Cornwall Community Hospital
Hôpital communautaire de Cornwall

CORPORATE SCORECARD 2024/2025

Vision: Exceptional Care. Always.

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

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

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

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

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

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

Results:

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

Overall Indicator Performance:	Q1	Q2	Q3	Q4
% Indicators equal to or outperforming targets:	64%	41%	64%	50%
% Indicators within 10% of targets:	14%	32%	27%	36%
% Indicators underperforming targets:	23%	27%	9%	14%

Reference Definitions:

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

Return to Dashboard

Indicator: Clostridium Difficile Incidence

Strategic Direction: RECOVERY

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

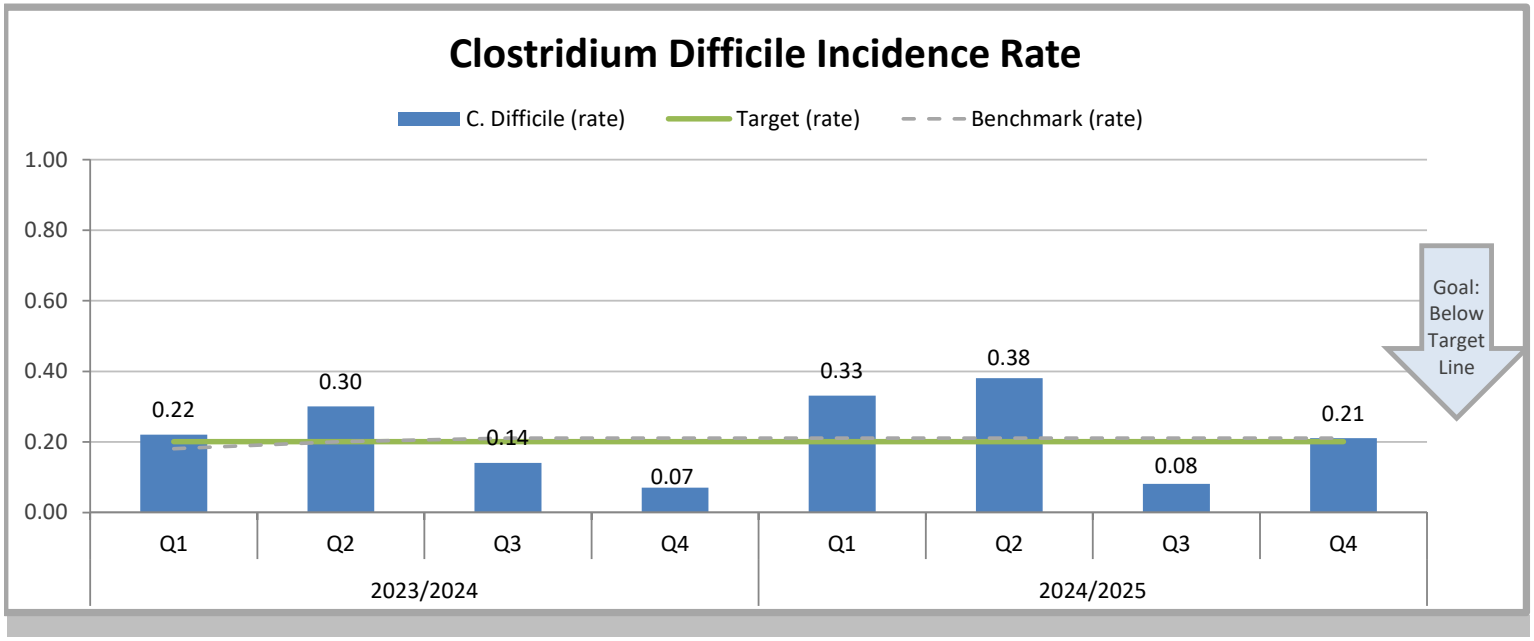
Significance: This bacteria is commonly found in the environment; it can exist in spore form and is resistant to some chemicals. It lives in approx. 3-5% of humans as normal flora and can develop if exposed to risk factors such as: prolonged antibiotic use, bowel surgery, chemotherapy and hospitalization.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

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

Target Information: Target is based on HSAA performance standard obligations

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
C. Difficile (rate)	0.22	0.30	0.14	0.07	0.33	0.38	0.08	0.21
Benchmark (rate)	0.18	0.20	0.21	0.21	0.21	0.21	0.21	0.21
Target (rate)	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20



Performance Analysis:

Q1 Target not met. There were a total of 4 cases this quarter.

Q2 Target not met. There were a total of 4 cases this quarter (July-1, August-3, September-1).

Q3 Target met. There was only 1 case this quarter.

Q4 Target not met. There were a total of 3 cases this quarter (Jan.-2, Mar.-1).

Plans for Improvement:

Q1 CCH has increased the frequency of hand-hygiene audits done by IPAC. We no longer have C. Diff positive patients on Level 6 South (lack of dedicated hand-hygiene sinks). We connect with the EVS Manager to coordinate terminal cleans when a C. Diff isolation is discontinued and the patient remains admitted.

Q2 Further enhancements have occurred with cleaning practices moving to a sporicidal for all cleans to reduce the incidence of hospital-acquired C-Diff. IPAC continues to do hand hygiene and PPE audits to provide in-the-moment education.

Q3 Continue to practice the above mentioned measures.

Q4 Continue to practice the above mentioned measures. There has been ongoing construction necessitating the use of alternative placements for patients and overcensus in ED with not having overflow space open. Should see this pattern decrease again in the coming quarter.

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

Return to Dashboard

Indicator: Current Ratio

Strategic Direction: RECOVERY

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

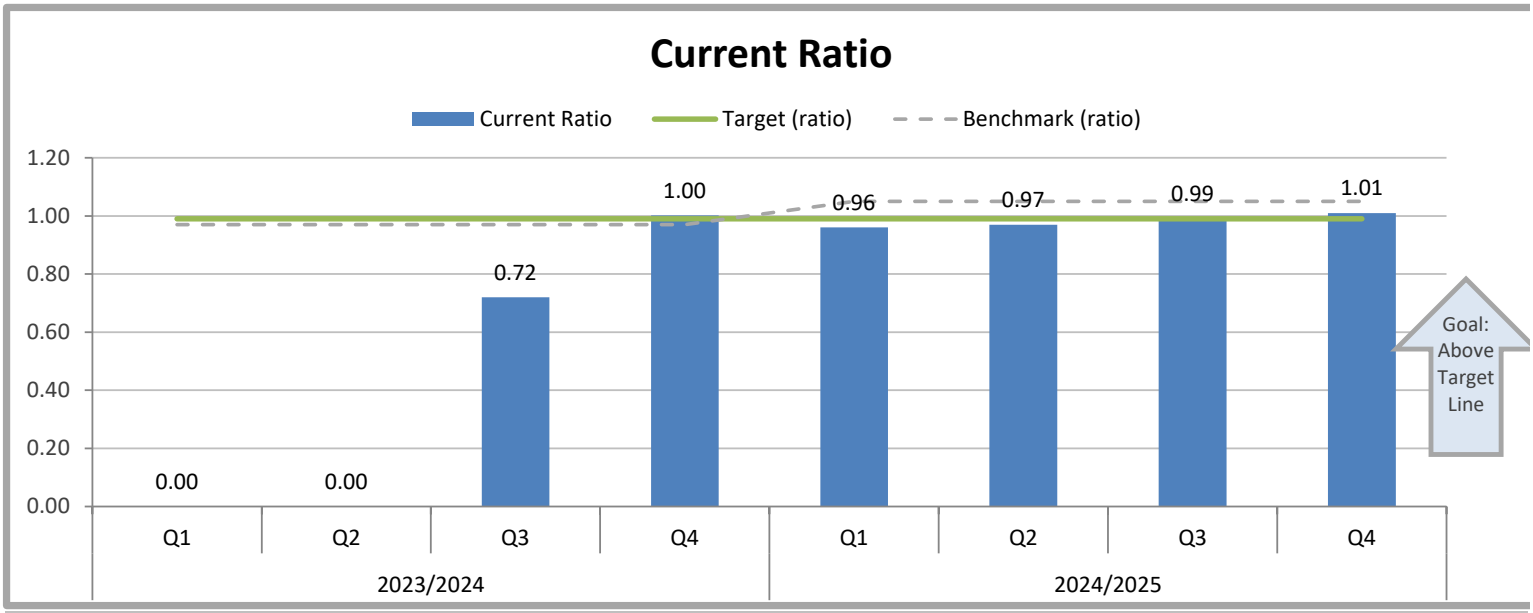
Significance: Indicates the overall financial health of the organization.

Data Source: Monthly Financial Statements - Balance Sheet

Target Information: Set according to HSAA obligations

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Current Ratio	N/A	N/A	0.72	1.00	0.96	0.97	0.99	1.01
Benchmark (ratio)	0.97	0.97	0.97	0.97	1.05	1.05	1.05	1.05
Target (ratio)	0.99	0.99	0.99	0.99	0.99	0.99	0.99	0.99



Performance Analysis:

Q1 Target not met.
Q2 Target not met. Q2 saw a slight increase compared to previous quarter.
Q3 Target met.
Q4 Target met.

Plans for Improvement:

Q1 Review base staffing schedules and adjust staffing to reflect daily acitivty.
Q2 Review base staffing schedules and adjust staffing to reflect daily acitivty on an ongoing basis.
Q3 Continue to review staffing needs on a regular basis.
Q4 Align and adjust staffing with activity on an ongoing basis.

Accountable: Chief Financial Officer / Director, Financial Services

Return to Dashboard

Indicator: Emergency Visits - Wait Time for Physician Initial Assessment (Hrs) (90th Percentile)

Strategic Direction: RECOVERY

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

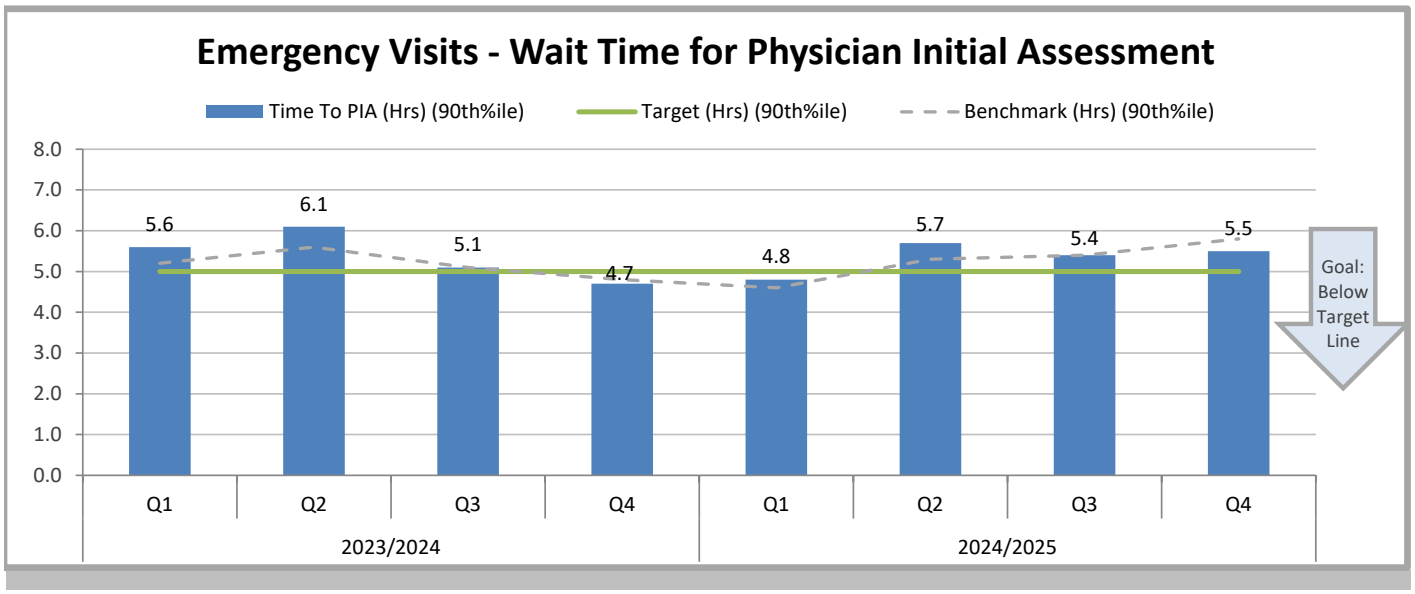
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. Multiple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

Data Source: Anzer-NACRS

Target Information: Target set in accordance to QIP indicator, to obtain a 10% ranking score improvement of prior P4R year (Dec2022-Nov2023) of peer 75 hospital at the 90th percentile.

