Cornwall Community Hospital
Hôpital communautaire de Cornwall

CORPORATE SCORECARD 2020/2021

Vision: Exceptional Care. Always.

Mission: Our health care 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.

PATIENT INSPIRED CARE					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
CAM Administration	Senior Friendly	G	G	G	G
Complaints Acknowledged	Board	G	G	G	Y
Falls per 1,000 Patient Days	Senior Friendly	G	R	G	Y
Patient Experience Survey: Information	QIP	R	Y	Y	Y
Readmissions within 30-Days for Select HIG Conditions	HSAA	Y	R	G	G
Repatriate Patients within 48-Hours Rate	HSAA	R	R	R	R
Repeat ED Mental Health Visits	QIP/HSAA/MSAA	R	G	G	G
Repeat ED Substance Abuse Visits	HSAA/MSAA	G	G	G	R
Same Day Discharge to Home Care Rate	HSAA	G	Y	Y	R

PARTNERING FOR PATIENT SAFETY AND QUALITY OUTCOMES					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Actual LOS to HIG Expected LOS Rate	Board/OPT	Y	Y	R	Y
Clostridium Difficile (C.Diff) Incidence	HSAA/MoHLTC	G	G	R	R
Discharge Summary Sent to Primary Care Within 48 Hours	QIP	G	Y	G	Y
Elective Repeat Low Risk C-Section (>37weeks) Rate	HSAA/Board	G	G	G	G
Emergency Visits - Wait Time for Inpatient Bed (TIB)	QIP/OPT	G	Y	R	R
Emergency Visits - Wait Time for Non-Admitted High Acuity	HSAA/OPT	G	G	G	G
Emergency Visits - Wait Time for Non-Admitted Low Acuity	HSAA/OPT	Y	R	R	R
Incomplete Charts	Board	G	G	R	R
Indication of Induction Post-Dates (<41 Weeks) Rate	HSAA	G	G	G	G
Inpatients Receiving Care in Unconventional Spaces/Day	QIP	G	G	G	G
Medication Reconciliation on Discharge Rate (ROP)	QIP/Accreditation	Y	Y	Y	Y
Inpatient PODS (Patient Oriented Discharge Summary) Rate	Board	Y	Y	G	Y
Smoking Cessation Rate	HSAA	G	G	G	G
Wait Time - CT Scans	HSAA	R	R	R	R
Wait Time - Hip Replacement	HSAA	R	R	R	R
Wait Time - Knee Replacement	HSAA	R	R	R	R
Wait Time - MRI Scans	HSAA	R	R	R	R

OPERATIONAL EXCELLENCE THROUGH INNOVATION					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Current Ratio	HSAA	Y	Y	Y	G
Overtime Rate	HSAA	G	R	R	R
Total Margin	HSAA	R	Y	R	G

OUR TEAM OUR STRENGTH					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Absenteeism	Board	Y	Y	Y	Y
Indigenous Cultural Awareness	HSAA	G	G	G	G
Workplace Violence Prevention - Incidents	QIP	G	G	G	Y

Results:

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

Overall Indicator Performance:	Q1	Q2	Q3	Q4
% Indicators equal to or outperforming targets:	53%	41%	47%	34%
% Indicators within 10% of targets:	22%	31%	16%	28%
% Indicators underperforming targets:	25%	28%	38%	38%

Reference Definitions:

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

Indicator: CAM Utilization in Elderly Patients

Strategic Direction: Patient Inspired Care

Definition: The rate of administration of the approved delirium screening tool - Confusion Assessment Method (CAM) in admitted patients 65 or older entering via the Emergency Department. Minimum of one administration upon admission to hospital. Calculated by dividing the total number of cases with the CAM administered by the total number of applicable admitted patients 65 or older entering via the Emergency Department.

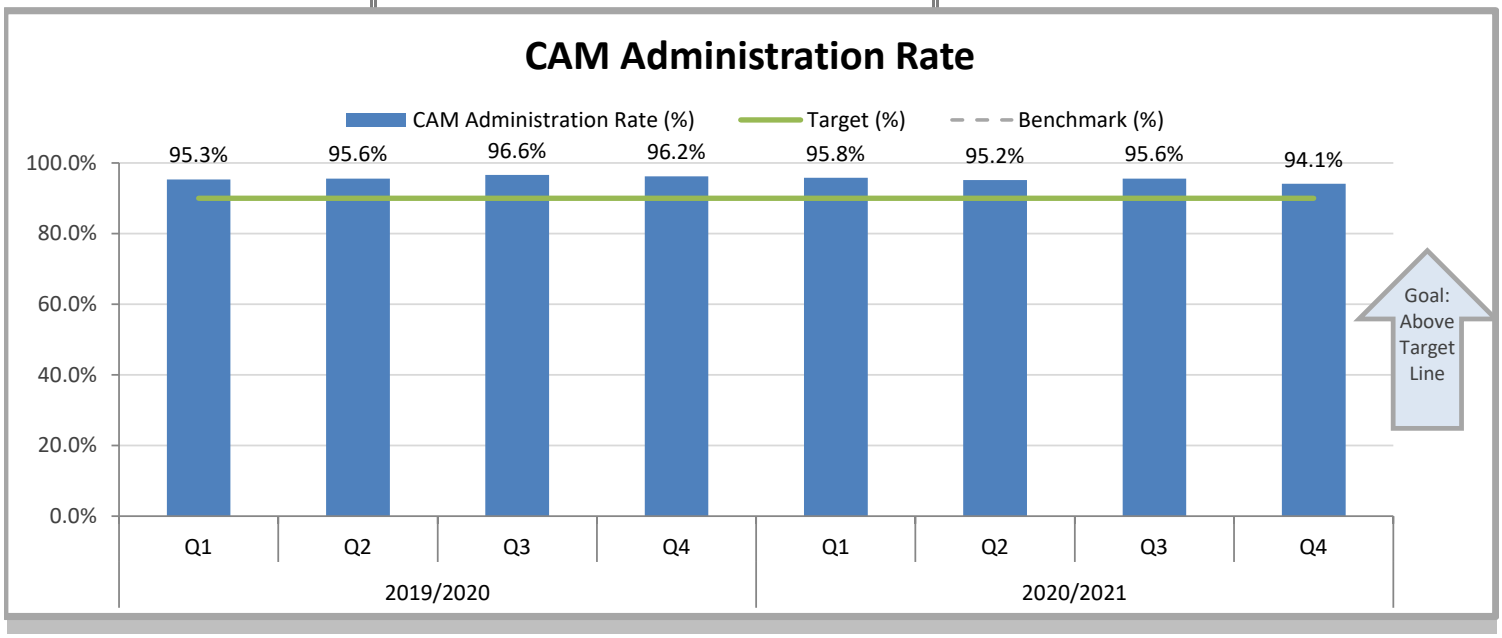
Significance: The Confusion Assessment Method (CAM) is a standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings. The screening tool alerts clinicians to the presence of possible delirium. CAM utilization builds external partnerships and internal awareness, and educates around the Senior Friendly Hospital Strategy. This is our number one quality indicator to support the clinical aspect of being Senior Friendly.

Data Source: Cerner electronic health record

Target Information: Target is based on internal directives

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CAM Administration Rate (%)	95.3%	95.6%	96.6%	96.2%	95.8%	95.2%	95.6%	94.1%
Benchmark (%)								
Target (%)	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Performance Analysis:

Q1 Target met. Results continue to trend well within projected target.

Q2 Target met. Performance continues to exceed target.

Q3 Target met.

Q4 Target met.

Plans for Improvement:

Q1 Continue monitoring performance.

Q2 Continue monitoring performance. CAM administration rates are captured on admission as well as regularly to assess for delirium.

Q3 Continue with current strategies and monitoring compliance.

Q4 Continue current strategies and compliance monitoring

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

Indicator: Complaints Acknowledged Within Five (5) Business Days

Strategic Direction: Patient Inspired Care

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.

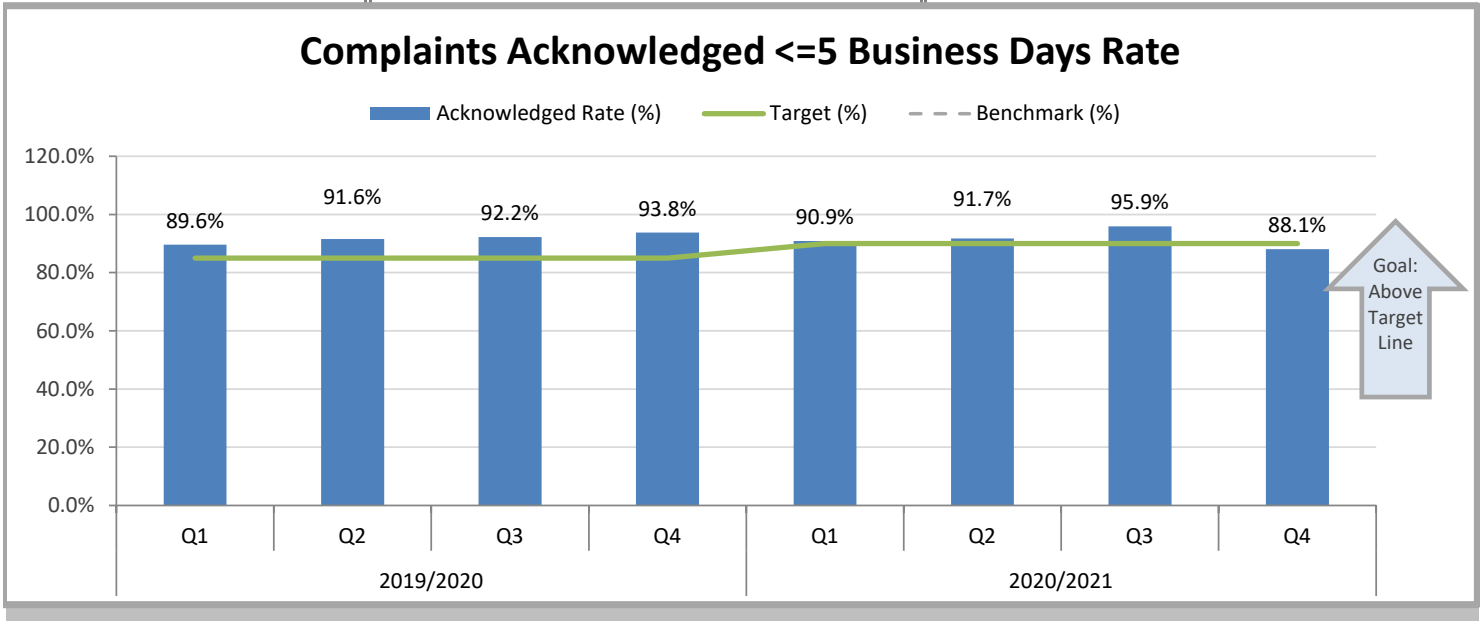
Significance: This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint. This indicator is calculated on the number of complaints received in the reporting period. By regulation, hospitals must acknowledge complaints within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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acknowledged Rate (%)	89.6%	91.6%	92.2%	93.8%	90.9%	91.7%	95.9%	88.1%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	90.0%	90.0%	90.0%	90.0%



Performance Analysis:

Q1 Target met. For FY2021, target has been increased to 90%. There were 30 complaints acknowledged out of the 33 total complaints for this reporting period.

Q2 Target met.

Q3 Target met.

Q4 Just below target. There were a total of 37 complaints acknowledged within 5 days out of a total of 42 complaints for Q4.

Plans for Improvement:

Q1 Continue monitoring performance.

Q2 Continue monitoring performance.

Q3 Continue monitoring performance.

Q4 Continue monitoring performance.

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

Indicator: Falls per 1,000 Inpatient Days

Strategic Direction: Patient Inspired Care

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.

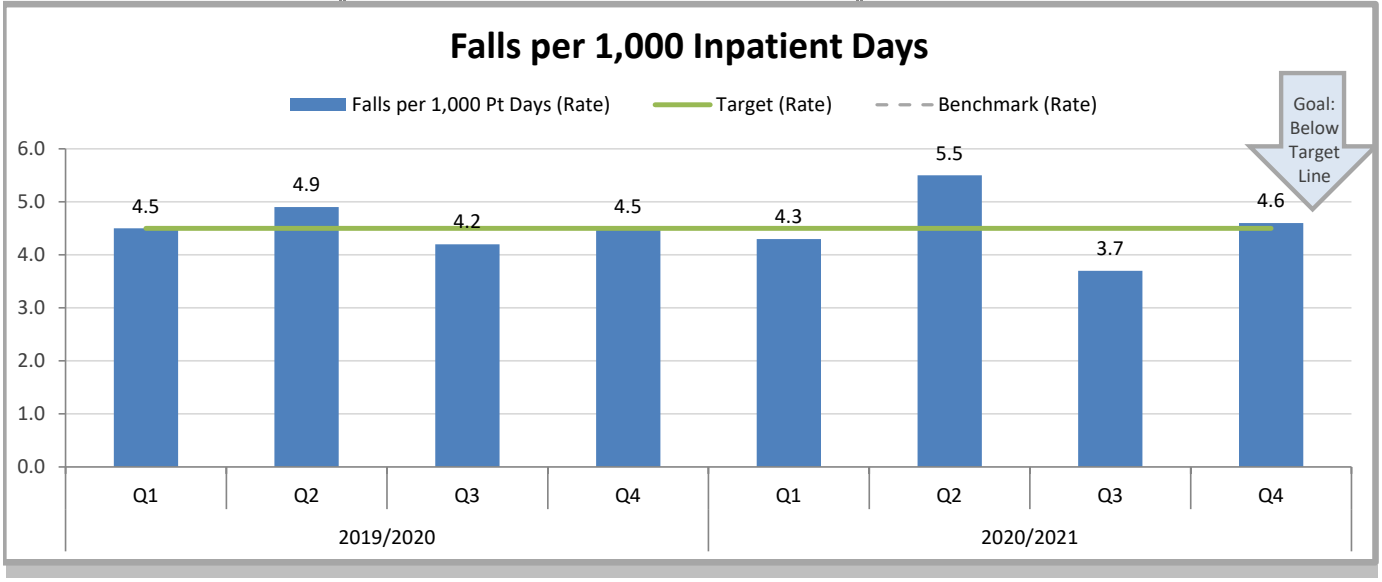
Significance: Falls, while in hospital, increase morbidity and mortality, increased length of stay, and decreased quality of life. Reducing falls indicates success in improving quality. According to Safer Healthcare Now, "A fall is defined as - An event that results in a person coming to rest inadvertently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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Falls per 1,000 Pt Days (Rate)	4.5	4.9	4.2	4.5	4.3	5.5	3.7	4.6
Benchmark (Rate)								
Target (Rate)	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5



Performance Analysis:

Q1 Overall, target met for this reporting period. Most areas remain well within target, except for Rehab Department showing a falls rate of 7.0 per 1,000 patient days and Medicine Department at 4.6 falls per 1,000 patient days..

Q2 Target not met. Fall rates on Medicine (6.8%) and Rehab (5.9%) increased overall fall rate this quarter.

Q3 Target met.

Q4 Target not met. Fall rates on Medicine (6.9%) and Rehab (8.2%) increased the overall fall rate for Q4.

Plans for Improvement:

Q1 Review clinical areas where incidents of falls are higher and develop strategies to improve. Overall, the rate is below target and remains consistent. However, opportunities exist for improvement.

Q2 Falls rates are examined monthly. Fall reduction strategies are reviewed with clinical staff (Medicine/Rehab) and measures are audited. Falls reduction strategies include decreasing risk of functional decline and delirium prevention.

Q3 Continue current practices and fall reduction strategies, including ensuring efforts to minimize clutter and promote mobilization while implementing universal precautions.

Q4 Outbreaks on the medical and rehab units, as well as universal precautions/isolation have resulted in decreased mobility opportunities and deconditioning, which is likely contributing to the falls for this quarter

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

Indicator: Patient Experience Survey - Information Inpatient

Strategic Direction: Patient Inspired Care

Definition: Percentage of Inpatient respondents who responded positively (positive response include "completely" and "quite a bit") (Top2Box) to "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?" (Question #38).

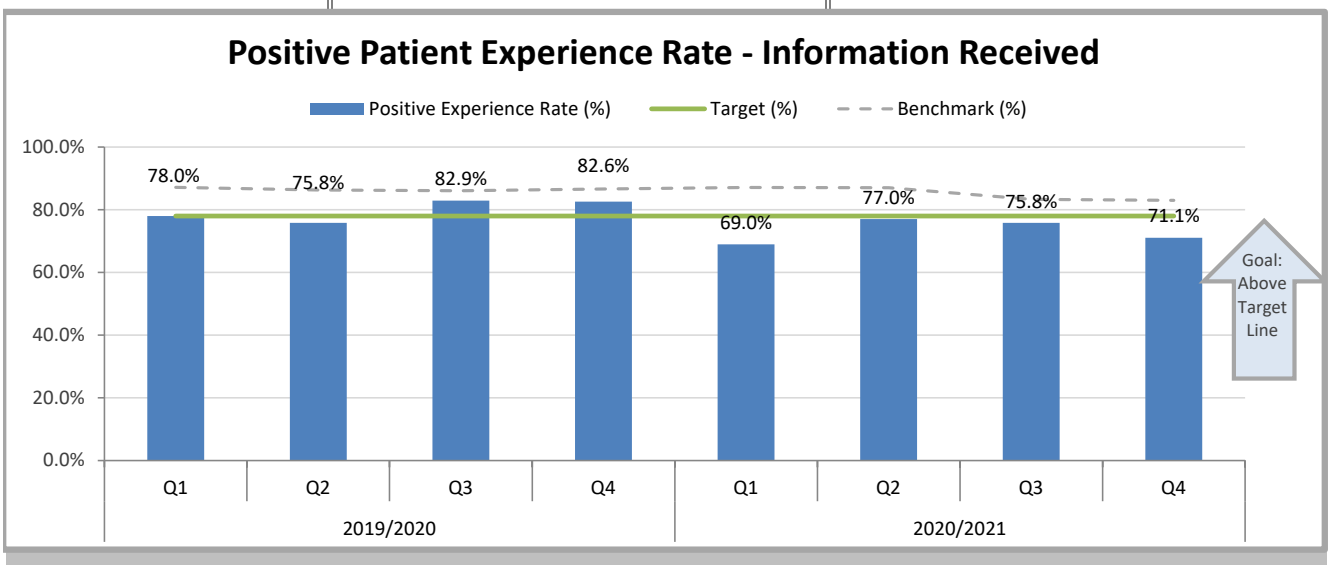
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that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

Data Source: NRC (National Research Corporation)

Target Information: Set internally at 78%

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	78.0%	75.8%	82.9%	82.6%	69.0%	77.0%	75.8%	71.1%
Benchmark (%)	87.1%	86.3%	86.1%	86.6%	87.1%	87.0%	83.3%	83.0%
Target (%)	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%



Performance Analysis:

Q1 Target not met. The biggest impact on Q1 were the low results for April at 55.6%; results for May at 73.1%, and June at 77.4% show an increase by 20% each month over April. Response rate for Q1 is also a bit low at 26.0% due to June being incomplete with closure date being mid September.

