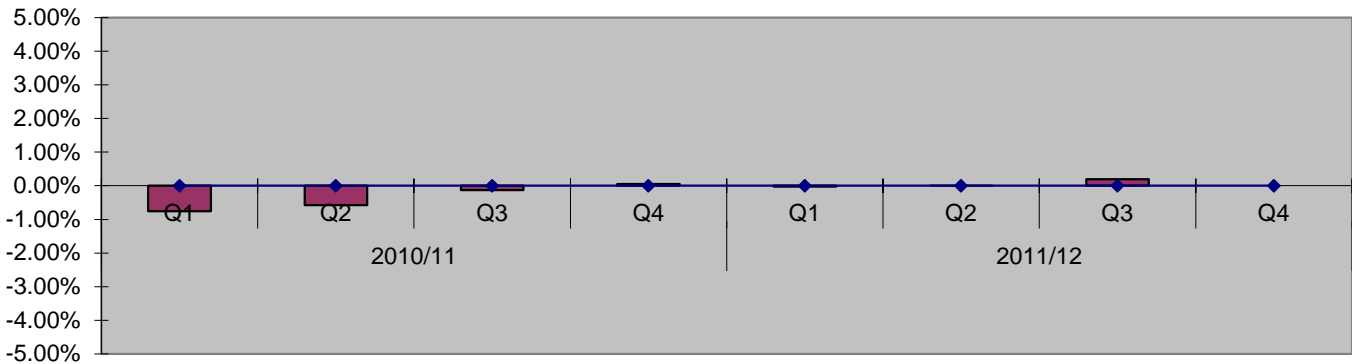
Definition: The percentage by which total revenues exceed total expenses. A negative value indicates that expenses have exceeded revenues and a positive value indicates an excess of revenue over expenses.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total Operating Margin	-0.76%	-0.58%	-0.13%	0.05%	-0.03%	0.005%	0.195%	
Benchmark (%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Target Rate (%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Significance: Indicates a balanced operating position. The MOHLTC, through the Hospital Accountability Agreement process, has set our benchmark to be 0%.

Total Margin

Total Operating Margin Target Rate (%)



Analysis:

1st and 2nd Quarters: Results for first quarter on target to balance operations at year end.
3rd Quarter: results are consistent with direction to balance budget at year end.

Plan for Improvement/Timelines:

1st and 2nd Quarters: Continue to monitor budget and respond to variances monthly.
3rd Quarter: No action required. Hospital is anticipating a balanced budget at year end.

Corporate Scorecard FY 2011/2012

Current Ratio

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input checked="" type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

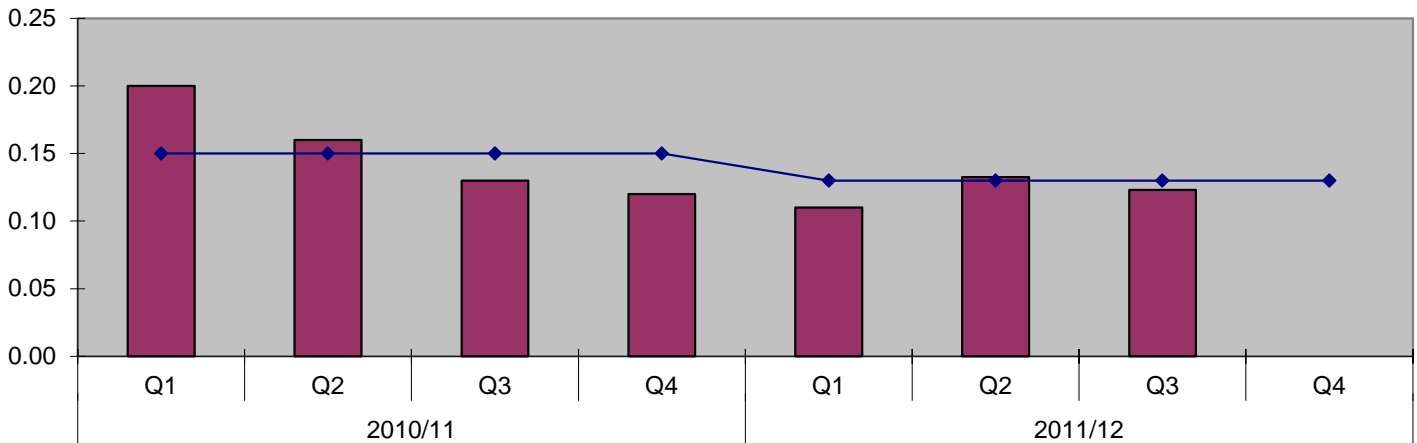
Definition: Current Ratio is a key measure of liquidity. It reflects to what extent short-term financial obligations can be met from short term assets. Current Ratio = Current Assets/Current Liabilities. Target is based on HSAA performance Target 2011/12.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Current Ratio	0.20	0.16	0.13	0.12	0.11	0.13	0.12	
Benchmark (ratio)	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Target Rate (ratio)	0.15	0.15	0.15	0.15	0.13	0.13	0.13	0.13

Significance: Indicates the overall financial health of the organization. The MOHLTC, through the Hospital Accountability Agreement process, has set our benchmark range between 0.8 and 2.0.

Current Ratio

Current Ratio Target Rate (ratio)



Analysis:

1st 2nd and 3rd Quarters: The hospital has a significant working capital deficit which has accumulated over the first few years of operation. This situation is **not** expected to worsen at current year end.

Plan for Improvement/Timelines:

1st Quarter: Cornwall Community Hospital participating in provincial initiative looking at these working capital issues across the province. **2nd Quarter:** OHA has indicated that hospitals are expected to receive further information on MOHLTC working capital process Nov/Dec 2011. **3rd Quarter:** No action required.

Corporate Scorecard 2011/2012

Administration Expense to Operating

[Scorecard](#)

SUCCESS FACTOR:

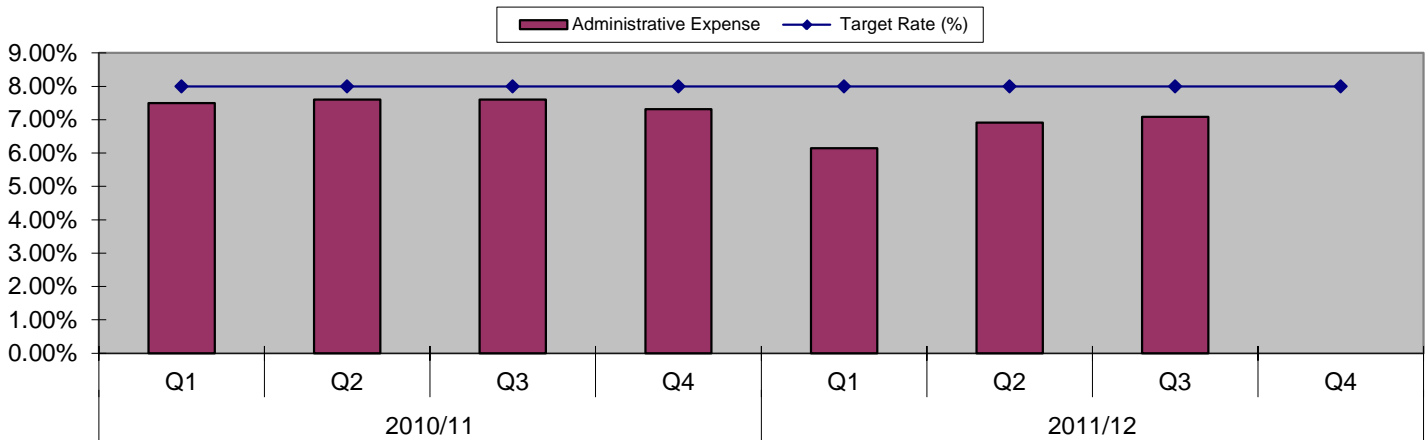
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input checked="" type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: This measures the expenditure on administration to Operating Expense.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Administrative Expense	7.50%	7.60%	7.60%	7.31%	6.14%	6.91%	7.08%	
Benchmark (%)	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%
Target Rate (%)	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%

Significance: High values could indicate a potential for overhead reduction. Data taken from the FIM website the benchmark and target rate are based on the 25th percentile.