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To PIA (Hrs) (90th%ile)	5.6	6.1	5.1	4.7	4.8	5.7	5.4	5.5
Benchmark (Hrs) (90th%ile)	5.2	5.6	5.1	4.8	4.6	5.3	5.4	5.8
Target (Hrs) (90th%ile)	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0



Performance Analysis:

Q1 Target met. Q1 results are on trend with peers.

Q2 Target not met. All periods for Q2 were above target (Jul. 5.7, Aug. 5.8, Sep. 5.6). However, performance is improving vs the benchmark. Potential impact from summer holidays.

Q3 Target not met. Although we were above target this quarter we align with our peer hospitals.

Q4 Target not met. Q4 had a total of 10,655 emergency visits with January having the highest PIA at 6.1 hours (90th percentile).

Plans for Improvement:

Q1 We continue to optimize the role of our Physician Assistant in the Emergency Department. There has been increased awareness amongst staff and Physicians in the ED. Workflow changes are ongoing to ensure we maintain and improve PIA.

Q2 Continue with our optimization and expansion to ED Flow and Medical Directives utilization. □

Q3 We continue to optimize the role of our Physician Assistant in the Emergency Department, in particular when faced with unexpected Emergency Department Physician staffing challenges. Optimization of ED patient flow is ongoing, including evaluation of process improvement initiatives to ensure we maintain and improve PIA.

Q4 We continue to optimize the role of our Physician Assistant in the Emergency Department, particularly when faced with unexpected Emergency Department Physician staffing challenges. Optimization of ED patient flow is ongoing, including evaluation of process improvement initiatives to ensure we maintain and improve PIA.□

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

Return to Dashboard

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

Strategic Direction: RECOVERY

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

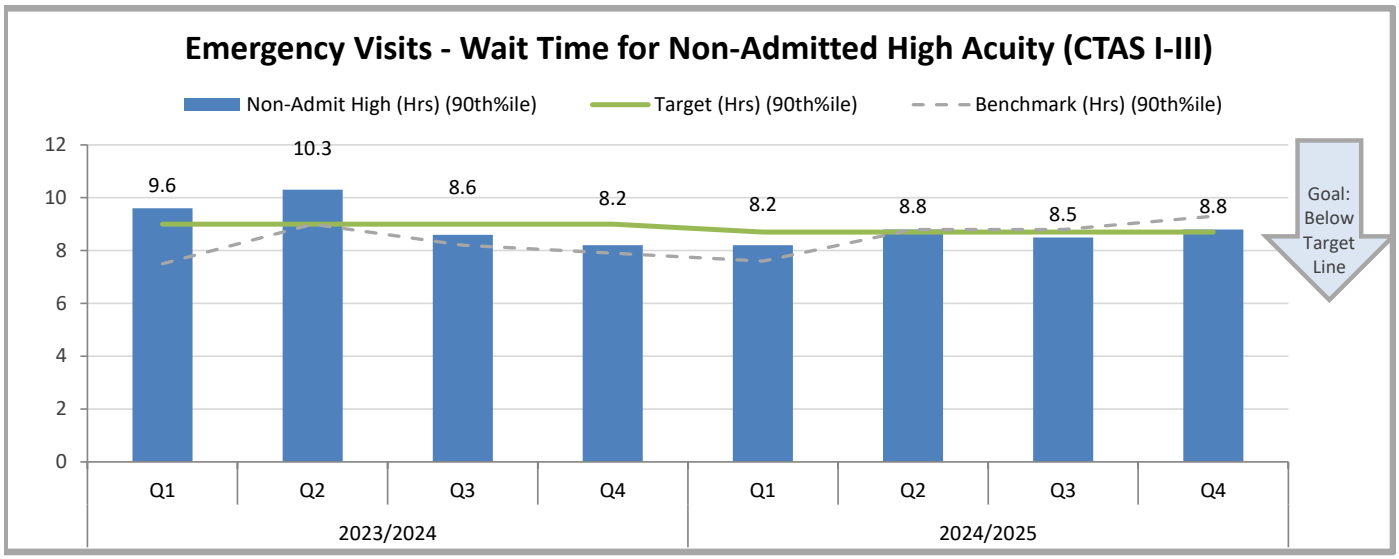
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer -NACRS

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

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit High (Hrs) (90th%ile)	9.6	10.3	8.6	8.2	8.2	8.8	8.5	8.8
Benchmark (Hrs) (90th%ile)	7.5	9.0	8.2	7.9	7.6	8.8	8.8	9.3
Target (Hrs) (90th%ile)	9.0	9.0	9.0	9.0	8.7	8.7	8.7	8.7



Performance Analysis:

Q1 Target met.

Q2 Target not met. August (9.3) and September (9.0) both contributed to a higher length of stay for this quarter. However, performance is improving vs the benchmark. Potential impact from summer holidays and Physicians/specialists availability.

Q3 Target met. All periods this quarter were below target. October had the lowest wait time this period at 8.2 hours.

Q4 Target not met. January had the highest wait time this quarter at 9.9 hours. Out of 3,457 visits, 540 were above 8 hours. Of those 540 visits, 20 were above 24 hours.

Plans for Improvement:

Q1 We continued our expanded Emergency Department Flow Nurse coverage. We continue to optimize the use of our Medical Directives (and have increased the number of Medical Directives available) to facilitate a shorter time spent in the ED. The ED Social Work role is now more established and is decreasing the time spent in the ED. Physician coverage in the ED has improved and fewer gaps are expected moving forward.

Q2 Continue with our optimization and expansion to ED Flow and Medical Directives utilization.

Q3 Continue collaboration with community partners and internal stakeholders to reduce length of stay in the ED for patients who are not admitted. Increased awareness and use of medical directives in the ED has facilitated a reduction in non-admitted length of stay. Ongoing evaluation of process improvement intiatives with Diagnostic Imaging.

Q4 Continue collaboration with community partners and internal stakeholders to reduce length of stay in the ED for patients who are not admitted. Ongoing evaluation of process improvement initiatives with Diagnostic Imaging in order to reduce length of stay in the ED awaiting Diagnostic Imaging. Increased awareness and education on the use of CDU ongoing.

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

Return to Dashboard

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

Strategic Direction: RECOVERY

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

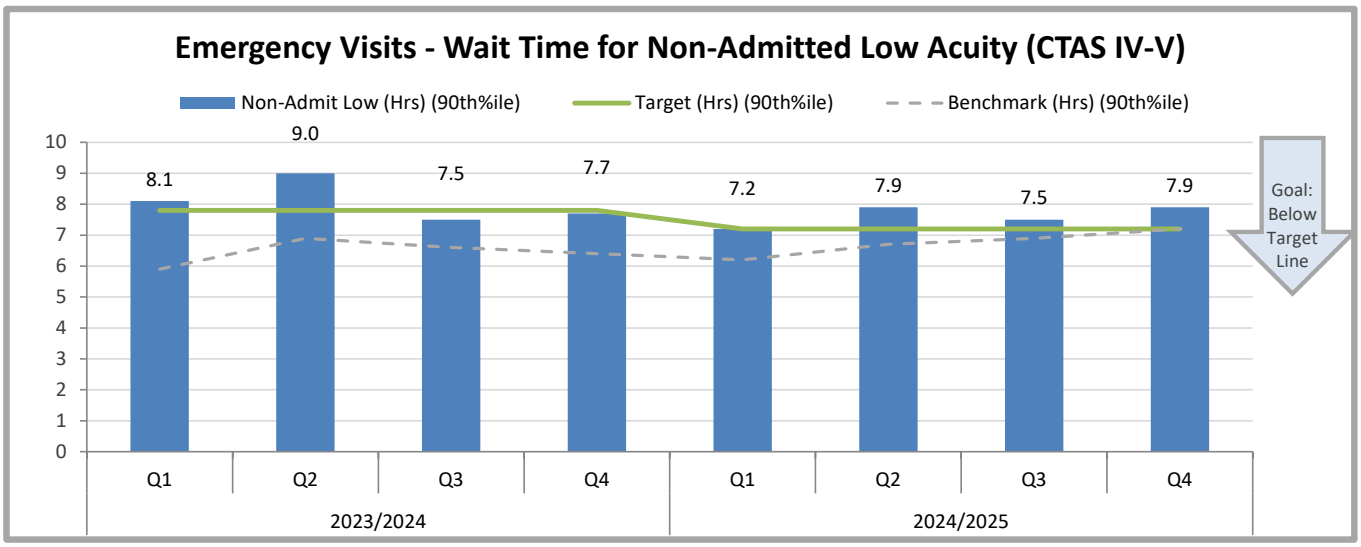
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer -NACRS

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

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit Low (Hrs) (90th%ile)	8.1	9.0	7.5	7.7	7.2	7.9	7.5	7.9
Benchmark (Hrs) (90th%ile)	5.9	6.9	6.6	6.4	6.2	6.7	6.9	7.2
Target (Hrs) (90th%ile)	7.8	7.8	7.8	7.8	7.2	7.2	7.2	7.2



Performance Analysis:

Q1 Target met.

Q2 Target not met. All periods within Q2 were above target with Aug. (8.6) being the highest. However, performance is improving vs the benchmark. Potential impact from summer holidays.

Q3 Target not met. All periods this quarter were above target but December was the highest at 8.1 hours compared to October (7.1) and December (7.3).

Q4 Target not met. January had the highest wait time this quarter at 8.5 hours. February and March were within 5% of reaching target (Feb.7.6, Mar.7.4).

Plans for Improvement:

Q1 We continued our expanded Emergency Department Flow Nurse coverage. We continue to optimize the use of our Medical Directives (and have increased the number of Medical Directives available) to facilitate a shorter time spent in the ED. The ED Social Work role is now more established and is decreasing the time spent in the ED. Physician coverage in the ED has improved and fewer gaps are expected moving forward. There has been increased collaboration with Diagnostic Imaging in regards to wait times for DI when in the ED.

Q2 Continue with our optimization and expansion to ED Flow and Medical Directives utilization.

Q3 Continue collaboration with community partners and internal stakeholders to reduce length of stay in the ED for patients who are not admitted. Increased awareness and use of medical directives in the ED has facilitated a reduction in non-admitted length of stay. Ongoing evaluation of process improvement intiatives with Diagnostic Imaging.

Q4 Continue collaboration with community partners and internal stakeholders to reduce length of stay in the ED for patients who are not admitted. Ongoing evaluation of process improvement initiatives with Diagnostic Imaging in order to reduce length of stay in the ED awaiting Diagnostic Imaging. Increased awareness and education on the use of CDU ongoing. Environmental scan in progress regarding flow strategies for low acuity visits to the ED.