Q2 Results for Q2 just slightly below target at 77%, however, it is a significant increase from Q2. The biggest impact on Q2 were the low results for August at 66.7%; both July and September are above target at 81.1% and 82.8% respectively. Response rate for Q2 at 28.2%; however, September is incomplete with closure date being mid-December.

Q3 Target not met. The biggest impact on Q3 were the low results for November at 69.7%; results for October are at 77.8%, and December is currently above target at 80%. Response rate for Q3 is at 30.3%; however, December is incomplete with closure date being mid-March.

Q4 Target not met. Q4 includes results from January at 63.6% and February at 70.1%. March data is not included in Q4 due to analysis calculated over an 11 month period.

Plans for Improvement:

Q1 Continue to educate staff about the importance of PODS (patient oriented discharge summaries) usage and perform regular audits.

Q2 Improve distribution of "discharge folders" (previously circulated by volunteers pre-COVID) to inpatients to retain their PODs and all other education material provided while in hospital. This folder also includes a letter from Mrs. Despatie that links the value of the information received back to the survey satisfaction question.

Q3 Continue to provide the discharge folder for patients' to organize their patient education material. Continue to educate front line staff on the importance of sharing the PODS package with patients on discharge.

Q4 Continue as above.

Accountable: VP, Community Programs / Director, Quality and Risk

Return to Dashboard

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

Strategic Direction: Patient Inspired Care

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

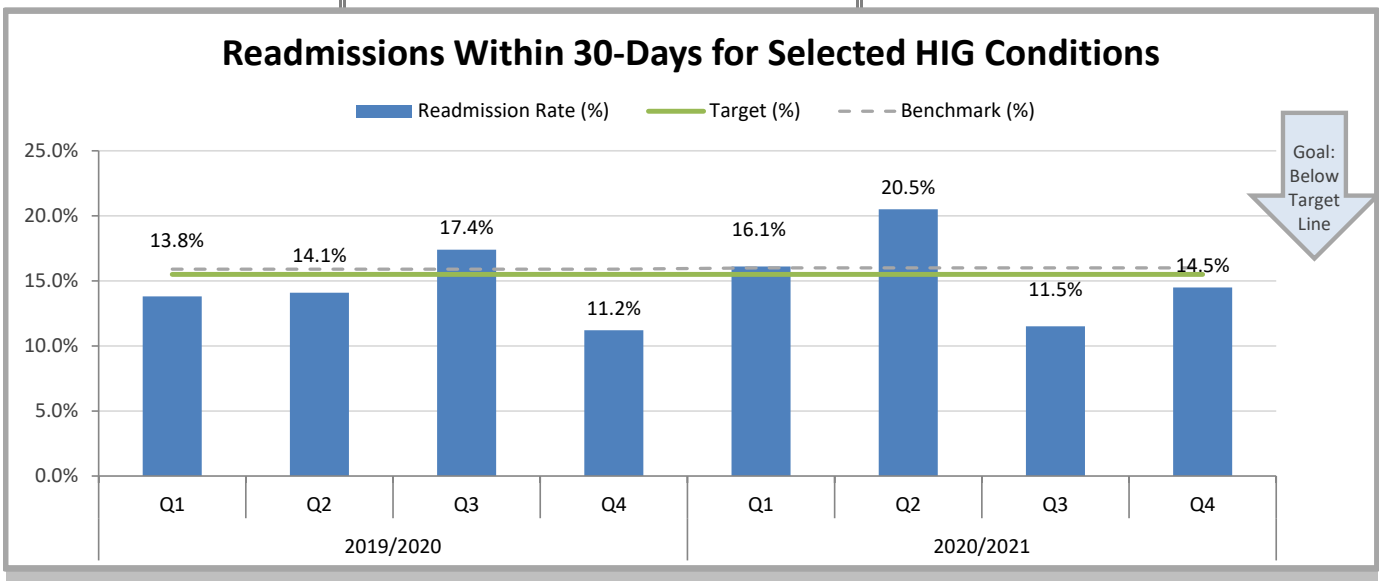
Significance: Unplanned hospital readmissions exact a toll on individuals, families and the health system. Avoidable readmissions remain a system-level issue that is also linked to integration among providers across the continuum of care. If patients get the care they need when and where they need it,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

Data Source: Anzer -DAD (Discharge Abstract Database)

Target Information: Target is based on HSAA performance standard obligations

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	13.8%	14.1%	17.4%	11.2%	16.1%	20.5%	11.5%	14.5%
Benchmark (%)	15.9%	15.9%	15.9%	15.9%	16.0%	16.0%	16.0%	16.0%
Target (%)	15.5%	15.5%	15.5%	15.5%	15.5%	15.5%	15.5%	15.5%



Performance Analysis:

Q1 Target not met, but just slightly. There were 274 select HIG condition visits with 44 readmissions within 30 days.

Q2 Target not met. There were 341 select HIG condition visits with 70 readmissions within 30 days. The top 3 most responsible diagnosis of these particular HIG conditions are Heart Failure (17 readmits), COPD with lower respiratory tract infection (11 readmits), and COPD without lower respiratory tract infection (10 readmits).

Q3 Target met.

Q4 Target met.

Plans for Improvement:

Q1 The top 3 most responsible diagnosis of these particular HIG conditions are Heart Failure, COPD with lower respiratory tract infection, and viral pneumonia. Information will be shared with physician groups, and strategies identified to ensure patients are referred to appropriate services upon discharge from hospital.

Q2 A closer review will be conducted to determine internal factors that can be addressed. There has been a significant decline in the ability to access LHIN Home and Community Care Services, which at times factor in to patients returning to hospital.

Q3 Continue current strategies and closely monitor concerns and trends.

Q4 Continue monitoring performance

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

Return to Dashboard

Indicator: Repatriate Patients within 48-Hours

Strategic Direction: Patient Inspired Care

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

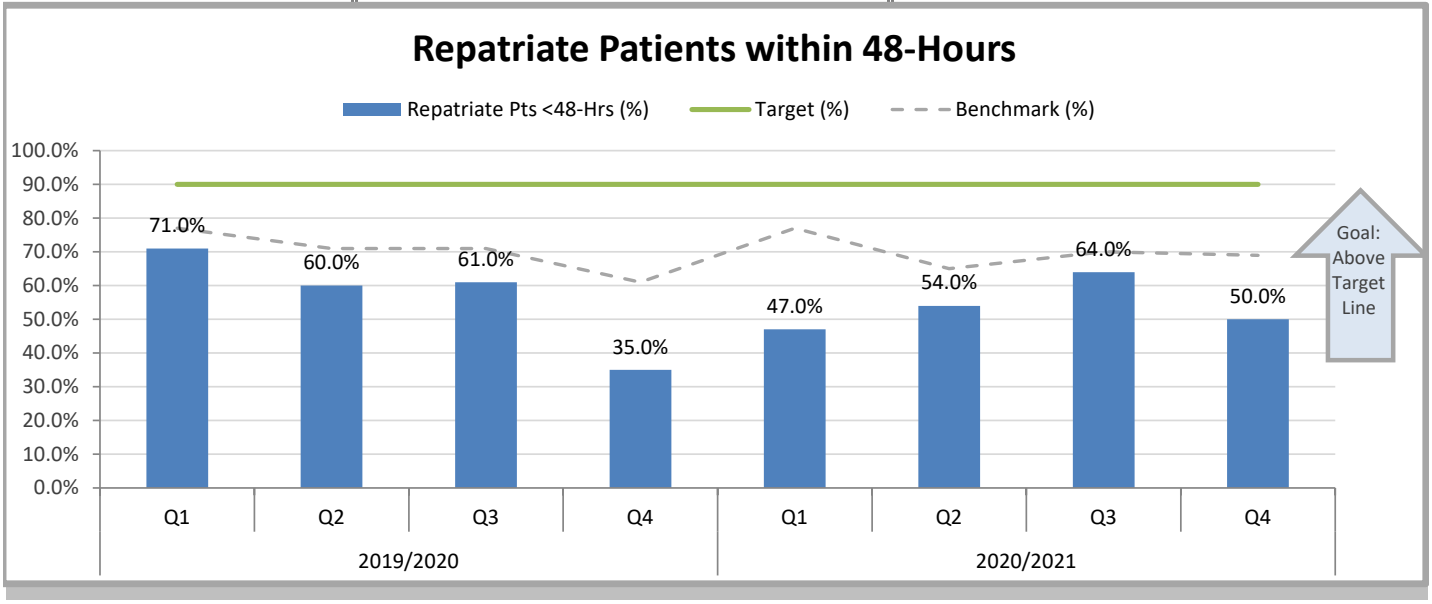
Significance: The process of transferring the patient to his or her referring acute care hospital or to the acute care hospital that is the "closest" to his or her home address once the patient is deemed to be medically stable and/or suitable for transfer. The receiving acute care hospital is determined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

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

Target Information: Target is based on HSAA obligations

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repatriate Pts <48-Hrs (%)	71.0%	60.0%	61.0%	35.0%	47.0%	54.0%	64.0%	50.0%
Benchmark (%)	77.0%	71.0%	71.0%	61.0%	77.0%	65.0%	70.0%	69.0%
Target (%)	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Performance Analysis:

Q1 Below target. Total repatriation volume of 34, with 16 repatriations within 48 hours, compared to quarterly average last FY1920 of 36.

Q2 Below target, although an increase over Q1. Benchmark hospitals saw a decrease in Q2. Total repatriation volume of 35, with 19 repatriations within 48 hours.

Q3 Below target, although an increase over Q2. Total repatriation volume of 45, with 29 repatriations within 48 hours.

Q4 Below target. Total repatriation volume of 37, with 18 repatriations within 48 hours for Q4.

Plans for Improvement:

Q1 Challenge continues as Ottawa Hospital's requests can be multiple in a 24-48 hour period, and the patient requires a private room and swab on arrival. In addition, during this shutdown period, many repatriations were coordinated through the Regional Flow Center in Ottawa. Continue daily return of patients while balancing ER admission needs, and assessing if patients can be re-directed to GMH or Winchester hospitals.

Q2 Continue same strategies as Q1. Performance continues to trend in the right direction towards target.

Q3 Continue same strategies as Q1. Performance continues to trend in the right direction towards target.

Q4 Continue as above. Outcome affected by capacity challenges.

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

Return to Dashboard

Indicator: Repeat ED Mental Health Visits

Strategic Direction: Patient Inspired Care

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

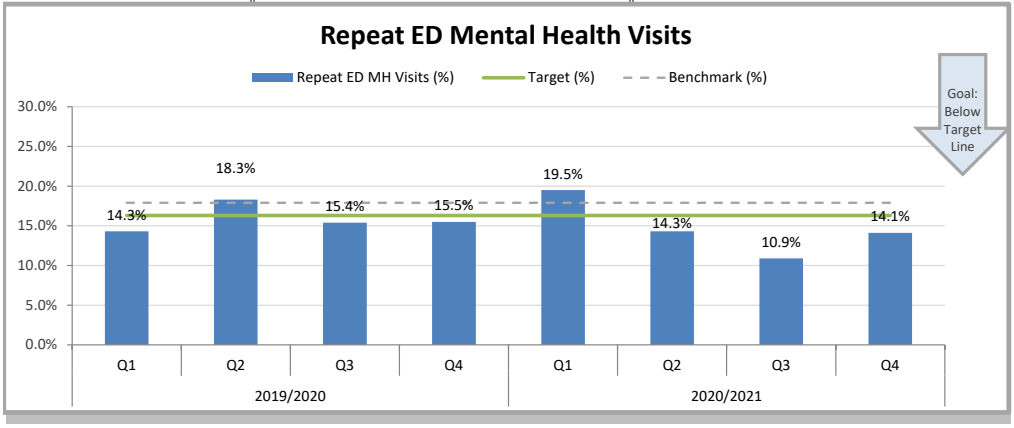
Significance: Repeat emergency visits among those with mental health conditions contribute to emergency visit volumes and wait times. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care. Given the chronic nature of the mental health conditions,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

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

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

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED MH Visits (%)	14.3%	18.3%	15.4%	15.5%	19.5%	14.3%	10.9%	14.1%
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%	16.3%	16.3%	16.3%	16.3%



Performance Analysis:

Q1 Data for Q1 is reported on this quarter. All coding has been completed. Total visits to the ED was 267. Of these, 52 were repeat visits representing 19.5% and above our target of 16.3%. There was a slight reduction in overall visits which historically exceeds 300 visits per quarter. This is notable as community programs moved most of their services to virtual and there was concern we would see increased volumes to the ED. There were multiple clients with 3 or more repeat visits within this reporting period. Often, individuals are presenting with complex mental health and concurrent disorders and are involved with multiple services including community programs who require a number of service interactions before stabilizing.

Q2 Data for Q2 is reported on this quarter. All coding has been completed. Total visits to the ED was 328. Of these, 47 were repeat visits representing 14.3% and below our target of 16.3%. There were multiple clients with 3 or more repeat visits within this reporting period. Often, individuals are presenting with complex mental health and concurrent disorders and are involved with multiple services including community programs who require a number of service interactions before stabilizing. A number of clients left against medical advice and returned within the 30 days for ongoing symptoms.

Q3 Data for Q3 is reported on this quarter. All coding has been completed. Total visits to the ED for mental health was 339. Of these, 37 were repeat visits representing 10.9% and below our target of 16.3%. There were multiple clients with 3 or more repeat visits within this reporting period. As previously seen, often individuals are presenting with complex mental health and concurrent disorders and are involved with multiple services including community programs who require a number of service interactions before stabilizing.

Q4 Data for Q4 is reported on and all coding has been completed. Total visits to the ED for mental health was 291 – a reduction from last quarter. Of these, 41 were repeat visits representing 14.1% and below our target of 16.3%. YTD saw 1225 total visits of which 177 were repeat representing 14.4% and meeting our target. This is a slight reduction from the fiscal 19/20 repeat visit rate of 15.3%. Again this quarter, there were multiple clients with 3 or more repeat visits. As previously seen, often individuals are presenting with complex mental health and concurrent disorders and are involved with multiple services including community programs and require a number of service interactions before stabilizing

Plans for Improvement:

Q1 The automatic notification report to the Manager is in que to be built into Cerner. This will allow us to more quickly identify and intervene with individuals who are repeatedly accessing the ED. Strengthening discharge planning and collaboration between community programs and IMHU will continue to be a focus as will increased collaborative case planning between ED, Community Programs and Inpatient Mental Health in the coming year. The one-year funding of one FTE RN to implement co-response with OPP is moving forward.

Q2 The automatic notification report to the Manager has been built in Cerner and became active November 2020. Repeat visits are now being monitored in real time and individuals are being contacted to offer support and information of services available. Strengthening discharge planning and collaboration between community programs and IMHU continues to be a focus as is increased collaborative case planning between ED, Community Programs and Inpatient Mental Health in the coming year. The Mental Health Crisis Team has received base funding to support mobile co-response with police. The funding will support 1 FTE which will be shared between OPP and CPS. One goal of the program is ED diversion.

Q3 Continue to monitor repeat visits in real time and follow-up where needed. Continued focus on discharge planning and collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and Inpatient Mental Health. New power form document has been launched in Cerner to allow MHCT staff to document client status which ED staff now have immediate access to. Additionally, MHCT now receives automatic referral faxes from the ED when a consult is ordered.

Q4 Continue to monitor repeat visits in real time and follow-up where needed. Utilize power form in cerner consistently and continued focus on discharge planning and collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and Inpatient Mental Health.