Administrative Expense to Operating



Analysis:

1st/2nd/3rd Quarters: Administration expenses as a percentage of total operating budget is less than 25th percentile indicating very low levels of administration expenditures.

Plan for Improvement/Timelines:

1st/2nd/3rd Quarters: No action required.

Accountability: Chief Executive Officer

Corporate Scorecard FY 2011//2012

Equipment Expense to Operating Expense

[Scorecard](#)

SUCCESS FACTOR:

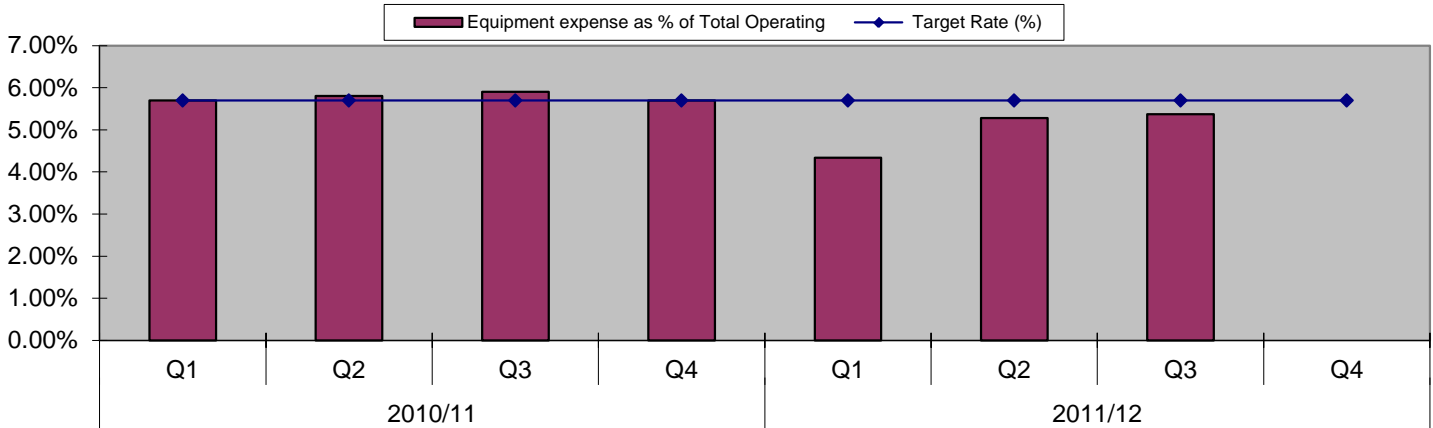
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input checked="" type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: Measures the total equipment related expenditures over total hospital operating expenditures. Equipment expenditures include amortization of equipment, maintenance contracts and repairs.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Equipment expense as % of Total Operating	5.70%	5.80%	5.90%	5.70%	4.34%	5.28%	5.37%	
Benchmark (%)	5.90%	5.90%	5.90%	5.90%	5.90%	5.90%	5.90%	5.90%
Target Rate (%)	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%	5.70%

Significance: Benchmark and Target are taken from the FIM website, the 25th percentile of our peer hospitals. Assuming Year End remains at 5.7%. FIM website 10/11 25th percentile is 5.8%

Equipment Expenditures as % of Total Operating Cost



Analysis:

1st, 2nd and 3rd Quarters: CCH is below target levels as expenditures in the first six months of the fiscal year are traditionally lower.

Plan for Improvement/Timelines:

1st Quarter: The Hospital has approved a capital expenditure plan for 2011/12 in the amount of \$4.5M. The majority of these expenditures along with other equipment expenditures will occur in the latter part of the year. We expect to meet target by end of year.

2nd and 3rd Quarters: No action required.

Accountability: Chief Operating Officer

Corporate Scorecard FY 2011/2012

Percentage Actual LOS to Expected LOS - Typical Cases (Cumulative)

[Scorecard](#)

SUCCESS FACTOR:

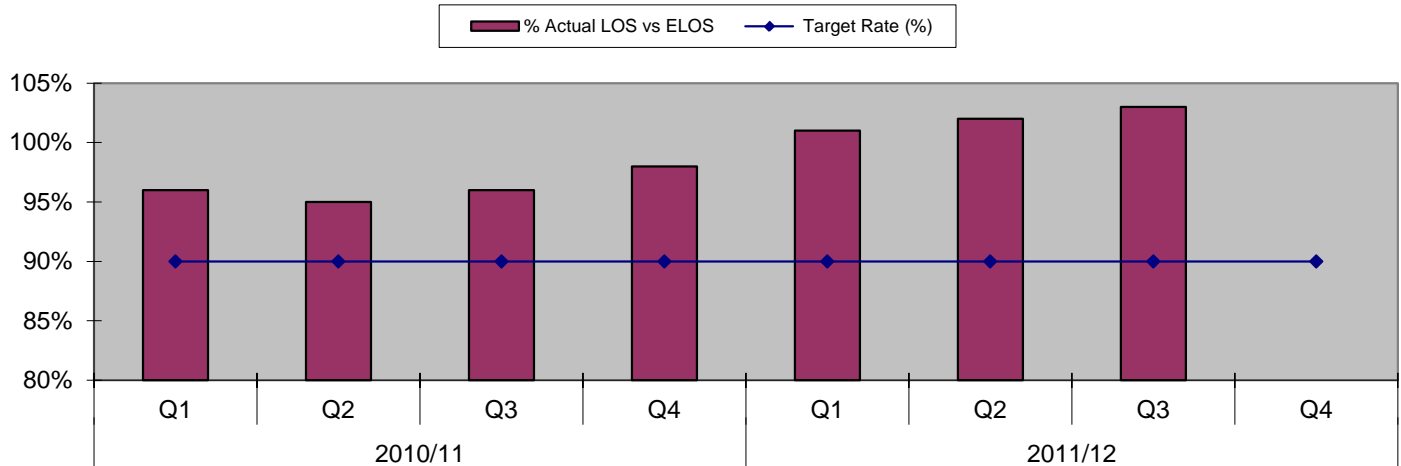
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input checked="" type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

Definition: The total number of days for the actual length of stay for typical cases compared to the total expected length of stay. The benchmark and target is based on the 25th percentile of the first 3 quarters for fiscal year 2010/11 of our Benchmark Hospitals.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
% Actual LOS vs ELOS	96%	95%	96%	98%	101%	102%	103%	
Benchmark (%)	90%	90%	90%	90%	90%	90%	90%	90%
Target Rate (%)	90%	90%	90%	90%	90%	90%	90%	90%

Significance: Any measure below 100% indicates the total length of stay was less than the expected length of stay and any measure over 100% indicates the actual length of stay exceeded the expected length of stay, thus less efficient.