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

Return to Dashboard

Indicator: Falls per 1,000 Inpatient Days

Strategic Direction: RECOVERY

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

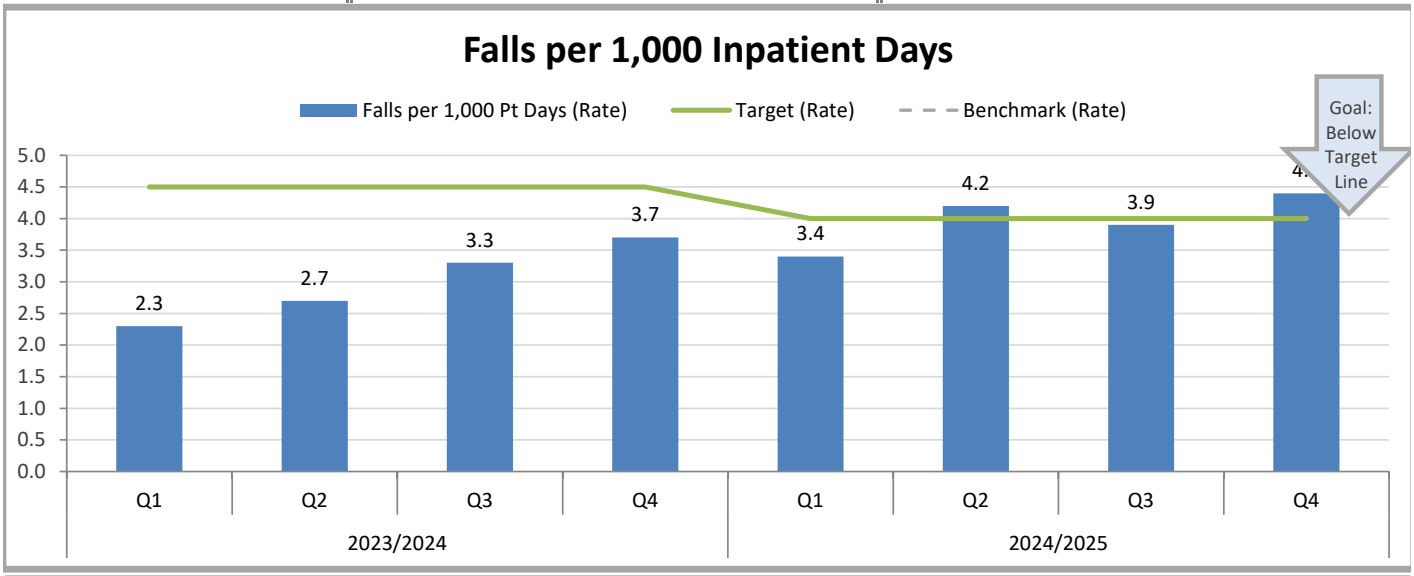
Significance: Falls, while in hospital, increase morbidity and mortality, increased length of stay, and decreased quality of life. Reducing falls indicates success in improving quality. According to Safer Healthcare Now, "A fall is defined as - An event that results in a person coming to rest inadvertently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

Data Source: RL Solutions; Virtuo MIS - General Ledger

Target Information: Target is based on internal directives

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Falls per 1,000 Pt Days (Rate)	2.3	2.7	3.3	3.7	3.4	4.2	3.9	4.4
Benchmark (Rate)								
Target (Rate)	4.5	4.5	4.5	4.5	4.0	4.0	4.0	4.0



Performance Analysis:

Q1 Target met. Q1 had a total of 41 falls reported. Level 1 Med (10) and Level 6 South (19) both contributed to higher results this quarter.

Q2 Target not met. Q2 had a total of 54 falls reported; Level 1 Med (28) being the unit with the highest falls reported for this quarter.

Q3 Target met. Q3 had a total of 52 falls reported. Although we saw an increase in inpatient days this quarter, the number of incidents remained lower.

Q4 Target not met. Q4 had a total of 57 falls reported. Level 1 Med (16) and Level 6 South (12) both contributed to having higher results this quarter.

Plans for Improvement:

Q1 Falls reduction is a priority for the Senior Friendly Care Committee. There are plans to revamp the current audit tool which has already started with the review process. The Mobility Group meets regularly; a Mobility Coordinator has been hired to implement Mobility Teams (goal to support/enhance mobility for patients at risk).

Q2 Plan as above. The Mobility Team has been implemented and is focused on Level 1 Medicine. Further review of falls and mitigation strategies is required. Managers continue to audit falls in their departments.

Q3 Plan as previous. The Mobility Team has assisted with mobilization of those at risk for falls and ALC on Acute Medicine and will be working with patients in the Emergency Department. Plans underway to provide educational opportunities to staff in other areas on patient transfers and mobilization.

Q4 Continue plan as previous. A Falls subcommittee has been formed to evaluate fall risk mitigation strategies through auditing. The Mobility Team continues to support ambulation. For Level 6 South, further initiatives are targeted to support management of responsive behaviors which may be a contributing factor in some falls events.

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

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

Strategic Direction: RECOVERY

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

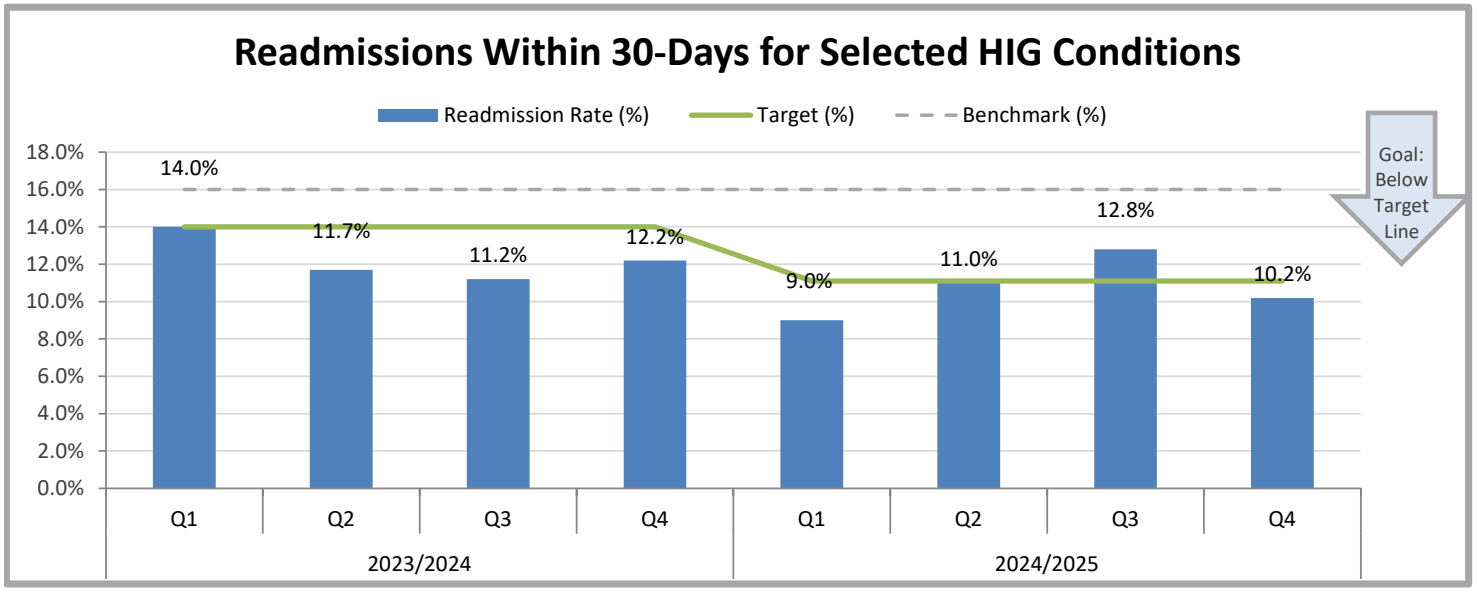
Significance: Unplanned hospital readmissions exact a toll on individuals, families and the health system. Avoidable readmissions remain a system-level issue that is also linked to integration among providers across the continuum of care. If patients get the care they need when and where they need it,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

Data Source: Anzer -DAD (Discharge Abstract Database)

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

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	14.0%	11.7%	11.2%	12.2%	9.0%	11.0%	12.8%	10.2%
Benchmark (%)	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%
Target (%)	14.0%	14.0%	14.0%	14.0%	11.1%	11.1%	11.1%	11.1%



Performance Analysis:

Q1 Target met. Q1 had 368 select HIG condition index visits with 33 readmission visits within 30 days.

Q2 Target met. Q2 had 327 select HIG condition index visits with 36 readmission visits within 30 days.

Q3 Target met. Q3 had 384 select HIG condition index visits with 49 readmission visits within 30 days. Of Oct., Nov., and Dec., Oct. had the highest readmission rate at 16.4%.

Q4 Target met. Q4 had 461 select HIG condition index visits with 47 readmission visits within 30 days. February had the highest readmission rate of 11.2% this quarter.

Plans for Improvement:

Q1 Performance within target. Will continue to work with inpatient units to ensure discharge instructions are printed and provided to patients to reduce readmissions.

Q2 Performance within target.

Q3 Target not met. Clinical units will continue to provide written instructions to patients upon discharge. Greater focus will be on the review of these instructions with patients and families moving forward.

Q4 Performance within target, will continue to monitor closely.

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

Indicator: Repeat ED Mental Health Visits

Strategic Direction: RECOVERY

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

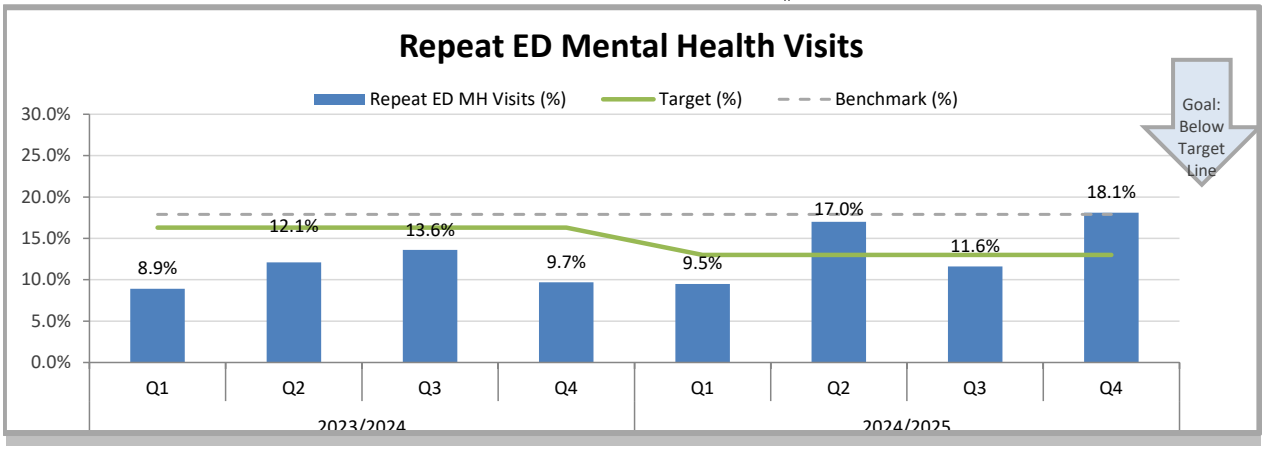
Significance: Repeat emergency visits among those with mental health conditions contribute to emergency visit volumes and wait times. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care. Given the chronic nature of the mental health conditions,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

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

Target Information: Target set internally using prior year performance.