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

Return to Dashboard

Indicator: Repeat ED Substance Abuse Visits

Strategic Direction: Patient Inspired Care

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

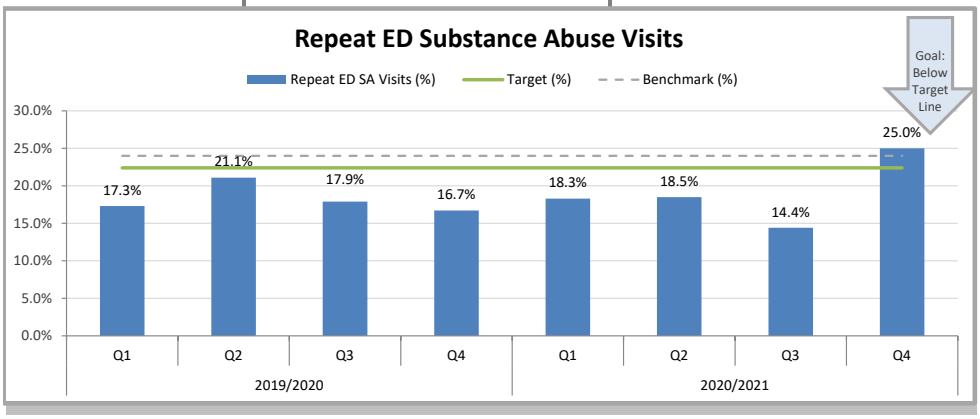
Significance: Repeat emergency visits among those with substance use disorders contribute to emergency visit volumes and wait times. Given the chronic nature of substance use disorders, access to effective community services should reduce the number of repeat unscheduled emergency visits. This indicator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

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

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

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED SA Visits (%)	17.3%	21.1%	17.9%	16.7%	18.3%	18.5%	14.4%	25.0%
Benchmark (%)	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%	24.0%
Target (%)	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%



Performance Analysis:

Q1 Data for Q1 is reported on this quarter. All coding has been completed. Total visits to the ED for substance use was 104. There were 19 repeat visits representing 18.3% and below our target of 22.4%. We did not see an increase in ED volume for SU which is notable in that CWMS was relocated because of the Covid Assessment Centre needing that space and walk-in visits were put on hold. Again this quarter, the majority of repeat visits were related to alcohol and we did note a slight increase in visits for multiple drug use and cocaine. Often individuals were presenting with complex concurrent disorders and involved with multiple services including community programs who require a number of service interactions before stabilizing.

Q2 Data for Q2 is reported on this quarter. All coding has been completed. Total visits to the ED for substance use was 157. There were 29 repeat visits representing 18.5% and below our target of 22.4%. This is an increase of overall visits to the ED from last quarter. CWMS has moved back into the community building and is actively supporting clients in the ED. Again this quarter, the majority of repeat visits were related to alcohol use and withdrawal and we have seen a slight increase in opioid repeat visits. We are monitoring this as there has been an increase in overdose and death in the community due to substance use. A number of visits to the ED were planned in order to treat complicated withdrawal from alcohol.

Q3 Data for Q3 is reported on this quarter. All coding has been completed. Total visits to the ED for substance use was 132. There were 19 repeat visits representing 14.4% and below our target of 22.4%. This is a decrease in overall visits to the ED from last quarter. Again this quarter, the majority of repeat visits were related to alcohol use. A slight increase is noted in cannabinoid and opioid repeat visits. We continue to monitor this as there has been an increase in overdose and death in the community due to substance use.

Q4 Data for Q4 is reported on and all coding has been completed. Total visits to the ED for substance use was 104 – a reduction from last quarter. There were 26 repeat visits representing 25.0% and above our target of 22.4%. January and February saw elevated repeat visits at 28.6% and 30.6% respectively. YTD saw 497 total visits of which 93 were repeat representing 18.7% and meeting our target. This is very similar to the 19/20 repeat visit rate of 18.1%. Of note, although alcohol remained the primary identified substance in repeat visits, there was a slight increase identification of cocaine and sedative/hypnotics. We continue to see an increase in overdose and death in the community due to substance use.

Plans for Improvement:

Q1 The automatic notification report to the Manager is in que to be built into Cerner. This will allow us to more quickly identify and intervene with individuals who are repeatedly accessing the ED. The NP continues to increase involvement with clients needing medication to manage withdrawal (when appropriate) to reduce the need to attend ED. We will continue to work with ED to call CWMS to support clients once medically cleared. We will also look to providing the ED with simple resources for clients and/or loved ones to follow-up with CWMS at a later date if refusing services in the moment. Increased collaborative case planning between ED, Community Programs and Inpatient Mental Health is a priority in the coming year.

Q2 The automatic notification report to the Manager has been built in Cerner and became active November 2020. Repeat visits are now being monitored in real time and individuals are being contacted to offer support and information of services available. The NP continues to increase involvement with clients needing medication to manage withdrawal (when appropriate) to reduce the need to attend ED. We will continue to work with ED to call CWMS to support clients once medically cleared. We will also look to providing the ED with simple resources for clients and/or loved ones to follow-up with CWMS at a later date if refusing services in the moment. Increased collaborative case planning between ED, Community Programs and Inpatient Mental Health is a priority in the coming year.

Q3 Continue to monitor repeat visits in real time and follow-up where needed. Continued focus on discharge planning and collaboration between community programs, IMHU and ED. Continue to involve NP in cases needing medication to manage withdrawal (when appropriate) to reduce the need to attend ED. CWMS now receives automatic referral faxes from the ED when a consult is ordered. Power form document is being built in Cerner to allow CWMS to document status in Cerner which ED will have immediate access to.

Q4 Continue to monitor repeat visits in real time and follow-up where needed. Continued focus on discharge planning and collaboration between community programs, IMHU and ED. Continue to involve NP in cases needing medication to manage withdrawal (when appropriate) to reduce the need to attend ED. Utilize power form in Cerner when available. Further develop programming to utilize new medical van to engage more difficult to reach individuals.

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

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

Strategic Direction: Patient Inspired Care

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

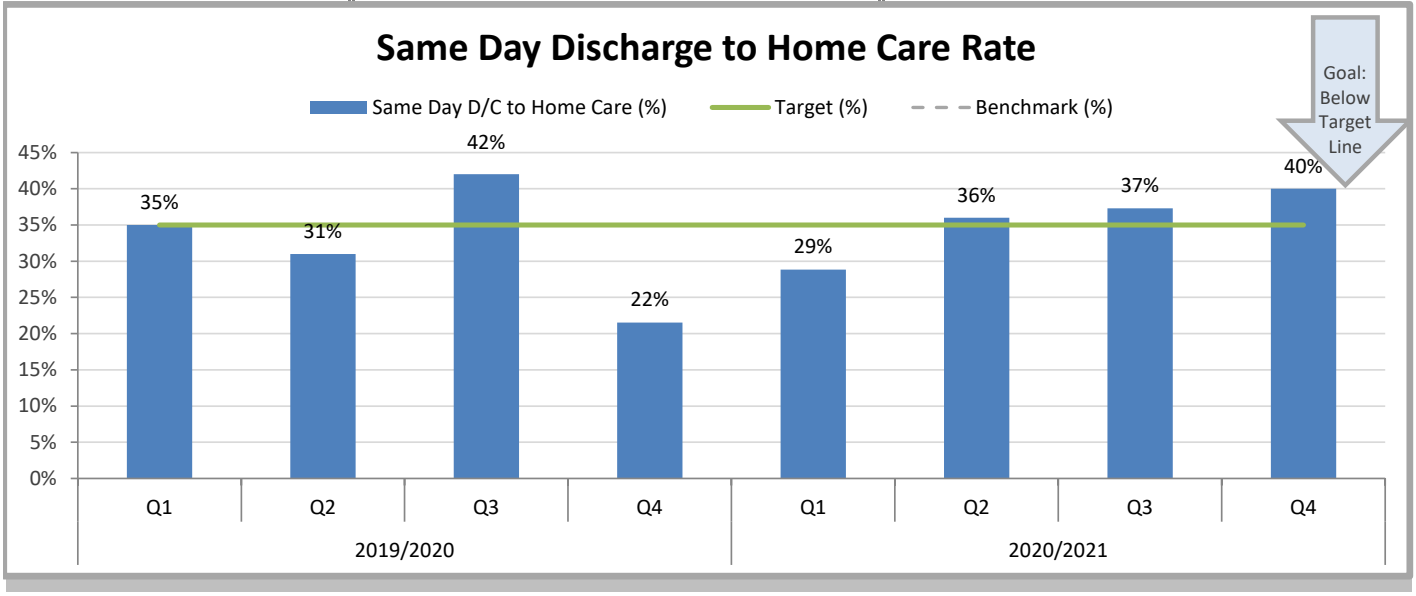
Significance: Effective transition from acute care to community care is an essential element of high quality patient care and is a core business of hospitals and Community Care Access Centres (CCACs). Transition planning is most effective when hospitals, community providers and primary care physicians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

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

Target Information: Target to align with HSAA obligations

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Same Day D/C to Home Care (%)	35%	31%	42%	22%	29%	36%	37%	40%
Benchmark (%)								
Target (%)	35%	35%	35%	35%	35%	35%	35%	35%



Performance Analysis:

Q1 Target met.

Q2 Target not met by 1%. September increased the rate at 48%, with July and August at 29% and 33% respectively.

Q3 Target not met by 2%. October and November met target, however December's rate at 43% affected our overall quarterly target requirements.

Q4 Target not met.

Plans for Improvement:

Q1 Continue current strategies and review performance at departmental meetings to encourage early referrals.

Q2 Continued monitoring and discussions with hospitalists are ongoing.

Q3 Continue monitoring and review with transitions nurse and hospitalists to promote consults the day before discharge.

Q4 Continue reviewing performance with hospitalists, manager of patient flow, transitions nurse and discharge planning team

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

Return to Dashboard

Indicator: Percentage Actual Length of Stay to HIG Expected Length of Stay (LOS) (Typical Cases)

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

Definition: The total number of days for the actual length of stay of HIG (HBAM Inpatient Grouper) typical cases compared to the total HIG expected length of stay. Typical cases exclude palliative deaths, transfers, voluntary sign-outs, and cases where the actual LOS is greater than the 'trim point' established by CIHI. The HIG is developed and maintained by MoHLTC.

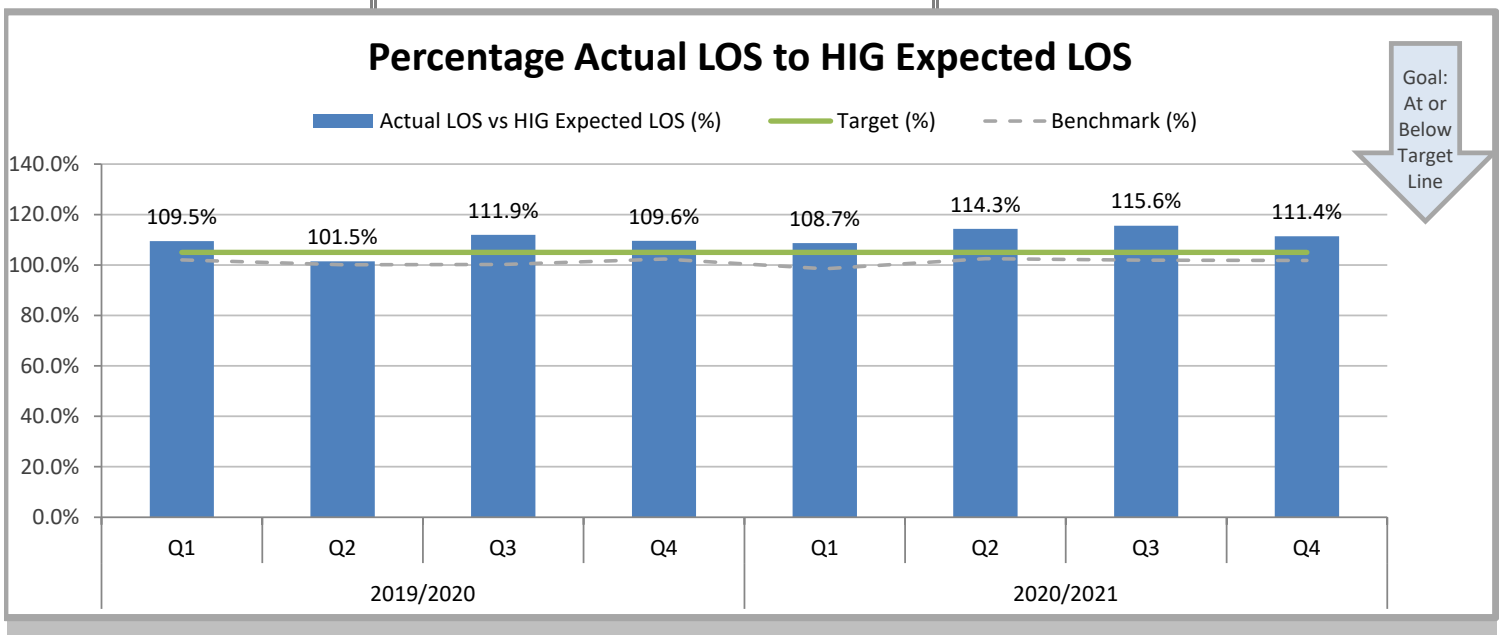
Significance: Any measure below 100% indicates the total length of stay was less than the HIG expected length of stay and any measure over 100% indicates the actual length of stay exceeded the expected length of stay, thus less efficient.

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

Target Information: Target is based on internal directives and set at 105%

Benchmark Information: Benchmark performance is based on our Peer (20) Hospital quarterly performance

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Actual LOS vs HIG Expected LOS (%)	109.5%	101.5%	111.9%	109.6%	108.7%	114.3%	115.6%	111.4%
Benchmark (%)	102.0%	100.1%	100.2%	102.4%	98.5%	102.5%	101.9%	101.8%
Target (%)	105.0%	105.0%	105.0%	105.0%	105.0%	105.0%	105.0%	105.0%



Performance Analysis:

Q1 Target not met. Results are slightly above target, however, they have trended downward somewhat from FY1920 Q4 results of 109.6%. Q1 was not a good indicator of LOS due to the lower number of admissions, type of admissions with Covid, and lack of community services availability.

Q2 Target not met. All but one service, Hospitalists at 129.7%, were below target for Q2.

Q3 Target not met. December's ALOS vs HIG ELOS results are preliminary as the final has not been complete at this time.

Q4 Target not met.

Plans for Improvement:

Q1 Continue working with the hospitalists on LOS. Establish a revamped LOS management strategy that focus on specific patient population.

Q2 Continue working with above mentioned strategies.

Q3 Continue working with above mentioned strategies.

Q4 Continue working with above mentioned strategies.

Accountable: Chief of Staff / Chief Information and Operating Officer

Return to Dashboard

Indicator: Clostridium Difficile Incidence

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

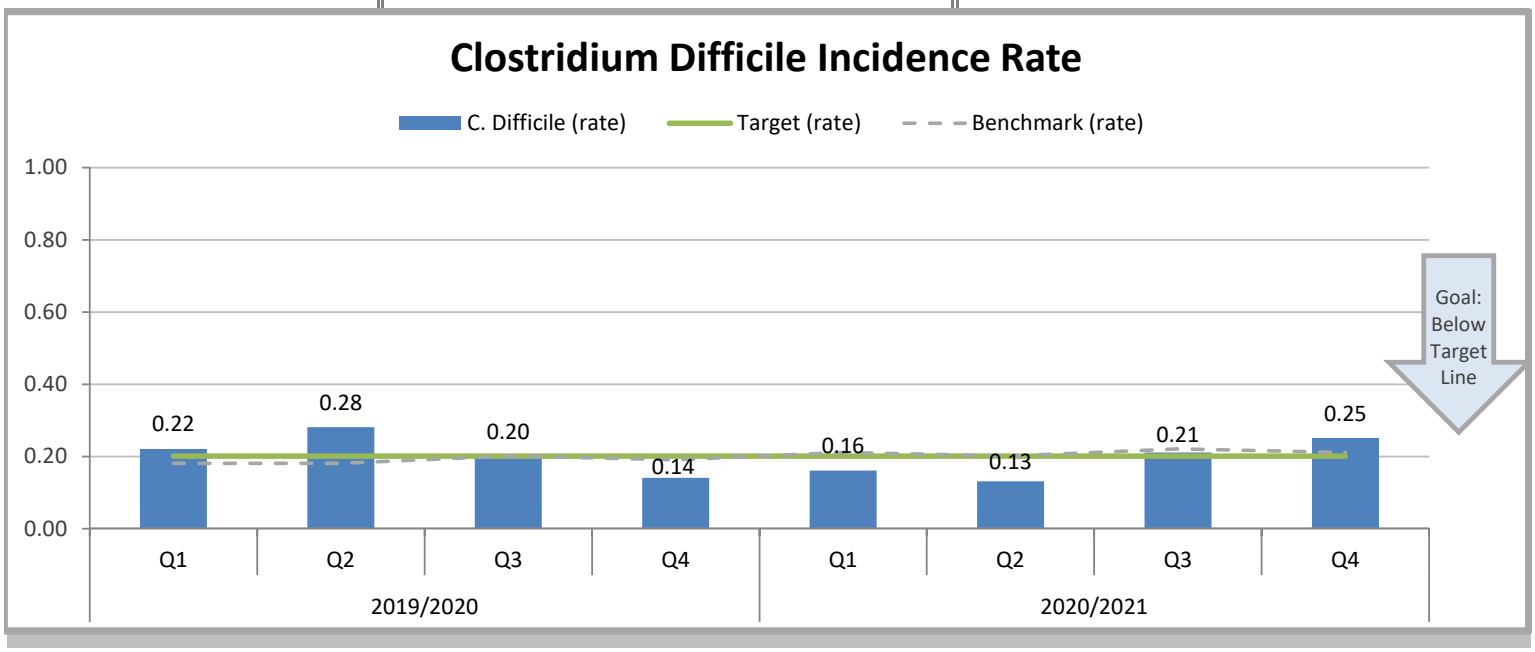
Significance: This bacteria is commonly found in the environment; it can exist in spore form and is resistant to some chemicals. It lives in approx. 3-5% of humans as normal flora and can develop if exposed to risk factors such as: prolonged antibiotic use, bowel surgery, chemotherapy and hospitalization.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

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

Target Information: Target is based on HSAA performance standard obligations

Benchmark Information: Benchmark rates taken from HQO - Hospital Patient Safety quarterly provincial performance

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
C. Difficile (rate)	0.22	0.28	0.20	0.14	0.16	0.13	0.21	0.25
Benchmark (rate)	0.18	0.18	0.20	0.19	0.21	0.20	0.22	0.21
Target (rate)	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20



Performance Analysis:

Q1 Target met. Two cases this quarter.

Q2 Target met. Two cases this quarter.