Percentage Actual LOS to Expected LOS - Typical Cases



Analysis:

1st Quarter: Actual length of stay is slightly over the expected length of stay for first quarter - trending upwards in four quarters.

2nd Quarter: The upward trend continues on length of stay. Further analysis indicates that the length of stay variance is primarily in surgery. **3rd Quarter:**

The trending on length of stay is consistently raising.

Plan for Improvement/Timelines:

1st Quarter: Length-of-stay results will be communicated to individual physicians and Chiefs of department in an effort to raise awareness. **2nd Quarter:**

Various initiatives are being introduced to impact surgical length of stay including, MAC endorsed direction that surgeons complete daily patient rounds in the morning; communication on performance to individual physicians, introduction of clinical pathways, compliance with traffic light policy. Monitoring will continue. **3rd Quarter:** Several

initiatives continue with length of stay. The variance continues to be primarily in surgery; strategies introduced in 4th Quarter may have an impact. That is, surgical bed occupancy and surgical cancellation are linked directly on a daily review of capacity.

Accountability: Chief of Staff

Corporate Scorecard FY 2011/2012

ALOS - Hip Fractures

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input checked="" type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

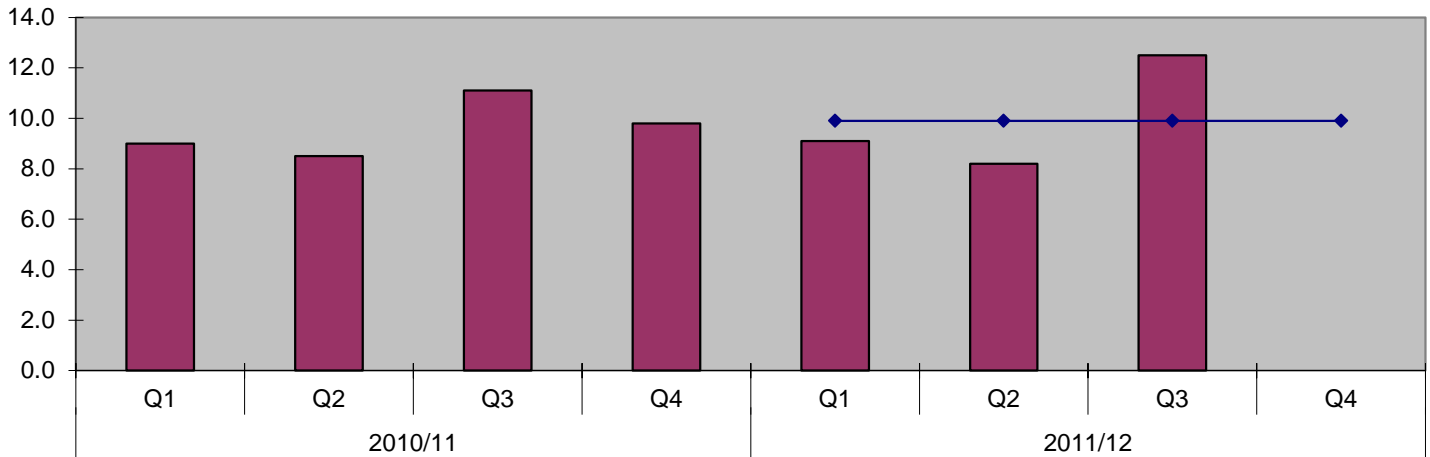
Definition: The average LOS in acute care for all patients with a diagnosis of hip fracture who had fixation of hip joint or fixation of femur. Typical cases only. Data Source: CIHI DAD. Target based on QIP: 5% reduction in ALOS from 2010/11.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALOS (days)	9.0	8.5	11.1	9.8	9.1	8.2	12.5	
Benchmark (days)								
Target Rate (days)					9.9	9.9	9.9	9.9

Significance: The purpose of this indicator is to report the ALOS for all patients who have a hip fracture and underwent fixation of hip joint or fixation of femur.

ALOS - Hip Fractures

ALOS (days) Target Rate (days)



Analysis:

1st Quarter: Patients with hip fractures tend to be elderly with comorbidities. CCH has focused on providing physiotherapy for inpatients to reduce LOS. Champlain Ortho Planning Committee is developing an orthopedic scorecard as well as providing support for development and adoption of orthopedic clinical pathways. Goal is that pathways for fractured hip should be initiated in ER for 90% of patients with fractured hip.

2nd Quarter: It is worth mentioning that at CCH, 100% of fractured hip patients have surgery within the 72 hour target.

2nd and 3rd Quarters: Protocol approved and implemented.

Plan for Improvement/Timelines:

1st Quarter: Meet with orthopedic surgeons to present Regional information (September 19,2011). Continue with education for interprofessional team on pathway for fractured hip.

2nd and 3rd Quarters: Protocol approved and implemented, continue with education.

Accountability: Chief Clinical Officer / Chief of Staff

Corporate Scorecard FY 2011/2012

ALOS - Total Hip Replacements

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration

Excellence in Quality & Service Delivery

Outstanding Operational & Financial Performance

People Development/Workplace of Choice

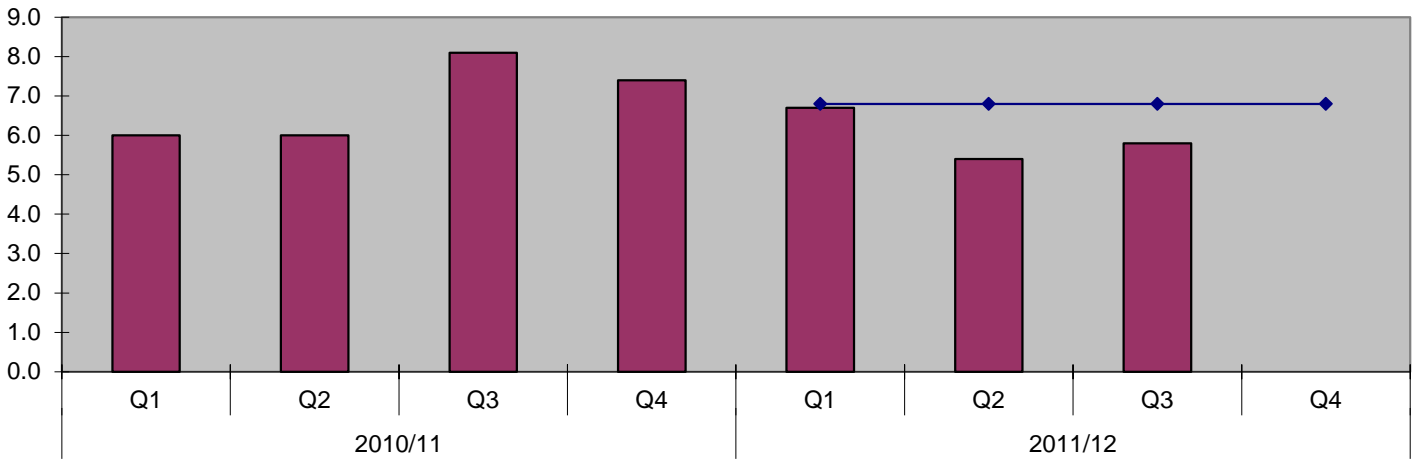
Definition: The average LOS in acute care for all elective primary unilateral hip replacement patients regardless of discharge destination. Data Source: CIHI DAD. Target based on QIP: 5% reduction in ALOS from 2010/11

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALOS (days)	6.0	6.0	8.1	7.4	6.7	5.4	5.8	
Benchmark (days)								
Target Rate (days)					6.8	6.8	6.8	6.8

Significance: The purpose of this indicator is to report the ALOS for all patients who have a hip replacement regardless of discharge diagnosis.