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED MH Visits (%)	8.9%	12.1%	13.6%	9.7%	9.5%	17.0%	11.6%	18.1%
Benchmark (%)	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%
Target (%)	16.3%	16.3%	16.3%	16.3%	13.0%	13.0%	13.0%	13.0%



Performance Analysis:

Q1 Target met.

Q2 Target not met. There were 45 repeat visits out of 265 this quarter.

Q3 Target met. This quarter had 27 repeat ED visits out of 233 visits. November saw the most repeat ED visits this quarter with a return rate of 18.3%.

Q4 Target not met. This quarter had 40 repeat ED visits out of 221. 30% of the repeat ED visits were for reasons releated to anxiety (F41.9).

Plans for Improvement:

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

Q2 Will continue to work with ED Social Work, Inpatient Mental Health, and Outpatient Mental Health services to maintain and improve repeat ED Mental Health visits. The CCH Mental Health Support Resources handbook is provided to appropriate patients and their families in the ED. Discussions with Decision Support to take place regarding extended stays in the ED for this patient population group due to coverage and capacity concerns on Inpatient Mental Health.

Q3 Will continue to work with ED Social Work, Inpatient Mental Health, and Outpatient Mental Health services to maintain and improve repeat ED Mental Health visits. The CCH Mental Health Support Resources handbook is provided to appropriate patients and their families in the ED. Discussions with Decision Support to take place regarding extended stays in the ED for this patient population group due to coverage and capacity concerns on Inpatient Mental Health.

Q4 Will continue to work with ED Social Work, Inpatient Mental Health, and Outpatient Mental Health services to maintain and improve repeat ED Mental Health visits. The CCH Mental Health Support Resources handbook is provided to appropriate patients and their families in the ED. Extended stays in the ED for this patient population group due to coverage and capacity concerns on Inpatient Mental Health.

Indicator: Repeat ED Substance Abuse Visits

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED SA Visits (%)	13.5%	18.8%	11.1%	14.2%	13.2%	12.2%	11.2%	9.2%

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

Return to Dashboard

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

Strategic Direction: RECOVERY

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

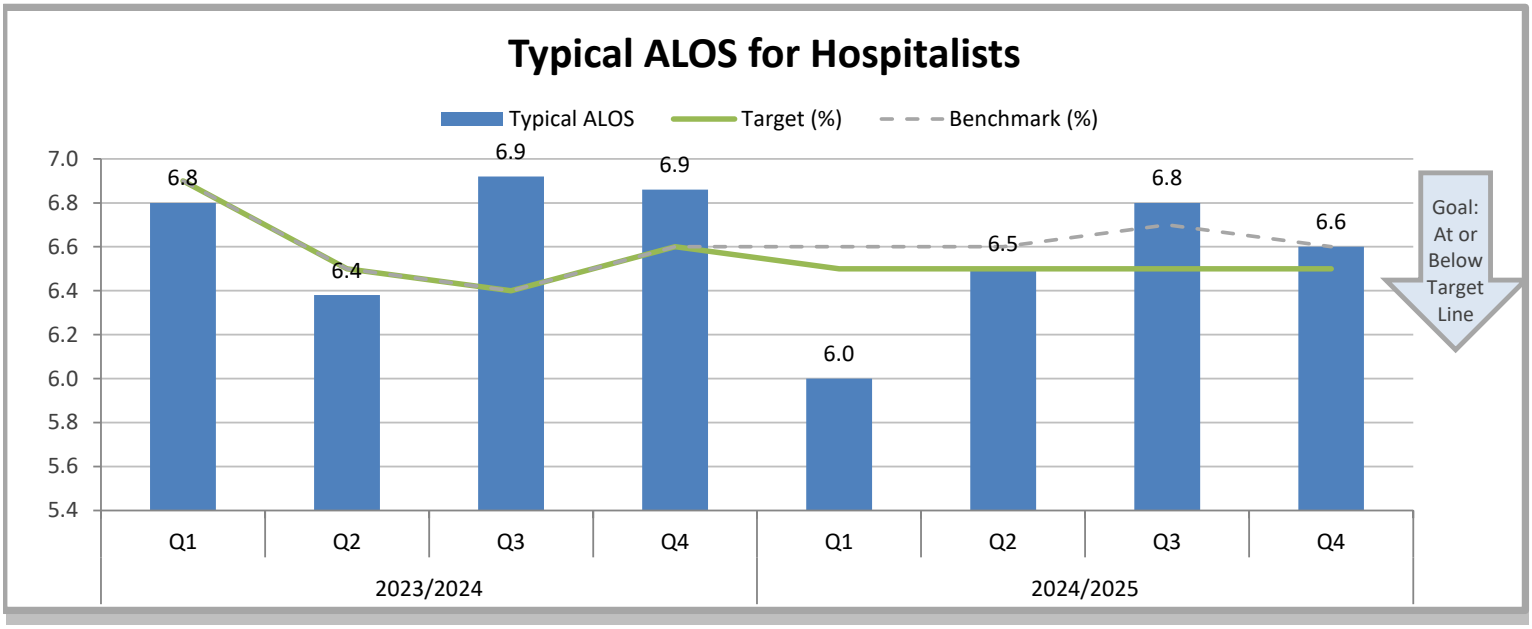
Significance: Be in more in line with our benchmark hospitals.

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

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

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Typical ALOS	6.8	6.4	6.9	6.9	6.0	6.5	6.8	6.6
Benchmark (%)	6.9	6.5	6.4	6.6	6.6	6.6	6.7	6.6
Target (%)	6.9	6.5	6.4	6.6	6.5	6.5	6.5	6.5



Performance Analysis:

Q1 Target met. All months were below target in Q1 (Apr. 5.8, May 6.2, Jun. 5.8).

Q2 Target met. All months were below target for Q2 except for Jul. (6.9). The hospitalists had 100 more cases for the quarter compared to previous quarter.

Q3 Target not met. October and November were both above target (7.3 and 7.2) with December falling below target (6.3).

Q4 Target not met. January and March were above target (6.7 and 6.9), with February falling below target at 6.1. This quarter saw a 5% increase in typical cases compared to the previous quarter, rising from 765 to 808 cases.

Plans for Improvement:

Q1 Continue to optimize discharge servics and the hospitalist team model.

Q2 Continue to optimize discharge services and the hospitalist team model as the length of stay for the whole hospital is still improving.

Q3 Continue to work with the Hospitalists and patient flow team during these high activity quarters.

Q4 High activity quarters have been a challenge. Will continue to plan for these regular fluctuations.

Accountable: Chief of Staff / Chief Information and Operating Officer

Return to Dashboard

Indicator: Total Margin

Strategic Direction: RECOVERY

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

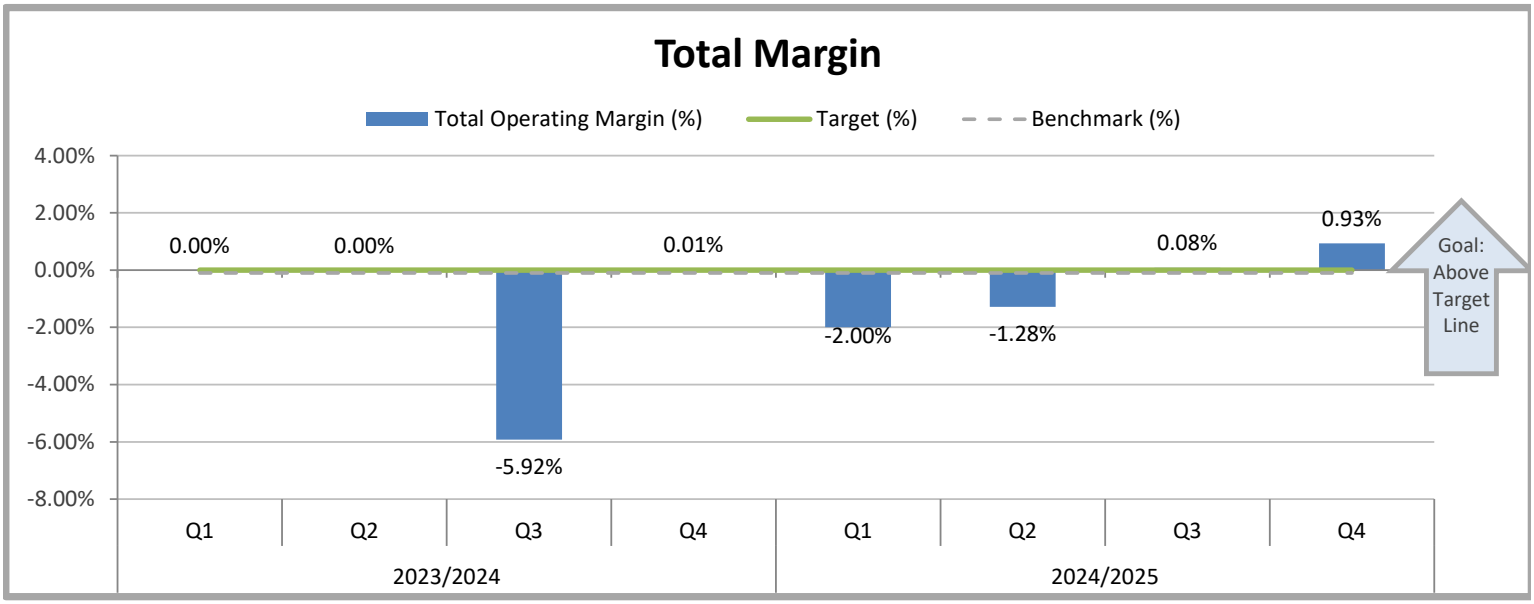
Significance: Indicates a balanced operating position.

Data Source: Monthly Financial Statements - Income Statement

Target Information: Target set according to HSAA obligations

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total Operating Margin (%)	N/A	N/A	-5.92%	0.01%	-2.00%	-1.28%	0.08%	0.93%
Benchmark (%)	-0.10%	-0.10%	-0.10%	-0.10%	-0.10%	-0.10%	-0.10%	-0.10%
Target (%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%



Performance Analysis:

Q1 Target not met.

Q2 Target not met. Q2 continues to improve and is trending upwards from previous quarter.

Q3 Target met. Additional funding received to address operational pressures and sustain operations.

Q4 Target met. Additional funding received to address operational pressures and sustain operations.

Plans for Improvement:

Q1 Review base staffing schedules and adjust staffing to reflect daily acitivty.

Q2 Review base staffing schedules and adjust staffing to reflect daily acitivty on an ongoing basis.

Q3 Continue to review staffing needs on a regular basis.

Q4 Align and adjust staffing with activity on an ongoing basis.