Q3 Target not met. Three cases this quarter; 2 in November and 1 in December.

Q4 Target not met. Four cases this quarter, 1 in February and 2 in March.

Plans for Improvement:

Q1 Continue monitoring and audits.

Q2 Continue monitoring and audits.

Q3 Continue monitoring and audits.

Q4 Continue monitoring and audits.

Accountable: VP, Community Programs / Manager, Infection Control

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

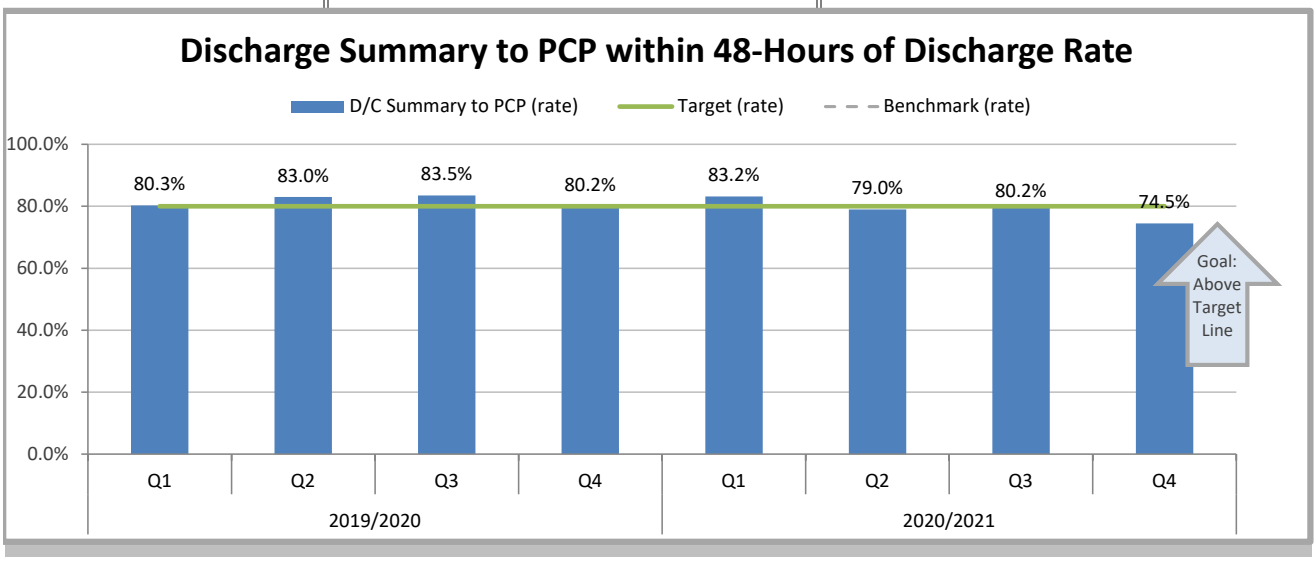
Significance: Health Quality Ontario (HQO) explains "Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete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

Data Source: Cerner - Discern Analytics, Electronic Health Record

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

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
D/C Summary to PCP (rate)	80.3%	83.0%	83.5%	80.2%	83.2%	79.0%	80.2%	74.5%
Benchmark (rate)								
Target (rate)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Performance Analysis:

Q1 Target met. This is a new QIP initiative for FY2021. There were 874 discharge summaries within 48 hours sent to primary care providers in Q1 out of the 1050 applicable discharge summaries. The rate for FY1920 was 81.7%

Q2 Q2 results are slightly below target. There were 286 discharge summaries not sent to PCP within the 48-hour target out of the 1359 applicable discharges. Compared to Q1, we saw a 30% increase in applicable discharges. Of the delinquent discharge summaries, there were six physicians contributing to 64% of the discharge summaries due to timing and beyond the 48-hour target.

Q3 Target met. There were 281 discharge summaries not sent to PCP within the 48-hour target out of the 1420 applicable discharges. While this quarter is green, it was a marginal improvement over last quarter.

Q4 Target not met. There were 324 discharge summaries not sent to PCP within the 48-hour target out of 1272 applicable discharges. It is worth acknowledging that this quarter reports the lowest performance since we began reporting on this indicator. A higher than usual numerator coupled with a lower than usual denominator has had a significant impact on performance in this area.

Plans for Improvement:

Q1 Continue monitoring; look for opportunities for additional automation of processes.

Q2 Further review of automation process to identify gap in performance. Ensure strategies are in place with physicians to close the gap and ensure the 48-hour target is met.

Q3 Continue monitoring. We anticipate that the increased awareness of clear, efficient, timely documentation to support the CCH Patient Portal will have a positive affect on this indicator.

Q4 This indictor is closely related to the "Incomplete Charts" indicator. As we continue to improve in our chart completion and work closely to support the individuals affecting these volumes we expect to see improvement in both areas.

Accountable: Chief Information and Operating Officer / Manager, Health Information Services

Return to Dashboard

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

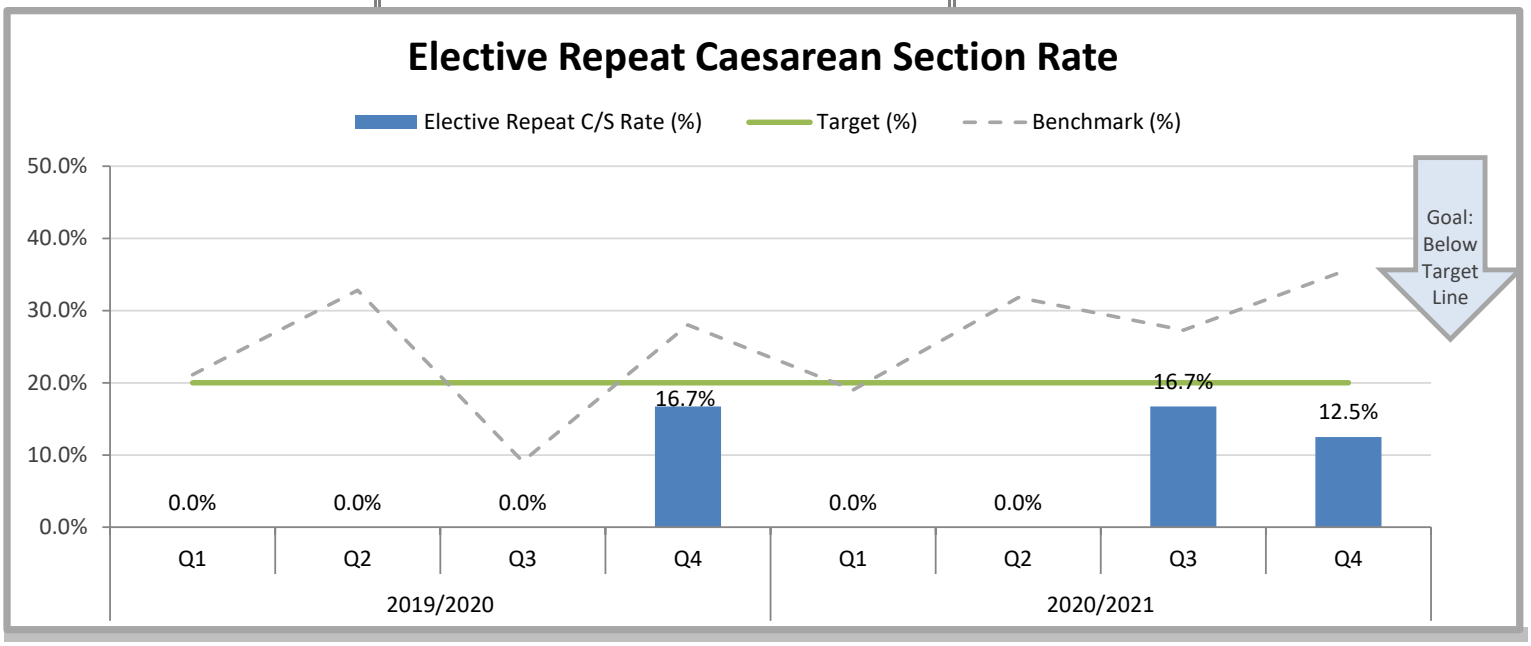
Significance: The long-term outcome is to minimize risk (greater risk of cardiac arrest, hysterectomy, infection, fever, pneumonia, blood vessel clotting and hemorrhaging, and neonatal risk).

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

Target Information: Target is based on HSAA obligations

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Elective Repeat C/S Rate (%)	0.0%	0.0%	0.0%	16.7%	0.0%	0.0%	16.7%	12.5%
Benchmark (%)	21.1%	32.8%	9.1%	28.0%	19.0%	31.8%	27.3%	35.7%
Target (%)	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%



Performance Analysis:

Q1 No cases. Target met.

Q2 No cases. Target met.

Q3 Target met. November had 1 case.

Q4 Target met.

Plans for Improvement:

Q1 Continue current strategies and review results at departmental meetings.

Q2 Continue current strategies and review results at departmental meetings.

Q3 Continue current strategies and review results at departmental meetings.

Q4 Continue current strategies and review results at departmental meetings.

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

Return to Dashboard

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

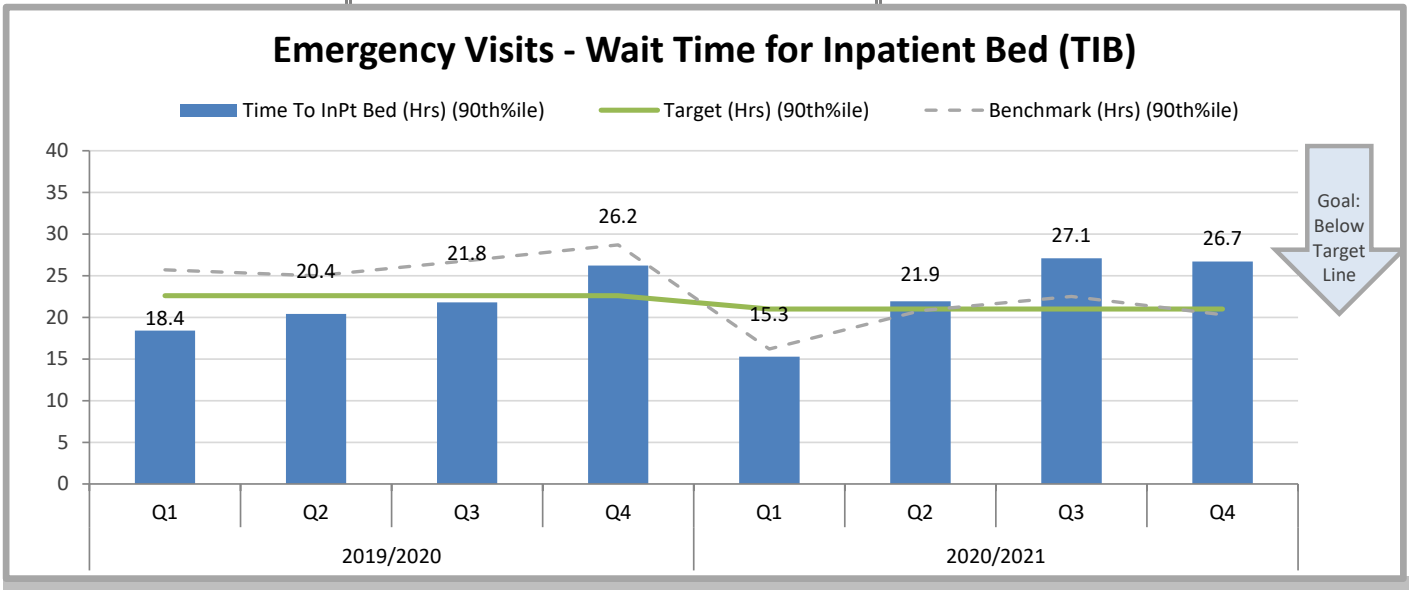
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the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

Data Source: Anzer -NACRS

Target Information: Target set in accordance to QIP indicator. Established at 5% reduction of prior FY1920 (Q1-Q4) performance of 22.2.
*Formula is 22.2 * (1 - 5%) =21.0

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To InPt Bed (Hrs) (90th%ile)	18.4	20.4	21.8	26.2	15.3	21.9	27.1	26.7
Benchmark (Hrs) (90th%ile)	25.7	25.0	26.8	28.7	16.2	20.8	22.5	20.3
Target (Hrs) (90th%ile)	22.6	22.6	22.6	22.6	21.0	21.0	21.0	21.0



Performance Analysis:

Q1 Target met and continues to trend well below benchmark high-volume hospitals.

Q2 Q2 slightly above target.

Q3 Target not met.

Q4 Target not met.

Plans for Improvement:

Q1 Adopt a structured and phased approach to manage patient flow based on the number on patients requiring isolation and the total number of inpatients with immediate escalation within the phases by PFM and AHM. Ensure maximum efficiency of space utilization (utilize privates on all levels for new admissions requiring isolation).

Q2 Continued monitoring and strategies as above.

Q3 Continued monitoring and strategies as above.

Q4 Phased approach utilized to increase inpatient capacity based on total volume with goal of zero admissions in ED.

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

Return to Dashboard

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

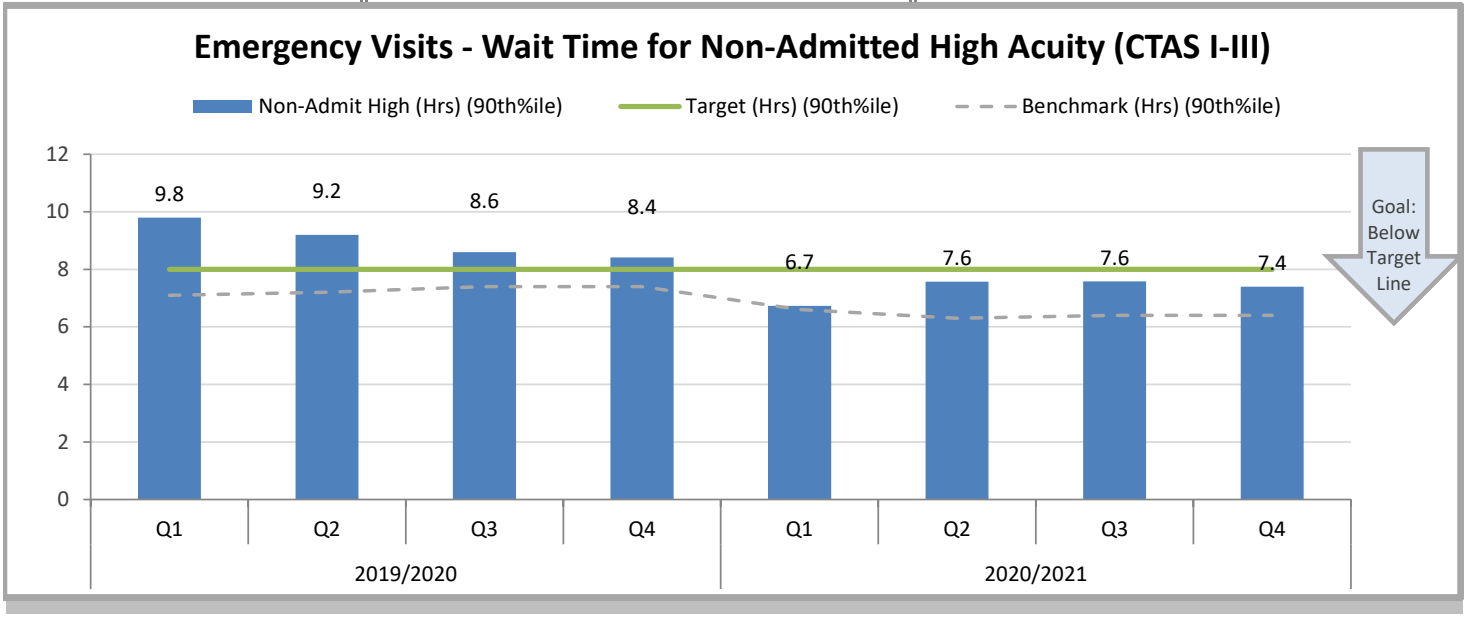
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer -NACRS

Target Information: Target to align with HSAA obligations

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit High (Hrs) (90th%ile)	9.8	9.2	8.6	8.4	6.7	7.6	7.6	7.4
Benchmark (Hrs) (90th%ile)	7.1	7.2	7.4	7.4	6.6	6.3	6.4	6.4
Target (Hrs) (90th%ile)	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0



Performance Analysis:

Q1 Target met.

Q2 Target met.

Q3 Target met.

Q4 Target met.

Plans for Improvement:

Q1 Implemented ED Nursing Medical Directives that address Sepsis, Abdominal pain, and Chest pain with cardiac features. Work on ED output for admitted patient flow to create flow and avoid delay of access to ED beds. Develop Surge document to manage predetermined levels of surge.

Q2 Continue as above.

Q3 Continue as above.

Q4 Continue as above.