ALOS - Total Hip Replacements

ALOS (days) Target Rate (days)



Analysis:

1st Quarter: Patients with hip replacements require aggressive therapy. CCH strives to provide intensive physiotherapy. Those patients that may require rehab should be assessed for Home First Program and then return for Rehab if required.

2nd and 3rd Quarters: No change.

Plan for Improvement/Timelines:

1st Quarter: Implement pathways. The goal is that 90% of patients that have a Total Joint Replacement return home. Meet with orthopedic surgeons to present Regional information (September 19, 2011). Continue with education for interprofessional team on pathway for THR.

2nd Quarter: Chief of Surgery presented with data re: individual physician LOS. Protocols to go to Pharmacy and Therapeutics in December.

3rd Quarter: Medical protocols awaiting approval at Department of Surgery approved by Pharmacy and Therapeutics.

Accountability: Chief Clinical Officer / Chief of Staff

Corporate Scorecard FY 2011/2012

ALOS - Total Knee Replacements

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input checked="" type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

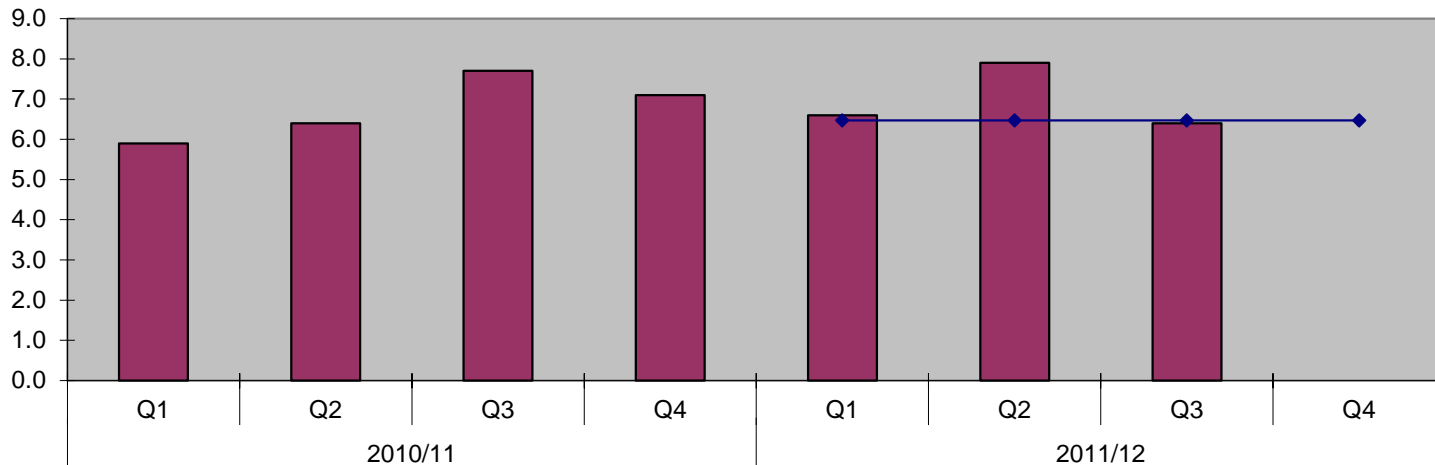
Definition: The average LOS in acute care for all elective primary unilateral knee replacement patients regardless of discharge destination. Data Source: CIHI DAD. Target based on QIP: 5% reduction in ALOS from 2010/11.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALOS (days)	5.9	6.4	7.7	7.1	6.6	7.9	6.4	
Benchmark (days)								
Target Rate (days)					6.5	6.5	6.5	6.5

Significance: The purpose of this indicator is to report the ALOS for all patients who have knee replacements, regardless of discharge diagnosis.

ALOS - Total Knee Replacements

ALOS (days) Target Rate (days)



Analysis:

1st Quarter: LOS for patients admitted for total knee replacements. When the Champlain pathway for Total Knee Replacement is adopted the LOS should be reduced. CCH data will be reviewed by the Regional Ortho Committee.
2nd and 3rd Quarters: No change.

Plan for Improvement/Timelines:

1st Quarter: Implement pathways. The goal is that 90% of patients that have a Total Joint Replacement return home. Meet with orthopedic surgeons to present Regional information (September 19, 2011). Continue with education for interprofessional team on pathway for TKR.
2nd Quarter: Chief of Surgery presented with data re: individual physician LOS. Protocols to go to Pharmacy and Therapeutics in December.
3rd Quarter: Medical protocols awaiting approval at Department of Surgery, approved by Pharmacy and Therapeutics.

Accountability: Chief Clinical Officer / Chief of Staff

Corporate Scorecard FY 2011/2012

Emergency Department Worked Hours to Equivalent Visits

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input checked="" type="checkbox"/>	People Development/Workplace of Choice <input type="checkbox"/>

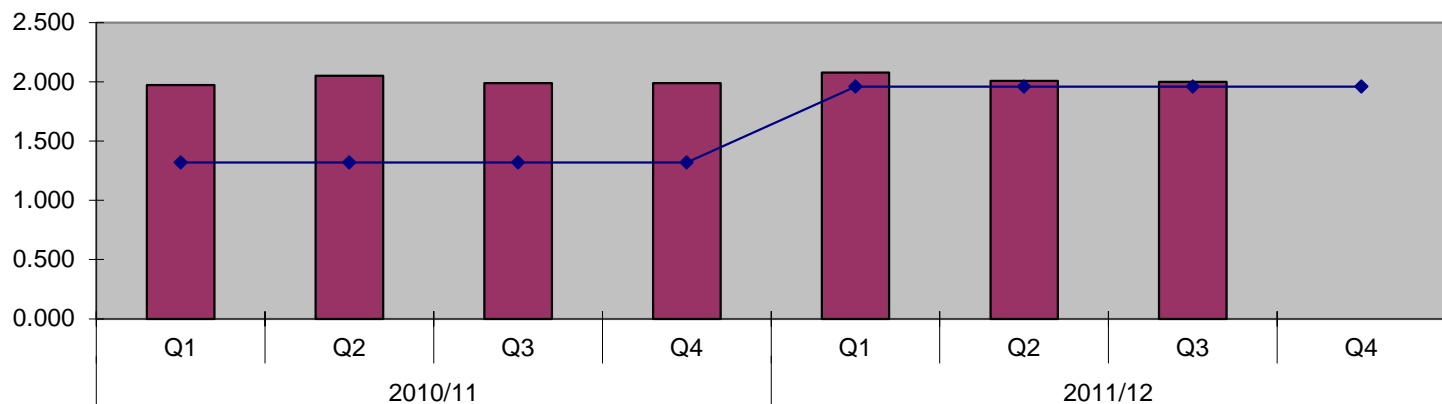
Definition: Total MOS, UPP & purchased worked hours/ equivalent visits. An inpatient day in Emergency is equivalent to 4 Emergency Visits. Based on April 2009 to March 2010 performance, reduce by 10%. Benchmark and target is taken from QIP scorecard.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ED Worked Hours to Visits	1.974	2.052	1.989	1.990	2.08	2.01	2.00	
Benchmark (ratio)	1.319	1.319	1.319	1.319	1.96	1.96	1.96	1.96
Target Rate (ratio)	1.319	1.319	1.319	1.319	1.96	1.96	1.96	1.96