Accountable: Chief Financial Officer / Director, Financial Services

Return to Dashboard

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

Strategic Direction: RECOVERY

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

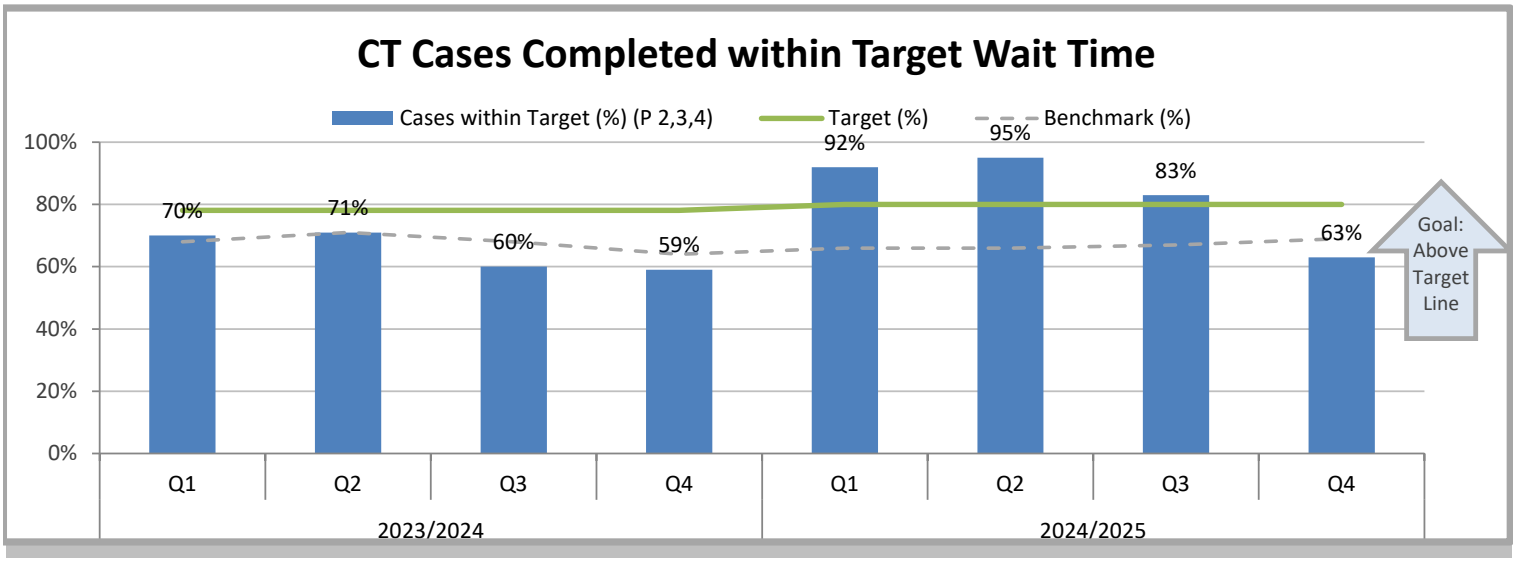
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%) (P 2,3,4)	70%	71%	60%	59%	92%	95%	83%	63%
* Priority 2	83%	80%	93%	92%	98%	98%	97%	94%
* Priority 3	70%	91%	92%	97%	97%	95%	96%	93%
Benchmark (%)	68%	71%	68%	64%	66%	66%	67%	69%
Target (%)	78%	78%	78%	78%	80%	80%	80%	80%



Performance Analysis:

Q1 Target met. Q1 results are above the quarterly improvement target which is 65%.

Q2 Target met. Q2 results continue to be above target.

Q3 Target met. This quarter we had a decrease of 12%, although we are still above target. December was the contributing factor for this quarter as only 62% of cases were completed within target compared to October (94%) and November (96%).

Q4 Target not met. Monthly results for Q4 are trending in an upward trajectory (Jan. 54%, Feb. 63%, Mar. 81%) despite being below target.

Plans for Improvement:

Q1 Continue to focus on recruitment, retention and training of technicians.
Introduce flexible scheduling to accommodate patients and staff outside of usual operating hours.

Q2 Continue with plan in Q1.

Q3 Efforts continue to ensure that staffing is sufficent to meet demand. Some extra shifts on evenings have been added, when possible, to address backlog.

Q4 Absenteeism and recruitment efforts continue to be closely monitored to ensure appropriate staffing levels are achieved and maintained. Service backlogs will be addressed as staffing stabilizes, with a focus on restoring access and improving patient flow.

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

Indicator: Cases of Long Waiters Exceeding Targeted Wait Times

Strategic Direction: RECOVERY

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

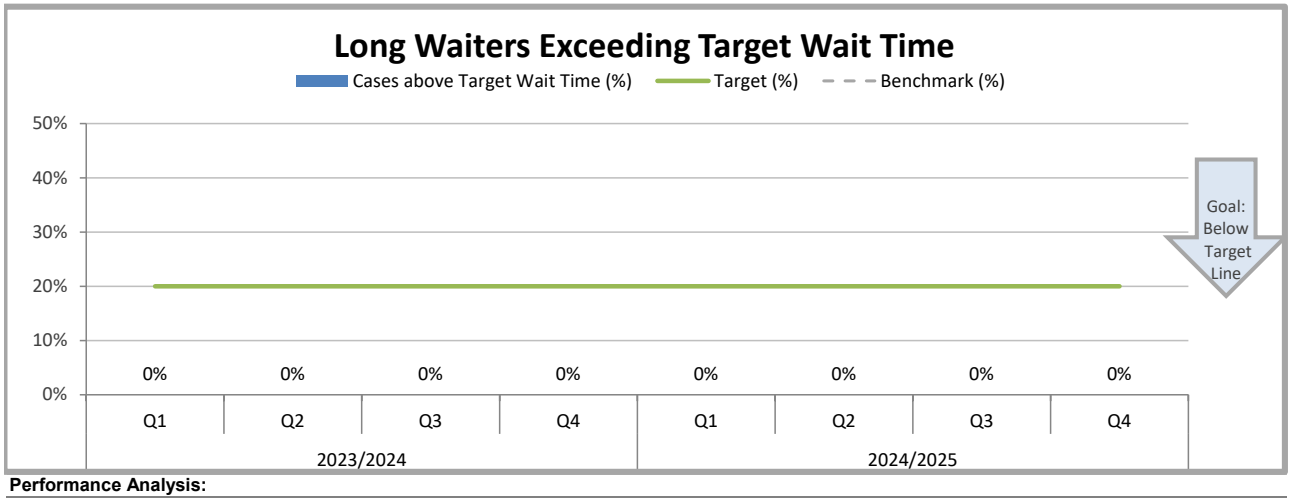
Significance: New HSAA indicator identified to decrease the volume of long waiters. Patients whose surgeries have been delayed longer than their maximum clinical guidelines are considered long waiters. The Ministry Surgical Recovery Programs are targeted at reducing the number of long waiter patients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

Data Source: WTIS iPort Access

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

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases above Target Wait Time (%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Benchmark (%)								
Target (%)	20%	20%	20%	20%	20%	20%	20%	20%



Performance Analysis:

Q1 N/A
Q2 N/A
Q3 N/A
Q4 N/A

Plans for Improvement:

Q1 N/A
Q2 N/A
Q3 N/A
Q4 N/A

Indicator: Cases Completed within Target Wait Times - Cancer Surgery

(Priority 2,3,4)

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	52%	67%	73%	49%	59%	44%	62%	65%

Indicator: Cases Completed within Target Wait Times - Cataract Surgery

(Priority 2,3,4)

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	73%	28%	19%	19%	30%	52%	30%	71%

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

Return to Dashboard

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

Strategic Direction: RECOVERY

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

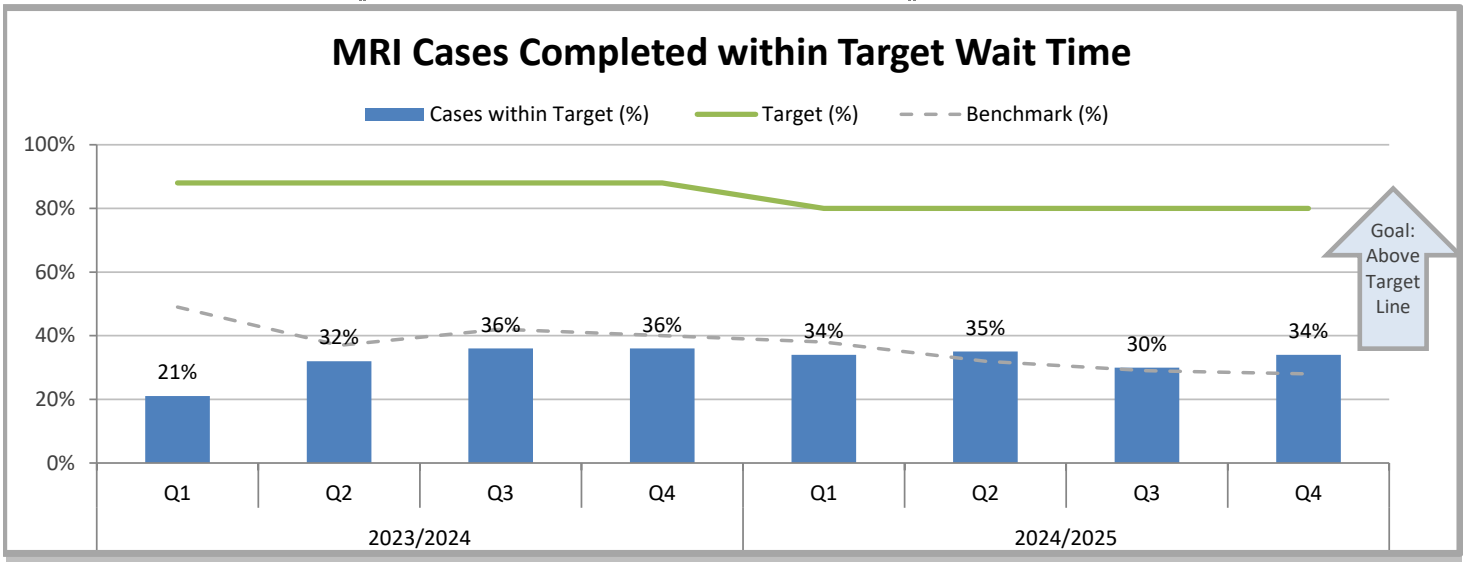
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	21%	32%	36%	36%	34%	35%	30%	34%
* Priority 2	88%	97%	98%	99%	96%	96%	93%	97%
* Priority 3	57%	97%	99%	97%	90%	97%	97%	100%
Benchmark (%)	49%	37%	42%	40%	38%	32%	29%	28%
Target (%)	88%	88%	88%	88%	80%	80%	80%	80%



Performance Analysis:

Q1 Target not met. Q1 is below target, however, priority level 2 and 3 are both above target. Priority level 4 was 16% which is the contributing factor to the low performance for Q1. Q1 is below the quarterly improvement target of 50%.

Q2 Target not met. Q2 is below the quarterly improvement target of 60%. Priority level 4 (19%) continues to be below target.

Q3 Target not met. Q3 is below target, however, priority levels 2 and 3 continue to be above target. Priority 4 continues to be the contributing factor for being under target.

Q4 Target not met. Q4 continues to be below target. Priority 4 continues to be the contributing factor for being below target. However, priority 4 did see a slight increase from previous quarter from 21% to 23%.

Plans for Improvement:

Q1 Continue to focus on recruitment, retention and training of technicians. (Two new technicians have joined the team and finished orientation).
Introduce flexible scheduling to accommodate patients and staff outside of usual operating hours.
Perform an analysis for cases in the queue to establish the output level required with the current staffing level to achieve the completion target.

Q2 Continue with plan from Q1. Gradual expansion of service hours to start in Q3.

Q3 Activity levels increased by 127 Jan 2025,over previous month; wait list cleansing complete. Net waitlist decrease of 186 requisitions.

Q4 The backlog continues to decrease, supported by ongoing use of overtime hours as part of our recovery strategy.