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: Partnering for Patient Safety and Quality Outcomes

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

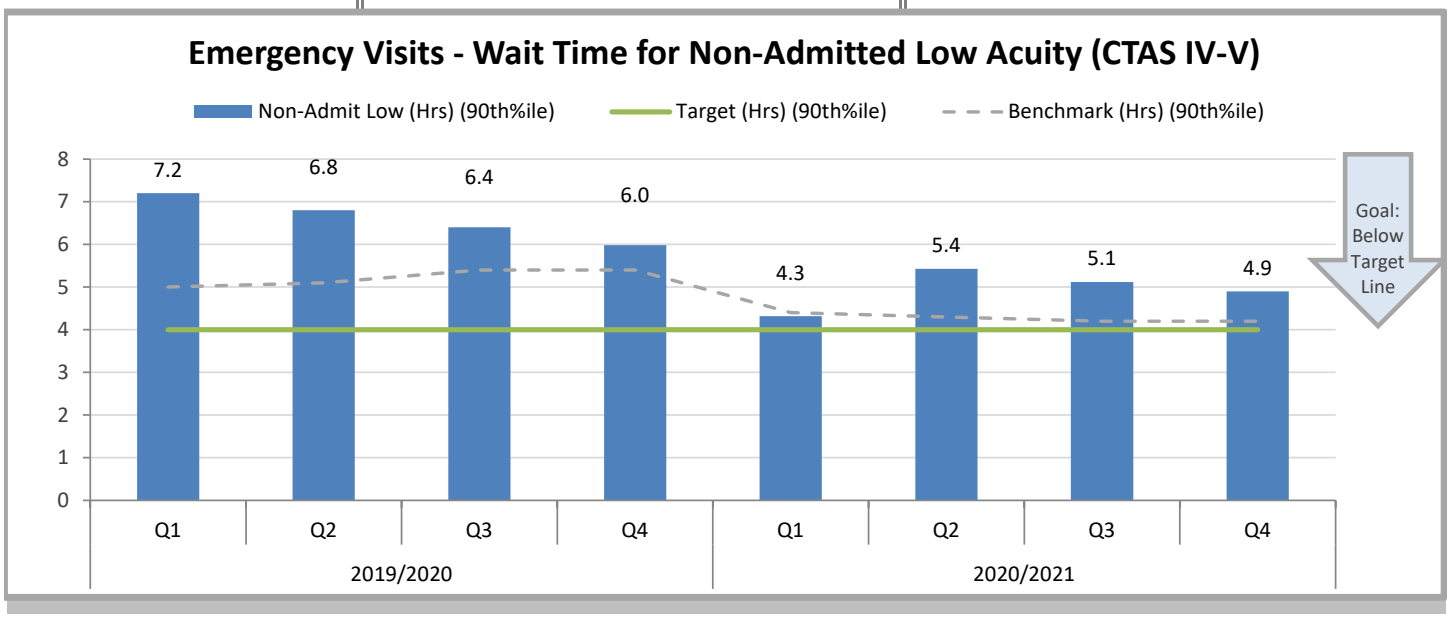
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer -NACRS

Target Information: Target to align with HSAA obligations

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit Low (Hrs) (90th%ile)	7.2	6.8	6.4	6.0	4.3	5.4	5.1	4.9
Benchmark (Hrs) (90th%ile)	5.0	5.1	5.4	5.4	4.4	4.3	4.2	4.2
Target (Hrs) (90th%ile)	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0



Performance Analysis:

Q1 Target not met, but just slightly. There is great improvement from FY1920 Q4. Quarterly performance continues to consistently trend positively closer to target compared to our benchmark hospital performance.

Q2 Target not met, however, there is great improvement when compared to Q2 of FY1920.

Q3 Target not met, however, there is great improvement when compared to Q3 of FY1920.

Q4 Target not met, however, there is great improvement when compared to Q4 of FY1920.

Plans for Improvement:

Q1 Reinforce use of ED Nursing Medical Directives to increase efficiencies related to early determination of treatment plan and disposition. Work with ED Physicians to see Covid suspect patients regardless of time of day to decrease wait time. Utilize developed surge document.

Q2 Continue strategies as above.

Q3 Continue strategies as above.

Q4 Working with ED physicians to reinstate fast track physician and remove title of Covid physician.

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

Return to Dashboard

Indicator: Incomplete Charts

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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.

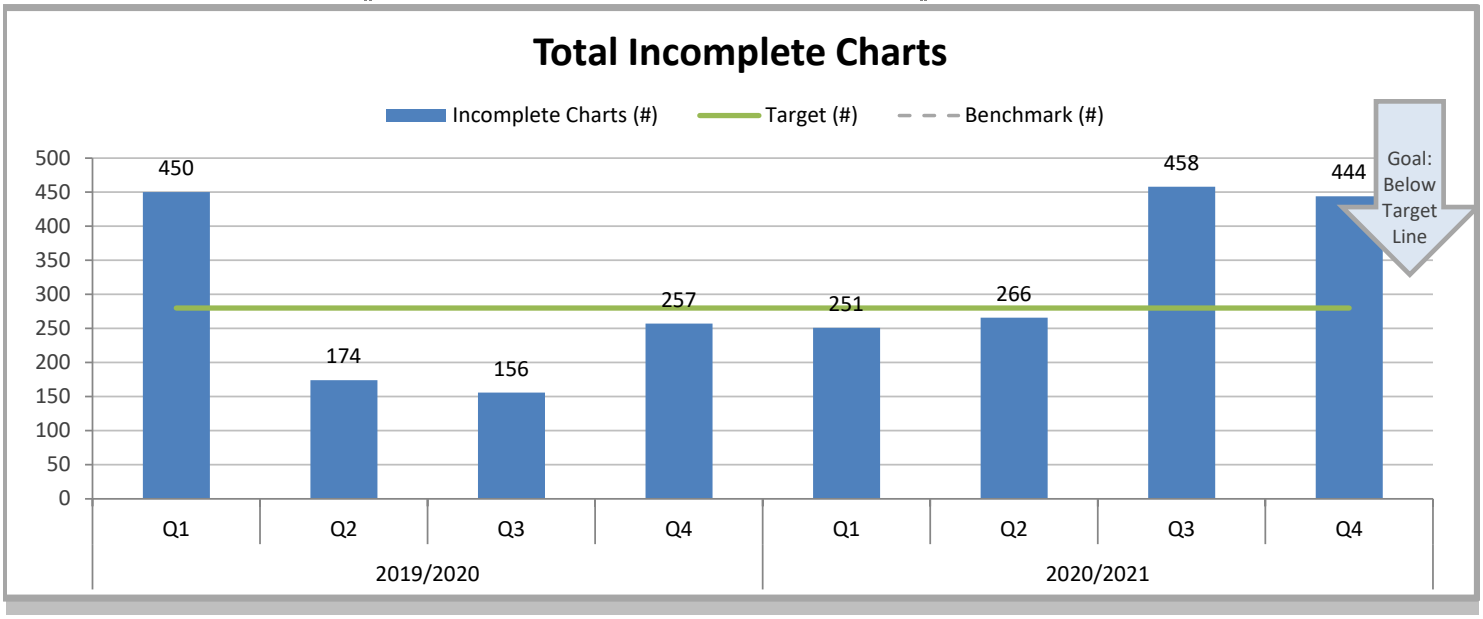
Significance: The purpose of this policy is to ensure that patient health records are completed in accordance with legal requirements, including the Public Hospitals Act (PHA) and Hospital Management Regulation 965 (Regulation), professional obligations, as well Hospital by-Laws, policies, rules and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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incomplete Charts (#)	450	174	156	257	251	266	458	444
Benchmark (#)								
Target (#)	280	280	280	280	280	280	280	280



Performance Analysis:

Q1 Incomplete chart numbers are within target.

Q2 Target met.

Q3 Target not met. These results are impacted by two individuals only.

Q4 Target not met.

Plans for Improvement:

Q1 No improvement plan required at this time.

Q2 No improvement plan required at this time.

Q3 A performance improvement plan has been put in place to ensure that the charts of the two individuals are completed and that expectations are met going forward.

Q4 Over Q1 2021/22 there has been significant progress on the charts of the two noted individuals. This is being monitored closely by the CEO and COS office.

Accountable: President and Chief Executive Officer / Chief of Staff

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

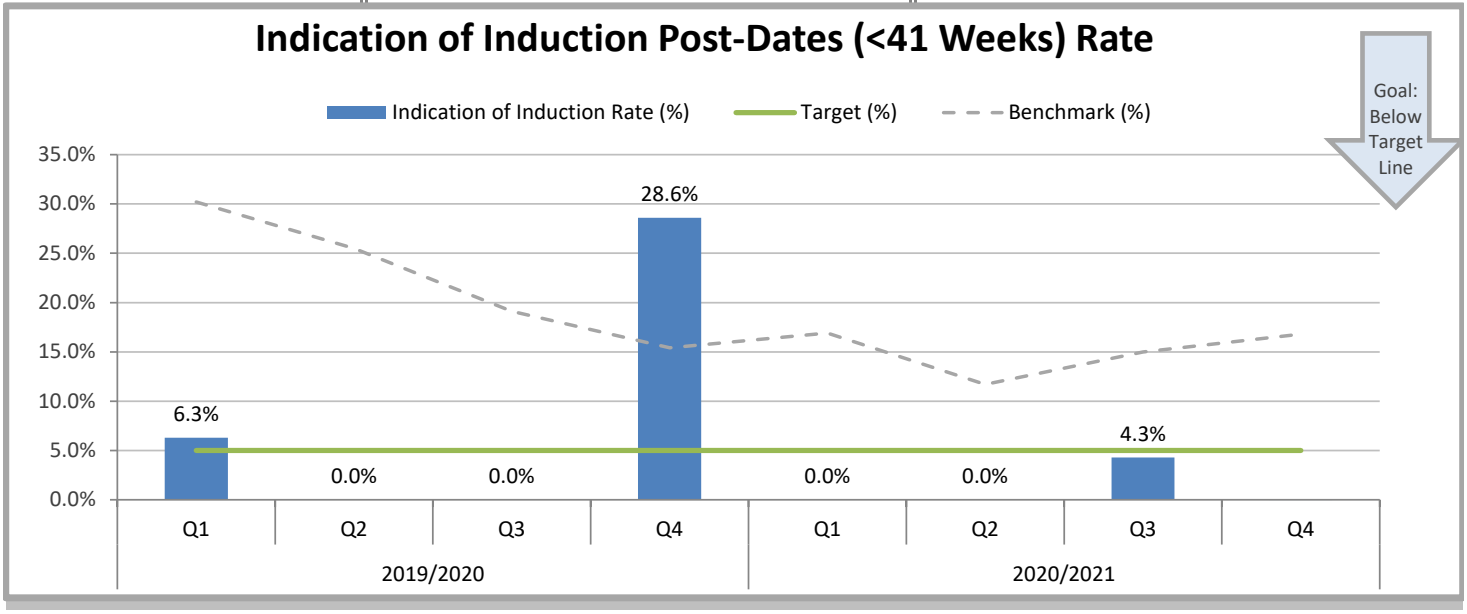
Significance: Inducing labour after the due date slightly lowers the risk of stillbirth or infant death soon after birth compared with watchful waiting. But the overall risk is very low. Induced deliveries may reduce admissions to the neonatal intensive care unit. Pregnant women having induced labour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

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

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

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Indication of Induction Rate (%)	6.3%	0.0%	0.0%	28.6%	0.0%	0.0%	4.3%	0.0%
Benchmark (%)	30.2%	25.5%	19.1%	15.4%	16.9%	11.7%	15.0%	16.8%
Target (%)	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%



Performance Analysis:

Q1 Target met, 0-cases this quarter.

Q2 Target met, 0-cases this quarter.

Q3 Target met. November had 1 case.

Q4 Target met, 0-cases this quarter.

Plans for Improvement:

Q1 Continue current strategies and review performance at departmental meetings.

Q2 Continue current strategies and review performance at departmental meetings.

Q3 Continue current strategies and review performance at departmental meetings.

Q4 Continue current strategies and review performance at departmental meetings.

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

Return to Dashboard

Indicator: Inpatients Receiving Care in Unconventional Spaces per Day

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

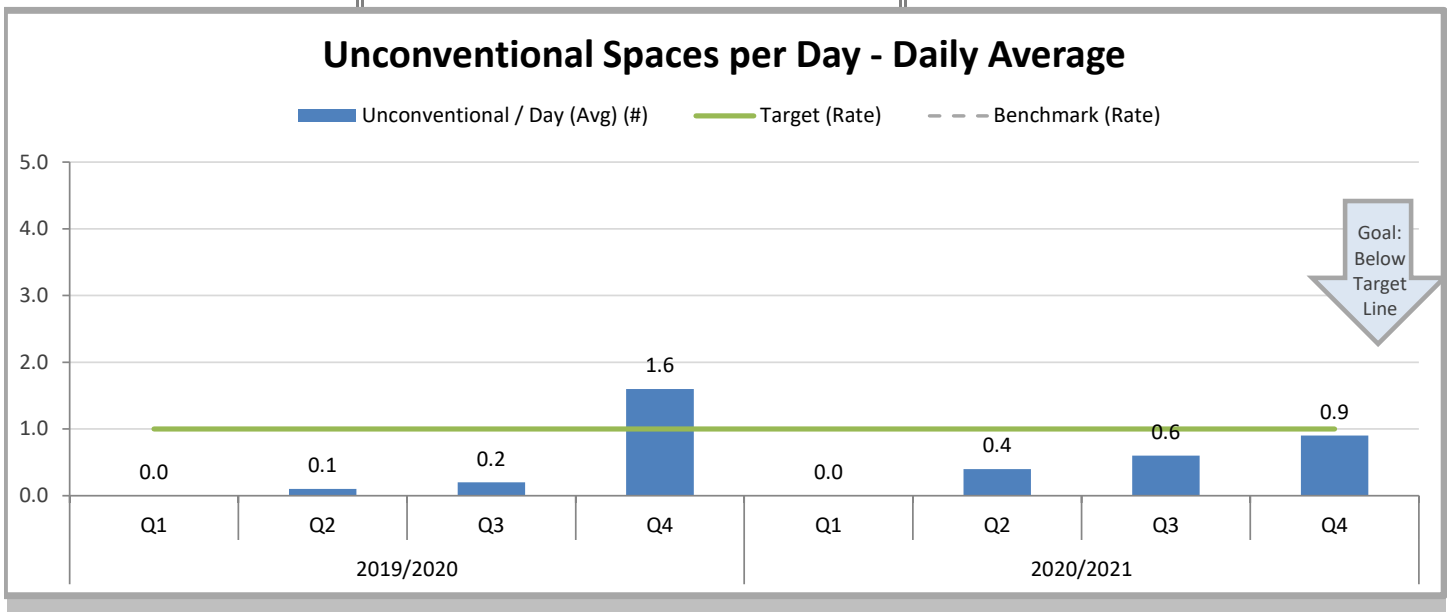
Significance: This indicator provides contextual information on the average number of patients who were admitted into hospitals receiving care in unconventional spaces during the third quarter, 2018/19. This may reflect seasonal surges. The indicator profiles the average number of beds over capacity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

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

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

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Unconventional / Day (Avg) (#)	0.0	0.1	0.2	1.6	0.0	0.4	0.6	0.9
Benchmark (Rate)								
Target (Rate)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance Analysis:

Q1 Target met for overall bed census count.

Q2 Target met.

Q3 Target met.

Q4 Target met.

Plans for Improvement:

Q1 No plans for improvement at this time.

Q2 No plans for improvement at this time.

Q3 No plans for improvement at this time.

Q4 Continue with current process.

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

Return to Dashboard

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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 - Obstetrical and Newborn patients).

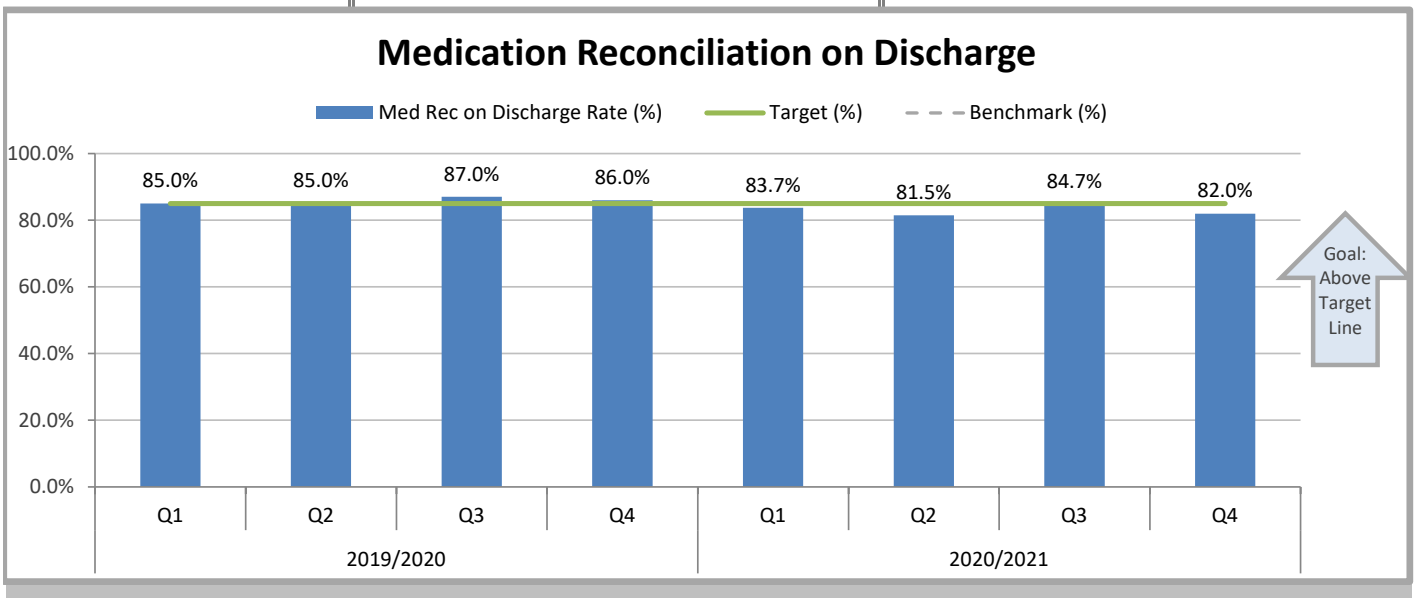
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	85.0%	85.0%	87.0%	86.0%	83.7%	81.5%	84.7%	82.0%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target not met, but just slightly. Breakdown by department shows CCU and Mental Health below target at 50% and 80%. All other departments are well within suggested target.

Q2 Target not met. Breakdown by department shows CCU and Mental Health below target at 47.6% and 74.5% respectively. Surgery slightly lower at 77.9%. All other departments are well within suggested target.