Significance: To improve resource utilization.

ED Worked Hours to Equivalent Visits

ED Worked Hours to Visits
 Target Rate (ratio)



Analysis:

1st Quarter: Data used in calculation of worked hours per patient activity is currently under review.

2nd and 3rd Quarters: ED Worked hours per patient activity remain above target. The increased number of admitted patients in ED increases workload and staffing requirements.

Plan for Improvement/Timelines:

1st Quarter: Once data reviewed and hours adjusted, a recovery plan targeting actual patient volumes and worked hours will be developed.

2nd and 3rd Quarters: Monitoring of workload and appropriate use of resources. Working on initiatives to decrease LOS of admitted patients in the ED.

Accountability: Director of Critical Care

Corporate Scorecard FY 2011/2012

Leadership Education

[Scorecard](#)

SUCCESS FACTOR:

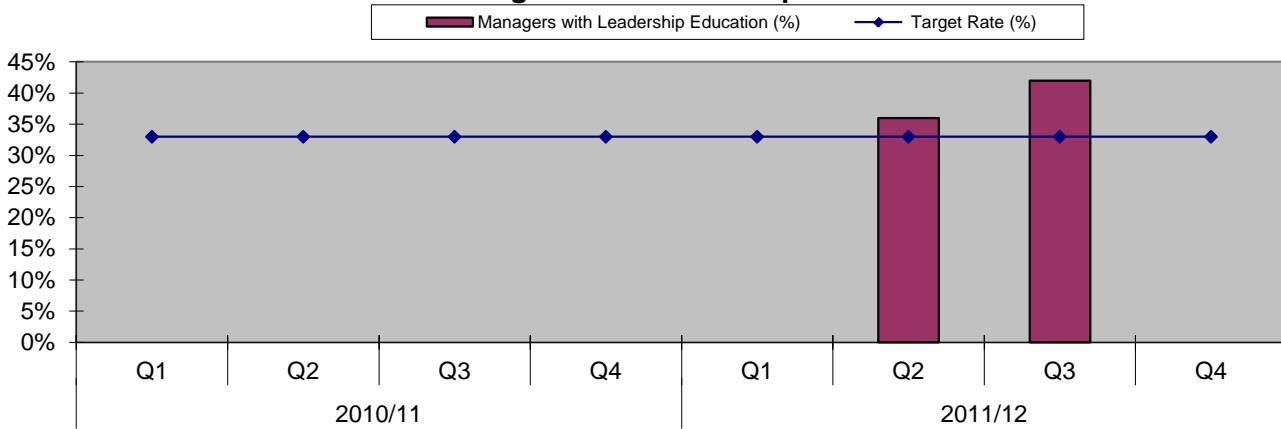
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input checked="" type="checkbox"/>

Definition: The percentage of managers who have participated in a leadership development program to the total number of managers.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Managers with Leadership Education (%)					0%	36%	42%	
Benchmark (%)	33%	33%	33%	33%	33%	33%	33%	33%
Target Rate (%)	33%	33%	33%	33%	33%	33%	33%	33%

Significance: To engage and empower our staff to lead and drive internal organizational and health system transformation.

Managers with Leadership Education



Analysis:

1st Quarter: Leadership Training has been identified.

2nd Quarter: Working towards our goal. Four sessions were delivered in this quarter, twenty-two managers attending.

3rd Quarter: 2 sessions were delivered in this quarter, 8 managers attended

Plan for Improvement/Timelines:

1st Quarter: Leadership Training has been launched, and enrolment in courses will begin in Q2.

2nd Quarter: We will continue to launch new programs in the upcoming quarters.

3rd Quarter: Continue the management training

Accountability: Director of Human Resources

Corporate Scorecard FY 2011/2012

Communication Plan

[Scorecard](#)

SUCCESS FACTOR:

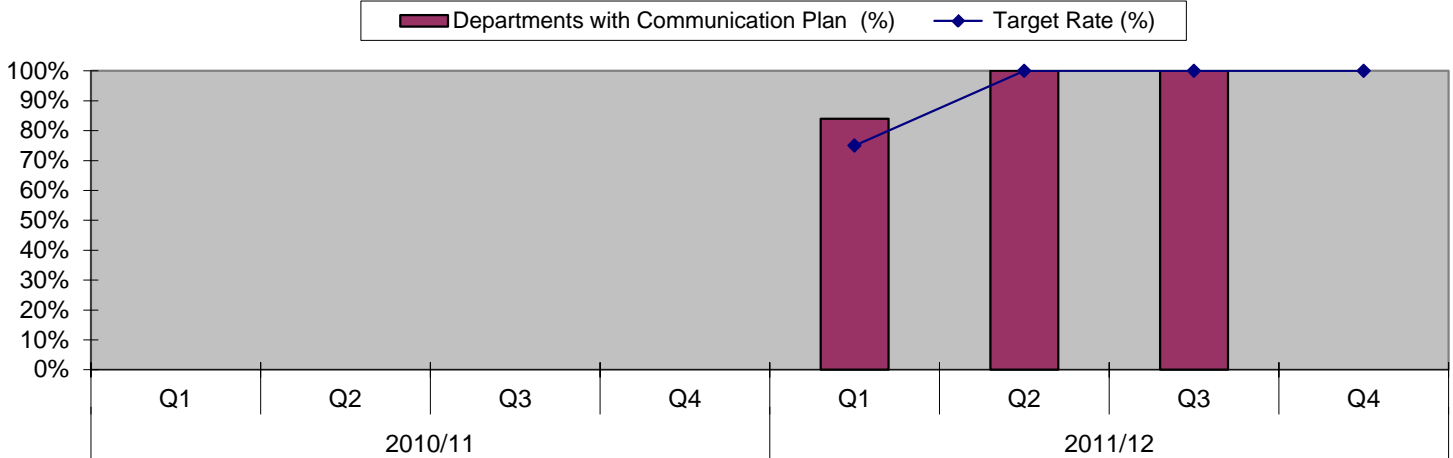
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input checked="" type="checkbox"/>

Definition: The percentage of departments having developed and implemented a communication plan.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Departments with Communication Plan (%)					84%	100%	100%	
Benchmark (%)					100%	100%	100%	100%
Target Rate (%)					75%	100%	100%	100%

Significance: The Cornwall Community Hospital staff and physicians will continue to work together to strengthen and formalize relationships and communication pathways to ensure continuous and high quality care through the patient's experience.