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

Return to Dashboard

Indicator: Alternate Level of Care (ALC) Throughput

Strategic Direction: INTEGRATION

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

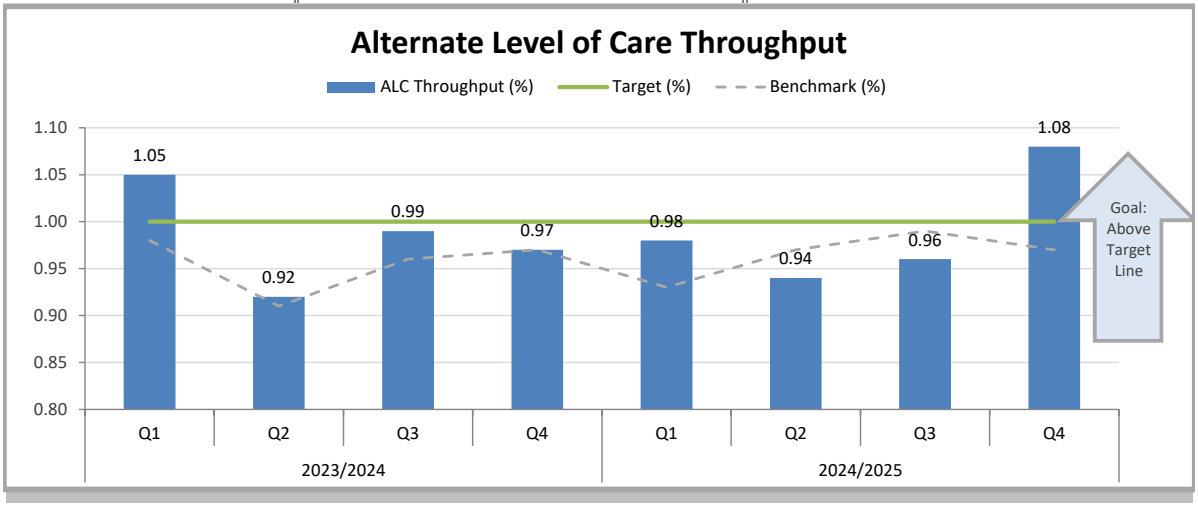
Significance: Cornwall Community Hospital will continue to identify and implement additional strategies with Champlain health care providers to reduce alternate level of care days.

Data Source: ATC CCO ALC Throughput Report

Target Information: Target rate is standardized according to HSAA specifications

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Throughput (%)	1.05	0.92	0.99	0.97	0.98	0.94	0.96	1.08
Benchmark (%)	0.98	0.91	0.96	0.97	0.93	0.97	0.99	0.97
Target (%)	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00



Performance Analysis:

Q1 Target not met. 4 ALC designated cases exceeded the total volume of ALC discharges (179 discharges/183 designated).

Q2 Target not met. 9 ALC designated cases exceeded the total volume of ALC discharges this quarter (149 discharges/158 designated).

Q3 Target not met. 8 ALC designated cases exceeded the total volume of ALC discharges this quarter (186 discharges/194 designated).

Q4 Target met. Q4 had 11 ALC discharged cases that exceeded the total volume of ALC new cases this quarter (154 discharges/143 designated).

Plans for Improvement:

Q1 ALC reduction remains a priority; plans currently in place to decrease risk of ALC and timely discharge continue (weekly Joint Discharge Review; BSO strategies; Mobility Teams; CCH @Home Program; collaboration with external partners - Community Care at Home, etc.)

Q2 Plan as above. Focused strategies with Managers/Patient Flow to review long-stay ALC patients and ensuring appropriate ALC designation is in process.

Q3 Continue plan as Q2; Developing a new ALC policy along with focusing on the ALC designation process in efforts to support accuracy of designation.

Q4 Continue with the previous plan. All ALC patients are reviewed weekly at Joint Discharge Review; continued collaboration with Ontario Health @ Home supports review of long-stay patients and the identification of options for appropriate discharge destinations - this remains ongoing.

Indicator: Alternate Level of Care (ALC) Rate

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Rate (%)	28.7%	25.9%	28.6%	29.7%	29.5%	30.0%	27.5%	24.4%

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Days (%)	33.6%	29.5%	32.8%	34.0%	34.0%	35.4%	32.3%	28.3%

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

Return to Dashboard

Indicator: Incomplete Charts

Strategic Direction: INTEGRATION

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

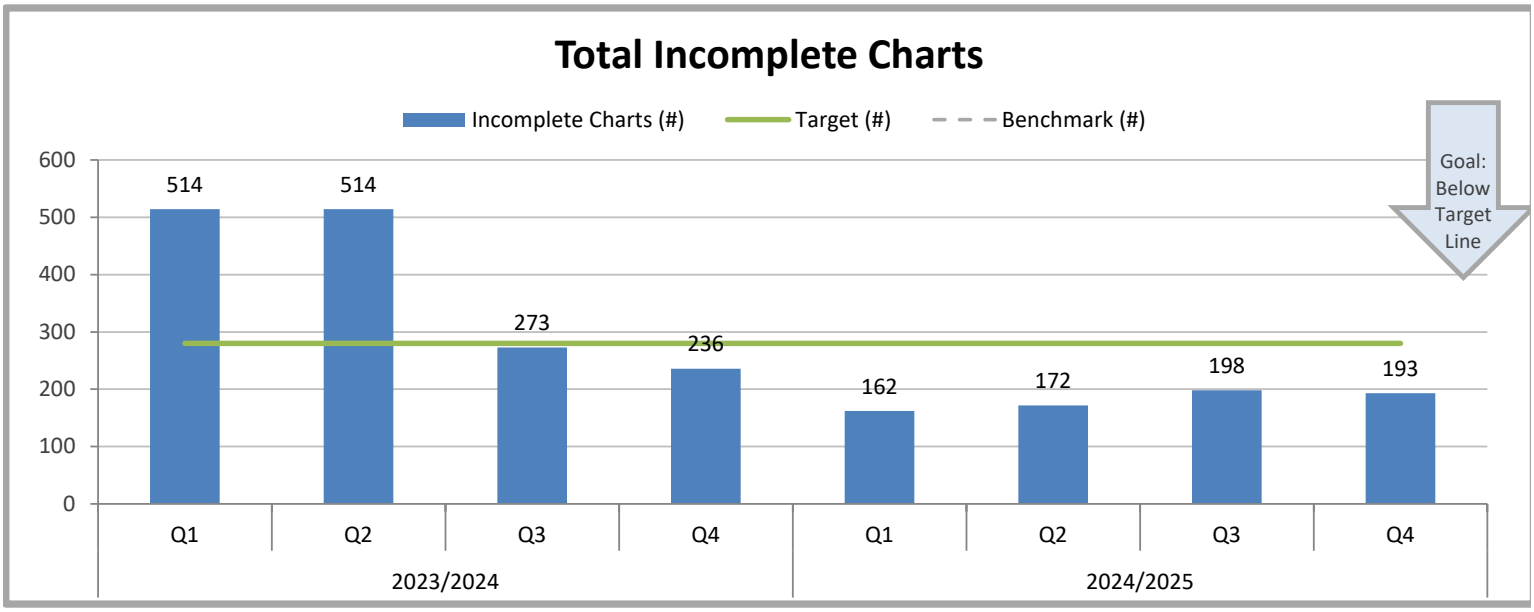
Significance: The purpose of this policy is to ensure that patient health records are completed in accordance with legal requirements, including the Public Hospitals Act (PHA) and Hospital Management Regulation 965 (Regulation), professional obligations, as well Hospital by-Laws, policies, rules and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

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

Target Information: Continue with prior year target.

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incomplete Charts (#)	514	514	273	236	162	172	198	193
Benchmark (#)								
Target (#)	280	280	280	280	280	280	280	280



Performance Analysis:

Q1 Target met. Q1 had a decrease of 74 charts compared to the previous quarter. Due to this significant drop, the results for Q1 are 42% below target.

Q2 Target met. Q2 had a slight increase in incomplete charts, however, we continue to remain below target.

Q3 Target met. This quarter had a 15% increase in incomplete charts, though we remain 29% below target. The increase of incompete charts is attributed to process changes that have been implemented. This has led to a physician having a higher volume of deficiencies than normal.

Q4 Target met. This quarter we continue to improve on incomplete charts as we had a decrease of 2.5% compared to previous quarter.

Plans for Improvement:

Q1 Continue to monitor.
Q2 Continue to monitor.
Q3 Continue to monitor.
Q4 Continue to monitor.

Accountable: President and Chief Executive Officer / Chief of Staff

Return to Dashboard

Indicator: Medication Scanning Compliance

Strategic Direction: INTEGRATION

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

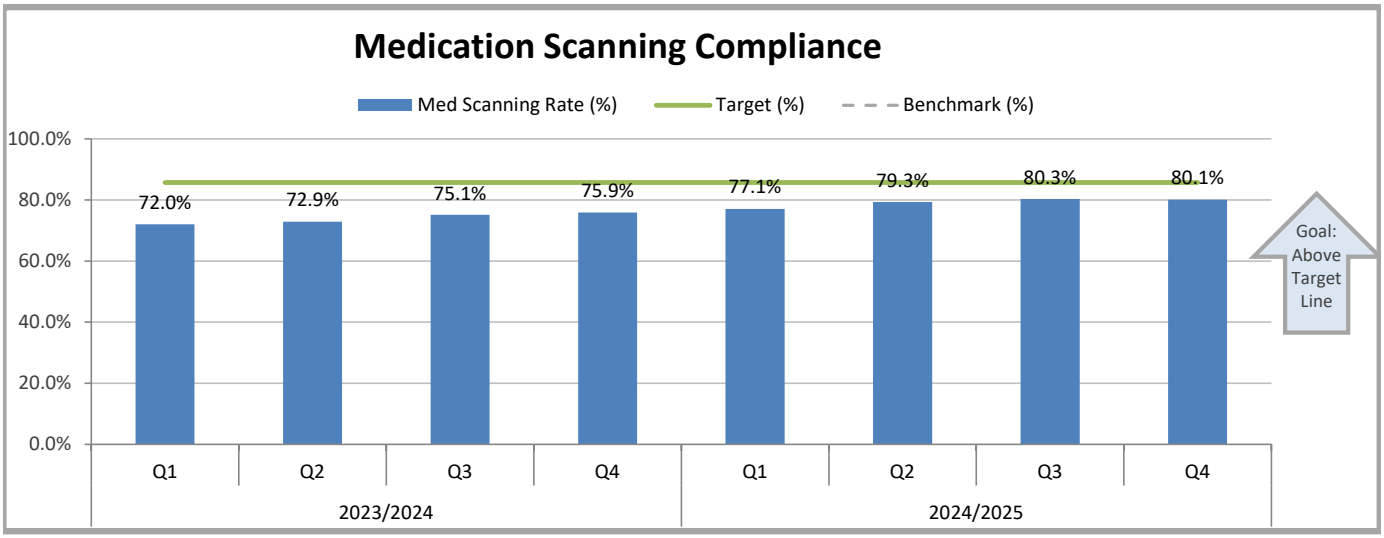
Significance: Barcode medication administration (BCMA) systems scan a patient's wristband and medication to be given in order to prevent medication errors. BCMA has shown to reduce medication administration errors significantly and to reduce harm from serious medication errors.

Data Source: Cerner Reporting Portal

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

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Scanning Rate (%)	72.0%	72.9%	75.1%	75.9%	77.1%	79.3%	80.3%	80.1%
Benchmark (%)								
Target (%)	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%



Performance Analysis:

Q1 Target not met. Q1 had 172,084 medications scanned out of 223,283. April and June were within 10% of reaching the target (Apr. 77.5% / Jun. 77.2%).

Q2 Target not met. Q2 had 182,141 medications scanned out of 229,698 with all months being within 10% of reaching target.

Q3 Target not met. We continue to see improvement from previous quarter. There were 202,012 medications scanned out of 251,425. 4 out of the 9 nurse units met target and 1 unit was within 10% of target.

Q4 Target not met. Q4 had 194,195 medications scanned out of 242,469. This quarter, 3 nurse units met the target, 2 were within 10% of the target, and 4 did not meet the target. Of those 4 units, 3 saw an improvement from the previous quarter.