Q3 Target met.

Q4 Target not met. Below target are CCU at 34.3%, Cornwall ED at 62.2% and Mental Health at 74.7 for Q4.

Plans for Improvement:

Q1 Focus on CCU and work with intensivists and department to identify barriers and opportunities for improvement, continue improvement in IPMH.

Q2 Ongoing review of department specific strategies.

Q3 Continue as above.

Q4 Continue as above.

Accountable: Chief Information and Operating Officer / Chief of Staff

Return to Dashboard

Indicator: Inpatient PODS (Patient Oriented Discharge Summary) Rate

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

Definition: This indicator measures the PODS information page with relevant discharge instructions reviewed with inpatients on discharge. The numerator includes the number of inpatient discharges in which PODS was used. The denominator includes all discharge disposition to Home, Home with Services, and Residential Care. Exclusions are transfers to other acute/ambulatory, LTC, CCC, deaths, and AMA.

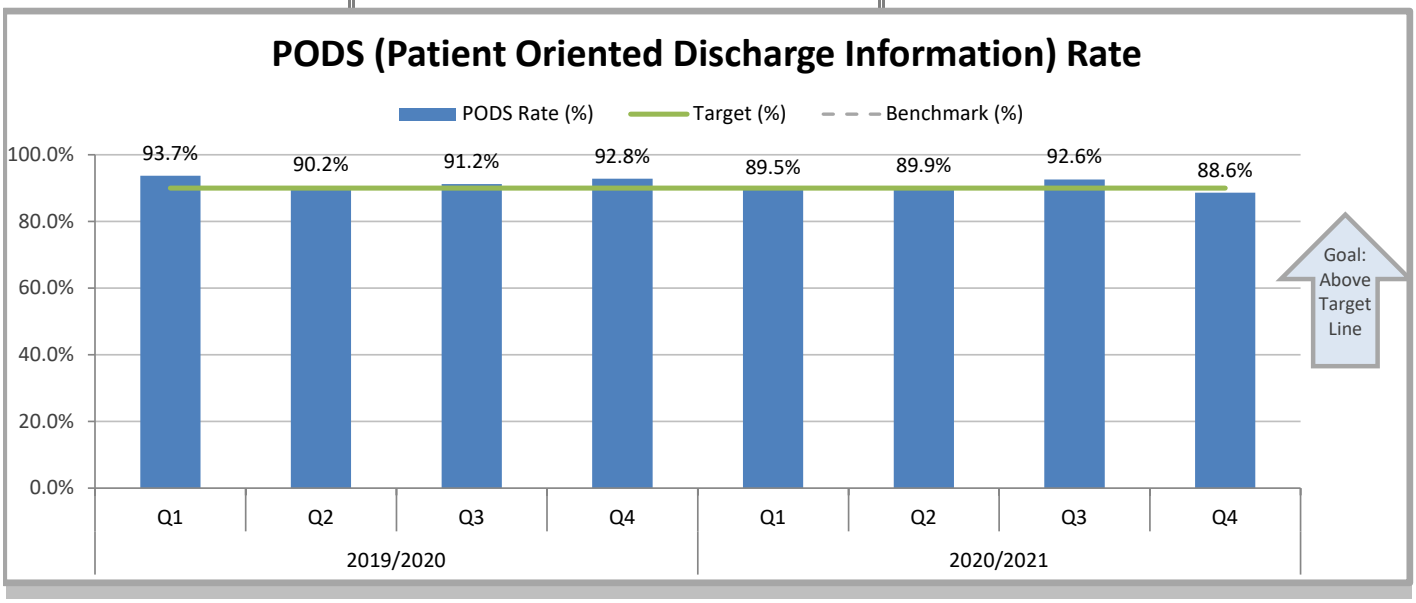
Significance: To ensure patients receive clear, comprehensive discharge information to support timely discharge and prevent readmissions. The PODS template includes patient diagnosis; medication list at discharge to stop/start/continue; instructions from the care team; patient-specific information about diagnosis, signs and symptoms, and self-management; follow-up appointments; community resources; and contract numbers.

Data Source: Cerner electronic health record

Target Information: Set internally at 90%

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
PODS Rate (%)	93.7%	90.2%	91.2%	92.8%	89.5%	89.9%	92.6%	88.6%
Benchmark (%)								
Target (%)	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Performance Analysis:

Q1 Rate slightly below target for Q1. April and May were slightly above target rate, however, June was at 87.3% bringing down the average for Q1. Just more than half of the departments were under the 90% rate in June.

Q2 Target not quite met. The departments below target are Level 2 Med, Level 5 CCU, and Pediatrics.

Q3 Target met.

Q4 Target not quite met. The departments below target are ED Hold and CCU.

Plans for Improvement:

Q1 Review department specific performances to develop strategies where falling below target. Performance is now reviewed on a regular basis with clinical managers, and reviewed with front line staff. Front-line staff will be engaged to find opportunities to improve this metric.

Q2 Ongoing reviews and department specific strategies being developed.

Q3 Continue with current strategies. Review and strategize areas where compliance is below target

Q4 Continue to focus on strategies to improve ER and CCU PODS.

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

Return to Dashboard

Indicator: Inpatient Smoking Cessation Screening Rate

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

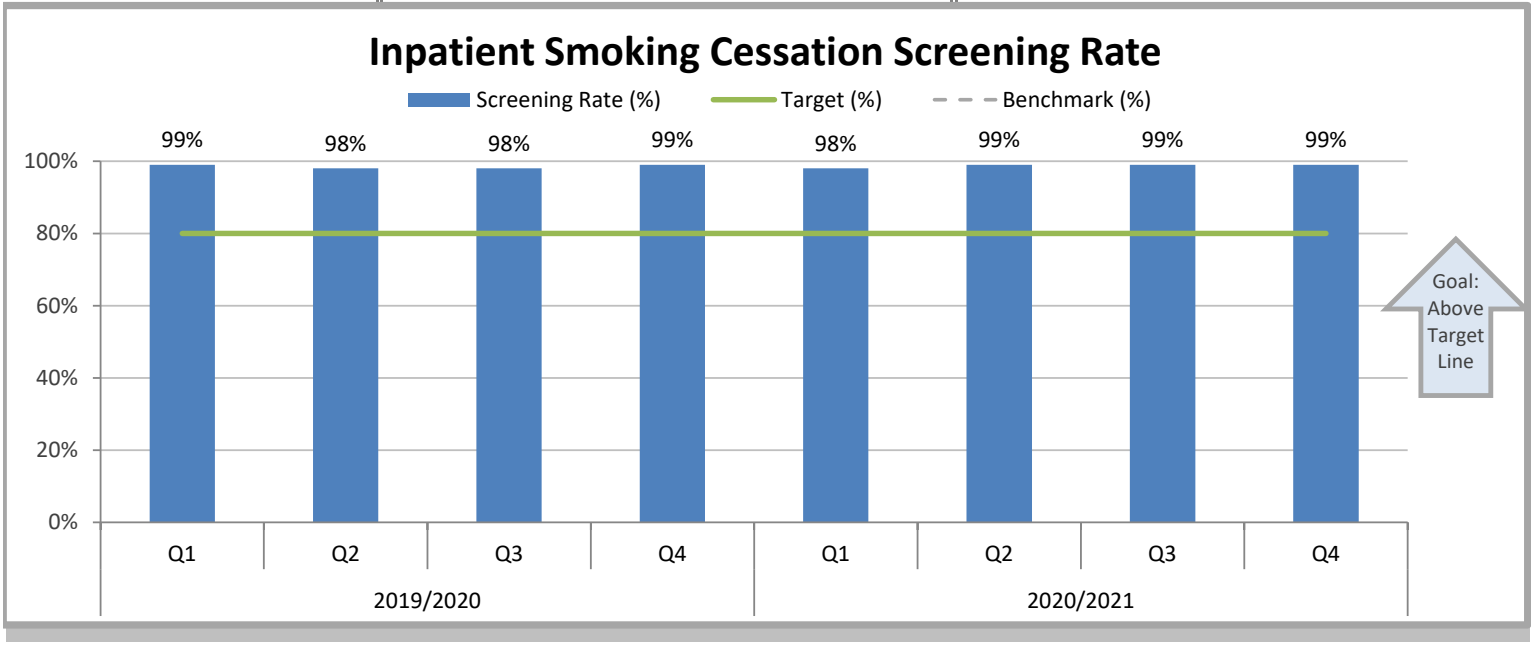
Significance: The Champlain LHIN has incorporated a performance standard in its Hospital Accountability Agreements stating that by 2013, 80% of smokers admitted to hospital must receive the OMSC intervention.

Data Source: Internal Tracking

Target Information: Target is set in accordance to the HSAA

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Screening Rate (%)	99%	98%	98%	99%	98%	99%	99%	99%
Benchmark (%)								
Target (%)	80%	80%	80%	80%	80%	80%	80%	80%



Performance Analysis:

Q1 Metric continues to meet target.

Q2 Target met.

Q3 Target met.

Q4 Target met.

Plans for Improvement:

Q1 No action required at this time.

Q2 No action required at this time.

Q3 No action required at this time.

Q4 No action required at this time.

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

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

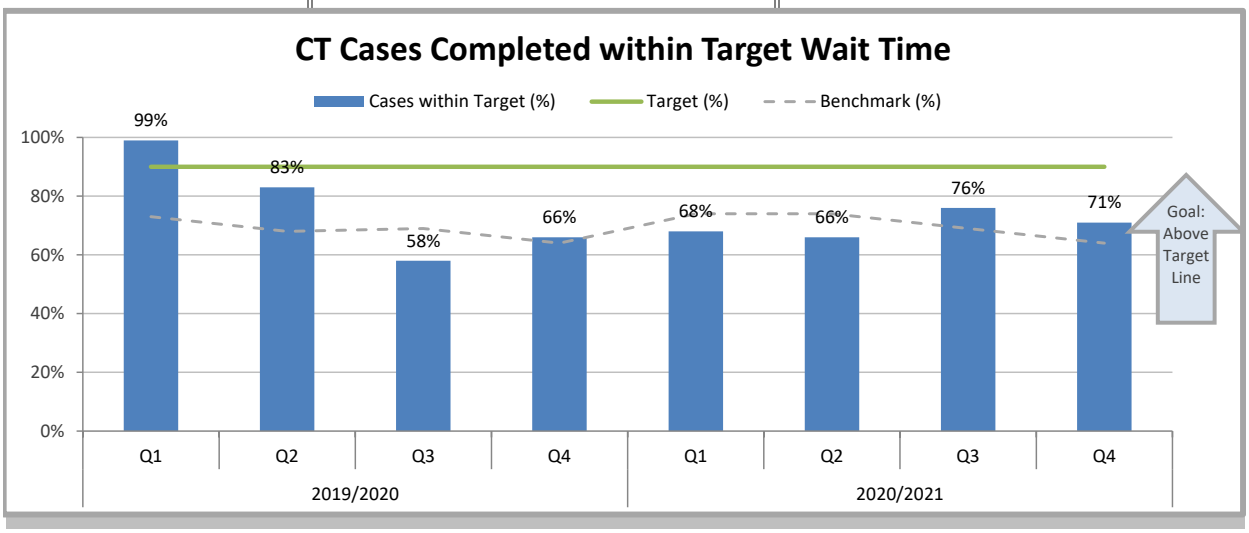
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	99%	83%	58%	66%	68%	66%	76%	71%
Benchmark (%)	73%	68%	69%	64%	74%	74%	69%	64%
Target (%)	90%	90%	90%	90%	90%	90%	90%	90%



Performance Analysis:

Q1 Target not met. When reviewing each priority level separately, priority level 4 shows to be the main culprit with results of 41% compared to priority level 2 at 99% and level 3 at 98%.

Q2 Target not met. Once again, priority level 4 shows to be the main culprit with results of 45% compared to priority level 2 at 99% and level 3 at 99%; although level P3 has shown a slight increase for Q2.

Q3 Target not met; however there has been an improvement of 10% over Q2 results. Additionally, CCH target is greater than the LHIN benchmark for Q2. Once again, priority level 4 shows to be the main culprit with results of 58% compared to priority level 2 at 100% and level 3 at 99%.

Q4 Target not met. CCH target is greater than the LHIN benchmark for Q4. Priority level 2 is at 100% and priority level 3 is at 99%. Priority level 4 is at 48% which is affecting the overall result for Q4.

Plans for Improvement:

Q1 CT was closed to all non-essential exams as directed by the Province. Any patient whose outcome would not be negatively impacted by a delay of 6-8 weeks was put "on hold" during the peak Covid period. Resumption of services commenced June 8 and highest priority was given to P1-2-3 followed by any P4 we could accommodate.

Q2 With the June resumption of services, CT had a backlog of 2200 patients waiting. With an average monthly intake of 792 referrals, the operational day was stretched from 0730-2400 hrs to make all attempts to provide access as quickly as possible and improve the wait time. CCH is out performing all regional partners however recovery of wait time remains a challenge.

Q3 Gains continue to be made each quarter as we work with all regional partners across the LHIN to address as quickly as possible the patients waiting. Regional investigation into the potential for mobile CT scanners to supplement the existing scanners in the LHIN. All scanners including CCH are running at, and above, capacity limits. Staffing resources are being offered additional overtime hours to lower the wait time, however this is a risk to staff wellness and work-life balance as the pandemic marathon continues.

Q4 Several wait time recovery initiatives have been implemented. CT staff have introduced temporary sessions of night shifts to address P4 routine study waits. "Super days" have also been added when feasible to ramp up the volume of outpatients in a day. These initiatives are not sustainable in the long term however they speak to the staff commitment to help the waiting patients of CCH. Wait time for P4 now sits at 8 weeks which is a huge gain over the last months. Recovery initiatives are ongoing.

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

Indicator: Cases Completed within Target Wait Time - Hip Replacement

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

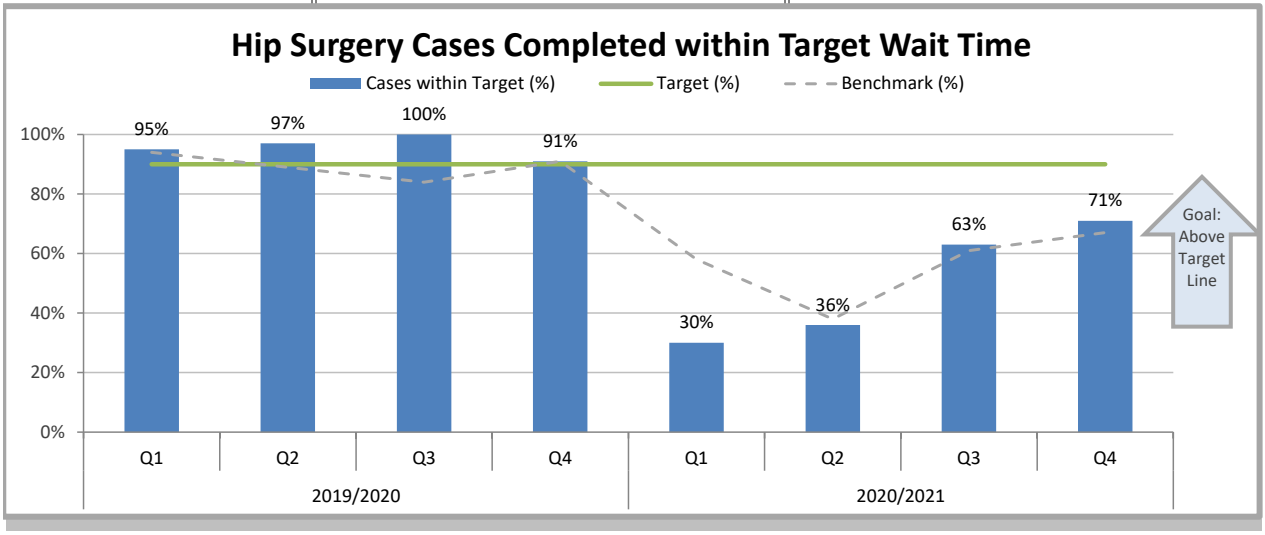
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. It will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	95%	97%	100%	91%	30%	36%	63%	71%
Benchmark (%)	94%	89%	84%	91%	58%	38%	61%	67%
Target (%)	90%	90%	90%	90%	90%	90%	90%	90%



Performance Analysis:

Q1 Target not met. Q1 Level P4 at 43% and no surgeries at level P2 and P3. With surgeries being kept at a minimum due to Covid during most of Q1, the results are to be expected.

Q2 Target not met. Q2 level P4 at 42%, level P3 at 15% and level P2 at 50%.

Q3 Target not met; however, Q3 saw significant increases in levels P2 and P4 over Q2. Q3 level P4 at 67%, level P3 at 17% and level P2 at 100%.

Q4 Target not met, however, Q4 has increased compared to Q3 and is above the LHIN benchmark. Q4 priority level 3 increased to 100% compared to Q3 at 17%.

Plans for Improvement:

Q1 Orthopedic elective surgeries have gradually resumed at the end of Q1 (mid-June). The number of booked OR theatres have increased from 2-3 OR theatres during the summer months, up to 4 OR theatres in operations the week of September 8th. A progressive improvement should be noted in Q2 and Q3. There is ongoing monitoring of Wait Times.

Q2 Impact of cancellation of elective surgeries during COVID has a lasting impact. It is anticipated that volumes will be recovered over the next two quarters.

Q3 75% improvement as OR block time/access increased to 4 rooms. Elective total joint cases booked during the weekends and closure to help minimize 2 week closure at Christmas. As of first week of January and until tentative date of March 2, SDA volume was decreased by 2/3 making joint volume access to the OR difficult when higher priority off service cases required SDA beds. Same day discharge total joints will help maintain some completed volume in Q4.