Communication Plan



Analysis:

1st, 2nd, and 3rd Quarters: Target met; at Q2 all departments have Communication Plans.

Plan for Improvement/Timelines:

1st Quarter: All departments will present quarterly communication plans to their respective Chiefs.

2nd and 3rd Quarters: No plans required. CCO: Monthly rounds being performed as part of ED PIP initiative. This includes a yearly rotational cycle of all clinical areas.

Accountability: COO, CPRO, CCO, CD

Corporate Scorecard FY 2011/2012

Percentage of Full-Time Nurses

[Scorecard](#)

SUCCESS FACTOR:

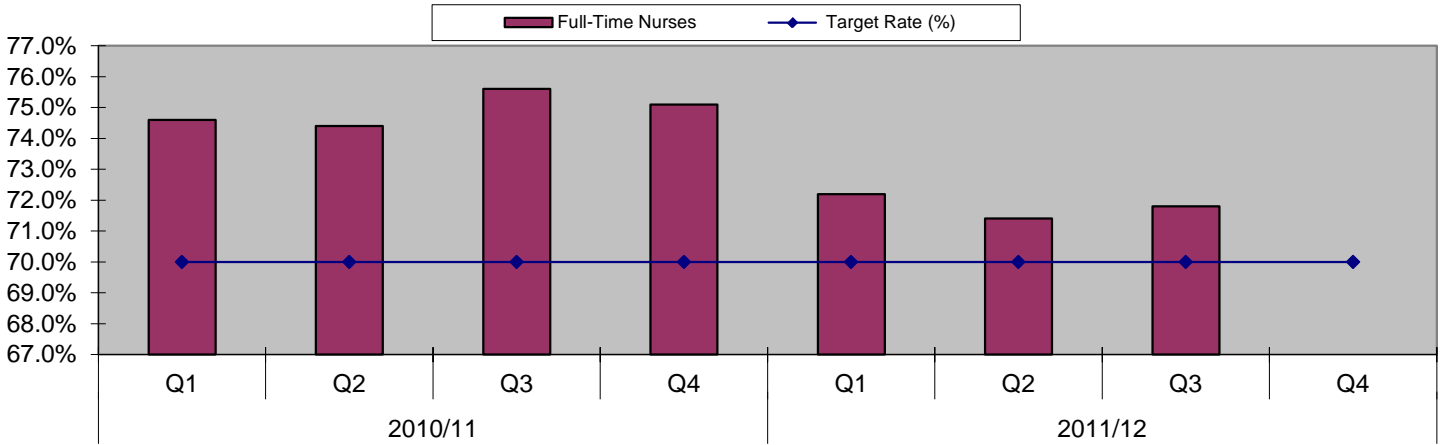
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input checked="" type="checkbox"/>

Definition: Total earned hours for full-time nurses over the total nursing earned hours.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Full-Time Nurses	74.6%	74.4%	75.6%	75.1%	72.2%	71.4%	71.8%	
Benchmark (%)	70%	70%	70%	70%	70%	70%	70%	70%
Target Rate (%)	70%	70%	70%	70%	70%	70%	70%	70%

Significance: The provincial target set by the Government of Ontario is 70%. This is an initiative to help recruit and retain nurses in the hospital.

Percentage of Full-Time Nurses



Analysis:

1st, 2nd and 3rd Quarters: The purpose of this Ministry initiative is to improve patient safety by reducing/eliminating the need for employing agency registered nurses. Currently exceeding target.

Plan for Improvement/Timelines:

1st, 2nd, and 3rd Quarters: No change or improvement required.

Accountability: Chief Clinical Officer

Corporate Scorecard FY 2011/2012

Staff Turnover

[Scorecard](#)

SUCCESS FACTOR:

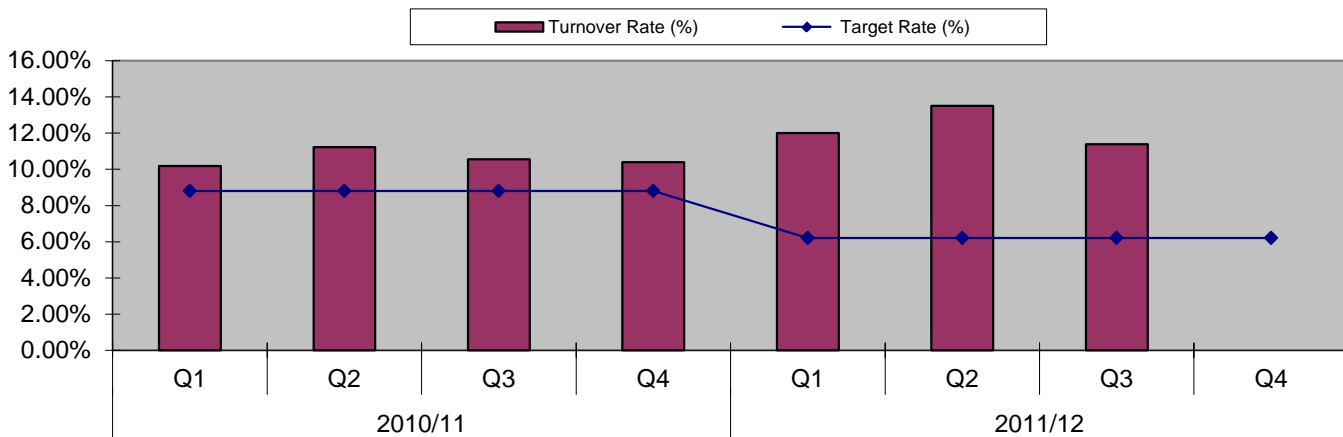
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input checked="" type="checkbox"/>

Definition: Forecast of the percentage of staff leaving the organization based on total number of staff. This measure is cumulative and includes casual staff. Benchmark and target taken from 2010 Saratoga Survey Results. (As at October 4, 2010)

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Turnover Rate (%)	10.18%	11.23%	10.55%	10.40%	12.00%	13.52%	11.38%	
Benchmark (%)	8.80%	8.80%	8.80%	8.80%	6.20%	6.20%	6.20%	6.20%
Target Rate (%)	8.80%	8.80%	8.80%	8.80%	6.20%	6.20%	6.20%	6.20%

Significance: A high degree of staff turnover may indicate a poor work environment. Benchmark and target source: HRBN Survey 2008 (25th percentile- best quartile)

Staff Turnover Rate



Analysis:

1st Quarter: Turnover for this quarter (April - June) was 12.05%.

35% of turnover resigned, 31% were casual employees terminated due to company policy, 22% of turnover was due to retirement and 12% other.

2nd Quarter: Turnover for this quarter (July - September) was 15%.

30% of turnover rate resigned, 30% were casual employee terminated due to company policy, 28% of turnover was due to retirement, 14% other.

3rd Quarter: Turnover for this quarter (October - December) was 7.5%.