Plans for Improvement:

Q1 One-on-one coaching sessions were conducted with department managers and directors to review departmental rates and identify potential areas for improvement. One unit exceeded target at the end of Q1. Employee performance recognition for rate improvements is being completed at the departmental level.

Q2 Managers have been meeting with staff starting in the summer and moving through to review scanning rates individually. Should see improvement in Q3.

Q3 Managers continue to run reports and meet with staff, continue to look for medications and IV fluids that cannot be scanned to make improvements. Slight improvement since previous quarter. Need to continue to discuss with staff. To improve in Q4, Pharmacy continues to work on creating "fake bar codes" for products that have lot and exp embedded in their bar codes to enable the products to be scanned by nursing. This is required since Cerner cannot capture the lot and exp. Pharmacy plans to test scanning with CI in more detail.

Q4 Q3 plans will be continued. A meeting was held at the end of March with Pharmacy, CI, and the ED manager to identify further barriers and next steps to improve. It was identified that diluents needed to be scanned in addition to the medication. If there are two bar codes present on a product, the linear bar code should be scanned, and further investigation is needed on the impact of whether the product or route modifications were made in a Powerplan on scanning ability. ED is routinely sending lists of medications that do not scan to Pharmacy for further investigation.

Accountable: Pharmacy, Manager of Pharmacy

Return to Dashboard

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

Strategic Direction: INTEGRATION

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

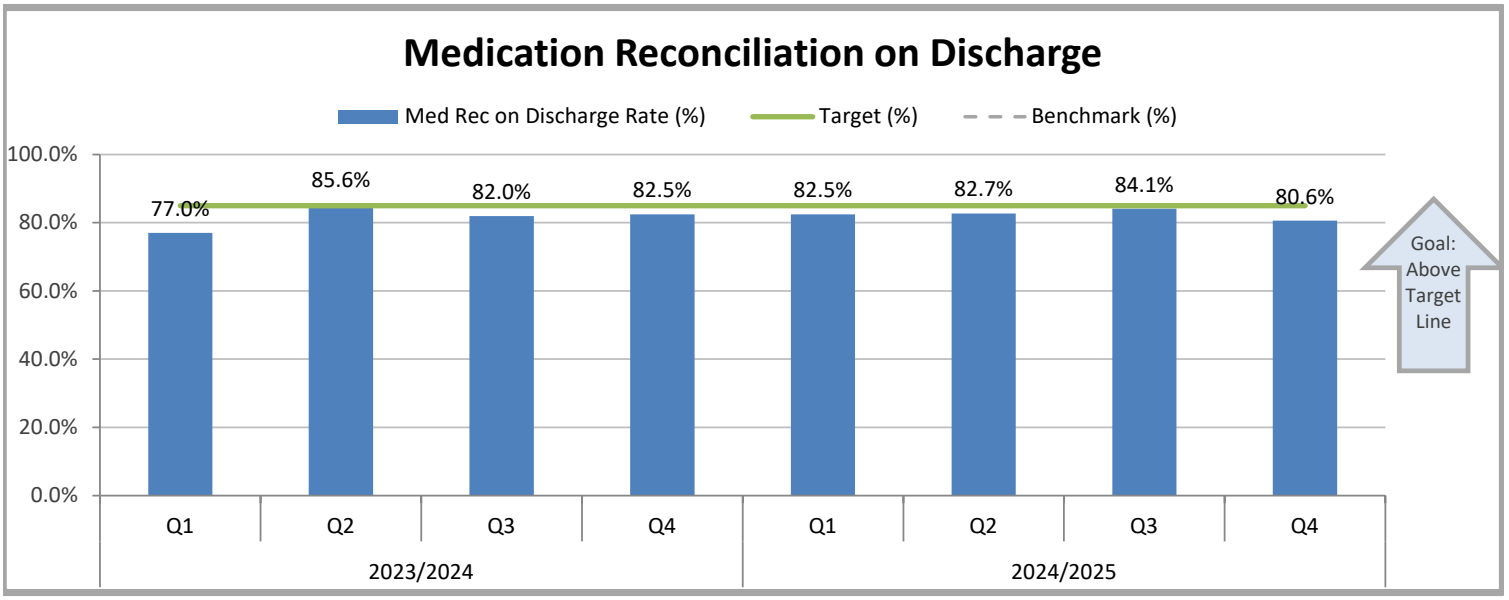
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a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

Data Source: Cerner electronic health record

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

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	77.0%	85.6%	82.0%	82.5%	82.5%	82.7%	84.1%	80.6%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target not met. Monthly results are within 5% of meeting target (Apr. 82.1%, May 84.3%, Jun. 80.8%).

Q2 Target not met. Monthly results were within 5% of meeting target this quarter (Jul. 85.6%, Aug. 83.1%, Sep. 79.4%). For Q2, 1,044 Medication Reconciliations were completed out of 1,262.

Q3 Target not met. However, we continue to trend upwards compared to previous quarters. If we can continue to increase our quarterly results by 1.0% to 1.5% next quarter we will meet target by year end. December results were above target (85.5%) with October and November both being within the 5% range of meeting target.

Q4 Target not met. February (76.9%) results played a significant role in not meeting the target this quarter. February had the most qualifying visits, with the lowest completed Medication Reconciliations at 350 out of 455.

Plans for Improvement:

Q1 Identify barriers in departments with lower rates and focus on improvement strategies in these departments.

Q2 Continue with plan from Q1.

Q3 Target not met however data demonstrates a 1.1% improvement rate. Continue with the initial improvement plan.

Q4 Continiue with plans to improve, further analysis required to understand barriers.

Accountable: Chief Information and Operating Officer / Chief of Staff

Return to Dashboard

Indicator: Patient Satisfaction Survey

Strategic Direction: INTEGRATION

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

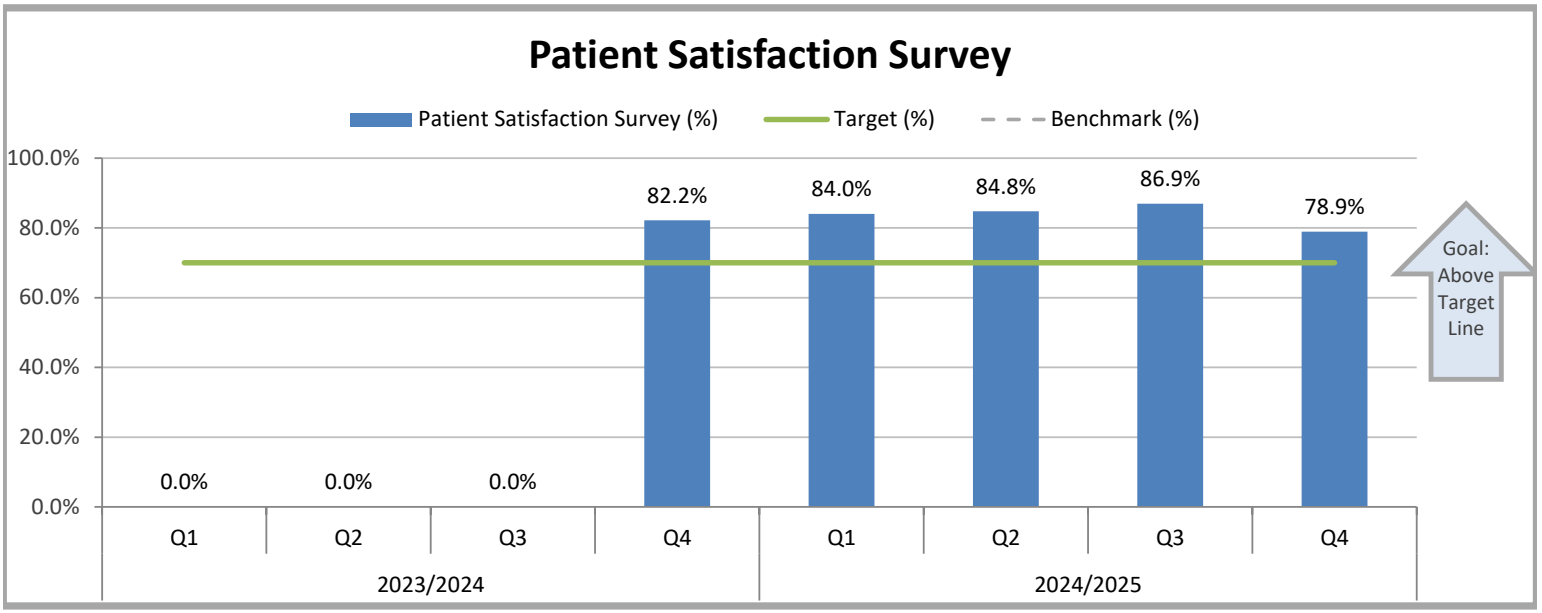
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that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

Data Source: Qualtrics

Target Information: Target set in accordance to QIP indicator using Peer Benchmark Hospitals FY20-21 (HQO - QIP Navigator).

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Patient Satisfaction Survey (%)	N/A	N/A	N/A	82.2%	84.0%	84.8%	86.9%	78.9%
Benchmark (%)								
Target (%)	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%



Performance Analysis:

Q1 Target met. 105 respondents responded positively out of 125 respondents.

Q2 Target met. 89 respondents responded positively out of 105 respondents.

Q3 Target met. 86 respondents responded positively out of 99 respondents.

Q4 Target met. 75 out 95 responses were received with a Top2Box response.

Plans for Improvement:

Q1 Will continue to monitor closely. Looking at opportunities to increase our sample size.

Q2 Target met. Continue to monitor action plan (POD's & Manager Patient Rounding) for consistency. Next step to work towards increasing response rates.

Q3 Target met. We continue to monitor our responses and seek immediate feedback through managers rounding with patients and families.

Q4 Target continues to be met although performance has declined since Q3. Low volumes significantly impact performance, and so we will continue to work on improving response rates. Clinical Manager Patient Rounding continues.