Q4 Same day admits were cancelled during Q4 due to hospital capacity needs during the 2nd wave and patients that fit same day discharge were booked to attempt to meet target but these numbers of patient was limited. This decreased the volume that could have been completed. Same day discharge protocol and guidelines are currently being improved to align with regional working group CCH is involved in.

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

Indicator: Cases Completed within Target Wait Time - Knee Replacement

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

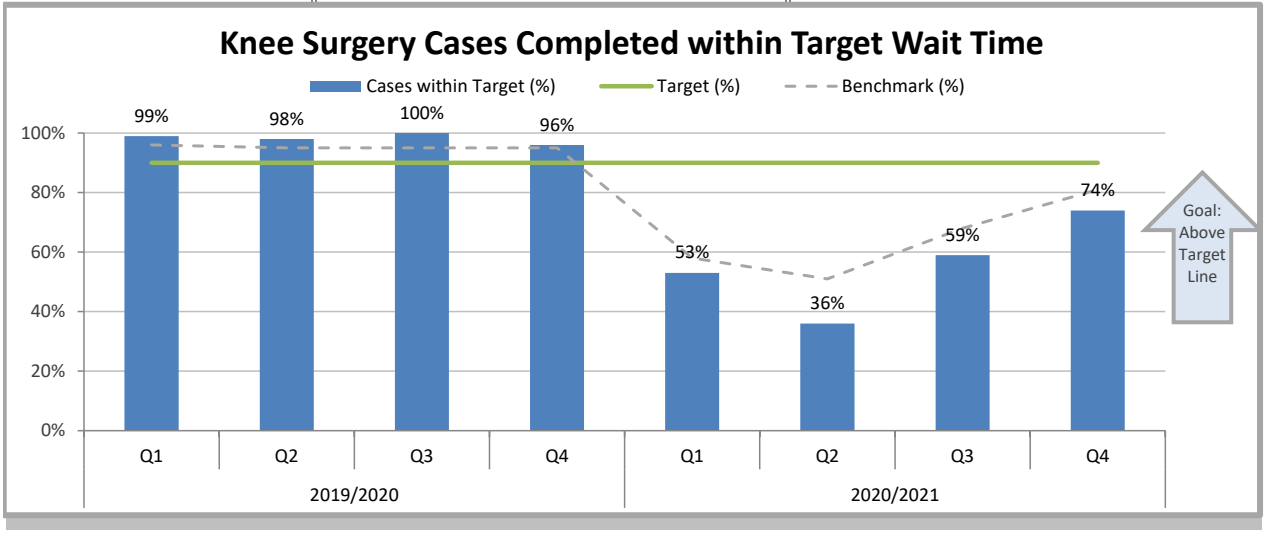
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. It will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	99%	98%	100%	96%	53%	36%	59%	74%
Benchmark (%)	96%	95%	95%	95%	58%	51%	68%	81%
Target (%)	90%	90%	90%	90%	90%	90%	90%	90%



Performance Analysis:

Q1 Target not met. Q1 Level P4 at 67% and no surgeries at level P2 and P3. With surgeries being kept at a minimum due to Covid during most of Q1, the results are to be expected.

Q2 Target not met. Q2 level P4 at 40%, level P3 at 16% and level P2 at 75%.

Q3 Target not met; however, Q3 had significant increases in levels P3 and P4. Q3 level P4 at 61%, level P3 at 31% and level P2 at 80%.

Q4 Target not met, however, Q4 had significant increase of 15% overall compared to Q3. Q4 level P4 at 72%, level P3 at 88% and level P2 at 100%.

Plans for Improvement:

Q1 Same plan as identified for hip replacement surgeries: Orthopedic elective surgeries have gradually resumed at the end of Q1 (mid-June). The number of booked OR theatres have increased from 2-3 OR theatres during the summer months, up to 4 OR theatres in operations the week of September 8th. A progressive improvement should be noted in Q2 and Q3. There is ongoing monitoring of Wait Times.

Q2 The Q2 knee wait time targets were not met related to COVID. Because of the shutting down of some surgical services, patients who, at the start of COVID, were classified as Priority 4 , were later classified as P3 (56-112 days) to match the patients clinical presentation (pain, mobility etc.). Their clinical picture, unsurprisingly, worsened with the wait. This was a regional approach to identify and change the priority for those patients within p4 that need to have a sooner surgical date. ORs are now open and improvements are anticipated in Q3.

Q3 61% improvement as OR block time/access increased to 4 rooms. Elective total joint cases booked during the weekends and closure to help minimize 2 week closure at Christmas. As of first week of January and until tentative date of March 2, SDA volume was decreased by 2/3 making joint volume access to the OR difficult when higher priority off service cases required SDA beds. Same day discharge total joints will help maintain some completed volume in Q4.

Q4 Same day admits were cancelled during Q4 due to hospital capacity needs during the 2nd wave and patients that fit same day discharge were booked to attempt to meet target but the numbers of those patients was limited. This decreased the volume that could have been completed. Same day discharge protocol and guidelines are currently being improved to align with the regional working group.

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: Partnering for Patient Safety and Quality Outcomes

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

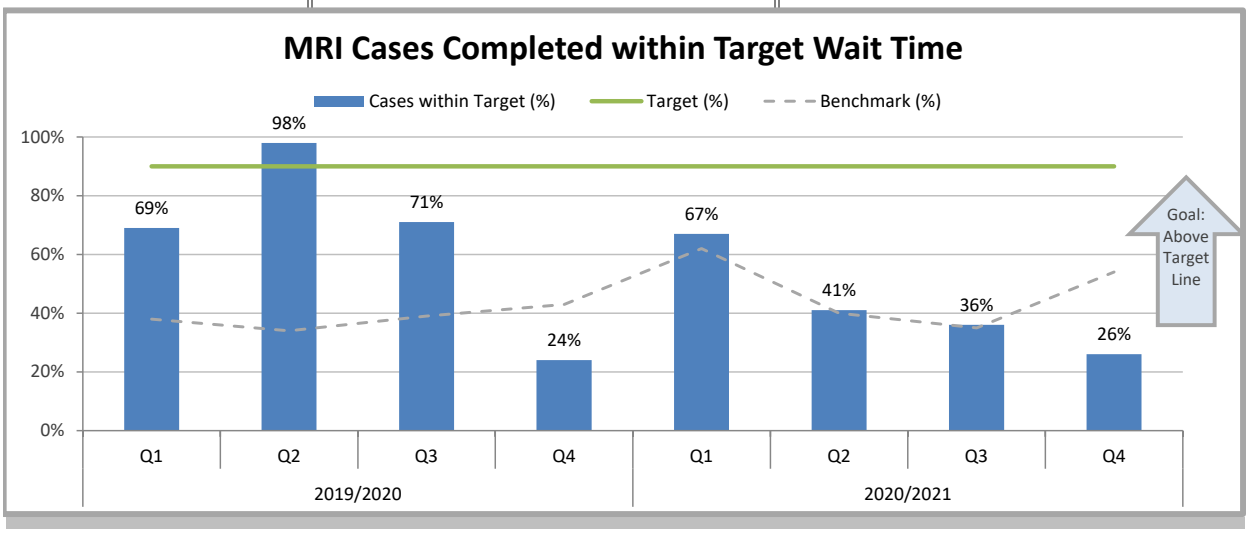
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target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

Data Source: WTIS iPort Access

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

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	69%	98%	71%	24%	67%	41%	36%	26%
Benchmark (%)	38%	34%	39%	43%	62%	40%	35%	54%
Target (%)	90%	90%	90%	90%	90%	90%	90%	90%



Performance Analysis:

Q1 Target not met. When reviewing each priority level separately, priority level 4 shows to be the main culprit showing results of 49% compared to priority level 2 at 98% and level 3 at 95%.

Q2 Target not met. Once again, priority level 4 shows to be the main culprit with results of 21% compared to priority level 2 at 100% and level 3 at 92%. Level P4 has decreased significantly for Q2.

Q3 Target not met. Once again, priority level 4 shows to be the main culprit with results of 20% compared to priority level 2 at 100% and level 3 at 98%. CCH target Q3 results are comparable to the Champlain LHIN Q3 results.

Q4 Target not met. Once again, priority level 4 shows to be the main culprit with results of 15% compared to priority level 2 at 97% and level 3 at 96%.

Plans for Improvement:

Q1 MRI was closed to all non-essential exams as directed by the Province. Any patient whose outcome would not be negatively impacted by a delay of 6-8 weeks was put "on hold" during the peak Covid period. Resumption of services commenced June 8 and highest priority was given to P1-2-3 followed by any P4 we could accommodate.

Q2 With the June resumption of services, MRI had a backlog of 2485 patients waiting. With an average monthly intake of 840 referrals, the operational day was stretched from 0730-2200 hrs to make all attempts to provide access as quickly as possible and improve the wait time. CCH is out performing all regional partners however recovery of wait time remains a challenge coupled with ongoing recruitment struggles. There are currently 96 vacant MRI positions in Ontario therefore competition is steep.

Q3 Recruitment was successful mid-December for an additional full time technologist. There remains one full time vacancy which is negatively impacting the wait time, however improvement has been noted for P4 (routine studies). Wait time has reduced from 9 months to approximately 5.5 months with only 1250 referrals pending from 2485 in June.

Q4 Demand continues to increase again in direct relation to staff resources. Q3 recruitment was not successful leaving two full time vacancies and one temp full time vacancy. (Employee out of country followed by mandatory quarantine). Recruitment of a new grad starting mid Q1 (21-22) post certification results and a LOA employee's return to work beginning of Q2 (21-22) will help rectify wait times once orientation and re-orientation are complete. Full staffing will be sufficient to produce desired performance results.

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

Return to Dashboard

Indicator: Current Ratio

Strategic Direction: Operational Excellence Through Innovation

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

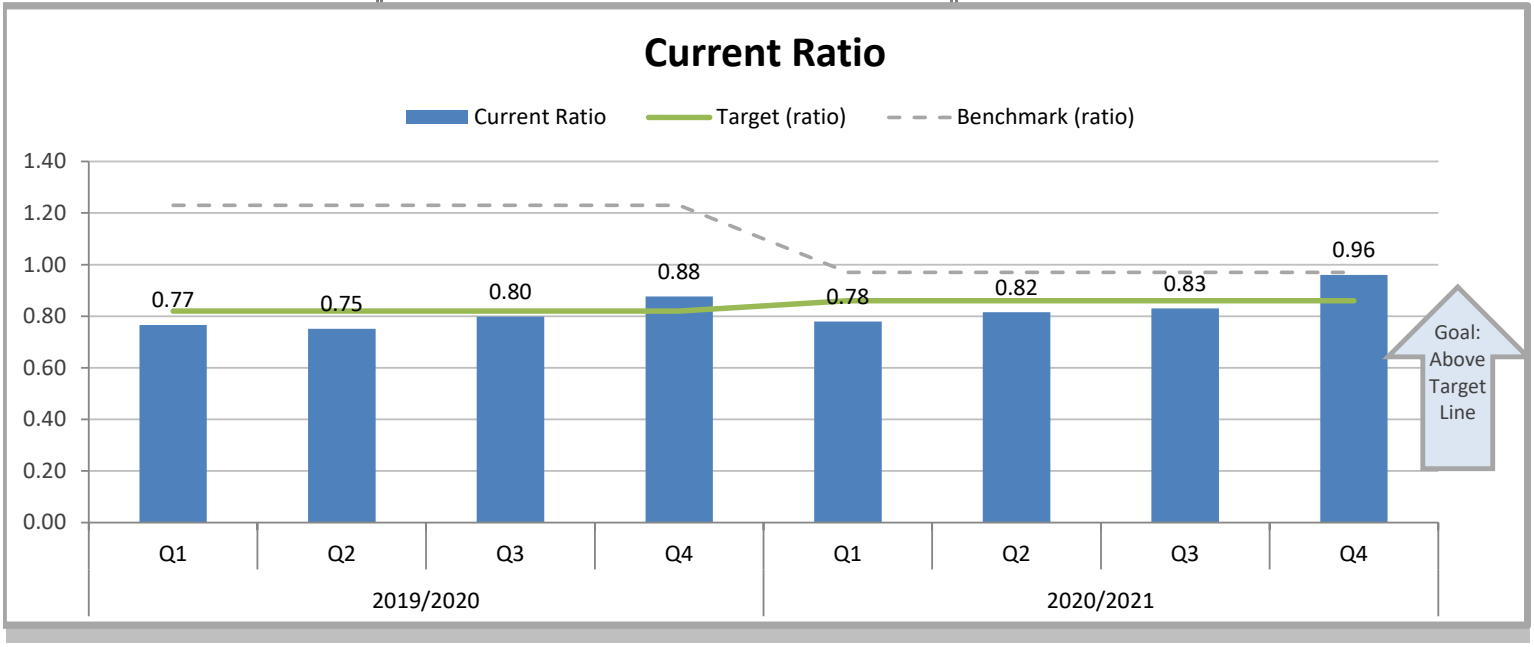
Significance: Indicates the overall financial health of the organization.

Data Source: Monthly Financial Statements - Balance Sheet

Target Information: Set according to HSAA obligations

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Current Ratio	0.77	0.75	0.80	0.88	0.78	0.82	0.83	0.96
Benchmark (ratio)	1.23	1.23	1.23	1.23	0.97	0.97	0.97	0.97
Target (ratio)	0.82	0.82	0.82	0.82	0.86	0.86	0.86	0.86



Performance Analysis:

Q1 Current Ratio is less than target due to the impact of the pandemic on revenues.

Q2 Current Ratio is less than target due to the impact of the pandemic on revenues.

Q3 Current Ratio is less than target due to the impact of the pandemic on revenues.

Q4 Current Ratio exceeds target due to the additional revenue received to cover lost revenues and working capital deficit.

Plans for Improvement:

Q1 The hospital is actively working with the region to advocate to the Ministry to fund lost revenue due to pandemic restrictions.

Q2 The hospital continues to work with the region to mitigate the effect of lost revenues due to pandemic restrictions.

Q3 The hospital continues to work with the region to mitigate the effect of lost revenues due to pandemic restrictions.

Q4 The hospital was successful in receiving support to cover lost revenues due to pandemic restrictions.

Accountable: Chief Financial Officer / Manager, Financial Services

Return to Dashboard

Indicator: Overtime Rate

Strategic Direction: Operational Excellence Through Innovation

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

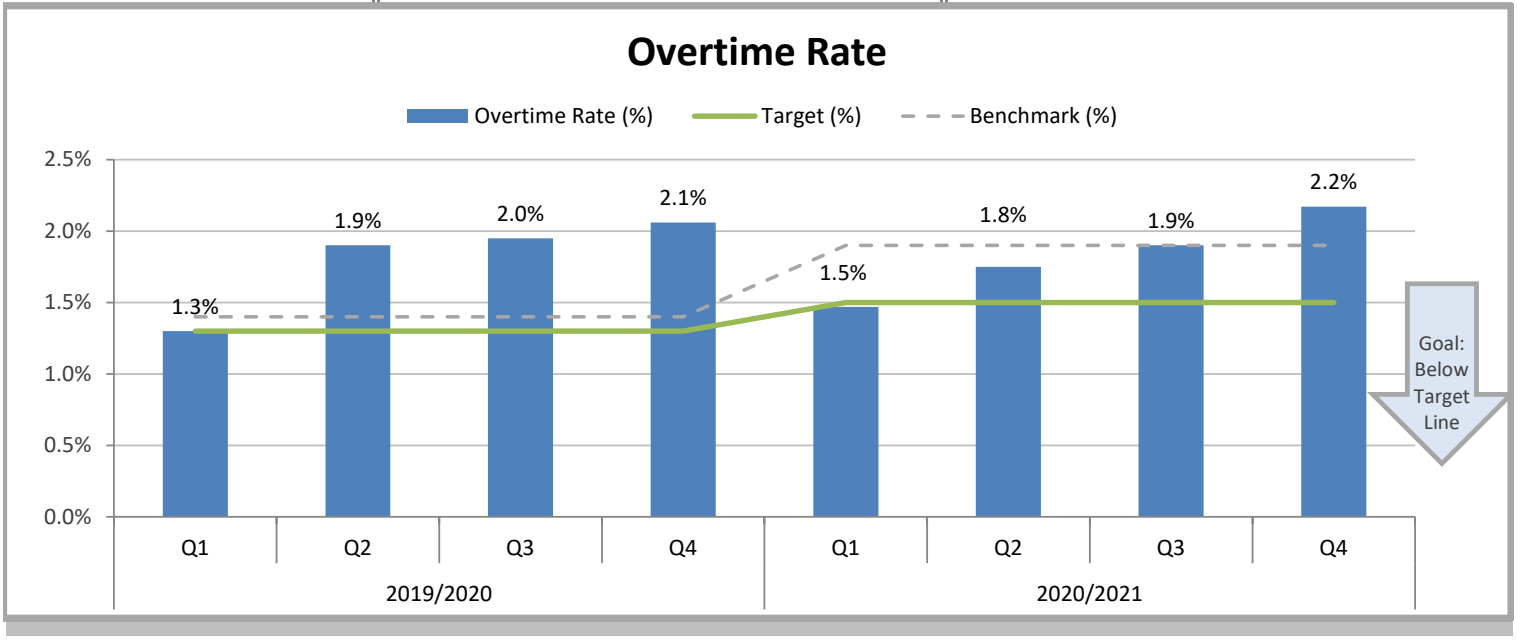
Significance: To control healthcare costs it is essential to analyze and improve staffing, the largest organizational expense, by improving utilization of human resources. Consideration of other factors is recommended, including staff turnover rates, productivity and efficiency, staff competency and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

Data Source: Virtuo MIS - General Ledger

Target Information: Set according to HSAA obligations

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overtime Rate (%)	1.3%	1.9%	2.0%	2.1%	1.5%	1.8%	1.9%	2.2%
Benchmark (%)	1.4%	1.4%	1.4%	1.4%	1.9%	1.9%	1.9%	1.9%
Target (%)	1.3%	1.3%	1.3%	1.3%	1.5%	1.5%	1.5%	1.5%



Performance Analysis:

Q1 Target met.