30% of our turnover is from retirement, 40% of turnover is of employees with 2 years or less of service. Turnover of Casual employees is 16%. The turnover rate is significantly lower this quarter but we continue to be high for the year and above our targeted goal. The two area's that have the largest negative impact on our turnover is our retirements and our turnover within the first two years of employment.

Plan for Improvement/Timelines:

1st Quarter: Compile information from exit interviews and apply recommendations that are appropriate.

2nd Quarter: Review exit interview to see what recommendation that the employee are given and apply to appropriate suggestions.

3rd Quarter: We now have sufficient volume of exit interviews to evaluate for any patterns. A report will be prepared and distributed to management for review. A special report will be prepared on the reasons for separations of any employees who left this year with less than 2 years service.

Accountability: Director of Human Resources

Corporate Scorecard FY 2011/2012

Absenteeism

[Scorecard](#)

SUCCESS FACTOR:

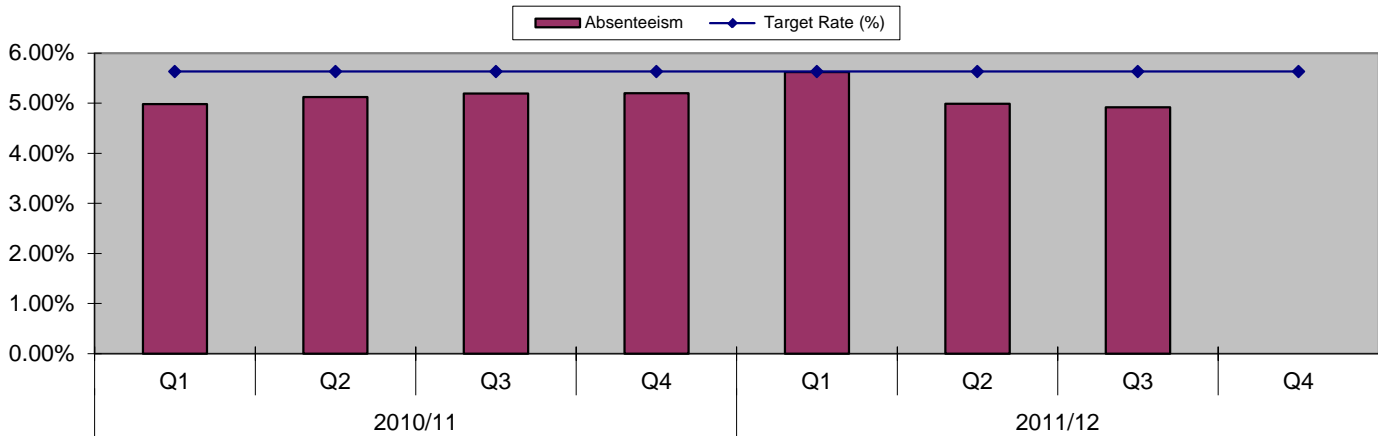
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input checked="" type="checkbox"/>

Definition: Sick time hours for Full Time Employees /Worked hours for Full Time Employees.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Absenteeism	4.98%	5.12%	5.19%	5.20%	5.62%	4.99%	4.92%	
Benchmark (%)	5.63%	5.63%	5.63%	5.63%	5.63%	5.63%	5.63%	5.63%
Target Rate (%)	5.63%	5.63%	5.63%	5.63%	5.63%	5.63%	5.63%	5.63%

Significance: Benchmark is based on HCM Sick Time Analysis Report 25th percentile of the last year HCM Benchmark available which is 09/10.

Absenteeism



Analysis:

1st Quarter: We are meeting benchmark. The Full time Attendance Support Coordinator was not able to make a significant impact into the first quarter results with ONA- the days were increased as a result of 6 long standing claims (>21 days) with medical support, however there were some decision made which impacted 2 of these 6 claims (see HR scorecard for details).

2nd Quarter: This quarter has seen a reduction in sick time hours. The Attendance Support Coordinator's (ASC) role has expanded from Nursing and Housekeeping and Dietary to include the staff of Patient Registration and Diagnostics for follow up. This role has significantly improved staff and management awareness of the processes involved, requirements for medical support, and entitlement to sick pay benefits. Staff are very aware that failure to provide the medical support for absent days due to illness when in the Attendance Support program can and has resulted in holding back sick pay benefits without the appropriate medical support. Management training on the Attendance Support program and revised/updated medical forms was rolled out in September to improve consistencies

3rd Quarter: 6th incident is being implemented and enforced (ONA,OPSEU) - Management are more available and are being very supportive of the attendance support coordinator's role. More accommodations have been implemented for ONA members (7 members are on return to work programs), overall several accommodations have seen staff members return to work earlier, - Modified work speeds up recovery and rehab, the return to work committee encourages and facilitates early, safe return to work, Managers better understand their role in the attendance support since the training session.

Plan for Improvement/Timelines:

1st and 2nd Quarters: On occasion, Manager support for the Attendance Support Program (ASP) can be inconsistent- education is planned to all managers in Fall 2011 and this should alleviate discrepancies and inconsistencies in the program managing attendance. Continue to support understanding and consistency of the disability process for managers and employees. Continue to notify Directors of patterns, concerns identified by the daily monitoring of absences. Continue with daily monitoring by the Attendance Support Coordinator & increase daily monitoring to include departments not presently under the program

3rd Quarter: We will be expanding the attendance support program to include the Mental Health departments. We'll - Continue to track the 6th Incidents (ONA,OPSEU)

Accountability: Director of Human Resources

Corporate Scorecard FY 2011/2012

Performance Appraisals

[Scorecard](#)

SUCCESS FACTOR:

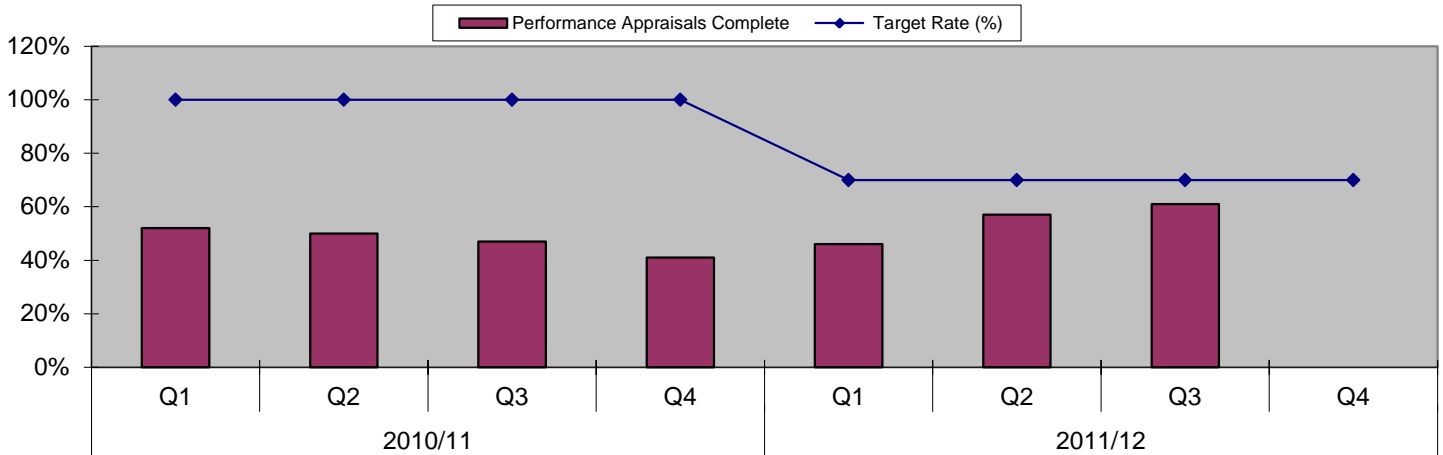
Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input checked="" type="checkbox"/>