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

Indicator: Complaints Acknowledged Within Five (5) Business Days

Strategic Direction: PEOPLE

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

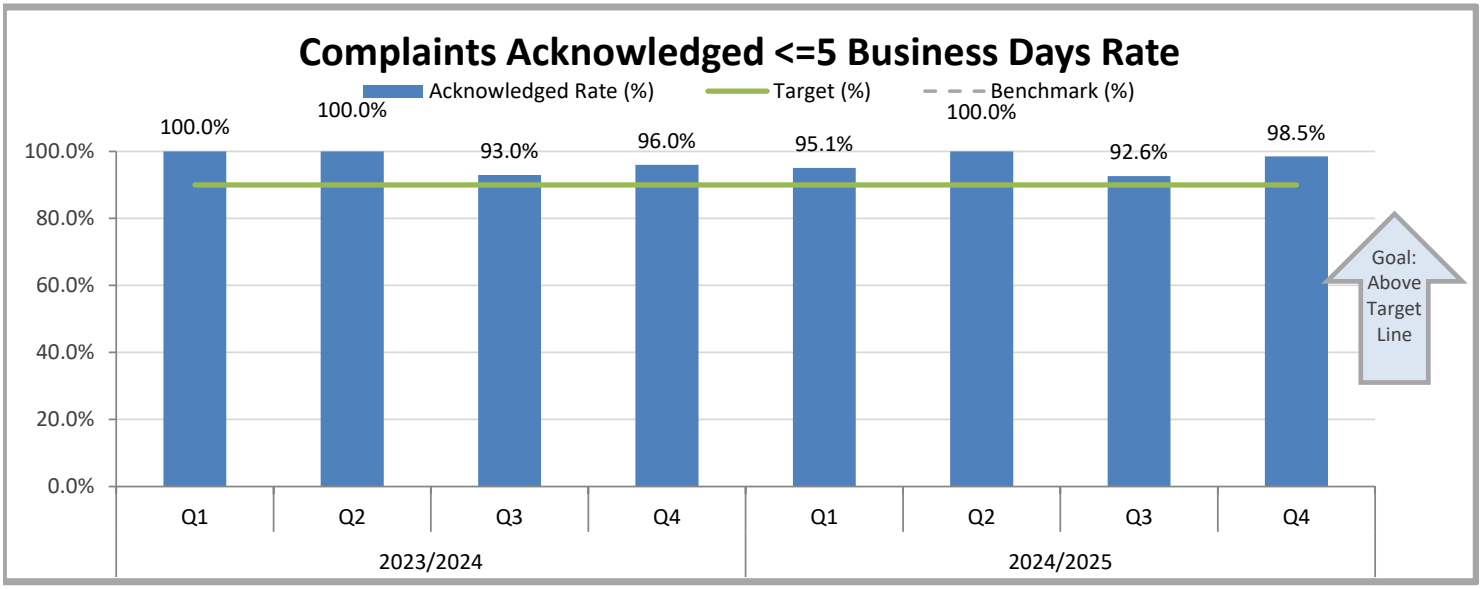
Significance: This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint. This indicator is calculated on the number of complaints received in the reporting period. By regulation, hospitals must acknowledge complaints within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

Data Source: RL Solutions

Target Information: Target is set internally at 90.0%

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acknowledged Rate (%)	100.0%	100.0%	93.0%	96.0%	95.1%	100.0%	92.6%	98.5%
Benchmark (%)								
Target (%)	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Performance Analysis:

Q1 Target met. There were a total of 58 complaints acknowledged within 5-days out of 61 total complaints.

Q2 Target met. There were a total of 86 complaints acknowledged within 5-days for this quarter.

Q3 Target met. There were a total of 63 complaints acknowledged within 5-days out of 68 total complaints this quarter.

Q4 Target met. There were a total of 64 complaints acknowledged within 5-days out of 65 total complaints this quarter.

Plans for Improvement:

Q1 Slight decrease from last quarter, but continue to be above target. Incident reporting system (RLDatix) has been online since June 18th, 2024. This system will allow us to capture and monitor feedback and complaints in a more comprehensive and efficient manner which will support continued improvement in timely responses.

Q2 Target met. Will continue current workflow to address timely complaint acknowledgement.

Q3 Down from Q2. Target continues to be met. Low volume can significantly impact performance. Will continue to ensure response processes are followed so that acknowledgement is sent within expected timeframe. Adjustment will be made to RLDatix (incident reporting system) to enhance monitoring of acknowledgements. This will improve our ability to identify those files that are approaching day 5 with no action.

Q4 Improvement from Q3 and target continues to be met. 1 miss this quarter. We will continue to monitor our response processes to ensure a coordinated approach. Will also continue to leverage system optimization opportunities within RLDatix.

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

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

Strategic Direction: PEOPLE

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

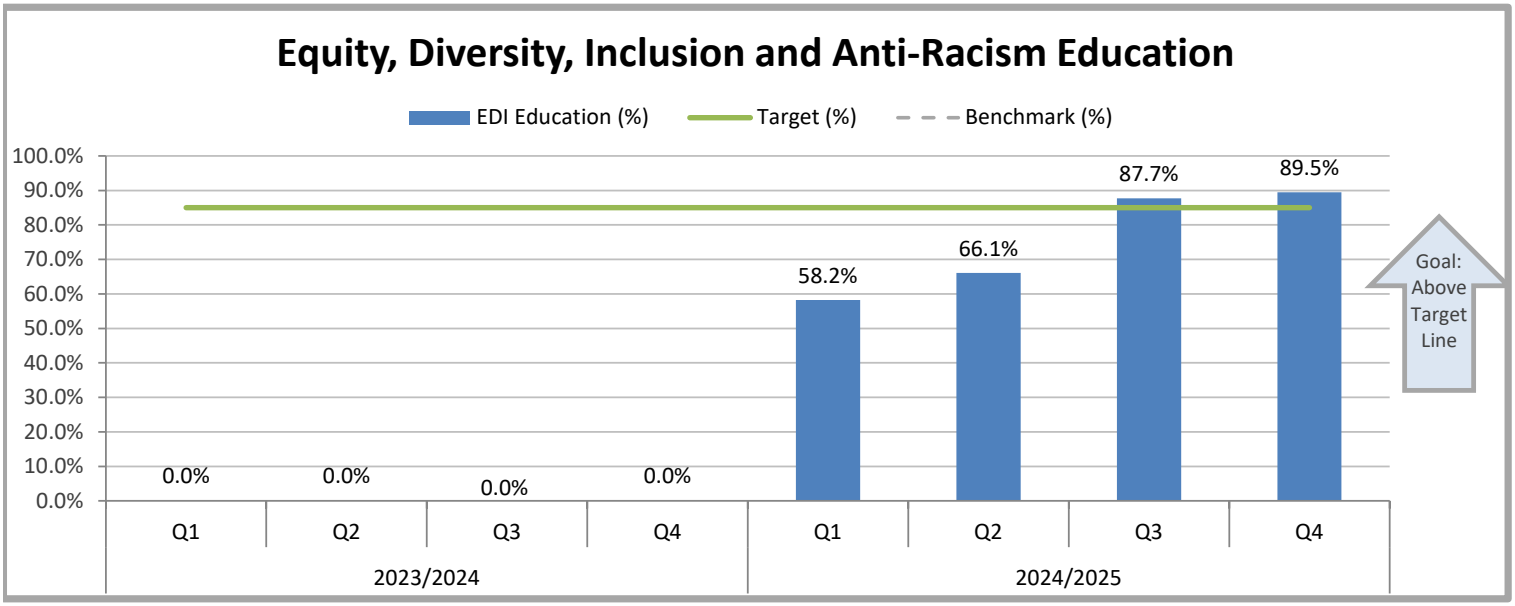
Significance: Education is essential to help guide and build a culture focused on equity, diversity, inclusion, and anti-racism, and to contribute to better outcomes for patients, families, and providers within the health system. The commitment to addressing racism and discrimination, reducing inequities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

Data Source: Learning Management System (LMS)

Target Information: Target set in accordance to QIP indicator.

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
EDI Education (%)	N/A	N/A	N/A	N/A	58.2%	66.1%	87.7%	89.5%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target not met. 32 staff were compliant with EDI training out of 55.

Q2 Target not met. 39 staff were compliant with EDI training out of 59.

Q3 Target met. 50 staff members were compliant with EDI training out of 57 this quarter. The physician compliance rate increased from 25% to 83% this quarter which was a signifcant factor in meeting target.

Q4 Target met. 51 staff were compliant with EDI training out of 57 this quarter. 10 of 11 physicians (91%), and 41 of 46 staff (89%) are compliant as of this quarter with EDI training.

Plans for Improvement:

Q1 Improve communication regarding the importance to complete required training.

Q2 Continue with communication strategies to build a culture focused on equity, diversity, inclusion, and anti-racism.

Q3 Target met. Continue with strategy.

Q4 Target met. Continue with strategy.

Accountable: Chief Human Resources Officer / Director, Human Resources

Return to Dashboard

Indicator: Indigenous Cultural Awareness

Strategic Direction: PEOPLE

Definition: The percentage of new staff (includes staff, students, physicians, and volunteers) who participated in Indigenous training over the total number of new staff. Performance is cumulative year-to-date.

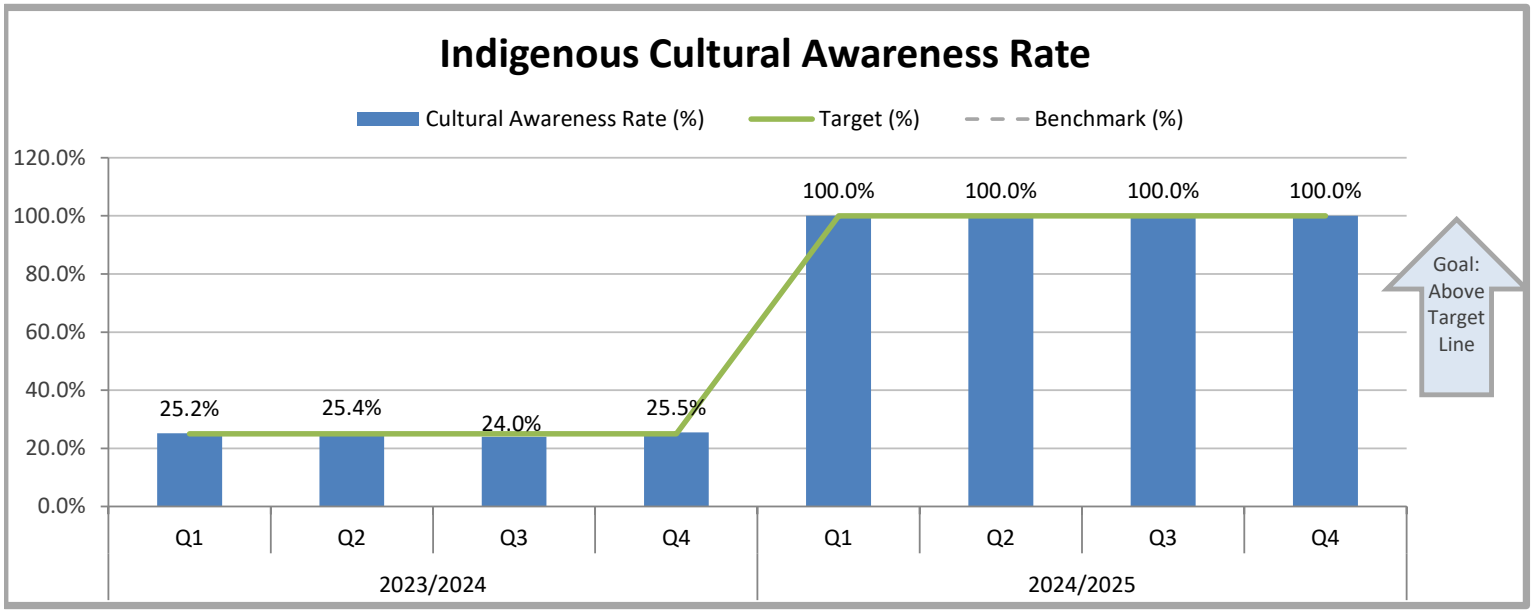
Significance: As part of our CCH Strategic Plan for 2016-2021, it identifies that CCH will partner with experts and our peers to foster a climate of culture competency. We will increase access to training with a focus on frontline staff, create a policy on smudging and plan to do at least one smudging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

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

Target Information: Target is set at 100% in accordance to HSAA Obligation

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cultural Awareness Rate (%)	25.2%	25.4%	24.0%	25.5%	100.0%	100.0%	100.0%	100.0%
Benchmark (%)								
Target (%)	25.0%	25.0%	25.0%	25.0%	100.0%	100.0%	100.0%	100.0%



Performance Analysis:

Q1 Target met.
Q2 Target met. For Q2, 54 staff members completed Indigenous training.
Q3 Target met.
Q4 Target met.

Plans for Improvement:

Q1 Continue with completing the training at hospital orientation for all new hires.
Q2 Continue with current strategy.
Q3 Continue with current strategy.
Q4 Continue with current strategy.

Accountable: Chief Human Resources Officer / Manager, Human Resources

Return to Dashboard