Q2 Target not met.

Q3 Target not met, due to demands of pandemic.

Q4 Target not met, due to demands of pandemic.

Plans for Improvement:

Q1 Continue current processes to ensure target maintained.

Q2 Continue to monitor and explore alternate staffing complements.

Q3 Ongoing recruitment as well as review of staffing complements across the organization to better manage day to day fluctuations.

Q4 Ongoing recruitment as well as review of staffing complements across the organization to better manage day in the upcoming fiscal year.

Accountable: Chief Financial Officer / Manager, Financial Services

Return to Dashboard

Indicator: Total Margin

Strategic Direction: Operational Excellence Through Innovation

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.

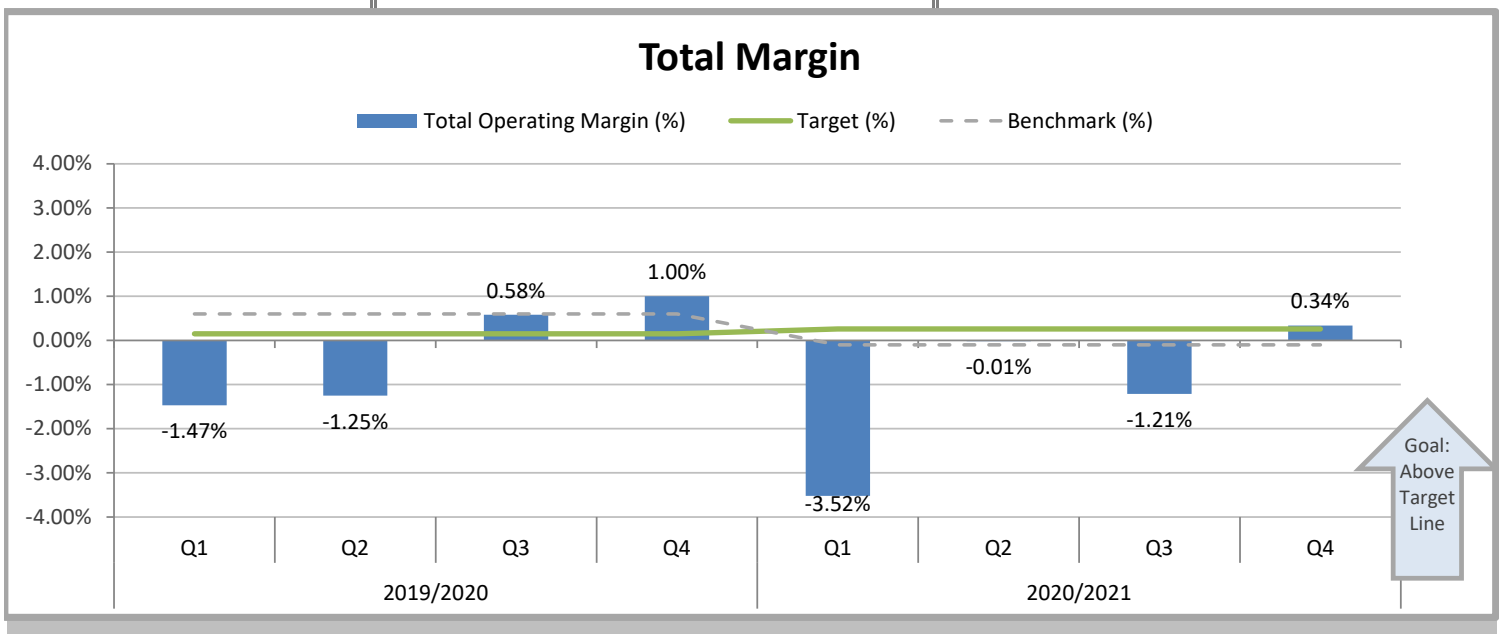
Significance: Indicates a balanced operating position.

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

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total Operating Margin (%)	-1.47%	-1.25%	0.58%	1.00%	-3.52%	-0.01%	-1.21%	0.34%
Benchmark (%)	0.60%	0.60%	0.60%	0.60%	-0.10%	-0.10%	-0.10%	-0.10%
Target (%)	0.15%	0.15%	0.15%	0.15%	0.26%	0.26%	0.26%	0.26%



Performance Analysis:

Q1 Target not met as a result of lost revenue due and increased expenses due to pandemic.

Q2 Target not met, but improved due to resumption of some elective procedures and Ministry support to cover incremental expenses related to the pandemic.

Q3 Target not met as a result of further lost revenues related to volume based activities due to pandemic restrictions.

Q4 Target met, as a result of funding received towards lost revenues.

Plans for Improvement:

Q1 The hospital is actively working with the region to advocate to the Ministry to fund lost revenue due to pandemic restrictions.

Q2 The hospital continues to work with the region to mitigate the effect of lost revenues in the first quarter of the year due to the pandemic restrictions.

Q3 The hospital continues to work with the region to mitigate the effect of lost revenues in the first quarter of the year due to the pandemic restrictions. In addition, the region is also advocating to waive the reconciliation process of volume based funding for 2020-21.

Q4 No further action is required at this time.

Accountable: Chief Financial Officer / Manager, Financial Services

Return to Dashboard

Indicator: Absenteeism

Strategic Direction: Our Team Our Strength

Definition: Average Annual Paid sick Days per Full Time Employee. Calculation: Total Paid Full Time Sick hours / Total Full Time Head Count / days in period * 365 / 7.5 hours. Performance is reported cumulatively on a year-to-date basis.

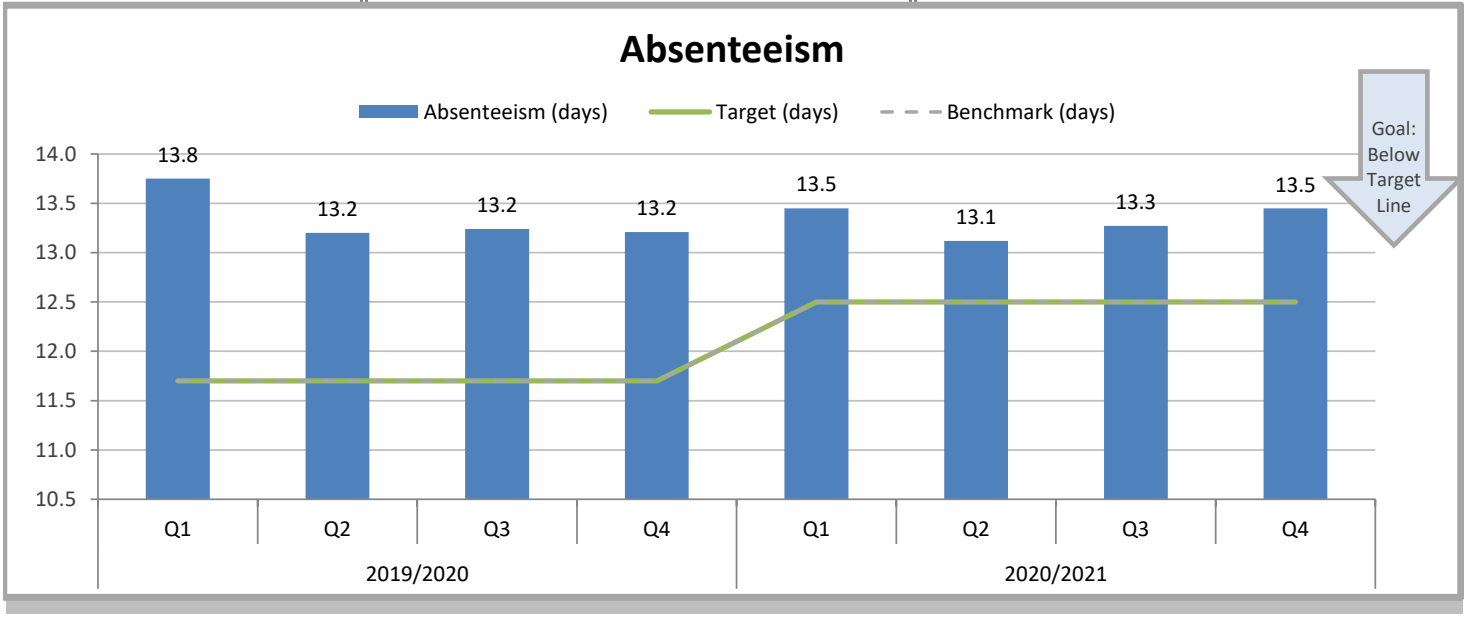
Significance: Absenteeism is a major concern in the health sector. Healthcare workers are absent from work as a result of illness or disability more than any other type of worker in Canada.

Data Source: Virtuo MIS - General Ledger

Target Information: Target is set to align with prior year OHA (Ontario Hospital Association) Benchmark Ontario hospital average median performance

Benchmark Information: Benchmark performance is based on OHA HR Benchmark Report - 2019 Ontario hospital average median performance

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Absenteeism (days)	13.8	13.2	13.2	13.2	13.5	13.1	13.3	13.5
Benchmark (days)	11.7	11.7	11.7	11.7	12.5	12.5	12.5	12.5
Target (days)	11.7	11.7	11.7	11.7	12.5	12.5	12.5	12.5



Performance Analysis:

Q1 Absenteeism above target.

Q2 Absenteeism above target.

Q3 Absenteeism above target.

Q4 Absenteeism above target.

Plans for Improvement:

Q1 Good work done during Q1 in regards to high volume of pandemic-related sick leaves and accommodations. Continue with targeted improvement strategies.

Q2 Decrease quarter over quarter during the pandemic is a good result despite pandemic-related sick leaves and accommodations. Continue with current strategies.

Q3 Continue with current strategies, ensuring staff wear appropriate PPE and follow all infection control practices to minimize pandemic-related sick leave.

Q4 Continue with current strategies.

Accountable: Chief Privacy and Human Resources Officer / Chief Financial Officer

Return to Dashboard

Indicator: Indigenous Cultural Awareness

Strategic Direction: Our Team Our Strength

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

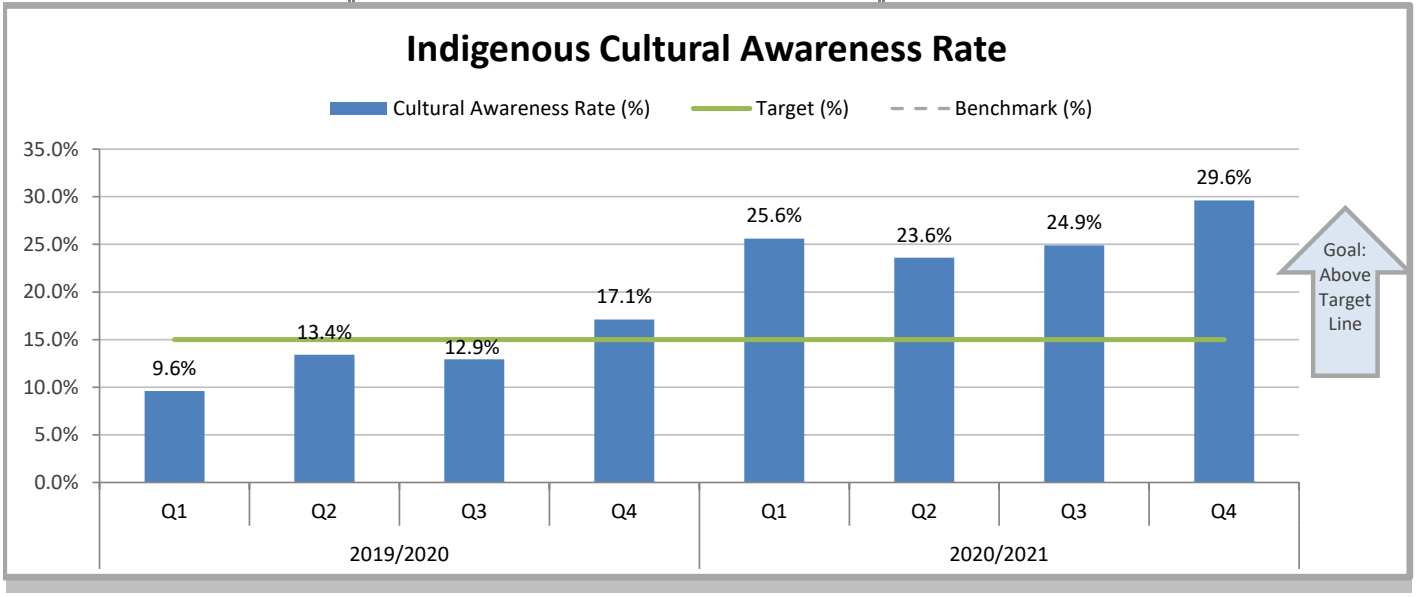
Significance: As part of our CCH Strategic Plan for 2016-2021, it identifies that CCH will partner with experts and our peers to foster a climate of culture competency. We will increase access to training with a focus on frontline staff, create a policy on smudging and plan to do at least one smudging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

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

Target Information: Target is set at 15.0% in accordance to HSAA Obligation

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cultural Awareness Rate (%)	9.6%	13.4%	12.9%	17.1%	25.6%	23.6%	24.9%	29.6%
Benchmark (%)								
Target (%)	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%



Performance Analysis:

Q1 Target met with great improvement over FY1920.

Q2 Target met.

Q3 Target met.

Q4 Target met.

Plans for Improvement:

Q1 Continue with orientation training and identifying additional opportunities to seek more in-depth training or education.

Q2 Continue with current strategy.

Q3 Continue with current strategy.

Q4 Continue with current strategy.

Accountable: Chief Privacy and Human Resources Officer / Manager, Human Resources

Return to Dashboard

Indicator: Workplace Violence Prevention - Incidents Reported

Strategic Direction: Our Team Our Strength

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

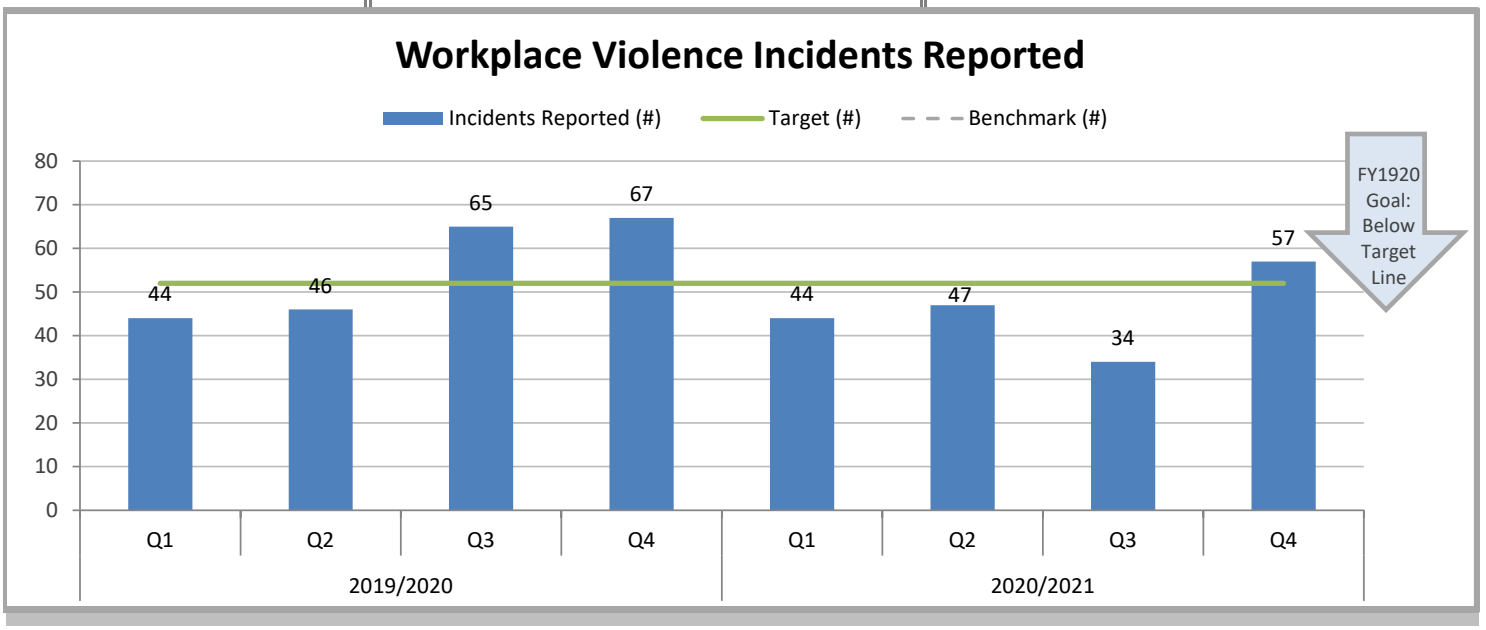
Significance: Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Violence in the workplace is an increasingly serious occupational hazard. Like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

Data Source: RL Solution -Incident Management System

Target Information: Target is set internally at 52 per quarter (total of 210 annually) in accordance to QIP indicator.

Benchmark Information: N/A

	2019/2020				2020/2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incidents Reported (#)	44	46	65	67	44	47	34	57
Benchmark (#)								
Target (#)	52	52	52	52	52	52	52	52



Performance Analysis:

Q1 Target met.

Q2 Target met.

Q3 Target met. Unclear at this point if downtrend is due to lack of reporting of incidents.

Q4 Target not met.

Plans for Improvement:

Q1 Continue with encouraging reporting of incidents by staff and improvement strategies through the Joint Health and Safety Committee.

Q2 Continue with current strategy.

Q3 Continue with current strategy. Emphasize importance of reporting of incidents.

Q4 Continue with current strategy.

Accountable: Chief Privacy and Human Resources Officer / Manager, Human Resources

Return to Dashboard