Definition: The number of employees in the hospital that have had a performance appraisal in the last year. Performance Appraisals are valid for 2 years. Fiscal year 11-12 include Full time and Part time employees, all Temporary and Casual employees are excluded as well as LTD's and Maternal Leaves.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Performance Appraisals Complete	52%	50%	47%	41%	46%	57%	61%	
Benchmark (%)	100%	100%	100%	100%	70%	70%	70%	70%
Target Rate (%)	100%	100%	100%	100%	70%	70%	70%	70%

Significance: Performance appraisals help to engage people in their jobs and wanting to work at their best and to improve individual performance.

Performance Appraisal Rate (%)



Analysis:

1st Quarter: Benchmark not met, There has been a moderate increase since last quarter. We have seen a increase in number of performance appraisals completed.

2nd Quarter: Benchmark not met, There has been a great improvement this quarter. With Management focusing on the advantages of completing their Performance Appraisal

3rd Quarter: We have seen a 4% increase in the performance appraisal rate since last quarter.

Plan for Improvement/Timelines:

1st Quarter: Each Chief has their respective targets to achieve by end of fiscal year. Cumulatively this results in an overall corporate target of 70%.

2nd Quarter: Ongoing monitoring.

3rd Quarter: Management are still focusing on the advancement of reaching the organizational goal.

Accountability: Chief Operating Officer, Chief Clinical Officer, Chief Planning & Resources Officer, Corporate Director

Corporate Scorecard FY 2011/2012

ROP - Workplace Violence Prevention

[Scorecard](#)

SUCCESS FACTOR:

Health System Integration <input type="checkbox"/>	Excellence in Quality & Service Delivery <input type="checkbox"/>
Outstanding Operational & Financial Performance <input type="checkbox"/>	People Development/Workplace of Choice <input checked="" type="checkbox"/>

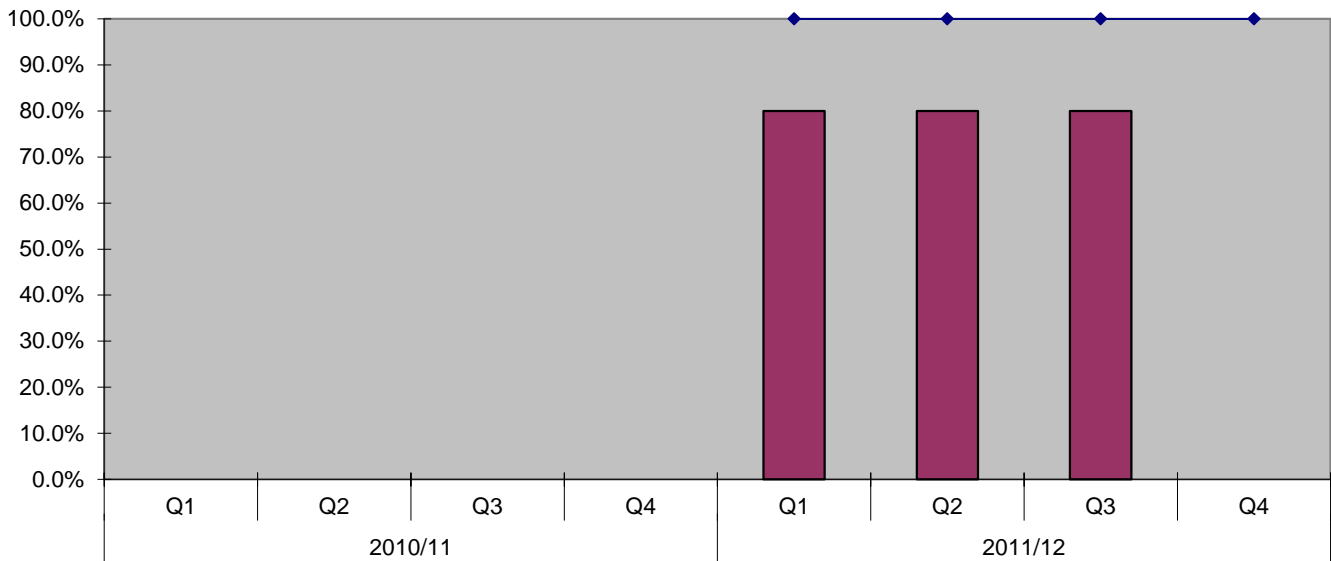
Definition: Accreditation Canada uses the modified International Labour Organization definition of workplace violence to describe the act as: 'Incidents in which a person is threatened, abused or assaulted in circumstances related to their work. These behaviours would originate from customers or co-workers, at any level of the organization. This definition would include all forms of harassment, bullying, intimidation, physical threats, or assaults, robbery and other intrusive behaviours.' This ROP for Workplace Violence Prevention will be implemented to dedicate efforts towards a safe, healthy work environment for our staff. Training is valid for 1 year.

	2010/11				2011/12			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Workplace Violence Prevention					80%	80%	80%	
Benchmark - N/A								
Target (%)					100%	100%	100%	100%

Significance: As of 2011 Accreditation Canada will require surveyed organizations to comply with the Required Organizational Practice on preventing workplace violence. The organization must satisfy eight tests for compliance in order to be considered successful in this ROP. Target determined by QIP 2011/12 and defined as 100% of Policy/Procedure/Training complete.

Workplace Violence Prevention

Workplace Violence Prevention
 Target (%)



Analysis:

1st Quarter: Prevention policy/procedure within evaluation phase, benefit of adding high/mod/low risk levels to be determined.
2nd and 3rd Quarters: Continued efforts are underway to ensure full adherence with implemented policy/procedure. Currently both the Occupational Health/Safety Coordinator and Patient Safety Coordinator review "Safety, Security, Conduct" incidents and confirm acting out behaviour (AOB) flagging has occurred when indicated. Electronic incident report form to be revised to capture whether involved person(s) had been previously flagged. The objective is to evaluate whether flagging does result in fewer incidents with individuals assessed to be at-risk.

Plan for Improvement/Timelines:

Policy/procedure compliance and impact on frequency of initial/subsequent events to be evaluated within Q4, 2011/12 and Q1, 2012/13.

Accountability: Director of Quality & Risk



Excellence in Quality & Service Delivery

CCH will embed and integrate quality into its organizational culture as this focus on quality will enable the drive towards service delivery and operational excellence.

Health System Integration

Lead efforts to establish formal linkages and pathways among providers in order to drive quality and play a leading role in health system integration

Outstanding Operational & Financial Performance

Support the continued improvement in operational and financial performance through accountability structures, staff training and resources.

People Development/Workplace of Choice

Engage and empower our people to lead and drive internal organizational and health system transformation.